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THE AWARE CONSUMER

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RESEARCH FEATURE
NCD: March Of The Silent Killer

UNIVERSAL HEALTH COVERAGE

THE LAST MILE
ASHA – Ray Of Hope

IN FOCUS
Time To Relook At Our Consumption Habits

प्रधानमंत्री जन आरोग्य योजना
आयुष्मान भारत
PM-JAY

Ayushman Bharat – Pradhan Mantri-Jan Arogya Yojana (PM-JAY)

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VIEWPOINT

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Time To Prioritize Universal Health Coverage

THE WORLD BANK Group holds universal health coverage (UHC) as the key to achieving its twin goals of ending extreme poverty and increasing equity and shared prosperity. It says UHC is about "ensuring that people have access to the healthcare they need without suffering financial hardship" and has made it the "driving force behind all of the WBG's health and nutrition investments". The Covid-19 pandemic proved that economies that had pushed UHC to the peripheries of their economic policy framework are suffering the most. A health crisis of this scale had not been anticipated and left governments scrambling to provide some kind of protective cover to their citizens. While overwhelmed health systems told a sorry tale of decades of neglect and policy myopia, the governments were left clutching at straws. The sufferers are the usual suspects – the citizens.

If you think this tragedy and travesty of consumer rights only happened in emerging economies, you are far off the mark. The much-touted health systems of the most advanced countries were also exposed. Reports came in of hospitals having to select the patients they would admit with health infrastructure stretched to the seams. Despite rapid advances in medical technology, not only is there no cure to coronavirus as yet, there is also no way to manage the burgeoning sick population. All the while, other medical needs of the citizens have taken a backseat and it is being feared that soon we may have a surge of fatalities unrelated to the virus.

What went wrong? At the outset, it is not our handling of the pandemic. Governments did what they could do best in the circumstances. The lockdowns were a means to check the spread. It succeeded in some places while failed in others. Sadly, all our responses were, as usual, a reaction to a disease outbreak and aimed at disease control. We built our response on a weak foundation. If we had mounted our offensive on a health system that attacked the root of diseases with a robust infrastructure of primary healthcare, preventive care and immunity building, perhaps the shape that the pandemic took would be different. Our over dependence on private health providers added to the mess.

Time, we prioritized UHC program to strengthen our nation's immune response.

If we had mounted our offensive on a health system that attacked the root of diseases with a robust infrastructure of primary healthcare, preventive care and immunity building, perhaps the shape that the pandemic took would be different.

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Message from the Editor-in-Chief

POOJA KHAITAN
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DESKTALK

Protecting Citizens' Fundamental Right

HEALTH AND THE health of an economy are inextricably linked. How a country's healthcare fares, is strongly dependent on how developed an economy is but it is also dependent on what kind of health systems that a country has established. For instance, a healthcare system largely dependent on private sector will not be just or equitable as only those will be able to access crucial health interventions who can pay for it. A commercialized healthcare system means high out of pocket expenses for the consumers and it also indicates the absence of adequate public healthcare infrastructure and the lack of quality of the existing one.

For governments, healthcare poses considerable challenges. It is difficult to maintain financial viability of state healthcare systems while also being a positive contributor to a country's microeconomic performance. It is a challenge to establish a quality healthcare system that provides universal health coverage while also being profitable. Yet, governments must invest in healthcare if they want to perform well on economic indicators. Wealthy countries have healthier population in comparison to poorer nations. In fact, infant mortality and life expectancy are a measure of the economic performance of a country. It's a unique riddle. You need to invest in health to improve economically and invest in economy to improve health.

However, leaving health in the hands of private sector is not the answer. Governments must establish robust healthcare systems that cover the entire population and are particularly oriented to protect the poor from catastrophic health shocks. Healthcare is expensive and it pushes the marginalized communities further into the vicious cycle of debt and poverty. Worse still, it prevents the poor from seeking healthcare.

India has already set in motion its universal health coverage program. It now must urgently build on it to expand the health coverage to cover the entire population. It is time we moved away from healthcare as a response to disease to healthcare as a fundamental right of the citizens.

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Scientist are pointing to the human interference in wildlife as the primary cause of epidemics and warn that this must stop if we do not want reruns of pandemic in the future.

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ROUNDUP

DR HARSH VARDHAN
UNION MINISTER OF HEALTH & FAMILY WELFARE, GOVT OF INDIA,
AT THE INTERNATIONAL UNIVERSAL HEALTH COVERAGE (UHC) DAY 2019 EVENT

"Concerted actions by coming together of varied stakeholders is must and for that the government departments at all levels, along with non-state actors and organizations must engage in a constructive, smart and intelligent manner, to accelerate towards UHC. Health is a multi-sectoral, multi-dimensional and complex sector; and achieving the agenda of 'Health for all' requires the buy-in of all the key stakeholders"

IMAGE: PIB

Universal Health Coverage:

Investing In Our Future

We need to move away from viewing universal health coverage as a benefit for the poor and recognize it as an investment in our collective future.

DATA BRIEFING

55%

– Disease burden from non-communicable diseases increased from 30 per cent to 55 per cent between 1990 and 2016.

COVID-19 HAS PROVED once and for all that your social and economic standing is a strong predictor of whether you will live or die of coronavirus. Even in wealthier countries it is the poorer sections who are bearing the brunt of the pandemic. For example, it's taking a deadly toll on black Americans. The reasons are not far to seek. As per various reports, minorities in the US are more vulnerable to COVID-19 because of the long history of health and socio-economic disparities.

The pattern of outbreak has made it evident that it is the vulnerable groups in poor countries that are at the greatest risk. The burden of existing illnesses on the poor in developing countries is much higher compared to their better off counterpart. Living in abject poverty they are malnourished, lack immunity, access to healthcare, are uneducated, and lack even the basic understanding of the importance of hygiene and do not have the means to it. The internal migrants live in slums packed like sardines. It is impossible for such people to observe social distancing, sanitize or constantly wash hands, when water is a luxury.

According to a UNAIDS report, around 50 percent of the world's people are denied essential healthcare even in normal times. The disparity between rich countries and the poor ones is stark. For instance, while Italy has one doctor for every 243 people; Zambia has one doctor for every 10,000 people; and India has one doctor for every 1,457 people as per the country's current population estimate of 1.35 billion, which is lower than the World Health Organisation norm of 1:1000. Mali has three ventilators per million people. According to a study by The Center For Disease Dynamics, Economics & Policy, India had 48,000 ventilators as of April. Average health spending in low-income countries is only $41 per person a year, 70 times less than high-income countries, says the UNAIDS report.

Primary healthcare that “ensures people receive comprehensive care — ranging from promotion and prevention to treatment, rehabilitation, and palliative care — as close as feasible to people's everyday environment”, according to the World Health organization; has had to bear the brunt of COVID-19. With healthcare facilities overwhelmed with coronavirus cases and government advisories asking people to stay at home to avoid the infection, many have been denied essential healthcare. From pregnant women to the elderly, those requiring dialysis to blood transfusion, stroke care to diabetes care, all kinds of patients are being denied critical care as hospitals are pressured by the pandemic. Many are not visiting doctors or hospitals for the fear of contagion. Cases are being reported where patients visiting for one ailment return with coronavirus infection, especially the elderly with comorbidities visiting for dialysis or diabetic care or some such ailment are becoming infected and succumbing.

India's case is further compounded by its historical neglect of public healthcare. In fact, it has for the last 73 years under-invested in its healthcare sector. With a large part of the population denied healthcare, it is obviously ill-equipped and under-prepared to face the pandemic. India ranked 57 out of 195 in the Global Health Security Index 2019. The index measures countries' preparedness for outbreak of infectious diseases. Though overall with stringent lockdowns India managed to avert a head-on crisis, the relaxations and reverse migration are now proving to be its undoing.

IMAGE: UNSPLASH

Health for all – investing in India's prosperity.

India's vulnerable position was exposed in the pandemic and it is clear that it must fast-track its healthcare reforms and accelerate investment in the sector.

In responding to a health crisis, many governments have been able to turn the country's health sector around. For example, as UNAIDS highlights in the post-Second World War, health systems across Europe and in Japan were overhauled and Thailand established its universal healthcare while responding to AIDS and the financial crisis. India too has responded to the crisis on a war footing and the number of people availing its Universal Health Coverage Ayushman Bharat scheme crossed the one crore-mark during the pandemic in May. Launched in September 2018, the Pradhan Mantri Jan Arogya Yojana-Ayushman Bharat is billed as the biggest government-sponsored healthcare scheme in the world. It remains to be seen how the government seizes the opportunity presented by the pandemic to build the health system and strengthen the schemes.

Universal healthcare

The high cost of treatment of coronavirus has shown to the world how inadequate private healthcare systems can be in a health crisis. Motivated by profit, the private healthcare system caters to only those who can afford it. However, this pandemic, even those with deep pockets had to seek public healthcare to survive. One's health should not have to be dependent on how much they can pay. The crisis that is ravaging economies has underlined the need to end the need for a the sick to pay for healthcare, especially the poor.

A blog post on the World Bank website states that health systems and UHC are what will make the difference to each country's response to COVID-19, precisely because it will determine if only a few receive treatment, and care or all do. It is the fundamental premise of UHC to ensure health for all without causing financial hardship so that everybody without discrimination will receive care wherever they are.

Not only free healthcare is essential to tackle a health crisis; it has been found that more people seek health intervention when they do not have to pay for it. UNAIDS cites the example of Democratic Republic of the Congo which had instituted free healthcare in 2018 to fight Ebola. This led to improvement in healthcare utilization across the board. Visits to healthcare centres for pneumonia and diarrhoea more than doubled and there was a 20%–50% increase in women giving birth at a clinic. However, all these gains were lost once free healthcare was withdrawn.

Advocates of UHC claim that universal health coverage and the capacity to address health crisis are interconnected. As cases explode in India, the neglect of the public healthcare system over the decades is haunting the authorities. The government has set the target of increasing healthcare spending to 2.5 percent of the GDP by 2025, which as of now is just 1 percent. Notably, the government raised the healthcare spend by 6 percent early this year. India however has utilized the lockdown to ramp up its healthcare infrastructure.

While Italy has one doctor for every 243 people; Zambia has one doctor for every 10,000 people; and India has one doctor for every 1,457 people as per the country's current population estimate of 1.35 billion, which is lower than the World Health Organisation norm of 1:1000.

Reports say that free healthcare may also help prevent about100 million people being driven into extreme poverty by the cost of healthcare every year. As per a 2018 study published in the Lancet, around 122 Indians per 100,000 die due to poor quality of care each year. India's death rate due to poor care quality was ranked worse than that of Brazil (74), Russia (91), China (46) and South Africa (93), Pakistan (119), Nepal (93), Bangladesh (57) and Sri Lanka (51). A 2018 Mint analysis of data from the last National Sample Survey Office health survey conducted in 2013-14 showed that 36 million households incurred health expenses that exceeded the annual per capita consumption of those households. The fact that rural India accounted for 25 million of the 36 million households that faced catastrophic health shocks, while urban India accounted for the remaining 11 million, tells a shocking story of neglect.

The current pandemic has taught us that no country can remain insulated from the next one too. Looking at the inevitability of future pandemics, every government must ensure a strong universal health system. Publicly funded, cutting-edge medicines and healthcare must be delivered to everyone no matter where they live.

Financing our health

Universal health coverage requires huge funding. It must be acknowledged now that universal healthcare is a global public good and investments must come forth from all sources. UNAIDS calls for stepping up support to developing countries to help them through the crisis. According to it, approximately $159 billion would be needed to double the public health spending of the world's 85 poorest countries, home to 3.7 billion people.

Business leadership

The pandemic has drawn out the need for a different kind of business leadership, one that acknowledges its role in public health and its dependence on healthy societies. We need business leaders who can establish a balance between market and state. An important lesson from the crisis is that certain goods and services should be above the rules of the market – healthcare being one of them. The rapid privatization of healthcare, its commercialization and financialization across the globe has revealed the virus of inequality.

The only way that we can fight this growing disparity is with responsible business leaders at the helm supporting fair taxation and shunning exemptions and subsidies, shutting tax havens and not exploiting tax loopholes. In short, they need to pay taxes conscientiously.

Private monopolies in health sector must be diluted and intellectual property right that leads to expensive drugs must be relaxed to allow medicines to reach a vast majority. To make essential health treatments available for all, we must prioritize collective health over private profit.

Leadership is the crux to ensuring universal health coverage across the globe. Leaders must be able to reshape global cooperation and work towards an inclusive and just multilateralism where countries across the world pursue the goal of universal health coverage.

No one can win this battle alone

As a footnote, COVID-19 pandemic has done a service in a cruel sort of way. While exacerbating inequalities it has also forced us to acknowledge and accept that inequalities exist, and we must work towards a more equitable and just society because our lives are intertwined.

Only when we learn to value all lives equally can we overcome the existential threat that pandemics pose. We can begin this by first recognizing that universal healthcare is not a gift from the rich to the poor. Rather, it a universal right and an investment that we jointly make in securing our future.

Source: Secondary research & media reports

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Consumers, Beware

WHEN YOUR DOCTOR IS A FRAUD

Medical frauds take many shapes but a common one is charlatans posing as qualified doctors to fleece the poor especially in the rural areas.

IMAGE: PIXABAY

Beware of quacks and doctors prescribing unnecessary medical procedures or tests.

CONSIDER THIS SCENARIO: A quack or a fake doctor in the process of treating poor villagers for common cold, cough and diarrhoea, infects at least 21 of them with HIV. How did this happen? He used contaminated syringes and needles. This story is not fabricated. According to reports, the incident came to light in a village in Uttar Pradesh in 2018 when the health department launched an investigation following a high number of HIV cases being reported. The officials held three screening camps in which 21 out of the 566 people checked were found to be HIV positive.

The investigations led to country quack on whom the villagers relied for treatment. The villagers told the officials that this 'doctor' would give injections for almost all ailments and they rarely saw him changing the needle.

The case however is not an isolated one. In the villages of India, millions depend on such quacks for their health. The reason is not always absence of or lack of access to a primary healthcare centre. It rather because of the mindset, ignorance, trust issues and the fact that treatment provided by these fake doctors comes at a fraction of the cost of hospital treatment.

Medical fraud can have lasting and irreparable repercussions. There have been reports of patients being left blind or losing a limb or an organ due to these malpractices. These so-called treatments not only end up aggravating the existing malaise but can also give new ones in the process or lead to loss of life. That is why medical frauds are way more serious and reprehensible than other kinds of malpractices. The lax regulations allow these fraudsters to flourish despite their being unqualified, lacking basic medical training, or found unfit to serve in any medical facility. Some get medical certificates from institutes of dubious distinction and set up practices in rural interiors to mint money without regard that their actions can have lasting consequences sometimes even fatal.

A World Health Organization report on India's healthcare system paints a grim picture. It says that of all the allopathic doctors, around 31.4% claiming to be qualified doctors are actually educated only up to a secondary level. A shocking 57.3% do not possess any medical degree.

Dentistry is even worse off with a mushrooming of private colleges that are producing all kinds of quacks, The WHO report found 46.2% of all urban and just 27.4 of all rural dentists possessed the minimum legal qualification to practice their profession.

