9 Health And Nutrition Issues

Introduction

The World Health Organization (WHO): Defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The determinants of good health are: access to various types of health services, and an individual's lifestyle choices, personal, family and social relationships.

India's health care system: It consists of a mix of public and private sector providers of health services. Networks of health care facilities at the primary, secondary and tertiary level, run mainly by State Governments, provide free or very low cost medical services. There is also an extensive private health care sector, covering the entire spectrum from individual doctors and their clinics, to general hospitals and super speciality hospitals.

Status Of Health In India

- ***Health expenditure:***
  - ***General Government expenditure on health:*** as percentage of GDP in 2019-20 was 1.6% (up from 1.5% in 2018-19)
  - ***Out-of-Pocket Expenditure (OOPE):*** as a percentage of Current Health Expenditure fell down to 58.7% in 2016-17 from 60.6% in 2015-16.
  - ***Population with health insurance coverage:*** About 14% of the rural population and 19% of the urban population had health expenditure coverage.
  - ***Source of hospitalisation expenditure:*** Rural households primarily depended on their 'household O income/savings' (80%) and on borrowings' (13%) for financing expenditure on hospitalisation. The figure is 84% and 9% respectively for Urban households.
- ***Life Expectancy:*** As per the 2019 Human Development Report released by United Nations Development Programme (UNDP), between 1990 and 2018, life expectancy at birth increased by 11.6 years in India.
- ***Child Health:*** As per estimates developed by the UN Inter-agency Group for Child mortality estimation Under-five mortality rate (U5MR) (deaths of children less than 5 years per 1,000 live births) has declined from 126 in 1990 to 34 in 2019, with Annual rate of reduction (ARR) of 4.5 per cent in the time period 1990- 2019.
- ***Infant mortality rate (deaths of children less than 1 year per 1,000 live births):*** It has declined from 89 in 1990 to 28 in 2019.
- ***Neonatal mortality rate (deaths of children within a month per 1,000 live births):*** It has declined from 57 in 1990 to 22 in 2019. Status of Immunisation among children aged 0-5 years.3
- ***Vaccinations:*** Mostly BCG and/or the first dose of Oral Polio Vaccine at birth, but two out of five children (40%) do not complete their immunisation programme. Among States, Manipur (75%), Andhra Pradesh (73.6%) and Mizoram (73.4%) recorded the highest rates of full immunisation. In Nagaland, only 12% of children received all vaccinations, followed by Puducherry (34%) and Tripura (39.6%).
- ***Maternal Health Institutional deliveries:*** In rural areas, about 90% childbirths were institutional (in Government/private hospitals) and in urban areas it was about 96%. Pre and Postnatal Care : Among women in the age-group 15-49 years, about 97% of women took prenatal care and about 88% of women took postnatal care.

➲ ***Maternal Mortality Rate (proportion of maternal deaths per 1,00,000 live births reported):*** It has declined from 130 in 2014-2016 to 122 in 2015-17.

What Are Public Health Services?

➲ Public health services are conceptually different from medical services. Their key goal is to reduce the population's exposure to diseases for example through assuring food safety and other health regulations, disease vectors control; monitoring waste disposal and water systems; health awareness and education to improve personal health behaviors and build citizen demand for improved public health outcomes.

Constitutional Framework Of Health

Right to health is not explicitly mentioned in the Fundamental Rights (Part III) of Constitution of India, however various other Articles regard health services as an important factor in achieving rights based approach to development. Most of the provisions related to health are mentioned in Part IV - Directive Principle of State Policy (DPSP) of Constitution-

1. Article 21 of the Constitution guarantees protection of life. The Supreme Court has expanded the reach of this right to include the right to health as an integral component of the right to live with dignity. The government therefore, has a constitutional obligation to provide health facilities.
2. Article 38 of Indian Constitution imposes liability on the State to secure a social order for the promotion of welfare of the people. Providing affordable healthcare forms the basis for securing people's welfare.
3. Article 39(e) calls on the state to make sure that the health and strength of workers, men and women, and the tender age of children are not abused.
4. Article 41 imposes duty on state to provide public assistance in cases of unemployment, old age, sickness and disablement, etc.
5. Article 42 makes provision to protect the health of infant and mother by maternity benefits.
6. Article 47 of the Constitution of India's Directive Principles, recognizes the duty of the state to raise the levels of nutrition and the standard of living and to improve public health as among its primary duties.
7. Article 48A ensures that the State shall endeavor to protect and improve the environment so as to maintain a pollution free environment for good health.

Judiciary On Health

Judiciary has widely interpreted the scope of Right to Health under Article 21 (right to life) and has thus established right to health as an implied fundamental right. The Supreme Court in Paramanand Katara v Union of India case gave a landmark judgement that every doctor at government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting the life of a patient.

Sustainable Development goals On Health

The health goal (SDG 3) is broad: 'Ensure healthy lives and promote well-being for all at all ages'. The SDG declaration emphasizes that to achieve the overall health goal, 'we must achieve universal health coverage (UHC) and access to quality health care. No one must be left behind'.

Healthcare Systems And Infrastructure In India

The Healthcare system is intended to deliver healthcare services. It constitutes the management sector and involves organizational matters. It operates in the context of the socio economic and political framework of the country. In India, it is represented by five major sectors which differ from each other by the health technology applied and by the sources of funds for operation. These are-

1. Public health sector

➤ Primary Health Care includes Primary Health Centres and Sub Centres Hospitals / Health Centres include Community

Health Centres, Rural Hospitals, District Hospitals / Health Centre and Specialist Hospitals Health Insurance Schemes include Employees State Insurance and Central Government Health Scheme Other agencies like Defence services and Railways also provide health services to their employees.

