Occasional Publication 99

IIC

Health Care in India

by

Preeti Sudan

India International Centre
40, Max Mueller Marg, New Delhi-110 003
Tel. : 24619431 FAX: 24627751

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Health Care in India*

Our topic today, is the journey of preventive and promotive health care from a government perspective. I must say at the outset that it was always the intention of the government to have a mix of promotive and preventive health care strategies closely integrated with curative care. However, it is the curative care aspects that are most visible and this is perhaps the reason for significant investments in setting up health care facilities. In addition, people's vocal demands for curative care, which are legitimate, led us to emphasise the curative part of health care.

So the focus was tilted in favour of care provision after people fell ill, and we became the Ministry of Managing Illness. But I am glad that since last year, we are now the Ministry of Health and Wellness, and I am fortunate that I am at this very place as this paradigm shift is happening in health care. I want to also say that I'm doubly blessed, because I also got to do Beti Bachao, Beti Padhao in the Ministry of Women and Child Development, and was able to take action on discriminatory practices against women and girls in our country So I had that satisfaction as well.

What is health promotion? The distinction between promotion and prevention also leaves me a little confused. There's a very thin line between health promotion and prevention. If we know what prevents ill health, then we would know what we need to promote. The Health Ministry acting alone and by itself cannot prevent illness. It has to be a multi-sectoral effort. We have to actually build an ecosystem that encompasses sanitation, clean drinking water, people empowered

* Lecture delivered by Mrs. Preeti Sudan at the India International Centre on 18 April 2019

with correct knowledge, demanding services, social audit of what we are doing for accountability, and a whole gamut of other things.

I believe that health promotion needs public education, awareness, and then taxation. Through the taxation rate, we try to prevent, or discourage, the sale of items which would cause ill health. Some states have been able to do this. We need legislation: on tobacco use, for example, and on e-cigarettes, and urgently. This must be followed by monitoring, evaluation and research.

The Indian Council of Medical Research (ICMR) and the Department of Health Research (DHR) have been doing excellent work. We have built synergies with them to encourage implementation and health systems research so that the needs of the health ministry are met.

I would now like to focus on the spectrum of prevention. The first is primordial prevention—thus, for example, breastfeeding will protect children against diseases, or, if building life-skills amongst adolescents reduces the chances of engaging in risky behaviours. Then we come to primary prevention which includes immunisation, or wearing seatbelts and helmets to prevent accidents. Secondary prevention, refers to increasing survival rate, treatment of hypertension and diabetes, which are now called lifestyle diseases. Tertiary prevention includes

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Increasingly, quaternary prevention is gaining importance, because hospital infections and anti-microbial resistance are a concern both in India and abroad.

Health promotion and prevention need good surveillance systems. By this I mean information on morbidity and mortality status, environment hazards, community health practices, providing timely warning to people on public health emergencies, triggering specific messages and strategies for promotion. For example, we were able to identify one case of Ebola in India and controlled its spread. That's one single case, and it happened only because of surveillance. We may sometimes criticise our own country, but despite constraints we have done well.

Similarly with Nipah. If you will recall, in Kerala, within a span of 40 days, we were able to contain it and ensured it did not spread. The single case of West Nile virus was identified in a young boy, also in Kerala, and unfortunately, the boy died.

Surveillance systems are in place, and the health system has been strengthened over the years. But, somehow, we have not been very good at engaging people to take responsibility for their health and we have also not told people how they can be our partners in not just surveillance, but health promotion and prevention. That too is a crucial need.

I would say that the key to health promotion is in integrating health in all policies of various departments of the government. For instance, in the Ministry of Environment, Forests and Climate Change, given that climate change has deleterious consequences on health, or in the Ministry of Road, Transport and

Highways, to prevent and minimise the effect of accidents and injuries.

The Sustainable Development Goals (SDGs) have been structured in such a way that health is foregrounded. It has to do with poverty alleviation, it has to do with rural development, it has to do with agriculture (by ensuring that pesticides and more insecticides are not used so that microbial resistance is not built). It is a whole gamut of very complex systems working together.

We need to create supportive environments, an ecosystem where promotive health actually thrives. We need to strengthen community action, without which we cannot function. It means developing personal skills and behaviour change, saying no to unsafe sex, saying no to tobacco, saying no to risky behaviours, and of course, reorienting health services. Has India ever tried to think about preventive–promotive interventions?