These numbers are revealing and at the same time just the tip of the iceberg. It is indeed scary that a big portion of medical practitioners in the country are playing with the lives and well-being of the citizens. In the process, they are also negatively impacting the integrity of the medical profession and eroding trust in it.

IMAGE: PIXABAY

IMAGE: UNSPLASH

This fancy clinic could leave you with a bigger pain than your infected root canal.

Healthcare frauds – the works

Medical frauds are attractive as there is a lot of quick money to be made. Also, the masses are ill-educated, lack awareness and are poor, which makes the low-priced treatment promises by quacks attractive. There is a lot of scope for obfuscation in diagnosis, treatment and billing. Patients are billed for higher medical treatment than that actually provided, prescribe investigations that make no sense and are not relevant or required for the disease, and incorrect diagnoses that go unnoticed in all the paperwork, illegible writing and ambiguity. It is not easy to establish prescription for unnecessary or additional treatments. Also, doctors receive substantial kickbacks for referrals to diagnostics and chemists or for describing certain brand drugs. Prescriptions can be forged for selling prescription drugs as well. Hence the scope of medical fraud encompasses almost anyone. It can be the patients, suppliers, vendors, providers as well as pharmacists.

Common Types of Medicare Frauds

Here are some of the most common medical frauds that are flourishing.

Upcoding: This is big medical fraud where patients are billed for expensive treatments or diagnosis that was not even provided.

Misrepresentation of treatments: This involves misrepresenting treatments that are not even covered or are unnecessary in the course of the treatment. ?obtain the payments from insurance claims. Such frauds are can be in connivance with the patient enabling them to claim insurance for a procedure that was not covered as the treatment actually done may not come under the insurance scheme.

Unbundling: To pull this fraud, hospitals will bill the patient for every step of the procedure treating each as a separate treatment.

Unnecessary procedures: Under this,medically unnecessary procedures are performed with the purpose of claiming insurance payments.

Medical identity thefts: This is a serious fraud with huge financial implications for both the patient and the insurer.The modus operandi involves stealing the medical identity of a person without their consent or knowledge for treatment or for submitting false insurance claims.

Can healthcare frauds be prevented?

Yes, it can.Consumer awareness is the key to preventing medical scams. On the government side, we need to establish a database of verified medical practitioners and making this repository publicly available through technological means. All healthcare practitioners in rural areas or practicing privately should be listed with the primary healthcare facility in the area and their names displayed prominently for the people. All doctors should also prominently display their registration numbers and other bonafides at the entrance of their private practices. Medical workers' degrees and certificates must be authenticated at source that cross verified with the institution from which it has been issued, as also the doctors' residency details. Data of doctors found to be fake or disqualified should also be uploaded to warn patients.

IMAGE: PEXELS

Is this procedure really necessary?

Source: Secondary research & media reports

NCD

March Of The Silent Killer

IMAGE: PIXABAY

Cardiovascular diseases like heart attacks and stroke kill silently as they can go undetected for long.

Noncommunicable diseases (NCDs) have proven to be the Waterloo in COVID-19 epidemic. It is imperative that we work towards stopping the march of NCDs and conquer it by 2030 to safeguard the masses.

NONCOMMUNICABLE DISEASES (NCDs) account for 41 million deaths each year, that is 71% of all deaths globally. Of these, around 15 million are between the ages of 30 years and 69 years. Worse, over 85% of these "premature" deaths occur in low and middle-income countries, says WHO. Ironically, these deaths were just numbers till the pandemic happened and experts began talking of comorbidities.

The coronavirus fatalities have proved the deaths occurring due to the pandemic are not random. Though the elderly who have lived longer with NCDs are more vulnerable to NCDs, the young need to worry too, as NCDs strike young. In fact, as per WHO, cardiovascular diseases account for most NCD deaths, or 17.9 million people annually, followed by cancers (9.0 million), respiratory diseases (3.9 million), and diabetes (1.6 million). Together, these 4 groups of diseases account for over 80% of all premature NCD deaths.

Now let us look at the figures for India published by the WHO. In 2016, 63% of all deaths in the country were due to NCDs. Of these 27% males and 20% females between the ages of 30 years and 70 years were at risk of premature deaths.

What are NCDs?

Cancer, diabetes, hypertension, obesity, heart and respiratory ailments, etc., are bracketed as non-communicable diseases (NCDs). Also known as chronic diseases, NCDs are with a patient for long, for many it is an entire lifetime spent struggling to manage and live with them. Generally, NCDs are the result of a combination of genetic, physiological, environmental and behavioural factors. According to WHO, tobacco users, physically inactive, alcoholics and those eating unhealthy diets are at a higher risk of dying from an NCD.

Chronic respiratory diseases are among the underlying causes of fatalities due to COVID-19.

Cardiovascular diseases (like heart attacks and stroke), cancers, chronic respiratory diseases (such as chronic obstructive pulmonary disease and asthma) and diabetes are the main NCDs.

It is these NCDs that are being labelled comorbidities or previously existing or underlying health conditions responsible for higher fatality due to COVID-19.

Who is at risk?

What evidence shows is that children, adults and the elderly are at risk of developing NCDs mostly due to risks arising from unhealthy diets, physical inactivity, exposure to tobacco smoke or the harmful use of alcohol.

IMAGE: PEXELS

It is not just the elderly who are at risk of getting non communicable diseases.

Health experts have been warning for long about the spread of NCDs and how it can impact countries. The developing countries or the poorer communities in developed countries are more susceptible to these diseases because of the medical costs associated with managing them. Since these are long term illnesses, often requiring lifelong medication and management, the poor cannot afford it. Unmanaged diseases have a high socio-economic cost and threaten not just individuals but communities and societies too.

The epidemic has served to underline why we should immediately focus attention on strengthening the public healthcare system to manage NCDs.It is tragic that years of neglect of public healthcare system have allowed NCDs to fester and have made the deprived sections susceptible to the virus. The economic and social inequality compounded by racial prejudices are manifesting in the higher fatalities amongst the poor and racial ethnicities, even in developed countries like the US and the UK.

True that NCDs cannot be directly attributed to socio-economic conditions. While a combination of genetic and physiological factors is responsible for these diseases, the poor communities are more vulnerable to it because the lifestyle choices that they make which are a result of the poverty and environmental factors. The marginalized communities live in squalid quarters of the city where there is crime and a predisposition to take to drugs,

IMAGE: PEXELS

The poor are more vulnerable to non-communicable diseases because of the lifestyle choices they are forced to make.

alcohol and tobacco abuse. Young children, especially in the slums, take to crime, drugs and alcohol at an early age. This combined with lack of healthy diet predisposes them to a variety of diseases and early death. Add to it the inability to afford healthcare and the absence of adequate and affordable public healthcare facilities for the poor. It was a recipe waiting for a disaster like COVID-19.

We also need to relook and reset our priorities. Rapid unplanned urbanization, unhealthy lifestyles and population aging, unhealthy food habits, lack of physical activity among others are driving NCDs. Raised blood pressure, increased blood glucose, elevated blood lipids and obesity, are all the result of our wrong choices. These metabolic risk factors are responsible for cardiovascular disease, which is the top NCD accounting for premature deaths.

NCDs treatment and care is expensive and of long duration. Starting with expensive clinical investigations, detection, treatment, palliative care to de-addiction, NCDs require a comprehensive response to control and cure. The long and expensive treatments push millions of the poor deeper into debt and poverty. Many give up on treatment as it becomes unaffordable. This problem can be tackled only if the poor have access to free universal health coverage.

What are the risk factors?

Modifiable risk factors

Despite the grim scenario, there is a silver lining – some behaviours that are modifiable can cut the risk of NCDs to a great extent. For example, giving up tobacco use, alcohol, adopting a healthy diet and becoming physically active can help in mitigating the predisposition to these diseases. Worldwide, according to WHO, annually 8 million die due to tobacco use. This includes more than 7 million who are smokers and 1.2 those exposed to second-hand smoke. In all, tobacco kills half of all the smokers.

IMAGE: PEXELS

Tobacco kills 8 million people globally each year.

IMAGE: PIXABAY

High salt consumption is linked to various non-communicable diseases.

According to an estimate, 2.5 million deaths can be prevented annually if salt consumption were reduced to the recommended level. WHO estimates 4.1 million annual deaths due to high intake of salt/sodium. High salt consumption and insufficient potassium intake are responsible for high blood pressure and increase the risk of heart disease and stroke. Reducing salt intake can lead to improved health of the population and is one of the most cost-effective measures to ensure better health.

WHO estimates, 3 million deaths take place each year globally due to alcoholconsumption. It also leads to disabilities and poor health and is responsible for 5.1% of the global burden of disease. Further, more than half of the 3.3 million annual deaths attributable to alcohol use are from NCDs, including cancer. Lack of physical activity is also a big killer and accounts for 1.6 million deaths annually.

IMAGE: PIXABAY

Metabolic risk factors

There are four key metabolic changes that increase the risk of NCDs. Those who suffer from raised blood pressure, are overweight or obese, have hyperglycemia or high blood glucose levels and hyperlipidemia, high levels of fat in blood, are prone to NCDs.

The top leading metabolic risk factor globally is elevated blood pressure. It is estimated that 19% of global deaths can be attributed to it followed by overweight, obesity and raised blood glucose.

What are the socioeconomic impacts of NCDs?

The rising incidence of NCDs poses a threat to sustainable development. Poverty is a double-edged sword that on the one hand predisposes one to NCDs, on the other hand, exacerbates poverty and disease. As NCDs rise, the burden of diseases would increase on poor households and impact the effort to reduce poverty in low-income countries. The increasing household costs of health care would push vulnerable and socially disadvantaged groups further into poverty and sickness. The poor are prone to die sooner than those in a better economics and social positions.They are at greater risk of being exposed to harmful products, as they are more likely to unhealthy lifestyle and dietary practices making them predisposed to NCDs while their access to health services remain limited.

For poorer households, healthcare costs are a burden that drain them financially, emotionally and physically. The high costs of NCD care including lengthy and expensive treatment and hospital stay drains them and can only lead to the death of the earning member. Most poor households are dependent on single incomes and the death or disability of a breadwinner often force millions of households into poverty. This is also a huge economic loss and hampers the development of nations.

The Cure

It is important to control NCDs,as the progress of a country is dependent on a healthy population. The best way to reduce the incidence of NSDs is to try and control risk factors associated with these diseases. Managing NCDs calls for a comprehensive approach and strategy. Governments and civil society need to work together on reducing modifiable risk factors. Policies must be designed so that they help in monitoring progress and trends of NCDs ad enable timely and strategic interventions.

NCDs cannot be reduced through health interventions alone. It requires educating the masses, securing livelihood, easy accessibility to health centres through better transport and above all universal health coverage that makes healthcare affordable.

IMAGE: PEXELS

WHO recommends a primary healthcare infrastructure for NCD management as it can strengthen early detection, and timely treatment. Early intervention can be a big differentiator as it can reduce the need for more expensive treatment at a later stage of detection.

Managing NCDs

The 2030 Agenda for Sustainable Development has recognized NCDs as a major challenge for sustainable development, governments across the world have committed to develop ambitious national responses.

The Government of India has rightly assessed that NCDs cannot be stopped simply by treating the sick. Its prevention lies in protecting the healthy persons by addressing the root causes. As such, Ministry of Health and Family Welfare (MOHFW) is focussing on reducing the major risk factors as the key to prevent deaths from NCDs.

In India, wellness clinics have been set up in rural areas and local health workers have been enlisted to screen and identify those with NCDs. It is to be seen whether this translates into better health outcomes.

If the risk factors are effectively addressed, it will provide a huge push to the economic development of the country, with a healthier workforce. In this regard, National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular disease and Stroke (NPCDCS) is being implemented by MOHFW. The objective of the program is to educate the masses on risk factors, set up infrastructure (like NCD clinics, cardiac care units) and to carry out opportunistic screening at primary healthcare levels.

In fact, India is the first country to institutionalize a National Action Plan with specific national targets and indicators in response to the WHO's call under the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020. The aim of the WHO Action Plan is to reduce the number of global premature deaths from NCDs by 25% by 2025. Though the global action plan has suggested 9 targets for countries to set, India has gone a step ahead setting a 10th target – to address household air pollution. Under this, the country's National Monitoring Framework for Prevention and Control of NCDs has committed to a 50% relative reduction in household use of solid fuel and a 30% relative reduction in prevalence of current tobacco use by 2025.

The government integrated NPCDCS with the National Health Mission (NHM) and this led to augmented infrastructure and human resources particularly frontline workers – the ANM and the ASHA – who could now be utilized to enable on the ground screening and awareness generation. With the active participation of these frontline workers, the government could commence population-based periodic screening of hypertension, diabetes, and common cancers (oral, breast, cervical cancers) to facilitate the early detection of common NCDs.

IMAGE: PIXABAY

Preventive healthcare at the primary level is the best route to reducing the burden of non-communicable diseases.

Apart from the above, under NPCDCS, the government is also working on the prevention and management of chronic obstructive pulmonary disease (COPD) and chronic kidney disease (CKD); and better management of co-morbidities such as diabetes and tuberculosis.

Another important step taken by the government was consolidating NPCDCS further with the integration of AYUSH. This has helped to promote healthy lifestyle changes among the population using natural choices. To increase awareness on NCDs, its prevention and cure among the people, social media is also being used as also mobile technology in applications called **mDiabetes** for diabetes control, **mCessation** to help for quit tobacco, and **No More Tension** as a support for mental stress management.

Conclusion

It is not the duty of the government alone to control the epidemic of NCDs. Covid-19 epidemic has proved that that epidemics can strike anytime and most insidiously. But more importantly, underlying NCDs can be the ground for epidemics to cause harsher damage and even death. To better manage epidemics in the future, we need to invest in managing NCDs better. This cannot be the task of the government alone. While admittedly, we need universal health coverage and efficient public health strategy to make healthcare accessible and affordable, facilitate early detection and timely treatment at the primary health care level, palliative care and prevention; as primary stakeholders each consumer-citizen is duty bound to work in this program alongside the government. We begin this by embarking on a corrective course regarding our lifestyle.

Source: Secondary research & media reports

IMAGE: PIXABAY

Role Of Private Sector In UHC

An ambitious program like universal health coverage requires all stakeholders to collaborate in pursuit of the common goal. The private sector needs to be an important partner in the mission.

THE PANDEMIC EXPOSED health systems across the globe; and the price that the poor had to pay for the state pushing its primary duty onto the private sector. The result has been a highly profit-oriented commercialized healthcare system that caters to only those who can pay for it.

Universal health coverage ensures that all citizens without distinction have access to the requisite healthcare without "catastrophic health expenditure"due to out of pocket expenses. The aim is to ensure that no citizen needs to spend more than 30 percent of their household income on healthcare.

Healthcare is becoming increasingly costlier. As a result, public health expenditures are rising around the globe. Therising incidence of non-communicable diseases has added to the expenses around managing communicable diseases. Ironically, increasing life expectancy due to better healthcare across all demographic segments is adding to the expenditure.

In low income countries, the outofpocket expenditure on healthcare pushes more into poverty while deepening the misery of the already poor. Healthcare financing has remained abysmal in India leading to insufficient, inefficient and inequitable healthcare. According to a report by the Public Health Foundation of India published in 2018, around 55 million Indians fell into poverty in a single year because of catastrophic health expenses. Around 38 million of them were pushed below the poverty line due to funding their medicines alone.