- ***At village level–*** Village Health & Sanitation Samiti (at village level consisting of Panchayat Representative/s, ANM/MPW, Anganwadi worker, teacher, ASHA, community health volunteers).
- ***At district level–*** District Health Mission, under the leadership of Zila Parishad with District Health Head as Convener and all relevant departments, NGOs, private professionals etc. represented on it
- ***At State level–*** State Health Mission, chaired by Chief Minister and co-chaired by Health Minister and with the State Health Secretary as Convener-representation of related departments, NGOs, private professionals etc.
- Integration of Departments of Health and Family Welfare, at National and State level.

2. ***Private sector***
   a. Private Hospitals, Polyclinics, Nursing Homes and Dispensaries
   b. General Practitioners and Clinics
3. ***Traditional systems of medicine***
   a. Ayurveda and Siddha
   b. Unani and Tibbi
   c. Homeopathy
   d. Unregistered practitioners
4. ***Voluntary health agenciese.***Indian Red cross society, Tuberculosis Association of India, Bharat Sevak Samaj etc.
5. ***National health programmes-***National Vector Borne disease control programme, National Aids control programme Universal immunization programme etc.

Policy Framework

- The government policies propose an achievable target of raising public health expenditure to 2.5% of the GD in a time bound manner. Programs like Swachh Bharat Abhiyan aim to help in improving the hygiene conditions for better health outcomes. Others like Yatri Suraksha help in preventing deaths due to rail and road traffic accidents. Government policies are also aimed at reducing stress at the workplace; promoting balanced, healthy diets and regular exercises; addressing tobacco, alcohol and substance abuse; and reducing indoor and outdoor air pollution.

National Health Mission- 2013

The National Health Mission (NHM) envisions achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs. It encompasses two sub- Missions–National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). The main components include strengthening of health systems in rural and urban areas, Reproductive-Maternal- Neonatal Child and Adolescent Health (RMNCH+A) and communicable and non-communicable diseases.

National Rural Health Mission (NRHM) seeks to provide accessible, affordable and quality health care to the rural population especially the vulnerable ones. The North Eastern states, Empowered Action Group (EAG) States, Jammu & Kashmir and Himachal Pradesh have been given special attention under NRHM. The focus of the mission is on establishing a community owned fully functional decentralized health delivery system with inter-sectoral convergence at all levels. This would help in ensuring simultaneous actions on a wide range of health indicators such as water, sanitation, social and gender equality, education and nutrition.

National Urban Health Mission (NUHM) seeks to facilitate access to primary health care for the urban populations, particularly urban poor and

other vulnerable sections in order to improve their health status. NUHM covers all State capitals, district headquarters and other cities/towns with a population of 50,000 and above (as per Census 2011) in a phased manner. Cities and towns with population below 50,000 will continue to be covered under NRHM.

National Health Policy -2017

The National Health Policy, 2017, seeks to promote wellness as an important theme in a comprehensive and integrated manner. It aims for universal health coverage with both quality and affordability of healthcare services, without anyone having to face any financial hardship as a consequence. The attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental programmes, is the motive of the policy. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery.

Quantitative goals and objectives include:

1. Life expectancy and healthy life

- Increase the life expectancy at birth from 67.5 to 70 by 2025.
- Establish regular tracking of Disability Adjusted Life Years (DALY) Index as a measure of burden of disease and its trends by major categories by 2022.
- Reduce TFR to 2.1 (Replacement Level) at national and sub-national level by 2025.

2. Mortality by age and/ or cause

- Reduce Under Five Mortality to 23 by 2025 and MMR from current levels to 100 by 2020.
- Reduce infant mortality rate to 28 by 2019.
- Reduce neonatal mortality to 16 and stillbirth rate to "single digit" by 2025.

3. Reduction of disease prevalence/ incidence

- To achieve the target of 90:90:90 (global target of 2020) for HIV/AIDS i.e. 90% of all people living with HIV should know their HIV status, 90% of all people diagnosed with HIV infection should receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy effectively has viral suppression.
- To achieve and maintain elimination status for Leprosy by 2018, Lymphatic Filariasis in endemic pockets by 2017 and Kala-Azar by 2017.
- To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.
- To reduce the prevalence of blindness to 0.25/ 1000 by 2025 and disease burden by one third from current levels.
- To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.

4. Coverage of health services

- To increase utilization of public health facilities by 50% from current levels by 2025.
- Antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025.
- More than 90% of the new-born are fully immunized by one year of age by 2025.
- Meet the need of family planning above 90% at national and sub national level by 2025.
- 80% of known hypertensive and diabetic individuals at household level maintain "controlled disease status" by 2025.

5. Cross sectoral goals related to health

- Relative reduction in prevalence of current tobacco use by 15% by 2020 and 30% by 2025.
- Reduction of 40% in prevalence of stunting of under-five children by 2025.
- Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).
- Reduction of occupational injury by half from current levels of 334 per lakh

agricultural workers by 2020.

- National/ State level tracking of selected health behaviour.

6. *Health finance*

- Increase health expenditure by Government as a percentage of GDP from the existing 1.15 % to 2.5 % by 2025.
- Increase State sector health spending to > 8% of their budget by 2020.
- Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25% by 2025.