This came to me as a surprise. The Bhore Committee, named after Sir Joseph Bhore, was set up in 1943, prior to independence, and gave its recommendations in 1946. It was a very comprehensive report. It had envisaged a 'social physician', instead of the MBBS and postgraduate doctors that we have today, and they laid emphasis on a Comprehensive Primary Health Care system. Unfortunately, it wasn't really adopted entirely in the spirit in which it was intended.

Dr. Reddy was earlier sharing that it was because the finance minister at that time said that, if we are to implement the Bhore Committee, then the entire budget of the country will go into health alone. I wish we had done that.

In 1952, the National Family Planning Programme came into being. This was the first of its kind in developing countries. It initially covered only birth control,

because, at the time, policy makers were influenced by the Malthusian theory and feared that population increase would eat up resources—and therefore promoted birth control. But then given our high infant and mortality rates, it slowly became evident that without mother and child health care, and nutrition, we would not be able to move forward.

Therefore, in 1966, the Ministry of Health and Family Welfare created a separate Department of Family Planning, but in 2005, we reverted to the Ministry of Health and Family Welfare. My work is therefore in both family welfare and health in general. We have moved to and fro, but I think this integration is better.

Then came the revised national family welfare programme around 1978. It was the post-emergency period that triggered the movement from planning to welfare. It was a reaction to sterilisations, and the acceptance that family planning methods shall not be by compulsion, but voluntarily. Something interesting happened at this point. Because vasectomies were no longer the emphasis, there was no pressure. So, it was the women who actually bore the brunt of family planning. But in a way, it was good. Why am I, as a woman, saying this? Because an empowered woman could make reproductive decisions herself—she could get her copper-T inserted, she could take a contraceptive pill, and slowly, when the choices expanded, real empowerment would come. However, I still feel that we need to work with men as far as family welfare measures are concerned.

This first national health policy was enunciated in 1983. This was basically a response to the commitment to the Alma-Ata declaration for health for all by 2000, and mind you, this was a global goal. It became an accepted fact that health is central to development, and we must focus on access to health services by all.

However, it remained a policy, because it was not really followed by any programmatic intervention. In the meantime, we took up a very ambitious universal immunisation programme. It was introduced in 1978 as an expanded programme of immunisation, but it was only in 1985 that the universal immunisation programme (UIP) was taken up in right earnest.

This fit in well with our emphasis on RMNCHA, the Reproductive Maternal and Child Health Care, to which Adolescence was later added. So our primary health care policy, The Bhore Committee, as we know, had talked about Comprehensive Primary Health Care, but when we set up our primary health care centres, we concentrated on women in the reproductive age, and not women through a life cycle continuum. As a consequence, women and child welfare, universal immunisation and such preventive interventions became an important part.

The Reproductive Child Health Programme came into existence in 1996. Again, as I said, that along with reproductive RMNCH, all the elements of child health care became very important. Then the National Population Policy, which prioritised that a reduction in fertility levels to reach replacement levels by 2010 were to be achieved; 2.1 per cent is the replacement level, the country right now has a total fertility level of 2.2 per cent. Twenty-four states have already actually achieved this target. However, Bihar, UP, for example, are the states where we need to work better. During this time, also, I would say that child health care services further got strengthened. Then we got the national health policy in 2002 which was also very important.

We have talked about the Bhore Committee, the National Health Policy 1983, and the National Health Policy 2002. We see here that the causal links between health outcomes and social determinants of health were emphasised, but again,

this was not followed up by any comprehensive programmatic intervention.

In the 1990s we also implemented the Reproductive Child Health Programme, where the focus was largely on mothers and children.

In 2005, the National Rural Health Mission (NRHM) came into existence. This was the first time we saw the involvement of the Panchayati Raj institutions and community in the management of primary health care programmes, and infrastructure got priority. Village health, sanitation, nutrition committees were institutionalised. Under this programme, a one million army of Ashas, or field level community health workers, proved to be a great resource as far as outreach is concerned, and we depend very heavily on them.

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Next, in 2013, the National Urban Health Mission was added. We come now to the National Health Policy of 2017, which was followed by Ayushman Bharat.

As I mentioned, promotive and preventive health was always our intention, but in practice it was only concentrated to RMNCHA, but it was the National Health Policy 2017, within one year, which was followed by a comprehensive programme of Ayushman Bharat that made the realisation of universal health care a possibility.