Public health requires vast funding. At the same time, it cannot be left to the private sector alone as has been painfully highlighted by the pandemic. The best course seems to be a government led initiative with partnership with private players.

Engaging private sector in public health

Experts believe that the private sector can be a powerful ally in India's UHC mission. However, this is not easy as private sector in health system is complex, diverse and heterogeneous. To bring these diverse players onto a common platform requires well thought out policy approach. The government needs to understand the private actors operating in primary care and their attributes. Some are working for profit while there are also philanthropic ventures or social sector not for profits working at the community level. There are some that are also being funded by foreign affiliations while others may be receiving CSR backing or domestic funding. To be able to bring the private sector on board, the government will need to work out a common platform, policies and guidelines which would guide their engagement in primary health sector.

To achieve universal health coverage goals public financing is essential. It must be ensured that the funds are used efficiently and for the purpose of providing healthcare to the priority populations, equitable access and financial cover. Towards this aim, countries must use all domestic resources and the private sector can be a crucial resource in achieving universal health coverage if managed properly. This calls for governments to assume the role of stewards of their health systems and establish regulatory controls to manage the private sector. A supportive financing, policy and regulatory framework would help promote innovation and competition.

UHC needs an urgent push if we are to control the cumulative cost of NCDs facing the economy – more than USD 6 trillion dollars by 2030. The participation of the private sector is a must to accelerate and amplify state efforts towards the goal of health for all. It is urgent that we align the private sector to the national goals of quality, affordable, accessible and equitable healthcare and recognize the role it can play in India's march to UHC.

Let us look at the ways in which the private sector can be a partner in India universal health coverage program.

Accessibility

In the current scenario,over 70% of healthcare services in the country are courtesy the private sector. In fact, if we look at the percentage of people in rural and urban India who are dependent on private players, there is not much difference. Private health sector is catering to the needs of 72 percent rural residents and 79 percent residents of urban areas. Apart from the fact that public health services are inadequate, what is also pushing the majority to seek public healthcare is the quality of services, innovation and world-class infrastructure, their ability to scale up and fan out. Whether it is hospitals, diagnostics, palliative care, rehabilitation or physical therapy, the private sector has demonstrated a huge appetite for technology backed innovation. Using aggregators to apps, it has managed to reach to patients even in tier 2 and 3 cities. Backed by private capital and the spirit of entrepreneurship, the private sector has demonstrated its capacity in high quality healthcare. If with the right incentives and supportive policy, private players can be persuaded to branch out their services under UHC principles aligned with UHC goals, it can be momentous.

Healthcare is an investment-intensivesector which cannot be the sole responsibility of the government. It requires support from the private sector.

Affordability

It is an irony that while the low cost of quality healthcare has made India an attractive medical tourism destination; it costs about four times


IMAGE: PIXABAY

The private sector must be aligned to the national goal of universal health coverage to ensure affordable, accessible, equitable healthcare for all.

IMAGE: PIXABAY

Quality matters and though India has established a reputation for medical tourism, its public healthcare systems are dismal.

more than public healthcare in the country. This leads to high out of pocket expenses for the poor that pushes them into poverty and ruin. Public health system is highly subsidized – interest free and subsidized loans, free land, electricity, etc. To interest the private sector into UHC, the government needs to make the system more competitive. This will also act to enhance the efficiency and service delivery in the public sector, while providing a level playing field to private sector.

Quality

Though just 5-10% of private sector hospitals and diagnostic centres are accredited in India, they have managed to carve out a reputation for themselves globally as centres of excellence taking the country among the top three destinations for medical tourism. A January FICCI report forecast the sector could to touch the $9 billion mark by the end of 2020 in terms of Medical Value Travel (MVT) market. A leading reason why India is preferred by healthcare seekers is the considerable cost savings. The report says, treatment and travel costs in India when compared to countries like the US and UK are very low – at least up to 50 per cent can be saved. This quality when harnessed for UHC can change the face of health system in the country.


IMAGE: PIXABAY

Not for profit organizations have an important role to play in universal health coverage goals.

Conclusion

Recognizing the important role of public private partnership in India's ambitions health for all goal,the Government of India's National Health Policy 2017 looks at the areas wherein such partnerships can be forged. In fact, NHP 2017 is a comprehensive document that takes a hard look at the challenges the country's health sector faces and then goes on to propose possible strategies to deal with them. In the strategic roadmap for India's health system, the NHP 2017 elucidates the role that private sector can play in it.

The NHP 2017 recognizes CSR as an important area and recommends that it be which leveraged for filling health infrastructure gaps in public health facilities across the country. The CSR platform can also be used for awareness generation.The private sector can also be engaged through adoption of neighbourhood schools/colonies/slums/tribal areas/backward areas.

The NHP 2017 advocates building synergy with “not for profit” organisations and private sector under predefined norms to close critical gaps in health system. It also recommends a better public private healthcare interface.

These and other suggestion in NHP 2017 show the importance the government places on private sector engagement in its UHC mission.In the goal to universal health coverageboth public and private sectors have distinct yet supportive roles to play.

Source: Secondary research & media reports

As the world battles Covid-19, other health treatments have taken a backseat.

Health Crisis Imminent?

Primary healthcare suffered as combatting Covid-19 became the top priority for governments and health workers. Experts fear this could lead to a severe health crisis down the line.

IMAGE: PIXABAY

Maternal, newborn and child health services have suffered.

IMAGE: PIXABAY

LOOKING AT THE pattern of coronavirus outbreak, health experts had warned that as the pandemic sweeps across the country, primary healthcare would take a backseat. As feared, India like other countries around the world is staring at an imminent health crisis as citizens deferred check-ups, hospital visits and medical procedures fearing coronavirus infection. Overwhelmed health facilities too were turning away patients seeking non-coronavirus treatments fearing infections or due to their inability to deal with it for the lack of adequate facility and manpower. Cases where dialysis patients have been infected during a visit and later succumbed to coronavirus have been reported. Cases where hospitals' refusal to admit patients seeking life-saving treatments have also surfaced, which led the government to intervene and warn hospitals their refusal to treat or admit a patient would attract penal action.

In the rural areas, to strictly enforce social distancing and make people stay indoors, services traditionally delivered through outreach programmes at the grassroots level were reorganised. The impact of this could be seen on maternal, newborn and child healthcare services as also communicable diseases and non-communicable diseases. The Information Education Communication (IEC) campaigns also took a hit and health promotion, community-based screening and other screening programmes, were suspended. The pandemic led to the flooding of public health facilities and the health workers were drawn into the activities to check Covid-19. This resulted in essential health services to the communities becoming restricted to emergency services.

Though government allowed patients to seek peripheral facilities services on particular dates and times that could be arrived at telephonically or through accredited social health workers (ASHAs), for many it was not feasible.

Suspending or lessening the immunisation and screening sessions were recommended and services under Pradhan Mantri Surakshit Matritva Abhiyan was suspended. This program is vital for maternal health as it ensures free check-up for pregnant women in their first trimester. Home visits by ASHAs were also restricted and the health workers were asked to optimise their visits in a particular household/hamlet/mohalla and ensure that follow up care to all beneficiaries was provided during one visit to avoid repetitive visits to the same locality.

Those who suffered due to these restrictions were high-risk pregnant women or newborns, elderly and the disabled.

It is feared that that thousands of children have missed routine immunisations which is vital for their safety and growth. Thousands of adults and elderly too have missed or given a miss to medical treatment that is essential for their life.

Government advisory also led to restricted inpatient, outpatient and emergency treatment for other diseases – infectious and non-communicable. While telemedicine was promoted to allows consultations online, laboratory investigations suffered. Lockdown induced stress increased the requirement for mental health even as existing mental health patients suffered due to curtailed access and services.

Pregnant women could not access medical intervention and many preferred home deliveries rather than take the risk of hospital births. Fortunately, in rural areas, accredited social health activists, and auxiliary nurse and midwives could continue to provide their services. The lockdown also led to curtailment of maternal health care services which impacted the rural poor women dependent on Anganwadis and ASHA workers for these services.

According to reports, at least 100,000 children missed their BCG vaccination, which is essential for protection from tuberculosis (TB). Not only this, an estimated 200,000 children also missed each dose of the pentavalent vaccine, which protects against meningitis, pneumonia, whooping cough, tetanus, hepatitis B and diphtheria. Children also missed rotavirus vaccine, which prevents diarrhoea-causing rotavirus infections.

This is just the figure of March. Since then many thousands more have missed these life-saving vaccinations.

The lack of access to hospitals has resulted in lower admissions during the period for underlying non communicable diseases like severe acute respiratory illness and influenza-like illnesses. Reports show that medical treatment fell across the board for all diseases. A report in Livemint stated there was a reduction of 350,000 people receiving outpatient treatment for diabetes. Outpatient treatment for mental illness saw a reduction of 150,000 people and nearly there were 100,000 fewer people who received outpatient cancer treatment in March 2020 as compared to March 2019.

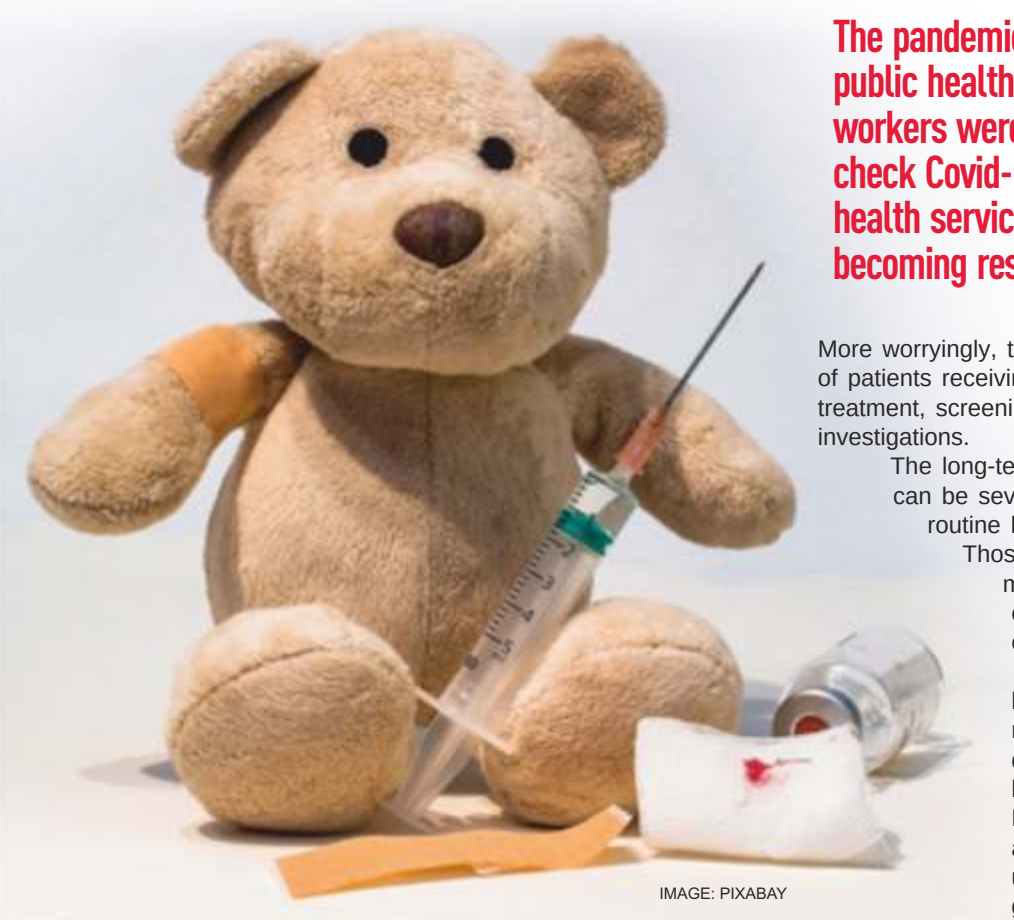

IMAGE: PIXABAY

Routine immunization of children has suffered due to lockdown.

The pandemic led to the flooding of public health facilities and the health workers were drawn into the activities to check Covid-19. This resulted in essential health services to the communities becoming restricted to emergency services.

More worryingly, there was also a decline in the number of patients receiving and completing standard TB treatment, screening for HIV/AIDS and other laboratory investigations.

The long-term impact of the healthcare curtailment can be severe. Experts have argued for keeping routine health services running at least partly. Those who have missed care and medication during the lockdown period could be severely impacted and can even die down the line.

The real picture will emerge only later after experts analyse mortality data not just for COVID-19 but for all diseases. It will help us understand the broader impact on public health. Meanwhile, analysis of NHM data paints a grim picture of the horrors that may unfold later. It could well wipe out the gains made in public health over the past years.

Source: Secondary research & media reports

Access to **Safe Drinking Water** is a Human Right

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Sabse Shudh Paani

HEALTH FOR ALL
And Soon

Health is a fundamental human right that has for decades not received the priority of the government. India too is struggling to cope with the sudden rise in healthcare requirement with a health system that at best is broken. The government must now prioritize PM-JAY, its Universal Health Coverage scheme, to future proof the nation against any health shocks.

IMAGE: PEXELS

India must implement universal health coverage on war footing for sustainable economic development.

HEALTH IS A fundamental human right and is essential for a country to achieve sustained economic and social development. According to the World Health Organization, half of the world's population do not have access to the required healthcare. Not only this, over 930 million are spending at least 10 percent of their household income on healthcare and being driven deeper into distress and poverty. In fact, out of pocket spending pushes more than 100 million people into poverty each year.

The inequality in access and the level of healthcare is widening the gap between the rich and the poor. It's a sad commentary on our social systems that while on the one hand healthcare is growing advanced with disruptive technologies and becoming more sophisticated and precise; more than half the population is denied even the basic healthcare.

Access to affordable and quality healthcare services is crucial to protect the poor from being pushed deeper into poverty, if we want the nation to progress.

Against this backdrop, the importance of Universal Health Coverage (UHC) scheme that guarantees equal healthcare facility to all citizens becomes important. The WHO defines UHC as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship.

Looking at the criticality of health for economic and social development, many countries have adopted universal health coverage as a priority goal.

UHC therefore embodies three objectives for any country that is adopting a healthcare scheme. WHO outlines them as:

- Equity in access to health services: Everyone who needs services should get them, not only those who can pay for them;
- The quality of health services should be good enough to improve the health of those receiving services; and
- People should be protected against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.

Why India needs UHC

Niti Aayog's SDG Index 2019, released on December 27, 2019, had reported more Indians have fallen into poverty, hunger and income inequality in the past two years. Though among the top three fastest growing economies of the world, and despite stupendous growth in some sectors in the past decade, India continues to be a Lower Middle-Income Country (LMIC), as per a World Bank classification of countries based on per capita GDP. The reason for this is that India's growth is not just uneven but also low on socio-economic and health indicators. There are swaths that remain poor, states that continue to struggle to develop and concentration of power and capital in the hand of a few. The Niti Aayog data showed, poverty going up in 22 states and UTs in 2019 over 2018 index. Not only this, more people are also going hungry in India since 2018 says the report.