7. *Health Infrastructure and Human Resource*

- Ensure availability of paramedics and doctors as per Indian Public Health Standard (IPHS) norm in high priority districts by 2020.
- Increase community health volunteers to population ratio as per IPHS norm, in high priority districts by 2025.
- Establish primary and secondary care facility as per norms in high priority districts (population as well as time to reach norms) by 2025.

8. *Health Management Information*

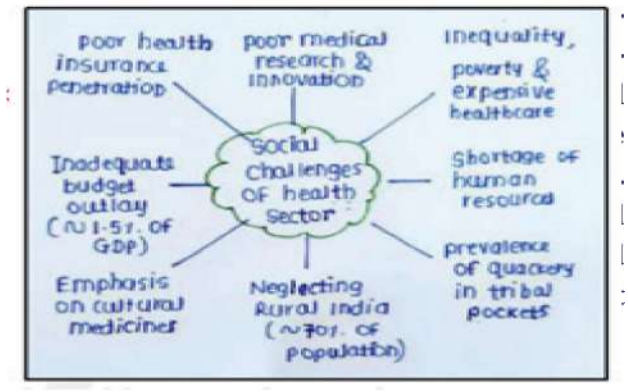
- Ensure district - level electronic database of information on health system components by 2020.
- Strengthen the health surveillance system and establish registries for diseases of public health importance by 2020.
- Establish federated integrated health information architecture, Health Information Exchanges and National Health Information Network by 2025.
- However, health is still not a justiciable right. A National Health Rights Act on the lines of the Right to Education Act 2005 would ensure that Right to Health gets the same status as Right to Education a health cess was also introduced in the draft policy by the Health Ministry to scale up public investments in healthcare but it has now been dropped off from the final policy.
- The health sector expenditure of the government has not exceeded 2 percent of the GDP, even once, in the past 15 years, even though different political parties have formed the National government since then and inspite of the government stating it as a goal in 2002 policy.
- The 2002 National Health Policy had set the target of eliminating leprosy by 2005, lymphatic filariasis by 2015 and kala azar by 2010, none of which could be achieved yet. Therefore, the issues of old targets and new deadlines remain as it is.

Social Challenges Of Health Sector

- ***Neglect of Rural Population:*** A serious drawback of India's health service is the neglect of rural masses. It is largely a service based on urban hospitals. Although, there are large no. of PHC's and rural hospitals yet the urban bias is visible.
- ***Emphasis on Culture Method:*** The health system of India depends almost on imported western models. Otherwise speaking, it has completely neglected preventive, pro-motive, rehabilitative and public health measures.
- ***Inadequate Outlay for Health:*** In India, public expenditure on health is low in comparison to China, USA and UK.
- ***Social inequality:*** The growth of health facilitis has been highly imbalanced in India. Rural, hilly and remote areas of the country are under served while in urban areas and cities, health facilities are well developed. The SC/ST and the poor people are far away from modern health service.
- ***Shortage of Medical Personnel:*** In India shortage of medical personnel like doctors, a nurse etc. is a basic problem in the health sector. In 1999-2000, while there were only 5.5 doctors per 10,000 population in India, the same is 25 in the USA and 20 in China.
- ***Medical Research:*** Medical research in the country needs to be focused on drugs and vaccines for tropical diseases which are normally neglected by international

pharmaceutical companies on account of their limited profitability potential.

- ***Expensive Health Service:*** In India, health services especially allopathic are quite



Government Initiatives

Rogi Kalyan Samiti (Patient Welfare Committees) / Hospital Management Committees are simple yet effective health management institutions.

- These committees are a registered society, and act as a group of trustees for the hospitals to manage the affairs of the hospital. They consist of members from local NGOs, Panchayati Raj Institutions (PRIs), local elected representatives and officials from government sector. They ensure compliance to minimal standards for facilities and hospital care and protocols of treatment, as issued by the Government.
- ***Accredited Social Health Activists (ASHA)*** are the first port of call in the communities, especially for marginalized sections of the society, with a major focus on women and children. More than 9 lakh ASHAs are in place across the country and serve as facilitators, mobilizers and providers of community level care. The ASHA scheme is presently in place in 33 states and UTs (except Goa, Chandigarh & Puducherry). After the launch of the National Urban Health Mission in 2013, ASHA workers are being employed in urban areas as well.
- ***National Quality Assurance Programme*** for improving Quality of care at public health facilities, Operational Guidelines for Quality Assurance in Public Health Facilities and Quality Standards for DHs, CHCs,PHCs and Urban PHCs (UPHCs) were released. These Standards have also received international accreditation by International Society for Quality in Healthcare (ISQua). Kayakalp - an initiative for recognizing good Public Health Facilities was launched to promote cleanliness, hygiene and infection control practices in public health facilities wherein under public healthcare, such facilities are appraised and those facilities that show exemplary performance, meeting standards of protocols of cleanliness, hygiene and infection control, receive awards and commendation. For this, Swachhta Guidelines for public health facilities have also been released.
- ***e-RaktKosh*** is a centralized blood bank management system to assist revamping of the existing systems and processes through process re-engineering and automating data entry, search and availability of blood and related components. National Ambulance Services (NAS): At the time of launch of NRHM, such ambulances networks were non-existent. About 32 States/ UTs have the facility where people can dial 108 or 102 telephone number for calling an ambulance. National Mobile Medical Units (NMMUs) have been established with universal colour and design to increase visibility, awareness and accountability.
- ***Janani Suraksha Yojana*** is a centrally sponsored scheme which is being implemented to reduce maternal and infant mortality by promotion of institutional delivery among pregnant women. Under the JSY, eligible pregnant women are entitled for cash assistance irrespective of the age of mother and number of children, if they give birth in a government or government accredited private health facility.
- ***Janani Shishu Suraksha Karyakaram (JSSK)*** scheme's objective is also to benefit pregnant women who access government health facilities for their delivery. They are provided free and cashless health service, including pre-natal and ante-natal delivery services. This helps in motivating those women who

still choose to deliver at their homes and rather encourages them to opt for institutional deliveries. All the States and UTs have initiated implementation of the scheme.