The National Health Policy's goal is Health for All, and in the area of health promotion and prevention, it has seven pillars—Swacch Bharat Abhiyan; Nirbhay Naari (violence against women); Yatri Suraksha, stress reduction, risk factors like tobacco, alcohol, reducing pollution, diet and yoga—leading to a Swasth

Nagrik Abhiyan. This policy therefore brings in all the elements of preventive and promotive health.

As I said earlier, I am fortunate to be here at this juncture, and working on the Ayushman Bharat programme. If you look at the continuum of care, or the health pyramid, then the foundation is primary health care. And, as I said, the existing services only included RMNCHA, with women in the reproductive age, children and adolescents. The unmet need was non-communicable diseases (NCD) and chronic diseases. We did have vertical programmes like TB, cancer, etc., but there was no comprehensive approach.

At the end, there was no real thinking on preventive, promotive, curative care. Curative, yes, but not rehabilitative and palliative care which has now been included under Ayushman Bharat. You will have also heard about PMJAY, the insurance scheme, where, in secondary and tertiary care, the government will ensure that 50 crore people or 10.7 crore families are covered with insurance or the assurance cover and the sum is five lakh rupees per annum per family.

Let us look at this more closely. What are the risk factors that drive most death and disability combined? It's very interesting. Where did we move in these 10 years? According to the Global Burden of Disease Report of India, malnutrition was the first and gravest risk, and remains so. But we have seen an improvement of (minus 35.3 per cent) over these years. The Poshan Abhiyan programme gives great visibility to malnutrition.

Next, air pollution. Interestingly, it is down by 2.7 per cent. I believe that indoor pollution got a little respite because of the use of cooking gas rather than coal and wood in kitchens. But air pollution, or vehicular air pollution, has increased.

Dietary risk is up by 34.9 per cent, caused largely by fast food, sedentary lifestyles, pesticides in vegetables, etc. High blood pressure shows a 40.7 per cent increase. Therefore, I believe that non communicable diseases like blood pressure, cancers and diabetes actually result in 67 per cent deaths, 55 per cent of which are premature. Given the shift in risk factors, we will need to also shift not only our policies, but our programmes and our narrative on prevention and promotion.

Health promotion interventions are required across a lifecycle continuum. Let's begin with infants and children. In Poshan Abhiyan, visits by Ashas include not merely immunisation, but also counselling on feeding practices, supplementary feeding, hygiene practices, early childhood development, deworming and iron supplementation.

Interventions are also required for adolescents, eligible couples and pregnant mothers, with whom we have been working. We are now beginning to work with the above 30 population through our health and wellness centres. For the elderly population above 60 years, we are lacking in geriatric care for the over 60 population, although the intention is there and we are preparing guidelines. We do have geriatric wards in AIIMS and in tertiary care hospitals, but we have not actually done any substantial work in preventive and promotive care for this category.

I will reiterate here that we have focused on reproductive and maternal health care, and we have ensured that primary health care gets strengthened with various interventions. Then reaching the unreached through health promotion. One example is Mission Indradhanush.

Earlier I spoke to you about EIP, then I spoke to you about the Universal

Immunisation Programme, now I'm speaking to you about Mission Indradhanush.

I believe we have done a good job. Polio has been eradicated, and we have been able to keep our children away from very dangerous diseases; smallpox is not an issue now. Health and nutrition day is observed every month through the committee of Village Health, Sanitation and Nutrition Committees. Another programme, Rashtriya Bal Swasthya Karyakram, once included only immunisation, but it has been expanded to undertake early identification and management of defects, deficiencies, disabilities and development delays among children. This is now a comprehensive programme through which we have been able to reach an incredible 100 crore children.

This has ensured that we don't only screen, but also give aid and assistance to people below the poverty line for any surgical interventions. Technology has greatly helped disease control and detection. This can be seen in the case of children with clubfoot, for example.

We have been able to reach 253 million adolescents over the last five to six years. The most important thing is that there is a peer educator programme, because we find that adolescents listen to their peers and friends. This is working very well. The goal is adoption of healthy lifestyles and ensuring mental and emotional well-being.

I would like to share a personal experience. As a child, I had moral science in school which is no longer a part of the curriculum. Moral science actually did a lot in the sense that a value system and an ethical framework was formed in impressionable minds. We used to do *shram daan,* we had NCC, or we could opt for the Girl Guides/Scouts programme. None of this is compulsory anymore. I have

been requesting Secretary, School Education, that these be re-introduced so that we will not need the Rashtriya Kishore Swasthya Karyakram type of programme. Because discipline, and national pride, an ethical framework and civic sense would be inculcated with this kind of training in schools itself.