A January 2020 study from the World Economic Forum (WEF) says the country's social inequality is keeping a significant section of the population poor forever despite the country's economic growth. The report adds that those born in low-income families in India would take seven generations to even approach the country's mean income. Around 220 million Indians live on an expenditure level of less than Rs 32/day — which is the poverty line for rural India as per a headcount of the poor in in 2013.

While the demographic dividend of India, (World Bank projects that by 2021 more than 34% of India's population will be in the age group of 15-35 years), makes one optimistic that India may be able to ensure sustained economic growth for few more decades before a higher dependency ratio sets in; however, much depends on how we ensure that the working population remains healthy. As of now, the epidemiological transition in India is currently facing the unique situation of a “triple burden of disease.” Even as the mission to eradicate major communicable diseases remains unfinished, there is a rising burden of non-communicable diseases (NCDs) and injuries. The combined factors are leading to higher demand for healthcare while the healthcare system remains hamstrung.

There is a high dependence on commercialized private sector for healthcare and concentration of healthcare services in the cities, when the need is to make it affordable and decentralized. The private sector caters to nearly 70% of all visits for healthcare needs in the country and has 50% of total hospital beds. The quality of healthcare even in the private sector is not uniform, hence there is a deficit in the supply side of health system that is woefully inadequate to cater to the diversified needs of 1.3 billion population.

The public sector hospitals are understandably overburdened and have suffered from persistent underfunding over the past two decades, when the Government of India's overall expenditure on health has stagnated at about 1.2% of its GDP (Source: National

Health Accounts, 2015). The result is that of its total expenditure on health, India spends only 21% from the Government revenue, and 62% is out-of-pocket expenses (Source: National Health Accounts, 2015).

Ayushman Bharat – Pradhan Mantri-Jan Arogya Yojana (PM-JAY)

The Government of India's vision of Universal Health Coverage saw it launch the flagship scheme – Ayushman Bharat – on the recommendations of the National Health Policy 2017. India's Ayushman Bharat initiative is entrenched in the principles of Sustainable Development Goals (SDGs) and underlines its commitment to "leave no one behind".

The government's decision to launch Pradhan Mantri-Jan Arogya Yojana (PM-JAY) was hence aimed at tackling the twin causes of poverty in India – increasing healthcare needs, coupled with high outofpocket expenditure, which is not only keeping people poor, but is also pushing nearly 6 crore Indians back into poverty each year.

PM-JAY also factors in the past efforts by the central and various state governments to strengthen demand side financing by launching various government-funded health insurance schemes. However, schemes like the Rashtriya Swasthya Bima Yojana (RSBY) worked independently of the larger healthcare system in the country and led to fragmentation of risk pools. More importantly, none of these schemes had any linkage with primary healthcare.

The Government of India hence took a two-pronged approach under the umbrella of Ayushman Bharat – disease prevention and health promotion to curb the increasing epidemic of non-communicable diseases and the launch of the Pradhan Mantri-Jan Arogya Yojana (PM-JAY).

Under the first approach, the government is working on upgradation of existing network of Sub-centres and Primary Health Centres to Health and Wellness Centres (HWC), with target of setting up nearly 150,000 HWCs over the next few years. These centres will work towards reducing the overall disease burden and hospitalisation needs of the population. The PM-JAY aims to create a system of demand-led healthcare reforms to meet the immediate hospitalization needs of the eligible beneficiary family. It aims at cashless healthcare and the purpose is to insulate affected family from debilitating financial shock.

The long-term plan for PM-JAY hinges on its system of incentives and aims to expand the availability of its services. It is expected that with higher demand, the private sector would join forces and expand services in the unserved areas of Tier-2 and Tier-3 cities. As regards public hospitals, PM-JAY incentivizes prioritization of poor patients. Notably, PM-JAY has subsumed the existing RSBY and also works in convergence with various state government funded health insurance/assurance schemes.

PM-JAY today is the world's largest health insurance/assurance scheme offering a health cover to nearly 10.74 crore poor families – a staggering 50 crore Indians that make up 40% of its bottom population. Fully funded by the Government, the scheme provides financial protection for a range of secondary and tertiary care hospitalizations.

If PM-JAY succeeds in its aim of reducing the huge healthcare bill of the poor by improving their access to quality healthcare, India can surely hope to be firmly on the path to sustainable growth.

Coverage under PM-JAY

At the bottom of the pyramid are not just the poor, but most illiterate as well. The lack of education and awareness makes any task of social inclusion of the poorest and most vulnerable population of any country a challenge. Their inclusion in health insurance programmes is even more challenging as they cannot pay any premium and are the hardest to reach. India is not an exception here, as most Lower and Middle-Income Countries (LMIC) face similar challenges.

The deprivation and occupational criteria of the Socio-Economic Caste Census 2011 (SECC 2011) forms the basis of the inclusion criteria of households in PM-JAY. The beneficiaries under PM-JAY also include families that were covered in the RSBY but were not present in the SECC 2011 database.

Rural Beneficiaries

The government has defined seven deprivation criteria for rural areas. PM-JAY covers all such families that fall into at least one of the following six deprivation

India launched its universal health coverage program in 2017.

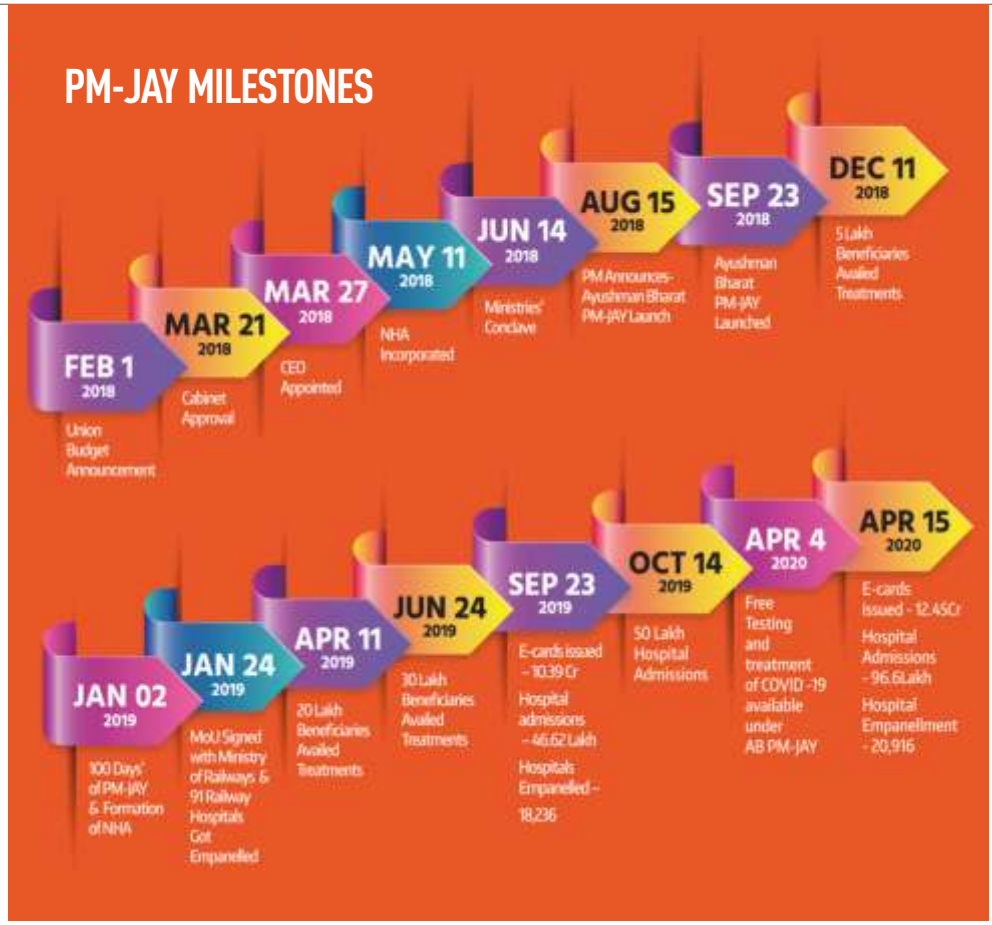
criteria (D1 to D5 and D7). Destitute or those living on alms, manual scavenger households, primitive tribal group, legally released bonded labour, etc., are automatically included.

- D1 - Only one room with kucha walls and kucha roof
- D2 - No adult member between ages 16 to 59
- D3 - Households with no adult male member between ages 16 to 59
- D4 - Disabled member and no able-bodied adult member
- D5 - SC/ST households
- D7 - Landless households deriving a major part of their income from manual casual labour.

Urban Beneficiaries

For urban areas, 11 occupational categories of workers are defined as eligible for the scheme. They include ragpicker, beggar, domestic worker; street vendor/cobbler/ hawker/other service provider working on streets; construction worker/plumber/ mason/labour/painter/ welder/security guard/coolie and other head load worker; sweeper/sanitation worker/mali; home-based worker/ artisan/handicrafts worker/tailor; transport worker/driver/ conductor/helper to drivers and conductors/cart-puller/ rickshaw-puller; shop worker/ assistant/peon in small establishment/helper/delivery assistant/attendant/waiter; electrician/mechanic/assembler/ repair worker; and washerman/chowkidar.

Under the scheme, states have the flexibility to use their own database for PM-JAY. However, they need to ensure that all the families eligible based on the SECC database are also covered.



Benefit under PM-JAY

Under PM-JAY, cashless cover of up to Rs 5,00,000 is provided to each eligible family per annum for listed secondary and tertiary care conditions. The cover under the scheme includes all expenses incurred on medical examination, treatment and consultation; pre-hospitalization; medicine and medical consumables; non intensive and intensive care services; diagnostic and laboratory investigations; medical implantation services (where necessary); accommodation benefits; food services; complications arising during treatment and post-hospitalization follow-up care up to 15 days.

Further, the grant can be used by one or all members of the family and there is no cap on family size or age of members. Pre-existing ailments are also covered from the very first day.

Conclusion

India's UHC covers the medical needs of the nation's poor well. All it needs is effective implementation on the ground. The urgency for such a program that can act as a safeguard for the vulnerable sections during an unprecedented health crisis cannot be overemphasized. More than that, an effective healthcare support will ensure a healthier population that can be an asset to the nation.

Source: Secondary research and media reports

IMAGE: PIXABAY

Health protection for the family under PM-Jay aims to insulate the poor from catastrophic health shocks.

> "It is too soon to call it a 'success'. The vision of Ayushman Bharat PM-JAY is to empower all the 500 million+ beneficiaries covered under PM-JAY"

Dr Indu Bhushan, Chief Executive Officer of National Health Authority, India – Ayushman Bharat Pradhan Mantri Jan Arogya Yojana – in conversation with The Aware Consumer throws light on the government's ambitious universal health coverage program.

Q Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) crossed one crore treatments recently – a landmark achievement. What do you attribute this success to?

It is too soon to call it a "success". The vision of Ayushman Bharat PM-JAY is to empower all the 500 million+ beneficiaries covered under PM-JAY through safeguarding them against catastrophic healthcare expenditure. Ayushman Bharat PM-JAY crossing one crore treatments is definitely an important milestone for the country. In this endeavour, we have received tremendous support from every concerned stakeholder. Working under the vision and leadership of Hon. Prime Minister and Hon. Union Minister of Health and Family Welfare, we have achieved this milestone within 20 months.

Teams working at the national and state levels have been responsible for this diligent implementation. All doctors, nurses, healthcare workers, para medical staff and all others associated with Ayushman Bharat, across all states and hospitals, have helped us achieve this milestone and make Ayushman Bharat PM-JAY the largest healthcare programme in the world.

Q How was PM-JAY enlisted in Covid-19 health crisis?

PM-JAY is supporting the COVID-19 response in following ways:

1. We have included COVID-19 testing and treatment packages as part of the Ayushman Bharat PM-JAY coverage to enable all the 500 million+ beneficiaries access free testing and treatment at the concerned private and public facilities
2. We have empanelled more hospitals to rapidly augment the supply available for undertaking COVID-19 and non COVID-19 related health services
3. NHA has started empanelling the ICMR approved private labs directly for COVID-19 testing
4. NHA facilitated availability of transportation support of health workforce by collaborating with private providers
5. We closely monitor and track of SARI treatments
6. NHA undertakes tele-consultation for PM-JAY high risk beneficiaries
7. We undertake tele-consultation for self-reported high-risk cases from Arogya Setu
8. NHA has organized outreach campaign for building awareness about COVID-19
9. NHA manages the COVID-19 helpline support 1075

"With 46 lakh treatments worth Rs. 7,500 crore that help save patients' Rs. 14,000 crore and 18,000+ hospitals on-board, Ayushman Bharat PM-JAY is growing stronger by the day. Let's keep our efforts going."

– Dr. Indu Bhushan
CEO,
Ayushman Bharat PM-JAY

Q Covid-19 exposed the underlying risk of non-communicable diseases (NCDs). India's real challenge post-Covid crisis will be fighting NCDs which is a silent killer. Given that the underprivileged and uneducated communities are not only ignorant of the factors that cause ill health but also cannot access or afford the healthcare costs related to NCDs; how is PM-JAY positioned to tackle this challenge?

In the past few decades, the NCD burden in India has risen significantly. The incidences of non-communicable diseases such as cancer, stroke, heart and kidney diseases are dramatically increasing in the country, which are also more expensive to treat as compared to the traditional communicable diseases. Further, the burden of NCDs and the associated mortality is very pronounced in the poor and vulnerable sections. Due to a lack of financial resources, these families either don't avail treatment or they sell their limited assets to access treatments and fall into the spiral of poverty and debt. Every year, around 6 crore families were falling below the poverty line because of such high catastrophic health expenditure.

Ayushman Bharat PM-JAY is now changing that scenario by providing financial support against such catastrophic health expenditure. We are witnessing that a substantial proportion of our funds is being utilized for tertiary care. Major areas of care include treatment for cancer, heart, respiratory and kidney diseases. In the years to come, we will extensively witness how PM-JAY has empowered citizens to face the increasing NCD burden. This will have a significant positive effect on the standard of living of the citizens as well as on the economy of the country.

Q The current health crisis has exposed the historical neglect of the right to health. The breadth of ambition of Ayushman Bharat does not match the healthcare infrastructure and resources. How does the government plan to bridge this gap?

Presently, we have more than 21,500 empanelled hospitals, of which around 50% are private hospitals. As the implementation expands and the demand increases, there would be a need for empanelment of more hospitals to match the demand and increase the overall access to the healthcare. For the same, the Union Budget 2020-21 announced the intent for augmenting the healthcare infrastructure, especially in tier 2 and 3 cities. The budget mentions creation of a Viability Gap Funding facility to set up hospitals in the public-private-partnership (PPP) mode. Currently, we are exploring various models which can be used for this purpose.

At the same time, NITI Aayog has also proposed a

framework to States and private entities for converting district hospitals into medical colleges to augment the overall capacity of providing healthcare. I believe such efforts towards galvanizing private sector investment and strengthening the public healthcare system will drastically improve the overall supply of healthcare services.

Q Ayushman Bharat calls for seamless collaboration between states and the Centre. Which are the success stories among states? What would you attribute their success to? Why are others lagging behind?