- ***The Mission Indradhanush*** aims to cover all unvaccinated, or partially vaccinated children by 2020 against vaccine preventable diseases. India's Universal Immunisation Programme (UIP) provides free vaccines against 12 life threatening diseases, to 26 million children annually. The vaccination under UIP protects children against Diphtheria, Pertussis, Tuberculosis, Tetanus, Hepatitis B, Polio, Pneumonia and Meningitis due to HaemophilusInfluenzae type b (Hib), Rubella, Measles, Rotavirus diarrhoea and Japanese Encephalitis (JE). (Rubella, JE and Rotavirus vaccine in select states and districts).
- ***National Ayush Mission–*** The basic objective of NAM is to promote AYUSH medical systems through cost effective AYUSH services, strengthening of educational systems, facilitate the enforcement of quality control of Ayurveda, Siddha and Unani & Homoeopathy (ASU&H) drugs and sustainable availability of ASU&H raw-materials. The National Nutrition Mission or POSHAN Abhiyan was launched in 2018 with the goal of attaining"KuposhanMukt Bharat" or malnutrition-free India, by 2022. It aims to improve nutritional status of children from 0-6 years, adolescent girls, pregnant women and lactating mothers in a time bound manner. 50% of the total budget will come from World Bank or such other multilateral institutions and the rest would be financed through Centre's budgetary support. The scheme includes mapping of other schemes which address malnutrition, creating a robust ICT based real time monitoring system. It also incentivizes States/UTs for meeting their targets and Anganwadi Workers (AWWs) for using IT based tools. The scheme ensure convergence with various programmes and Ministries i.e., Anganwadi Services, Scheme for Adolescent Girls (SAG) of MWCD, Pradhan Mantri Matru Vandana Yojana (PMMVY), Janani Suraksha Yojana (JSY), PublicDistribution System (PDS), Department Food & Public Distribution, National Health Mission (NHM), Swachh Bharat Mission, Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) and Ministry of Drinking Water & Sanitation.

Labour Room Quality Improvement Initiative or 'LaQshya' programme aims at improving quality of care in labour room and maternity Operation Theatre (OT). It aims to reduce maternal and new-born mortality & morbidity, improve the quality of care during delivery and immediate postpartum care. Its objectives also include enabling an effective two-way follow-up system to enhance satisfaction of beneficiaries visiting the health facilities and stabilizing complications and ensuring timely referrals. Provision of Respectful Maternity Care (RMC) to all pregnant women attending the public health facility is a foundation principle of this scheme.

Rashtriya SwasthyaBima Yojana (RSBY) is a centrally sponsored scheme, implemented by Ministry of Labour & Employment (MoLE) since 2008 under the Unorganized Workers' Social Security Act 2008. Initially it aimed to provide health insurance coverage to Below Poverty Line (BPL) families only, but later on 11 other categories of Unorganized Workers (UOWs) MGNREGA workers, construction workers, etc. were included. The scheme has now been transferred to the Ministry of Health & Family Welfare on an "as is where is" basis in 2015. The beneficiary family has to pay Rs. 30 per annum per family as registration/renewal fee and this amount is used by the state government to take care of the administrative cost for the scheme. The maximum premium payable is Rs. 750 per family. The scheme covers all pre-existing diseases and even hospitalization expenses. However, only secondary care hospitalization procedures are included in the scheme. Both public and private hospitals are empanelled under the scheme.

Ministry of Health and Family Welfare also issued a notification for the enforcement of HIV/AIDS Act, 2017, to provide legal recourse to protect the rights and interests of people suffering from HIV/AIDS. The act prohibits discrimina-

tion against person living with HIV in matters of employment, education, shelter, healthcare and insurance. HIV testing as a pre-requisite for employment or education or healthcare is prohibited. The Act also makes anti-retroviral treatment a legal right and adopts test and treat policy. It also states that no HIV positive person can be subjected to medical intervention without prior consent, including pregnant women.

The National TB Control Programme was started in 1962 with the aim to detect and treat tuberculosis cases at the earliest. With the declared objective of universal access to early quality diagnosis and quality TB care for all TB patients, the Revised National Tuberculosis Control Programme (RNTCP), based on the Directly Observed Treatment, Short Course (DOTS) strategy, began as a pilot project in 1993 and was launched as a national programme in 1997. RNTCP is being implemented through 13,000+ designated microscopy centers and free treatment across the nation through 4 lakh DOT centres.