Although we have a programme for iron deficiency and anaemia, our targets for 2022 are not very ambitious, and we are unable to root out anaemia from our population. This has a lot to do with our dietary habits. Further, with child marriage still prevalent, girls of a very young age are having children. As a result, the children could be premature or of low birth weight, and these deficiencies take a long time to get corrected. Through Poshan Abhiyan, we aim to achieve 3 per cent annual decline in the prevalence of anaemia.

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Next, we look at control of infectious diseases.
Over the past 10 years, from 2007 to 2017, we have reduced mortality by 20.1 per cent . However, there is a long way to go. There is a huge TB burden still, and not just pulmonary TB, but TB of the brain, spine, stomach, etc. The Prime Minister has set a very ambitious target to eliminate TB from India by 2025, while we still have to identify patients. We are therefore now working at active case finding in vulnerable areas. While nutrition support is important, most important is airborne

infection control. In earlier times, TB patients were segregated in sanatoriums, which we no longer have. TB patients use regular hospitals, but within that, attempts are made to isolate them in wards. Once again, promotive care is important in TB. Also not smoking or tobacco use, which I will come to later, are important aspects.

There are three key risk factors that we need to address: behavioural, biochemical or metabolic, and environmental. These are the factors which we need to address, but how? We are doing it through our health and wellness centres under the Ayushman Bharat Comprehensive Primary Health Care with 12 services envisaged. We have just started the screening of the above 30 population against NCDs. They are screened for blood pressure, diabetes, and three cancers—oral, cervical and breast. We have found that 7 per cent of the people have problems of blood pressure, 9 per cent have diabetes, which, if undetected, would result in catastrophic incidents and increase secondary and tertiary care expenditure. If we can give the patient these lifetime medicines, then things could be kept under control.

Free drugs and diagnostics are now available in our Primary Health Centres, and we are bringing them down to health and wellness centres too. We need to have 1.5 lakh health and wellness centres by 2022. This year, we have set up 15,000. By next year, we have to set up 40,000. Therefore, I am talking about preventive and promotive health care, but also emphasising that it is the broader ecosystem we are working on. We are also creating the infrastructure for this—while earlier it was only for RMNCHA.

These are our key health indicators. We do have a long way to go as far as SDGs is concerned. We have made considerable progress. The MDGs were basically concentrated on RMNCHA, more women centric, more child centric, but the SDGs

are more inclusive, as far as health outcomes are concerned. Still, I want to say also that between 1990 and 2015, the decline in MMR is 77 per cent as compared to the 44 per cent Global MMR decline.

We have equalled the global rate of under five mortality rate. That does not mean we have done very well; we need to work at it. Most such deaths take place at the time of birth itself. So what do we do? We need better training, better standards of delivery care, increase institutional deliveries, talk to people and ensure that antenatal care is provided. The latter is important so that the woman knows the progress of the pregnancy, ensures that she has tetanus injection, iron and folic acid supplementation, calcium supplementation. Once again we see that promotive and preventive care is crucial.

I had an interesting experience when I visited Nagaland recently. I was quite surprised that I was the first health secretary ever to visit Nagaland. I got very upset to see that institutional deliveries were terrible; not even 50 per cent. However, their IMR and MMR rates were as good as Western countries. So what is it that they were doing? Their traditional, community practices were so robust. We have now initiated a study with ICMR to see what Nagaland is doing traditionally. The women do not have institutional deliveries. When they discover that a woman is pregnant, the whole community gets together to ensure that she gets rest, a good diet, and that facilitates safe delivery.

It is time that we recognise that one size does not fit all, and we have to make adjustments for the diversities within our country. Again, as I said, in 2009, we accounted for 50 per cent of polio cases in the world. In 2014, we were declared polio free. We have maintained that status, which is a great achievement, not only by the government, but also the parents who brought their children for polio drops.

It is time that we recognise that one size does not fit all, and we have to make adjustments for the diversities within our country. Again, as I said, in 2009, we accounted for 50 per cent of polio cases in the world. In 2014, we were declared polio free. We have maintained that status, which is a great achievement, not only by the government, but also the parents who brought their children for polio drops. Our one million health workers have worked very hard. Personally, I think we are a case study in maintaining the cold chain. Vaccination needs a cold chain till it reaches the last mile. That our Ashas, ANMs and other field level workers have been able to maintain this is a remarkable achievement. We need to congratulate ourselves that India has made this great achievement.