The National Health Authority, right from the inception of the scheme had charted out contextual strategies to synergize the efforts at the national level with the priorities of the states.

Some of the mechanisms that we have followed, are as follows:

1. Convergence of schemes: Some States already were running their own respective insurance schemes. With the operationalization of Ayushman Bharat PM-JAY, the States were given the freedom to co-brand and make required customizations (such as adding beneficiaries) in alignment with their existing schemes. For example, in Karnataka, the PM-JAY scheme is called 'Ayushman Bharat - Arogya Karnataka', whereas in Madhya Pradesh, the scheme is called Ayushman Bharat 'Niramayam'.
2. Varied models to implement the scheme: States/UTs were provided with different models that they could leverage to implement the scheme viz., Trust mode, Insurance mode and Mixed mode. This provision ensured that the states/UTs get the required flexibility in choosing their mode of implementation. There are 20 states/UTs implementing the scheme in the trust model, 8 in insurance and 4 in mixed model.
3. Developing upward and downward feedback mechanisms: We have included the states/UTs in key elements of program design such as Hospital Empanelment, Health Benefit Packages, Claims Adjudication, Medical Audit Framework, etc. We've institutionalized a robust feedback mechanism to consider the suggestions of the states/UTs. In addition, we hold regular seminars and workshops across the country to foster a culture of information exchange and learning from best practices.

Due to these multifaceted initiatives, we have been able to on-board 32 states and Union Territories under the banner of the Ayushman Bharat scheme. Parallel efforts have been taking place to onboard the remaining states and UTs too.

Almost all states/UTs have done well under the scheme and it is difficult to single out any particular state/UT. We have to judge the performance in the context of state's past experience in implementing scheme, health care seeking behaviour and other socio-economic and governance related factors. The NHA is actively building capacities of States by providing them support in training PM Arogya Mitra and administrative officials, sharing data

analytics, highlighting potential fraud triggers, enabling assistance in medical audits, among others.

Q When do you envisage Universal Health Coverage (UHC) becoming a reality in India?

Ayushman Bharat PM-JAY has been one of the most formidable interventions made by the country towards the realization of UHC. After the launch of the program, India stands at the same juncture as many other countries in their journey towards Universal Health Coverage. The 3 key pillars of UHC: access, affordability and quality of care are the core tenets of Ayushman Bharat PM-JAY. With PM-JAY, the poor and vulnerable citizens are now covered but there is also a 'missing middle' who is not protected either by Government sponsored schemes or by self-purchased private insurance.

For the country to realize UHC, it would be important to target this population and institutionalize a mechanism to provide them some form of coverage. At the same time, it is critical to ensure adequate supply of healthcare services. Leveraging the private sector in the service delivery of PM-JAY has been a strategic priority area of the NHA. There is a need for a more cohesive approach for the Indian healthcare sector to attract more long-term funding and private equity.

It is also imperative to take cognizance that the journey towards UHC is not only a function of upgrading healthcare infrastructure and resources but also focusing on interventions around clean drinking water, hygienic sanitation facilities, and adoption of a healthy lifestyle by the population. There needs to be a focus on maintaining a balanced trade-off between cost, quality and access to healthcare services. A collaborative approach aligning patients, payers and providers, along with innovative partnerships, will hasten efforts to mitigate risks, drive impact, forge stronger social returns and achieve the target of UHC.

Q What are some of the major challenges facing the UHC program?

Despite India's size and dynamic nature, India has made immense strides in making UHC a reality. There are many challenges on the road to UHC for any country

– lack of adequate health financing, low availability of trained healthcare personnel, unstandardized care pathways, lack of continuum of care, disproportionate access to medicines and vaccines, and low community participation. India has made immense progress in many of these areas, for instance, in Ayushman Bharat PM-JAY we have created and operationalized a health financing infrastructure to support more than 500 million of our poorest citizens.

At the same time, the Health & Wellness centres and Jan Aushadhi stores are strengthening primary care, community participation and the availability of generic drugs. Going forward, creating a robust continuum-of-care system between primary care and higher forms of secondary and tertiary care will be a major leap in successfully providing UHC. There are various reforms happening in parallel which are making the Indian health system more resilient and ready for realizing the vision of UHC.

Q Public health expenditure is huge, and the government cannot be expected to make the noble UHC a success alone. What role is the private sector playing in India's health care goals? What is the government's expectation from the private sector in this regard?

In a country like India, where private healthcare accounts for 70% of the treatments, the road to UHC must be a joint effort between the public and private sector. The National Health Policy of 2017 states “there are many critical gaps in public health services which would be filled by 'strategic purchasing'. Such strategic purchasing would play a stewardship role in directing private investment towards those areas and those services for which currently there are no providers or free providers.” The private sector is already an integral part of the Ayushman Bharat PM-JAY effort, with close to 50% of the empanelled hospitals being private. Additionally, in recent years, we have seen stellar examples of Public Private Partnerships, where private sector organizations have partnered with state governments to demonstrate innovative models of primary and secondary care delivery.

The private sector can be an unparalleled pillar of support in India's journey towards UHC in the following ways:

a) Increase participation in government initiatives such as Ayushman Bharat to support the expansion of healthcare access to all Indians

b) Increase investments in physical and human resource infrastructure to expand into tier 2 and tier 3 Indian cities. There is immense opportunity here just waiting to be explored.

c) Innovate to bring costs of care down. By actively embracing innovation in technology, clinical processes and business models, our private sector can demonstrate a new standard of delivering high quality, accessible and affordable healthcare.

Q The low level of healthcare spending – 1.15% of GDP – is both a cause and an exacerbating factor accounting for the poor quality, limited reach and insufficient public provisioning of healthcare. Needless to say, we need higher investment in healthcare to protect the economy from the negative impact of endangered health. Your thoughts?

There is no doubt that a country like India ought to be spending much more on healthcare and we have continued to ramp up healthcare spending. India's spending on healthcare has increased more than twofold, from Rs 621 per person in 2009-10 to Rs 1,657 in 2017-18. The trajectory for the past ten years shows us that our public spending continues to increase and by 2025, we aim to raise spending on healthcare to 2.5% of GDP. However, more investment does not necessarily guarantee better outcomes as we've seen in other parts of the world. We don't just need higher investment but smarter and more targeted investment to improve quality, reach, and public and private sector availability of healthcare. This is also the principal aim of Ayushman Bharat.

Q With Union Health Minister Harsh Vardhan taking charge as the chairman of the Executive Board at the World Health Organization. How do you see this impacting India's healthcare reforms?

I believe it a matter of great pride for all of us to see Dr Harsh Vardhan taking the charge as the Chairman of the Executive Board at the World Health Organization. I sincerely believe that his deeply focused insights and practical experience in strengthening the Indian health system will tremendously help the WHO. I understand that this opportunity will help India showcase some of its efforts to the world and will also help us understand best practices around the globe. Further, I envision this will help us develop many new bilateral and multilateral partnerships wherein nations will come together to co-develop a roadmap for strengthening health systems. I am excited to see Dr Harsh Vardhan taking this charge and I am hopeful that this will strongly help the world to forge better partnerships and move towards realizing the vision of UHC.

CORONAVIRUS

COVID-19

Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus.

Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness.

The best way to prevent and slow down transmission is be well informed about the COVID-19 virus, the disease it causes and how it spreads. Protect yourself and others from infection by washing your hands or using an alcohol based rub frequently and not touching your face.

The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes, so it's important that you also practice respiratory etiquette (for example, by coughing into a flexed elbow).

At this time, there are no specific vaccines or treatments for COVID-19. However, there are many ongoing clinical trials evaluating potential treatments.

SYMPTOMS

COMMON SYMPTOMS INCLUDE:

- fever
- tiredness
- dry cough.

OTHER SYMPTOMS INCLUDE:

- shortness of breath
- aches and pains
- sore throat
- and very few people will report diarrhoea, nausea or a runny nose.

People with mild symptoms who are otherwise healthy should self-isolate and contact their medical provider or a COVID-19 information line for advice on testing and referral.

People with fever, cough or difficulty breathing should call their doctor and seek medical attention.

PREVENTION

To prevent infection and to slow transmission of COVID-19, do the following:

- Wash your hands regularly with soap and water, or clean them with alcohol-based hand rub.
- Maintain at least 1 metre distance between you and people coughing or sneezing.
- Avoid touching your face.
- Cover your mouth and nose when coughing or sneezing.
- Stay home if you feel unwell.
- Refrain from smoking and other activities that weaken the lungs.
- Practice physical distancing by avoiding unnecessary travel and staying away from large groups of people.

Helpline Number Toll free: 1075
+91-11-23978046

Email : ncov2019@gov.in • ncov2019@gmail.com

AFTERWORD

Pyush Misra
Director,
Consumer Online Foundation

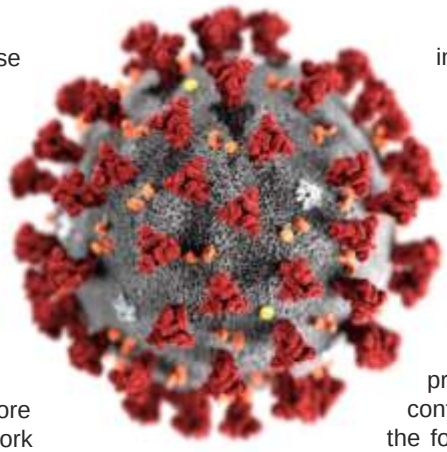
The traditional vertical health programs must give space to wider interventions that take the community along in the response to a health crisis.

Time For Horizontal Approach To

Healthcare

IMAGE: PIXABAY

Standalone disease control scheme fail in their purpose as they do not tackle the root causes of a disease.



THE PANDEMIC SERVED one big purpose – it exposed the chinks in India economic and social systems. The most important expose was of our healthcare system. The war against COVID-19 was badly hampered by the historical neglect of citizens' right to health. As always, the poor and marginalised are bearing the brunt of it. The incumbent Government of India had taken some crucial steps to right this wrong but that unfortunately has suffered a blow during the lockdown as everything came to a standstill. It is more important and urgent than ever that the work on public health system commences, is prioritized and expedited above all other development measures. Historically, the traditional approach to health has been top-down vertical health program mandate, a populist measure at best, that as the pandemic proved, will fail to ensure rights of patients, workers and citizens to health.

What are vertical health programs?

Governments launch standalone disease-specific programmes that have centralised management and have budgets earmarked for each segment of the program. Such vertical programmes are project-based donor-driven time-bound interventions that have set targets and deliverables. Experts differentiate vertical from horizontal as the latter whereas responds to the needs and demand of patients while the former is tailored to the state or international donor backing it.

These vertical programs with narrow targets and assistance of foreign aid have flourished in India as the width of the ambitious public health program failed to deliver in the absence of adequate infrastructure. There are many vertical programs running in India targeting specific diseases like malaria, tuberculosis, vaccine preventable diseases, population control, HIV and others. Unfortunately, the focus on these narrow programs has taken away the crucial funding from general health services. That these health interventions have also achieved limited success is another cause for worry. Running parallel and not as an integral part of the general health services, these vertical health initiatives have been hampered by the fragmented health system. The decision-making structure too is concentrated with a few at the top taken on the basis of evidence that is often fails to mirror the ground reality.

Health activists and experts have for long been demanding that public health should not be guided by a techno-centric approach that is left to the decisions of a handful of experts. There needs to be a focus on social determinant of health and right to health and not insurance models that have denied the te poor their right to a healthy life.

IMAGE: PIXABAY

Living with the pandemic requires the adoption of comprehensive horizontal approach to healthcare.

Horizontal approach calls for building enhanced surveillance and testing as part of the total response to a pandemic.

Fighting pandemic

During the pandemic, the fear of a highly infectious disease has become the predominant factor driving the government concerns for public health. This has led to certain violations of people's right to health and distribution of health resources. Lack of proper healthcare infrastructure put to risk health of many frontline workers including doctors and hospital staff. Covid-19, in the foreseeable future, is here to stay. While the initial response was hurried and unplanned largely, in the scenario that we have to live with the pandemic far longer, we need to adopt a horizontal approach to fighting infectious diseases.

The India COVID-19 Emergency Response and Health system preparedness package is a four-year program with $1 billion from the World Bank's COVI-19 Fast-Track Facility. From the directive issued by the Ministry of Health and Family Welfare which is in the public domain we learn that the emergency response and preparedness package is a 100% centrallyfunded plan which will be implemented in three phases during the period of January 2020 to March 2024. The package will help the government accelerate and scale up its response to COVID-19. In the process it will also serve build systems that will support our response to future disease outbreaks.

The major components of the program are: Emergency COVID-19 Response; Strengthening National and State health Systems to support Prevention and Preparedness; Strengthening Pandemic Research and Multi-sector, National Institutions and Platforms for One Health; Community Engagement and Risk Communication; Implementation Management, Capacity Building, Monitoring and Evaluation and Contingent Emergency Response Component.

Under the emergency COVID-19 response, funds have been earmarked for procuring essentials and improving existing diagnostic facilities. It envisages engaging private facilities, increasing capacities of hospitals for isolation

wards and providing safety gear to the healthcare workers.

Involving the private sector is a good move as the pandemic has shown that no government can combat a problem of this scale on its own. However, the government must lay down clear principles to guide the involvement of the private sector in public healthcare system. For example, to scale testing, private laboratories were engaged but this led to many controversies. The Supreme Court passed a judgement on April 8 making tests free in both government and private laboratories, but it was immediately modified that it would apply only to Ayushman Bharat card holders while others would be required to pay. It was feared that free testing would needlessly overwhelm already stretched testing centres as people would come out in huge numbers to avail unwarranted test. However, this has been perceived as appeasement of private players.

The document also mentions strengthening of the national and state health system which is a crucial step. The government will take several steps under this to strengthen the heath system. A network of biosafety level would be established, and steps would be taken to improve molecular testing for viral diseases in district and sub district laboratories. Sample transport mechanism will be improved, and diseases surveillance will be enhanced which will strengthen Integrated Disease Surveillance Program (IDSP). Integration of all health information would be done and community-based surveillance through the increased use of Information Communication and Technology (ICT) systems would be established. The government would also focus on developing workforce with core competencies to facilitate monitoring of outbreaks. District level mechanisms for disaster management and strengthening referral system linkages will also be done under this program.

IMAGE: UNSPLASH

Capacity building and developing a dedicated health workforce is a top priority.

Supporting the Healthcare Workforce is need of the hour

Developing health workforce

No program for public health will be successful unless we develop a cadre of public health workforce. The pandemic highlighted the need to strengthen primary healthcare system in the country. It is important that we deliver such care at the doorstep of the citizens regardless of their ability to pay. If combating COVID-19 is not to become another vertical program, we must invest in social determinants of health that mar any public health initiative.

For this, community engagement must focus on behavioural changes but at the same time work to enable physical, environmental, and social resources that make it a holistic change. We need to work towards improving the quality of life of the poor communities for any behavioural change to occur. Without access to basic services, food security, housing, etc., any attempts at behaviour change will remain half measures. The government must invest in the social determinants of health alongside instituting an alert public health system.