The major focus was early and complete detection of all TB cases, including drug resistant TB and HIV-associated TB in the community, with greater engagement of the private sector for improving care to all TB patients. The National Strategic Plan for 2017- 25 forTB elimination in India builds on the success and learnings of the previous programmes and encapsulates the innovative and bold steps required to eliminate Tuberculosis in India by 2030. It is designed in line with other health sector strategies and global efforts, such as the National Health Policy, World Health Organization's End TB Strategy, and the Sustainable Development Goals of the United Nations (UN).

National Pharmaceutical Pricing Authority, is an independent body set up in 1997 under the Department of Pharmaceuticals, Ministry of Chemicals and Fertilizers. Its mandate is to fix/revise controlled bulk drug prices and formulations, enforce prices and availability of medicines under Drug Price (Control) Order, 2013. It collects/maintains data on production, exports and imports, profitability of companies etc. for bulk drugs and formulations. The National list of essential medicines is one of the major instruments in a balanced healthcare delivery system of a country which includes accessible and affordable quality medicines at all the primary, secondary, tertiary levels of healthcare. It is prepared by Ministry of Health and Family Welfare, and contains a list of medicines considered essential for India's health needs. The first National List of Essential Medicines of India was prepared and released in 1996 (Eighth plan). The purpose is to ensure that the medicines listed under NELM are available at a reasonable price to the general public.

Over the years, there have been several issues with the functioning of the Medical Council of India with respect to its regulatory role, composition, allegations of corruption, and lack of accountability. The National Medical Commission Act, 2019, therefore sought to remove such issues ensuring transparency and better medical standards. The Act aims at regulating medical education and ensuring better medical research and policies by medical professionals. It also ensures accountability of medical institutions through their periodic assessment. It provides for an effective grievance redressal mechanism and aims to help in addressing the issue of corruption as was seen in Medical Council of India. It also plans to reduce shortage of medical professionals by giving licenses to community health providers and ensure ethical standards in the medical practice through Ethics board.

However, the NMC composition lacks diverse stakeholders such as public health experts, social scientists, health economists, and health related non-government organizations, leading to a monopoly of doctors. Also, disputes related to ethics and misconduct in medical practice require judicial expertise and should not be handled by Ethics board alone. Moreover, with the proposed cap on fees, the costs for the remaining seats are likely to escalate, thereby putting medical education out of the reach of vast, especially underprivileged sections of the society. Meritorious students would then have to enrol themselves in institutions where the quality of education is low. Additionally, due to no provision of election for all the chief posts of these multiple bodies, corruption and fa-

vouritism is bound to increase. Also, States have been reduced to mere advisory roles from being in governance mode, leading to centralization of power. With the Advisory council comprising of more than 100 members, it would be difficult to reach a consensus on any issue in such an overwhelmingly large body. This will hit the decision making at the top.

The Act mentions that National Exit Test, which is to gain a licence to practice after MBBS, can also serve as an entrance examination to post-graduate level. It has left a lot of room for confusion. It seems that those who don't clear the exam will not be allowed to practise at all. This will lead to acute shortage of doctors in our country. Also, a strong evaluation framework with a strong regulatory governance is extremely important to prevent corruption in medical field and related governing bodies. However, the Act entrusts the inspection process upon Medical Assessment and Rating Board who can inspect on their own, but can even hire and authorize any other third party agency or persons for carrying out inspections. This will only increase corruption and crony capitalism. The Act also does not specify the validity period of the licence to practice.

This can promote gross incompetence. Moreover, according to the Act, a community health service provider may prescribe specified medicine independently, which legalizes quackery and a six-month course will not be enough to train such personnel.

The National Family Health Survey (NFHS) is a large-scale, multi-round survey conducted based on the representative samples collected from households throughout India. It provides state and national information for India on various health parameters such as fertility, infant and child mortality, the practice of family planning, maternal and child health, reproductive health, nutrition, anaemia, utilization and quality of health and family planning services. Every National Family Health Survey (NFHS) has two specific goals to fulfill. They include- to provide essential data needed by the Ministry of Health and Family Welfare and other agencies for informed decision making and policy and programme intervention purposes; and to provide insight regarding important emerging health and family welfare issues.

The MOHFW in December 2020, released Phase – I of NFHS-5 comprising data for 22 states/UTs. NFHS-5 also included some new topics such as preschool education, disability, access to a toilet facility, death registration, bathing practices during menstruation (menstrual hygiene), methods and reasons for abortion, components of micro-nutrients to children, frequency of alcohol and tobacco use, additional components of non-communicable diseases (NCDs), expanded age ranges for measuring hypertension and diabetes among all aged 15 years and above etc.

Way Forward

- ***Enabling Preventive Care:*** In order to promote preventive care, the Union government has announced the conversion of primary health care centres into Health and Wellness Centers (HWCs). These HWCs will act as the pillar of preventive care and 'gateway' for access to secondary and tertiary health services.
- ***Bringing Behavioural Change:*** There is a need to ensure people eat right, sleep right, maintain good hygiene, exercise, and adopt a healthy lifestyle that necessitates concerted interventions at various levels of the system.
- ***Cooperative Federalism:*** Given the major role that States have to play in creating strong health systems across the country. State governments should be incentivized to invest in creating a dedicated cadre for public health at the state, district and block levels.
- ***More Funding:*** Public funding on health should be increased to at least 2.5% of GDP as envisaged in the National Health Policy, 2017.
- ***Decentralisation:*** There is a need to make nutrition, water, sanitation and hygiene (WASH) part of the core functions of Panchayati raj institutions and municipalities.
- ***Creating a Nodal Health Agency:*** There is a need to create a designated and autonomous focal agency with the required capacities and linkages to perform the functions of public health regulations. In this pursuit, NITI Aayog's National Health Stack is a step in the right

direction, which needs to be operationalised as soon as possible.