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I have spoken about tobacco, TB, about comorbidities. So while we have the anti-tobacco legislation in place, we are trying to increase awareness. This again demonstrates that preventive and promotive part is extremely important. The results are actually quite encouraging which I'll show you. So, we recently had the second round of the GATS survey, Global Adult Tobacco use survey, which showed that we have made considerable progress, but we do need to work harder.

The mean age of initiation of tobacco use has come down, but it is one area in which we need to work better. As mentioned earlier technology is very important in health promotion. We are able to connect to people through the use of the Internet, text messages, etc. There are e-initiatives for women, like Kilkari, for example, where weekly and time appropriate audio messages about pregnancy, childbirth, etc., are sent directly to the pregnant woman's mobile phone. Have you had

your medicine? Have you got your ANC done? How big has the child grown? I have also been told that we have a stress management app, which we should spread further.

How do we fund this? Dr. Reddy told me on the side-lines that the finance minister, the first finance minister, said that if the Bhore Report was implemented, then all our budget will be spent on health. So what are we doing now? I want to say that in the budget of last year, of the health and education cess of 4 per cent, one per cent was levied for health. And we have introduced 'sin taxes' to ensure that the risky behaviour and consumption are prevented.

Then another interesting thing has happened. You see our entire budget used to be gobbled by our infrastructure needs, which are much needed. We are also setting up All India Institutes of Medical Sciences; 22 AIIMS are coming up, other medical colleges are coming up, so all our budget will get used up by this. Now I have an alternative extra budgetary funding mechanism through what is called higher education funding agency, HEFA. So this year itself we have used 1015 crores so that now I'm free to use things on my health and wellness centres, on promotion and of course on PMJAY also.

I once again want to emphasise that health and health promotion cannot be tackled by the health ministry alone. Swacch Bharat Abhiyan has made a lot of difference. A WHO study showed that through Swacch Bharat Abhiyan we have prevented five lakh children from diarrhoea deaths. So, we can be infection free. We all know that cleanliness, sanitation and safe drinking water are important to good health.

Nutrition is a dual burden. There is under-nutrition, as well as over-weight, or obesity. Poshan Abhiyan looks at overweight and obesity. This fits well with the

movement to set up health and wellness centres which have provision for yoga, the importance of eating right, and other such promotional aspects which we need to emphasise.

Apart from Poshan Abhiyan, the Food Safety and Standards Agency for India (FSSAI) recently held an Eat Right movement from Kanya Kumari to Kashmir. Now, the point to emphasise again is that they are not only health centres; they are health *and* wellness centres. For the first time, we have programmatically not only enunciated the intent in our health policy, but we have followed it up with a programme.

Under the Eat Right movement, many schools have banned junk foods and also advertising, and there's an additional tax on processed food and drinks. Delhi and Maharashtra have banned high fat, sugar and salt foods in school canteens. We are working with the Ayush Ministry not only for promotion of yoga through wellness, but also curative care. All our AIIMS also have Ayush wards or Ayush wings. There is a vertical being created for synergy, especially for chemotherapy. We have found that practices under Ayush help to handle the toxic effects of chemotherapy.

Schools are a catchment of young children among whom health awareness can be developed. We are creating 2.2 million health and wellness ambassadors in public schools. Two teachers will be trained and designated as health and wellness ambassadors. Health is the real wealth, not pieces of gold and silver, as Mahatma Gandhi said.

As mentioned, one of the pillars is road safety. We are working with the ministry of road transport and in states to set up trauma centres. The Ujjwala programme works towards reducing indoor/outdoor air pollution. LPG coverage has now increased to 94 per cent in the last five years, and women have greatly benefited from it.

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Finally, I should mention that we work with groups in the villages under the Health and Wellness Centre: women's self-help groups, farmers' groups, youth clubs. We are working with Panchayati Raj institutions to see if we can converge and ensure that these groups can hold their activities and talk about wellness in our health and wellness centres on a weekly basis.

About the Author

Ms. Preeti Sudan is an lAS Officer (1983 batch) from the Andhra Pradesh cadre, currently serving as Secretary, Ministry of Health and Family Welfare. In her cadre, she has a distinguished track record of serving in Finance and Planning, Disaster Management, Tourism and Agriculture. Amongst her notable contributions to policy have been initiating and implementing two major flagship programmes of the country i.e., Beti Bachao Beti Padhao (addressing child sex ratio through life cycle empowerment of women) and Ayushman Bharat (Universal Health Coverage). She has also served as Consultant in the World Bank at Washington.

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