Conclusion

Lessons from the pandemic are crucial to shaping our future healthcare response. To begin with, we must ensure that our healthcare practices are not discriminatory and equal for all. Health is not just absent of diseases and our health system must be geared with this basic understanding as we step up our response to Covid-19. India carries a high dual burden of communicable and non-communicable diseases and also has the highest number of hunger deaths. As the pandemic stretches our resources and the economic fallout of the prolonged lockdowns become more visible, we need to get rid of the institutionalized apathy of decades. Our response to any health crisis needs to go beyond populist measures. The government, Centre and the states, must take determined steps to improve healthcare systems and work towards educating citizens to become an engaged and responsive community.

All the efforts should lead to guaranteeing the fundamental right to health not for the elite few but for all irrespective of their social reach.

Source: Secondary research & media reports

DIAGNOSTICS NEEDS CRITICAL CARE

Diagnostics play a critical role in overall health system. India must implement stringent rules to regulate its industry if it is to assist in universal health coverage goals.

Treatment depends on the accuracy of lab tests and diagnostics.

IMAGE: PEXELS

COVID-19 MORE THAN ever shined the spotlight on the important role that diagnostics play in healthcare. As the first step to disease management, a lot depends on how accurate the identification of a disease is.

A research report titled “Indian Diagnostic Services Market Outlook 2020”, forecasts the diagnostic services market will continue to grow at 27.5% for next five years. The market will grow on the back of improving healthcare facilities, medical diagnostic and pathological laboratories, private-public projects, and the health insurance sector. It is also expected that the rise in health consciousness among Indians and the rising burden of chronic diseases, will drive the market to grow to approximately Rs 860 billion in revenues by 2020.

Indian diagnostics industry

For diagnostic players, India is a land of opportunities. The growing middle class with rising disposable incomes to spend on healthcare and the rising incidence of non-communicable diseases has made India a major destination for various diagnostic services.

Rapid urbanization and more disposable income in the hands of the aging population along with changing lifestyles have led to the rapid growth in non-communicable diseases like cancer, diabetes and heart diseases. Management of these diseases requires extensive diagnostic services like imaging, ultrasound, radiology and pathology. As awareness rises regarding NCDs, people voluntarily seek early wellness testing and diagnosis. Wellness testing increases the chances of a positive outcome and saves lives and high cost of treatment at a later stage of detection. People are becoming aware there can be huge healthcare savings in the long run by making a small investment in preventive care. The boost in preventive care is also due to the medical policies of corporates and health insurances.

As a result, wellness testing is slated to grow double of sickness testing in the next 20 years. It is expected that wellness will grow to become 70% of the total testing. Currently, its share is just 10% in the total testing in India.

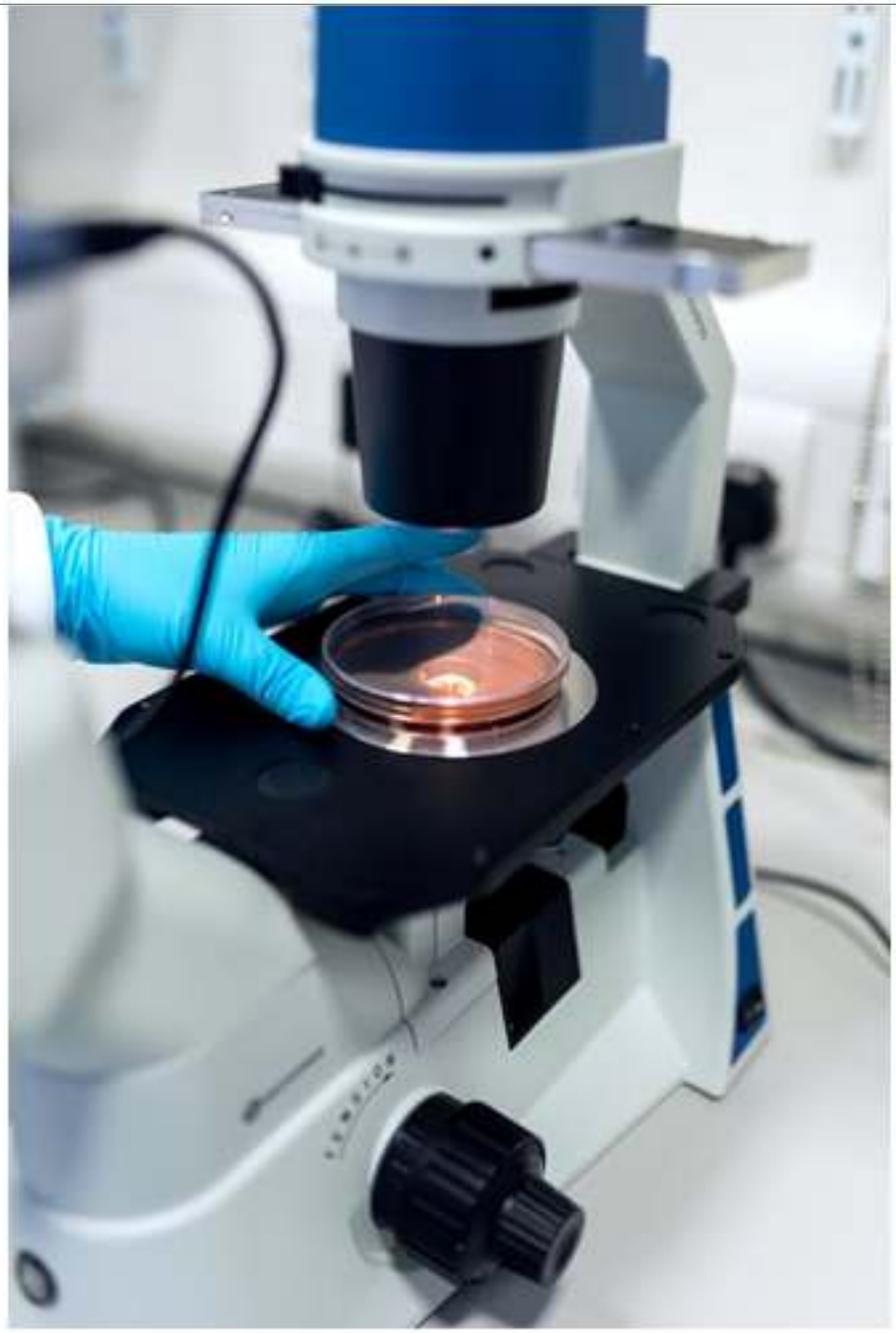


IMAGE: PEXELS

India's diagnostic sector is largely unorganized.

The global diagnostic market is valued around 42-45 billion USD. In India however, it is difficult to put a number as there are differing estimates the absence of a formal way to capture the data. One estimate puts the market at 8-9 billion USD, where half of it is pathology and the other half radiology.

Globally, diagnostics and the hospital industry are a package deal and largely funded by the government. In developed markets 80% of healthcare spends is borne by the government. In India, on the other hand, more than 2/3 of healthcare market is funded by the private players. Also, in advanced countries, the diagnostic test is also

covered in insurance but in India it is mostly funded by the patient. India's market is also dominated by routine tests and more advanced testing that involves a molecular or genomics-based test is limited. Diagnostics are also becoming digitalized with the rapid adoption of advanced AI and machine learning tools.

Currently, a larger part of the diagnostic business is under the unorganized sector. But is expected that the diagnostic service market will become much more organized and consolidated as the small and independent laboratory players are absorbed into the system becoming franchisees for the big players. The $9 billion diagnostic industry has received a further boost with Covid-19 and this should add further wind in its sails accelerating its growth.

Awareness regarding preventive health is rising and as the government pushes its universal health coverage program to manage NCDs, this awareness is set to percolate down the ranks. The only way to stay healthy and boost one's immunity to combat pandemics is changing the lifestyle for healthier options and taking preventive steps. This knowledge will boost the diagnostic sector further. The growing health insurance sector is also fuelling the preventive healthcare segment.

Reports say that the current Indian diagnostic sector is highly fragmented and has standalone centres that account for 45-50% share of the market. The organised players have less than 35% share of the market and the remaining share is that of hospital-based diagnostic centres. However, people's demand for quality diagnostics has led to major diagnostic chains disrupting the market as they go about acquiring smaller local labs to build a dispersed chain.The consolidation of the market that has already begun is expected to gain momentum as more small and independent laboratory players opt for franchisee for model.

According to a report, the number of small standalone labs in the past 5-7 years has hovered around one lakh. This has given space to organized labs to grow in size with the funding from private equity investors.Flush with capital they are on an acquisition spree acquiring smaller labs with good patient numbers, processes, and compliances in place.As a result, a kind of hub and spoke model of diagnostics is growing in the country allowing the big players to expand their presence pan India.

The real challenge in diagnostics however comes from lax rules that allow unauthorized labs or labs of suspect quality to function. Patients often end up with wrong diagnosis calling for repeated tests which means their precious resources are wasted. For the market, these labs impose pricing pressure as being low priced they attract the poor patients looking for a bargain. Not much is being invested in building clinicians'

IMAGE: PIXABAY

capacity and there are limited number of pathologists and radiologists. Further, patients' lack of awareness on the importance of quality healthcare services is also an impediment.

Regulatory challenges

The role of diagnostic services in early detection of health problems and in informing medical interventions makes the integrity of tests crucial to any decision taken by a medical practitioner. Medical decisions are based on clinical investigation reports. Hence, maintaining the integrity of testing right from the time the blood sample is collected till the report reaches the doctor must not be compromised. One misstep can lead to the whole detection and treatment process becoming complicated or even fatal.

Diagnostics is often marred by lack of accuracy in reports, improper methods of testing and delayed turnaround time in reports. The reasons are the presence of a large number of labs that are run by under-qualified technicians, lack of quality procedures that increase the possibility of erroneous reports and incorrect diagnosis. This has naturally made patients distrust pathology. In India specially, the common perception is that doctors prescribe unnecessary test and recommend that these be done at specific labs only for kickbacks they receive from the labs. It is all part a big plan to fleece the poor patients, they feel. The low level of trust in diagnostics hence is a huge deterrent in its growth.

It is a stinging commentary on how serious states are regarding the quality of pathlabs that till December 2018, just 11 states and all union territories except Delhi had adopted The Clinical Establishments (Registration and Regulation) Act, 2010. It has been enacted by the Central Government to provide for registration and regulation of all clinical establishments in the country with a view to prescribing the minimum standards of facilities and services provided by them.

In November 2018, the Delhi High Court had pulled up the Delhi government after the discovery of 875 illegal pathology clinics operating in Delhi. The High Court had issued a notice seeking closure of the labs. Subsequently, Delhi government gaveits nod to the Delhi Health Bill that once enacted would replace the need to implement the central act.

IMAGE: PIXABAY

Lax laws have led to mushrooming of path labs with dubious distinction.

Lax implementation of laws has led to a mushrooming of diagnostic centres of dubious distinction as almost anybody can open one. This has led to a general erosion of quality in the industry. There is an almost absolute absence of business ethics leading to exploitation of patients with either unnecessary tests or wrong diagnosis.

The pandemic has exposed the lack of adequate numbers of testing labs. However, low-quality pathology laboratories are not an answer.

India has a large untapped market for diagnostic labs, but it must not be at the cost of its citizens. It is urgent that the Clinical Establishment (Registration and Regulation) Act, 2010, is adopted and implemented across states to standardize diagnostic services. It is hoped that the government will pursue this goal of regulating the industry and establish minimum standards for operating a business as it impacts life and death of patients.

Notably, the government has shown its intent to regulate the industry with the proposal of “minimum standards” proposed in the amendments for the Clinical Establishment (Central Government) Rules, 2019. The regulation proposes denial of registration to health establishments that fail to comply with prescribed norms regarding infrastructure, manpower, equipment, drugs, support service and records.

The execution of these standards is urgent. We cannot afford to allow these substandard labs to function if we want to work on controlling the rising NCDs or another round of communicable pandemic. Without accountability towards patients or doctors, these mushrooming diagnostic and imaging centres are a drain on patients' finances that lead to catastrophic health shocks.

With hardly 1% of the path labs accredited by NABL, under the Quality Council of India, we are heading towards a health disaster that threatens the goal of health for all. The government must ensure greater enforcement of accreditation and recognition of the value that will underscore the need for quality services in the wider healthcare system.

Conclusion

India's diagnostic industry needs to undergo rapid changes in its functioning. As consumers grow more aware, there needs to be a shift in orientation from reporting with the doctor in mind to making reports that are patient and customer friendly. As the government increases it focus on primary healthcare and preventive healthcare under the health for all umbrella, the diagnostic industry too will have to become more regulated to answer to those needs.

Source: Secondary research and media reports

A nation's public health is critical for its sustainable economic growth. And, investing in public health system at this critical juncture promises rich dividends for India.

Public Health Needs Critical Care For Economy's Wellbeing

An economy is as healthy as its people.

IMAGE: PIXABAY

THERE IS A complex relationship between health of the people and the economic health of a nation. Hence, investment in health should be the top priority of countries. In emerging economies, it becomes an essential priority as a poor health system directly impacts the growth line it takes. But our health systems present a complex set of challenges and new pressures as we face the repercussions of rapid and unmindful growth. Lifestyle induced diseases are growing and so are chronic illnesses even as we have failed to eradicate communicable diseases. Meanwhile, health technologies are becoming more expensive and yet vital for health.

Modernising societies have raised the expectations that citizens have from their governments and health systems. Yet, inequities persist denying equitable access to all citizen groups without discrimination. For cash strapped governments in developing countries, the different pressing demands for funding pushes public health priorities down the ladder. The major issue is how to ensure the financial sustainability of health systems.

According to OECD, investments in health and the design of health financing policies should be addressed in terms of the interaction between health and the economy. It states that "just as growth, income, investment and employment are a function of the performance and quality of the economic system, its regulatory frameworks, trade policies, social capital and labour markets, etc., so health conditions (mortality, morbidity, disability) depend not just on standards of living, but on the actual performance of health systems themselves."

The linkage between health performance and economic performance is well established. If we look at developed countries, we find populations are healthier, and their health systems are also advanced, accessible and largely equitable – funded in a large measure by the government. Infant malnourishment and mortality lead to lower life expectancy and are direct measures of the economic prosperity of a country. National income of a country determines its capability to invest in health systems, for example, whether it can provide insurance coverage for the poor to protect them from health shocks through public spending on health. Health expenditures of a country are determined mainly by national income, but expenses on health increase faster than income.

Poorer countries also find it difficult to take institutional measures to promote health. For example, India's dependence on tobacco as a cash crop that feeds millions of its farmers, its bidi workers and tobacco dependent industries that make a large part of its earnings meant that for long it could not take steps to institutionalize a ban on tobacco consumption. Even now, the tobacco lobbies and the fiscal dependence on tobacco has hampered strict

Wealthier countries have healthier citizens as health depends not just on the standard of living but the quality of health systems too.

IMAGE: PIXABAY

implementation of bans. Same goes for the alcohol industry. Despite the pandemic, various state government opened alcohol vends and even worked out modalities for home delivery. The lack of efficient fiscal systems has watered down the government's efforts in implementing health policies for the public good. While high taxes have been imposed and rule-based restrictions on smoking in public places are there, yet tobacco continues to be a top killer. Courageous initiatives taken by the government can only succeed with institutional backing, whether legal or otherwise.