Mental Health And Associated Issues

According to the World Health Organization, over 90 million Indians, or 7.5% of the population, suffer from mental health issues. A study published in Lancet in December 2019, titled The burden of mental disorders across the states of India: the Global Burden of Disease Study 1990-2017, also highlights the scale of the challenge.

Facts And Figures

Mental health issues are among the leading causes of non-fatal disease burden in India:

- One in every seven Indian was affected by mental health issues in 2017;
- The proportional contribution of mental health to the total disease burden has almost doubled since 1990;
- Suicide was the leading cause of deaths among young people-aged 15 to 39 in 2016.

Status Of Mental Health In India

- ***WHO estimation:*** According to an estimate by the World Health Organization (WHO), mental illness makes up about 15% of the total disease conditions around the world. The same estimate also suggests that India has one of the largest populations affected by mental illness.
- ***India status:*** As a result of WHO estimation, India is the world's 'most depressing country'.

Indian mental history: Between 1990 to 2017, one in seven people from India have suffered from mental illness ranging from depression, anxiety to severe conditions such as schizophrenia, according to a study. It is no exaggeration to suggest that the country is under a mental health epidemic.

People under mental illness: More than 450 million people suffer from mental disorders. According to WHO, by the year 2020, depression will constitute the second largest disease burden worldwide (Murray & Lopez, 1996).

Importance Of Mental Health

- ***Emotional and mental health:*** It is important because it's a vital part of your life and impacts your thoughts, behaviours and emotions.
- ***For productivity and effectiveness:*** Being healthy emotionally can promote productivity and effectiveness in activities like work, school or caregiving.
- ***For healthy relationships:*** It plays an important part in the health of your relationships, and allows you to adapt to changes in your life and cope with adversity.
- ***Impact our day-to-day behaviour:*** Our mental health encompasses our psychological, emotional and social well-being. This means it impacts how we feel, think and behave each day.
- ***Impact our decision making process:*** Our mental health also contributes to our decision making process, how we cope with stress and how we relate to others in our lives.
- ***The social an economic costs:*** Associated with the growing burden of mental ill health focused the possibilities for promoting mental health as well as preventing and treating mental illness.

Reasons For Degenerating Mental Health Of Late

- ***Lack of awareness:*** The first and foremost reason for India to lose its mental health is the lack of awareness and sensitivity about the issue.
- ***Stigma concern:*** There is a big stigma around people suffering from any kind of mental health issues.
- ***Vicious cycle of shame:*** They are often tagged as 'lunatics' by society. This leads to a vicious cycle of shame, suffering and isolation of the patients.
- ***Lack of human resource:*** According to WHO, in 2011, there were 0.301 psychiatrists and 0.047 psychologists for every 100,000 patients suffering from a mental health disorder in India.
- ***Treatment gap:*** According to estimates nearly 92% of the people who need mental health care and treatment do not have access to any form of mental health care.
- ***Economic burden of mental illness:*** It

contributes significantly to the treatment gap in India. There are both direct (cost of long-term treatmept) and indirect costs (the inability of the patient and caregiver to work. social isolation, psychological stress) Contribute significantly to the economic burden.

- ***Violations of human rights:*** They have been reported in mental asylums and also at homes and places of traditional healing. In India, mental hospitals still practice certain obscure practices that violate human rights.
- ***Poor infrastructure:*** Such as closed structures, a lack of maintenance, unclean toilets and sleeping areas etc. clearly violate the basic human right to a life with dignity.

Way Forward

- ***Stigma and Awareness:*** If individuals continue to view mental illness with apprehension and resistance, it will continue to be difficult for people with mental illness and hence strong awareness is the need.
- ***WHO views:*** If the global community doesn't act urgently, by 2030 depression will be the leading illness globally.
- ***Early detection and treatment:*** Early detection and intervention of a psychological condition will allow you to live the life you deserve.
- ***Destigmatising the issue:*** Sharing one's story about mental health (through media campaigns) is the most effective strategy to reduce stigma attached with mental illness.
- ***Community Approach:*** There is need to deploy community health workers who, with appropriate training and supervision, effectively deliver psychosocial interventions for the needy
- ***Increase Funding:*** State governments need to scale up its psychosocial interventions through community health workers

Broadening the scope: Mental health care must embrace the diversity of experiences and strategies which work, well beyond the narrow confines of traditional biomedicine with its emphasis on "doctors, diagnoses and drugs"

Digital initiatives: To help improve rural India's mental health through telemedicine, initiatives like Schizophrenia Research India's (SCARF) mobile bus clinic is being run by an NGO. There is a need for scaling up such initiatives through public-private collaboration to bridge the rural-urban divide.

Conclusion

Considering that most of the earlier strategies to enhance mental health have not succeeded over the past six decades or more in less-developed countries, the time has come to take on a new approach with renewed vigour. Mental health awareness can become both the means and the way of ending this apathy. Progressive government policies based on evidence-based approaches, an engaged media, a vibrant educational system, a responsive industry, aggressive utilization of newer technologies and creative crowd-sourcing might together help dispel the blight of mental illnesses.

Violence Against Healthcare Workers (In Reference To Covid 19)

Since the beginning of the outbreak, health care providers have been shown more support, solidarity and gratitude than they ever have. Yet, attacks on health care have continuously been reported and now also include incidents linked to the COVID-19 pandemic across the world.

Factors Responsible For Violence Against Healthcare Workers In India

- ***Common reasons:***
  - Lack of infrastructure and a poor physician-patient ratio.
  - Absence of postgraduate training in emergency medicine in India.
  - Poor quality of emergency care in hospitals. o Poor communication skills of healthcare workers.
  - Lack of emergency resources i.e. blood, laboratory services workforce, relevant drugs, etc.
- ***Poor grievance redressal mechanism:*** The majority of the hospitals in India do not have a good grievance redressal system in place. A legal procedure in India also takes an

inordinately long time.

- ***Emergency intake capacity overwhelmed:*** Long waiting period, non-availability of crucial investigations and inordinate delay in referral unhygienic and extremely crowded conditions.
- ***Lack of civic responsibility in the public:*** In India, patients by themselves are not violence makers, but their relatives are Sometimes unknown apparently sympathetic individuals, political leaders, and political parties take the law in their hand.
- ***Absence of legislation:*** There is no strong law against violence to healthcare workers.
- ***The negative image of doctors portrayed in the media:*** Electronic and print media do not have a real understanding of the challenges faced by the doctors.
- ***Perceived Injustice:*** Feeling of wrongdoing by the doctors for financial gain or for avoiding his/her duties.
- ***Lack of security:*** Unrestricted public access to all areas in government hospitals with overcrowding and lack of security, surveillance, and mob preventing drills in the hospital.
- ***Impunity:*** In a majority of cases, the perpetrators of violence go unpunished.
- ***Pseudo-intellectuals:*** Deterioration of the moral ethics of intellectual class in India and the rise of pseudo- intellectuals.

WAY FORWARD:

- ***Better training:*** The doctor and medical personnel should have better training to tackle situations of emotional outbursts through anxiety alleviation techniques.
- ***Show empathy:*** The doctor should understand some of the patient-related characteristics that may be associated with violence.
- ***Reduce long waiting periods:*** Doctors probably should try to optimize and reduce long waiting periods for the patients in the waiting rooms and try to improve patient contact as much as possible.
- ***Use of digital technology:*** It has been seen that long queues in the hospital, lack of communication from the doctors and opaque billing systems are important predictors of violence in India. Both digital and mobile technology can substantially help in this area.

General reform for the hospital services in the form of:

- Improvement of services in a global fashion.
- Employment of an adequate number of doctors and other steps to ease the rush of patients and long waiting hours.
- Hospital security should be strengthened and it needs to be properly interlocked with the nearby police station. RML Hospital of New Delhi got 'bouncers' as a preventive measure in 2015.
- No arms/ammunition by patients or their relatives should be allowed inside the hospital.
- There should be transparency on rates of different investigations, rents, and other expenses in the hospital.
- There should be a proper complaint redressal system in the hospital.
- Install CCTVs at high-risk places like casualty.

- ***Concentrate on preventive medicine:*** Nutrition, immunization, health education, pollution control, personal hygiene, access to clean water, unadulterated milk, unadulterated food, facilities for exercise. playground, etc. are the basic requirements.
- ***Central law:*** There is a need for a central law instead of a state-wise Medical Protection Act for adequate security at hospital premises.

Conclusion:

- Hospitals should be retained as a safe zone. There is a need for a detailed longitudinal study across the country to understand the prevalence, nature and regional differences in violence perpetrated against doctors in this country. As there are certain responsibilities of doctors and other healthcare workers, similarly, responsibilities also have to be

borne by patients and their relatives, political parties, hospital authorities, law maintaining machinery, media, and government to see that health care improves and violence against doctors is strongly dealt with.

Legal Documents On Patient's Rights

- ***Article 21 of the Constitution of India:*** The Supreme Court has held that the right to live with human dignity enshrined in Article 21, derives from the directive principles of state policy and therefore includes the protection of health.
- Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002.
- The Consumer Protection Act 1986.
- Drugs and Cosmetic Act 1940.
- Clinical Establishment Act 2010 etc.
- Various societies and countries in the form of Charters of Patient's Rights: A patient is entitled to a certain amount of protection to be ensured by physicians, healthcare providers, and the state, which have been codified in various societies and countries in the form of Charters of Patient's Rights.
- ***Right to Safety and Quality Care According to Standards:*** Patients have a right to safety and security in the hospital premises. They have the right to be provided with care in an environment having requisite cleanliness, infection control measures, and safe drinking water as per BIS/FSSAI Standards and sanitation facilities.
- ***Right to Emergency Medical Care:*** As per the Supreme Court, all hospitals both in the government and in the private sector are duty-bound to provide basic emergency medical care, and injured persons have the right to get emergency medical care. Such care must be initiated without demanding payment/ advance, and basic care should be provided to the patient irrespective of paying capacity.
- ***International obligations:*** India is a party to the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights. The Universal Declaration of Human Rights recognizes the notion of patient rights.

Role Of Rural Health Care System In Tackling The Pandemic

Compared to the first wave in 2020, the second wave of 2021 has seen a rapid rise in the number of infections and deaths in rural parts, home to 65% of the country's 1.3 billion population. Given the precarious state of the health infrastructure in rural areas, the National Centre for Disease Control (NCDC) has conveyed the government to prioritize testing and vaccination in these areas.