Though institutional arrangements like universal provision of insurance coverage are considered to be successful initiatives for ensuring public health, India so far has met with limited success. An analysis of the reasons for its failure is beyond the scope of this article. Suffice to say that drawing important lessons from scattered insurance schemes' inability to make an impact, the government has subsumed these efforts (for example RSBY) into the larger umbrella program for universal health.

IMAGE: PIXABAY

Economists have established the connection between globalization in general, and trade liberalization in particular, and state that these negatively impact healthcare due to constrained pricing and trade policies of pharmaceuticals. Globalization and liberalization also require enhanced health surveillance across borders and populations – as evidenced by Covid-19 pandemic that swept across the world originating in China.

Health of the public impacts the economic development of a country as has been demonstrated. Countries that have weak health and education systems fail to achieve the desired growth. There is economic evidence that proves a 10% improvement in life expectancy at birth leads to rise in economic growth of some 0.3-0.4 percentage points annually.

Diseases are a big hinderance to institutional performance and individual productivity. Debilitating communicable diseases are an economic burden and so are non-communicable diseases that lower productivity, increase health costs and reduce life expectancy. Their impact on economic development has been well demonstrated.

Out of pocket health expenditures expose vast population segments to huge cost burdens. The disease/poverty trap is perpetuated while no actual development takes place. Health policy of a country cannot be taken lightly. Public health systems need huge financing and investment and yet governments must also consider that this does not impact national spending on other sectors for economic competitiveness.

It's a delicate balance that policymakers must strive for. Increasing health spending may require cuts in other sectors of the economic system. Yet health systems are crucial for economic growth. Governments must ensure that the spending on health leads to improved health outcomes otherwise increased investments will be a sheer wastage of resources.

The country's health system needs higher investment in health to protect the economy from the effects of pandemic outbreak. The government of India has responded to this need and in the financial package announced worth Rs 20-lakh-crore recently, it has made proposals to prevent and respond to future pandemics. The proposal stresses the need to strengthen health and wellness centres, establish infectious diseases hospital blocks in all districts, expansion of laboratory network and the need for research on zoonosis led by the Indian Council of Medical Research (ICMR).

In any public health initiative, states have a major role to play. They are fundamental to any plan for creating equitable healthcare system across the country. According to reports, the Fifteenth Finance Commission is examining ways to increase public financing of the health sector and will frame its recommendations basis that.

Traditionally, governments have focussed on growth engines like manufacturing and viewed health as an unavoidable cost that rises outstripping the value of services provided. It is time to change the policy focus and prioritize public health along with other areas. Human development is dependent on the services rendered by public health and health has direct correlation with economic development.

India's demographic gains depend on how it can ensure health of its public. Investing in health hence is critical to boost productivity. India must develop a proper plan to invest in education and skilling of health workforce that will then help lift its health services to a level where its population is well protected. A skilled health workforce will also help in expanding its medical tourism industryas also work to fulfil global health needs. Along with innovative health technologies and its pharmaceutical products, a skilled healthcare workforce can be a big chunk of its export basket.

This is the right time to for India to up its investments in the health sector and aggressively push its universal health coverage agenda. As history has demonstrated most countries established their robust public health systems in times of adversity.

Source: Secondary research & media reports

IMAGE: PIXABAY

We must learn to respect their boundaries.

Time To Relook At Our Consumption Habits

Scientist are pointing to the human interference in wildlife as the primary cause of epidemics and warn that this must stop if we do not want reruns of pandemic in the future.

THE UNMINDFUL DESTRUCTION of our natural resources is directly linked to Covid-19. So much so, that environmentalists and scientists have issued dire warnings that if we do not stop destroying our environment and killing wildlife for illegal trade the next pandemic could well wipe out the human race.

Three scientists, namely Professors Josef Settele, Sandra Díaz and Eduardo Brondizio, along and Dr. Peter Daszak, through an article that they wrote for The Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services (IPBES) titled: "COVID-19 Stimulus Measures Must Save Lives, Protect Livelihoods, and Safeguard Nature to Reduce the Risk of Future Pandemics", have warned that the "rampant deforestation, uncontrolled expansion of agriculture, intensive farming, mining and infrastructure development, as well as the exploitation of wild species" are the perfect recipe for diseases to spillover from wildlife to people.

The experts' warning gains urgency in the light of the fact that several diseases like Ebola, rabies or avian flu have crossed over from animals to humans in the past few years. More so as the death toll of these infectious diseases is an estimated 700,000 annually. Looking at the gravity of the threat imposed by zoonosis, these scientists warn that that if we fail to protect nature and separate animals from humans, the next pandemic could be far worse. We could face more frequent and far devastating pandemics if we do not get our act together.

How our future pans out, comes down to the choices we make. Governments must get together to take stringent actions banning wildlife trade, poaching and consumption of wild animals According to experts, 60 percent of infectious diseases originate in animals. They are then transferred to humans because of the rampant trade in wild animals, man-animal conflict as their natural habitats shrink encroached upon by rapacious humans, deforestation and climate change. We destroy forests to build roads, lay pipelines or just to build our habitats. This brings us in contact with animal species that we should have not had any contact with. Our greed has had us poaching these animals and selling them in live markets as exotic species to be consumed as a symbol of human elite. Experts say, the risk of zoonotic disease transfer increases when these animals are stressed or mixed withother species.

The genesis of COVID-19 is still under investigation and is disputed. However, some experts claim the pandemic could have started in a wet market in Wuhan, China. The virus could have been transferred from bats possibly through pangolins. It is being said that the cross-species jump happened due to mixing species by humans. In the wild they would never have come into close proximity of each other. The disease is said to transmit under stress and in close contact. Experts blame the rampant trade in wildlife trade for the pandemic. According to one school of thought SARS was transmitted from bats via civet cats; HIV is said to be the gift to humans from the bushmeat trade in monkeys and chimpanzees.

The killing of wild animals from elephants to rhinos leaves behind a trail of deaths, that of their young ones and is a leading cause of dwindling wildlife population. China and Vietnam are said to be the biggest procurers of poached animals and animal parts. Efforts are on by global wildlife experts to stop the trade at the root through efforts at the governmental level. Chinese have a history of eating wildlife. However, in the aftermath of pandemic and global pressure China has cracked down on its wet markets. Wildlife conservationists are also pressuring Vietnam to ban wildlife trade to prevent repeat of COVID-like pandemic. Vietnam is famous for its wildlife restaurants that serve bats, civet cats, snakes, bear, monkeys and pangolins.

IMAGE: PEXELS

Thankfully China and Vietnam both are looking at ways to curb the smuggling of wild animals and reportedly have set up airport detection systems to check if someone is trying to smuggle in animal parts.

French researchers raise alarm on ecological crisis

In another related development, 16 heads of French research organizations, members of the National Research Alliance for the Environment (AllEnvi*), including CIRAD's Michel Eddi, in an op-ed published in Le Monde, have red flagged the ecological crisis revealed by the COVID-19 epidemic. The researchers have drawn

IMAGE: PIXABAY

Mixing of species that would have otherwise never happened has led to infections crossing over from animals to humans.

attention to the role humans play in environmental degradation and highlight the link between pandemics and ecosystem degradation. The scientists state that all types of health are linked since health ecosystem includes plant, animal and human health.

This multidisciplinary scientific expert study at the request of the French ministries is currently working on increasing human understanding of these complex linkages between the infectious outbreak and biodiversity.

The scientists draw attention to the fact that epidemic outbreaks are becoming more frequent. Serge Morand, health ecologist at CNRS and CIRAD and author La prochaine peste (The next plague), notes that the number of epidemics has increased more than tenfold between 1940 and today globally.

Experts fear that COVID-19 epidemic is among the few epidemical outbreaks on a global scale after AIDS and Asian flu (H2N2), but it may not be the last. Looking at the causes of the pandemic, the scientists say the proliferation of epidemics, and especially of zoonotic diseases requires more concerted efforts towards global health and integration of health ecosystems, plants, animals and humans.

Underlining the role essayed by humans in the emergence and spread of viruses, the authors write thatit is due to the disturbance caused by humans in the environment and in the human-nature interface. They say that the disturbance has been magnified by rising globalization of trade and lifestyles. These factors are responsible for promoting the emergence of viruses. These viruses become more lethal and harmful to humans through recombination with viruses of different species.

Investigation in the genetic origin of SARS-CoV2 reveals that the virus originated in a bat needed an intermediate host that would allow it through recombination and mutation the capacity to infect humans. Researchers then narrowed down their search for the intermediate host to pangolin, that is poached mercilessly and is an endangered species.

In normal circumstances, such transmissions would be rare but in addition to rapid encroachment of wildlife

habitats, humans have also managed to increase antibiotics resistance in bacteria due to rampant use of chemicals in farming activities and misuse of antibiotics. These create an environment that is fertile for rapid multiplication of infectious diseases and the creates conditions to escalate disease spread on pandemic scales.

Experts also attribute the spread of these pathogens to biodiversity loss –ecosystems, plants, animals, etc. This loss is however not just the reducing numbers of wildlife species, but also concerns the loss of genetic diversity that is taking place due to human cultivation and farming of animal species. According to the scientists, genetic diversity is essential to the resilience of populations. It aids in limiting propagation and facilitates resistance to pathogens – bacterial, viral or fungal. Natural barriers and biological diversity play a huge roleinin regulating the transmission of pathogens, say the authors.

UNEP steps up work on zoonotics, protecting environment to reduce pandemic risks

In a welcome step, the United Nations Environment Programme (UNEP) is stepping up its work on mapping zoonotic threat and protecting the environment to reduce the risk of future pandemics, such as the COVID-19 crisis currently sweeping the globe.

In Working With the Environment to Protect People, released by UNEP recently, it lays out how it is adjusting its work in response to COVID-19 through supporting nations and partners to “build back better” – through stronger science, policies that back a healthier planet and more green investments.

According to the press release, UNEP's response covers four areas: helping nations manage COVID-19 waste, delivering a transformational change for nature and people, working to ensure economic recovery packages create resilience to future crises, and modernizing global environmental governance.

IMAGE: PIXABAY

The threat of zoonotic diseases has increased because of human greed that is destroying the biodiversity.

“In COVID-19, the planet has delivered its strongest warning to date that humanity must change,” the release quoted UNEP Executive Director Inger Andersen. “Shutting down economies is a short-term response to this warning. It cannot endure. Economies that work with nature are critical to ensure that the world's nations thrive.”

To support nations in their efforts to address the socio-economic and environmental impacts of COVID-19, UNEP will coordinate its work with the rest of the UN system, the release said. Examples of interventions include:

- Supporting decision makers to deal with the spike in hazardous waste – such as personal protective equipment, electronics and pharmaceuticals – in a way that does not further damage human health or the environment.
- A zoonotic risk and response program to improve countries' ability to reduce threats through nature-positive approaches – including a new global mapping of risks from the unregulated wildlife trade, habitat fragmentation and biodiversity loss.
- Promoting expanded opportunities for investing in nature and sustainability as part of the response to the COVID-19 crisis – including through existing funds UNEP manages and economic stimulus packages that countries are planning.
- Reaching real economy actors to rebuild, scale up and accelerate sustainable consumption and production, and create new green job – including reaching businesses through partnerships with UN agencies, finance, government and private sector institutions, and revitalizing markets and supply chains for green and sustainable products.
- Reviewing the implications of moving environmental governance and multilateralism towards virtual, and thus lower environmental footprint, meeting platforms.

Conclusion

The message is loud and clear. If we want to control pandemics in the future, we must learn to live in harmony with nature as our ancestors did. Our activities that harm biodiversityare expediting our end as these actions produce the conditions that are conducive for the spread of new diseases.

It is urgent that we work towards strengthening the foundation of an ecology of health. The focus as the experts say should be on the interdependencies between the functioning of ecosystems, sociocultural practices and the health of human, animal and plant populations taken together.

Source: Secondary research & media reports

THE PRESCRIPTION

India's indigenous healthcare systems are essential to its health for all scheme.

IMAGE: PIXABAY

INDIA'S INDIGENOUS HEALTH SYSTEMS ARE ROOTED IN NATURAL REMEDIES AND MUST BE MADE INTEGRAL TO THE OVERALL PREVENTIVE HEALTHCARE PROGRAM UNDER UNIVERSAL HEALTH COVERAGE INITIATIVE

INDIA'S TRADITIONAL MEDICINE system Ayush (ayurveda, yoga & naturopathy, unani, siddha and homoeopathy) can play an important role in management of pandemics. Though sceptics may detract from its benefits, a vast majority of the country's population is dependent on alternative health systems in the management of chronic ailments. Ayush is an important part of India's total health program and with the right push, it can be an important cost-effective health system.

According to reports, the global herbal products market is valued around $6.2 billion and forecast to reach $5 trillion by 2050. The rising health consciousness and a call to return to roots and adopt natural has led to a spike in the demand for traditional Indian herbal products or Ayurveda internationally as well as domestically.

Role in Covid-19

Recognizing Ayush's role in building immunity, Prime Minister Narendra Modi recommended the citizens to follow its precepts in that direction. In fact, the Ministry of Ayush (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy) is participating actively in India's fight against Covid-19. A number of initiatives have been launched in the past month or so by the ministry to support mainstream health systems and a number of studies are also being conducted to back treatment of Covid-19 with Ayurvedic herbs with scientific evidence.

The Ayush ministry came out with a series of advisories encouraging people to adopt simple immune boosting measures like use of spices and herbs and bringing about lifestyle changes and also ways to symptomatic management. The ministry advisory came with a disclaimer that the suggested measures are not to be considered as treatment the virus.

In a bid to bring scientific evidence to Ayush's interventions in the pandemic, the ministry is actively engaged in clinical studies of Ayush systems. It has set up an interdisciplinary Ayush research and development task force comprising experts to develop strategies for this initiative. Collaborative clinical studies have been initiated as a joint venture involving ministries of Ayush, health, and science & technology through CSIR and with the technical support of ICMR (Indian Council of Medical Research). These initiatives are to study identified Ayurveda herbs as supplement to the use of hydroxychloroquine in Covid-19 management. Research proposals have been invited by the ministry through a dedicated web portal for Covid-19. After rigorous screening, those found worth the effort would be studied further.

Rising popularity

Rising awareness regarding the importance of preventive healthcare has shifted the focus from cure-oriented treatments to health-oriented healthcare interventions. As people are becoming aware, they are adopting measures that make the body strong and strengthen the immune system. The pandemic has underlined underlying or undetected NCDs as the primary cause of fatalities due to the virus.

As people leaning more towards natural health management measures,these will gain importance post the pandemic. Ayush as a natural science is set to play a large role in people's choices for a healthy life. For generations, Indians have depended on indigenous medicine systems and now more than ever, people will opt for healthy lifestyle choices like using common herbs and spices, yoga, natural remedies, etc.

To make Ayush a globally recognized medicine system, the ministry is working on a global platform to improve its market. Initiatives like the establishment of Forum for Indian Traditional Medicine at Research & Information System for developing countries, which is an international agency specializing in international economic development, trade, investment and technology and is an autonomous body under the administrative control of external affairs ministry, are worth mentioning here.

IMAGE: PIXABAY

Efforts are also on to standardize Ayurveda products. Two voluntary certification schemes have been introduced that should go a long way in improving its global market. Under these certification schemes from Quality Council of India (QCI) and certificate of pharmaceutical products for Ayurveda products issued by Drug Controller General of India (DCGI) for the purpose of export, it is expected that Ayush products will get more credibility. Under the QCI scheme, there are two kinds of certificates – Ayush standards mark for those Ayurveda products that comply with domestic regulations, and Ayush premium mark to certify products as per international norms.

Another important step taken by the ministry along with commerce ministry is International Arogya which is aimed at making Indian system of medicine globally popular and to develop strategic partnership with other countries in the field of medical and integrated healthcare

IMAGE: PIXABAY

Rising awareness about the side effects of allopathy drugs is increasing the popularity of traditional medicines.

sector. Steps are also being taken with expert agencies to promote investment in the Ayush sector and promote ease of doing business.

Standardizing terminologies for traditional medicine systems

Globally, the importance of standardization of terms to facilitate better communication between modern and traditional medicine practitioners is now being recognized. This is also crucial to the integration of traditional medicine into the national health system.

As such, the World Health Organisation (WHO) has developed standardized terminologies for the Ayurveda, Unani and Siddha systems. This is part of a global strategy by the international body to strengthen the quality, safety and effectiveness of traditional and complementary medicines.

The efforts at standardization are a collaborative exercise by the WHO and the Ministry of Ayurveda, Yoga & Naturopathy, Unani, Siddha, and Homoeopathy. Under this, the WHO reviewed the 'Standard International Terminologies Documents'.

These terms relate to basic principles, fundamental theories, human structure and function, diagnosis, diseases, disease patterns and body constitutions, medicines, food, therapies, preventive and promotive health interventions, etc., of the respective medical systems, say reports. It is expected that this exercise will help facilitate better communication between practitioners of modern and traditional medicines and enable better integration of traditional medicine into the national health system.

For researchers and healthcare professionals too, standardized terms would be a big help. According to reports, around 20 international experts of Ayurveda, Unani and Siddha from 13 different countries, including Japan, Canada, Denmark, Austria, Sri Lanka, New Zealand, Switzerland, Malaysia, South Africa, Nepal etc., along with 21 experts from India and four WHO officials were part of this standardization exercise.

The documents prepared by experts, reviewed, and with international consensus on the structure and content of each of the documents, includes definitions, contextual meanings of the terms, classical usages and references, suggested English terms, synonyms, etc.

Conclusion

For India, its traditional medicines are integral to its universal health coverage program under Sustainable Developmental Goal-3 (SDG-3) of United Nations. As a cost-effective indigenous system of medicine, Ayush must be promoted aggressively. It has an important role to play in preventive healthcare and help reduce the burden on non-communicable diseases. Looking at these benefits, the government is taking all steps that promote integration of Ayush systems with mainstream healthcare delivery systems.

Source: Secondary research and media reports

Efforts are on with global collaboration to standardize terminologies used in traditional medicine systems to enable their integration with mainstream systems.

IMAGE: PIXABAY

ASHA
- Ray Of Hope

Rural healthcare workers took on the role of frontline Covid-19 warriors and have been tirelessly working to help the government in its war against the pandemic. The role played by the cadre of ASHA workers is especially appreciable in this endeavor.

India's army of grassroots health workers is its bridge to the rural communities.

IMAGE: PIXABAY

INDIA'S FIGHT AGAINST coronavirus pandemic illustrated the importance of its ninelakh-plus accredited social and health activists in its health system. Without this indefatigable army of foot soldiers, controlling the tentacles of the fast-spreading virus would be impossible. The government sought the help of these workers to fan out to the remotest corners of the country with its containment and communication strategy. This army of largely rural women was entrusted with the important task of door-to-door surveys, monitoring migrants' movements and educating people on the mandated precautions to keep the virus at bay.

These accredited health workers were asked to focus on the pandemic containment and that meant the other critical health services that they render took a backseat.

ASHA - First port of call

ASHA workers are the crucial bridge for ensuring primary health of the rural population. Each grassroots health worker provides services like immunization to pregnant women or birth control methods, calcium and iron tablets, etc., to the designated population base.

For the village women, these health workers are like a trusted family doctor to whom they can turn to for needs as varied as birth control measures to tetanus injections. ASHA 'didis', as these women are affectionately called, are family counsellors to the village women turn to when in need of advice.From taking women for delivery to the Community Health Centre (CHC) to taking care of the needs of lactating mothers and pregnant women, these women health workers do it all.

Under the National Rural Health Mission (NRHM) launched to address the health needs of rural population, especially the vulnerable sections of society, the government envisaged an enlarged role for accredited health workers or ASHA. The sub-centre which is the most peripheral level of contact with the community under the public health infrastructure, caters to huge population base, much beyond the norm of 5000. These centres were hamstrung as the ANM are heavily overworked. This impacted the outreach services in rural areas. The government realized that Anganwadi Workers (AWWs) who are engaged under the Integrated Child Development Scheme (ICDS) and are responsible for organizing supplementary nutrition programmes and other supportive activities, could not take up the responsibility of a change agent for health in the villages. From this need was born a new band of community-based functionaries, named as Accredited Social Health Activist (ASHA). The plan envisaged the role of ASHAs as the first port of call for any health-related demands of deprived sections, especially women and children, in areas where access to health services is not easy.

ASHA's role was envisaged as that of a community health activist who could be entrusted with the task of creating awareness on health and its social determinants. They were assigned to mobilize the community towards local health planning. They would also ensure increased

utilization and accountability of the existing health services.

As the promoter of good health practices, ASHA workers would provide a minimum package of curative care at the community level and ensure timely referrals. ASHA workers have to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health and family welfare services. ASHAs also provide counselling to women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.

An important duty of ASHAs is to mobilize rural communities and facilitate their access to health and health related services available at the village/sub-centre/primary health centres, such as immunization, ante natal check-up (ANC), post-natal check-up (PNC), ICDS, sanitation and other services being provided by the government. Not only this, ASHAs are also mandated to accompany pregnant women and children requiring treatment/admission to the nearest pre-identified health facility – Primary Health Centre/Community Health Centre/First Referral Unit (PHC/CHC /FRU). They function as the family doctor for primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries, and also oversee Directly Observed Treatment Shortcourse (DOTS) under Revised National Tuberculosis Control Programme.

Working closely with Village Health & Sanitation Committee of the Gram Panchayat, ASHAs help develop comprehensive village health plan. ASHAs act as depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. They are provided a Drug Kit with contents as per the recommendations of the expert/technical advisory group set up by the Government of India.

As the first port of call, they are also the first source of information on births and deaths in the village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre. They played an important role in the construction of household toilets under the Swachh Bharat Abhiyan.

Covid warriors

The lack of proper protective gear notwithstanding, these grassroots workers continued working from the front even as cases have spiralled unnerving health experts.

These women health workers are like family doctors and counsellors for the rural households.

IMAGE: PIXABAY

The health workers are working as frontline warriors in India's fight against Covid-19.

With migrant workers returning home and being sent to quarantine centres, the ASHAs took up the task to counsel the affected families. Their own families are worried about their health, but ASHA workers soldier on. The pandemic has also brought about suspicion in the community, as many fear stigmatisation, in case found to be coronavirus positive. People are also suspicious that these frontline workers maybe inadvertently carriers of the virus and will infect them. There is a lot of fear too as people are sure that getting infected means death. ASHA workers have to often face hostility from communities when the go about on Covid-19 duty. Surprisingly, it is the same communities that they have served for long that have become hostile towards them today.

Needless to say, that these women are facing immense hardship in this new duty that has been thrust upon them by the pandemic. However, they are not willing to give up.

Good Samaritans to the rescue

It is a good sign indeed that the hard work of ASHAs is being recognized and appreciated. Some good Samaritans have also come forward to help them with protective gear. One such story of appreciation has been scripted in Hisar, Haryana. Tayal Foundation collaborated with the Hisar Chapters of Indian National Trust for Art and Cultural Heritage (INTACH) and Indian Medical Association to launch 'Rakshak ki Raksha,' a campaign to support and protect frontline Covid-19 healthcare workers in rural India. Under the initiative, personal protective equipment kits or 'Raksha' kits are being provided to frontline healthcare warriors in rural India like the multipurpose healthcare workers (MHW), accredited social health activists (ASHA), auxiliary nurse midwife (ANM), Anganwadi (ANN) workers, ambulance drivers, sanitation workers, and ward attendants in civil hospitals.

The Foundation worked with the authorities to identify the districts that were under-served and where frontline healthcare workers were in need of resources and PPEs. Each Raksha kit has been assembled by employees of the Tayal Foundation in their facilities in Hisar and includes face shields, goggles, hand sanitizers, SS-96 and SITRA-certified triple layer cloth masks, soaps, and gloves. The masks were procured from manufacturers at cost price or even for free. The quality of the kit was maintained by ensuring the items were procured from only those manufacturers who had the necessary certifications. Also, the Chief Medical Officer in each district were asked to confirm if the products met quality standards. Sanitizers and soaps were procured from Hindustan Unilever, who donated all the sanitizers needed for each Raksha kit.

It is appreciable that since its launch in March, the Rakshak ki Raksha campaign has delivered more than 10,000 safety kits to healthcare workers in over 900 towns and villages spread across six different districts in Haryana and Delhi.

Conclusion

Grassroots health workers are an indispensable to the health of rural communities. They are playing an important role in India's universal health coverage program and have demonstrated that they can rise to the occasion in a pandemic situation.

Source: Secondary research & media reports

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No Health Without Social Security

The government must prioritize setting up a social security net for the informal sector workers including migrants.

Social security helps the poor in times of a health crisis.

IMAGE: PIXABAY

REVERSE MIGRATION HAS become the nightmare of poorer states in India. As long as internal migration happened and the onus of providing for the marginalized communities was elsewhere, things were moving with a silent acceptance, nay approval of the status quo. Covid-19 has now made us confront the uncomfortable reality of India's poor citizens who live in the shadows of the tall skyscrapers they help erect in the big rich cities. The world was treated to India's ignominy as millions of its labourers chose to defy the lockdown and return home. They were not afraid of dying from the disease. They were rather horrified by the thought of dying in the big bad callous cities, alone and uncared for. Why? Simply because we have never bothered to create a sustainable social security structure they can depend on in times of emergency.

Migration is the outcome of our inefficacy to create job infrastructure that caters to the employment needs of the poor near their homes.

However, with widespread outcry, migrants' plight was noted, and the government earmarked an additional Rs 40,000 crore under its Aatmanirbhar Bharat Abhiyan, for Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS). This boosts the earlier estimate of Rs 61,000 crore.

This 15-year-old statutory scheme is perhaps the only guarantee of intermittent employment for the rural poor. And, even this is inadequate to ensure two square meals for the hungry millions. Surprisingly, as reports suggest, the uptake on MGNREG scheme has been lower in the poorer states that provide India its millions of blue-collar workers.

The lockdown induced economic distress has highlighted what for decades we had been brushing under the carpet – the need for a nationwide social protection scheme to salvage the economy, as it depends on India's multitudes bringing the production back at the optimum level its pre-Covid-19 capacity before the crisis. For this to happen, the migrants need to be lured back to the cities and commercial and manufacturing centres.

To begin with, to drive this new social protection program, private sector must partner with the government, as neither can drive it alone. They must also realize that to ensure that the next pandemic does not end up in a similar economic crisis, instituting a social security net is a fundamental requirement.

As we saw, despite government advisories and even threats of penal actions, industries went about laying off workers, sending them on furlough and cutting salaries. The sufferers are both the white and the blue-collar workers. Landlords too, ignored the governments advise and threw tenants out over non-payment of rent. To expect the migrants to stay on roads or hastily constructed shelters with rickety amenities and no scope for social distancing, depending on meal handouts that at best were just twice a day, was expecting the moon. The migrants are not beggars and value their dignity above hunger and death. What could actually have worked to hold them back was perhaps a guaranteed payment of wages for at least six months. In fact, this minimum guarantee should become a part of the social security package to be implemented across industries and categories of employees –for all employees – whether unskilled, semi-skilled or skilled. It must also be made mandatory for organizations to register all employees under the Employees Provident Fund Organisation (EPFO) lowering the current requirement of minimum 20 employees to less than that. Among the worst sufferers were also the huge army of foot soldiers of gig economy players. The government must include these workers in the social security net.

Hunger became an overriding reason for the migrants to choose to walk back home. Obviously, combating hunger must be prioritized and along with the minimum guarantee of work, there must also be a minimum guarantee of food for the poor. The efficacy of large community kitchens in battling the widespread food distress shows that this model can be implemented across the country especially covering all rural areas. For example, Jharkhand government enlisted its huge self-help group network to operate community kitchens and dal-bhaat centres for the food needs of the remote and rural population during the lockdowns.

Guaranteed health protection is integral to any social security scheme. The government must encourage the states to rev up the universal health coverage program. Strengthening the primary health centres and the cadre of grassroots health workers is the only way to protect the poor from diseases. This will require extensive training and collaboration among all stakeholders.

Since India's workforce is spread across geographies and sectors, any social security program will have to factor in their diversity and come up with innovative plans to ensure no poor is left out of the social security umbrella.

It is urgently required that the government set up a separate body to monitor and manage inter-state migration in collaboration with respective states and make it mandatory for states to implement statutory provisions to safeguard the interest of migrant workers.

The industry may go back to full resumption of the industrial activity in some time, but if steps are not taken

Migrants' plight was noted, and the government earmarked an additional Rs 40,000 crore under its Aatmanirbhar Bharat Abhiyan, for Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS). This boosts the earlier estimate of Rs 61,000 crore.

IMAGE: PIXABAY

For migrant workers social security with guaranteed health cover is the safety net they desperately need.

to institute and implement rigorous social security measures for the workers, they will continue to be exploited and any economic downturn will see them sacrificed to business needs.

The demand for social security for all informal workers including migrants is not new. Yet, successive governments failed to realise that there cannot be work security in the absence of social security. While it is hoped that the proposed economic stimulus and livelihood packages that were announced recently will provide support for informal workers, but on its own it is not enough. There must be a minimum social security program to support these initiatives.

The must government also realise that women form 50 percent of the workforce and any social security program without taking into account their specific needs – health care, child care, insurance, pension and housing with basic infrastructure amenities like tap and toilet – is bound to be half-hearted and is doomed to fail.

Our economy cannot thrive without our informal workers bringing up the rear.

Source: Secondary research & media reports

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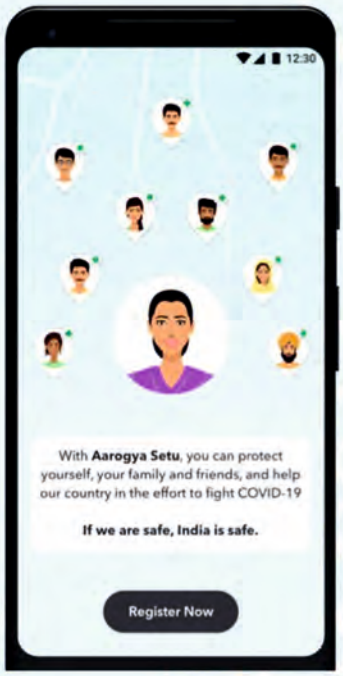

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