Indian Rural Healthcare System

The health care infrastructure in rural areas has been developed as a three tier system as follows:

1. ***Sub Centre:*** Most peripheral contact point between Primary Health Care System & Community manned with one HW (F)/ANM & one HW (M)
2. ***Primary Health Centre (PHC)***: A Referral Unit for 6 Sub Centres 4-6 bedded manned with a Medical Officer In charge and 14 subordinate paramedical staff
3. ***Community Health Centre (CHC):*** A 30 bedded Hospital/Referral Unit for 4 PHCs with Specialized services

ISSUES FACED

Indian Public Health Standards: Only 11% sub-centres, 13% Primary Health Centres (PHCs) and 16% Community Health Centres (CHCs) in rural India meet the Indian Public Health Standards (IPHS).

Doctor and nurses ratio: Only one allopathic doctor is available for every 10,000 people and one state run hospital is available for 90,000 people. In many rural hospitals, the number of nurses is much less than required.

Exploitation: Innocent and illiterate patients or their relatives are exploited and they are allowed to know their rights. Patients when in an emergency are sent to the tertiary care hospital where they get more confused and get easily cheated by a group of health workers and middlemen.

Unskilled or semi-skilled paramedics: Most of

the centres are run by unskilled or semi-skilled paramedics and doctors in the rural setup are rarely available.

Under-financed: The existing healthcare centres in rural areas are under-financed, use below quality equipment, are low in supply of medicines and lack qualified and dedicated human resources.

Lack of basic medicines: Medicines are often unavailable in rural areas. Supply of basic medicine is irregular in rural areas. It is a persistent problem of India's rural healthcare.

Way Forward

Affordable medical facilities: Should be provided to people living in rural areas.

Medical colleges: Need to encourage students to visit rural areas and understand the healthcare requirements of the poor and downtrodden.

Doctors in the government services: They must mandatorily serve in rural areas before getting his/her first promotion.

Young doctors: At the grass roots level need to be sensitive to patients and their family.

Private sector: It needs to work with a spirit of altruism, commitment and missionary zeal in providing modern and affordable healthcare facilities in the rural areas and bridge the urban-rural divide.

Medical associations: They should campaign to educate people on preventing lifestyle diseases which are slowly penetrating even the rural areas.

Conclusion

- Pandemics such as Covid-19 starkly remind us that public health systems are core social institutions in any society. The government has made several efforts to address the shortfall in the public health system through the schemes like the National Medical Commission (NMC) Act, 2019, Pradhan Mantri Bhartiya JanaushadhiPariyojana, Pradhan Mantri Jan Arogya Yojana etc. However, the need of the hour is an adequate investment, for creating a health system that can withstand any kind of public health emergencies, deliver universal health coverage and meet the targets of the Sustainable Development Goals.

Role Of Healthcare Worker In Tackling Pandemic

- ***Healthcare gives professionals a role:*** They play a central and critical role in improving access and quality health care for the population.
- ***Services:*** They provide essential services that promote health, prevent diseases and deliver health care services to individuals, families and communities based on the primary health care approach.
- ***Healthcare workers and MDG:*** Mechanisms for optimizing the strengths and skills of health professionals will be essential to achieving the Millennium Development Goals (MDG).
- ***Covid and healthcare professionals:*** The pandemic has shown the importance of healthcare professionals in saving the lives of people in this pandemic.

Way Forward For Improving The Health Professional Situation

- ***Support member states:*** To maximize the contributions of health professionals through interprofessional education and collaborative practice.
- ***Provide technical guidance:*** And develop policy options and tools for enhancing health professionals' contribution to health systems strengthening through the primary health care approach.
- ***Map the networks:*** the international and regional health professional networks that have the capacity to support global health initiatives.
- ***Link health professionals worldwide:*** Through virtual communities of practice so they can inform effective policies and promote successful practices.
- ***Support the maintenance and development:*** Of professional competencies through continuing education to ensure health profetonals are equipped to provide the best care possible.

Tribal Population In India And Health

- According to the 2011 census, the tribal population in India is over 104 million which is spread across 705 tribes and accounts for 8.6% of the country's population.
- More than 90% of tribal people live in rural areas.
- M.P. has the highest tribal population followed by Maharashtra, Odisha, etc. (Census 2011).

Tribal Health Status

Disease burden: Tribals suffer from a triple burden of diseases.

Malnutrition and communicable diseases: Tribal population share a disproportionate burden of communicable disease like malaria, for. e.g. tribals account for 30% of malaria cases and 60% of malaria related mortality, low body mass index and stunting in tribals is more than non-tribal population.

Genetic disorders and lifestyle diseases: like hypertension, diabetes, respiratory diseases etc. Also, genetic disorder in the form of sickle cell anaemia ranges from 1-40%. G-6-PD red cell enzyme deficiency is reported in tribes like Adiyan. Irula, Paniyan, Gonds.

Mental illness and addictions: According to NFHS-3, 72% of tribal men in the age of 15-54 use tobacco as compared to 56% of non-tribal men.

Mental illness and addictions: According to NFHS-3,72% of tribal men in the age of 15-54 use tobacco as compared to 56% of non-tribal men.

Other Indicators: The performance related to life expectancy, maternal mortality, adolescent health, child morbidity, mortality and under five mortality is below national average by 10-25%.

For example:

- Life expectancy of tribals is 63.9 compared to the national average of 67 years.
- Under 5 mortality rate is 74 as against the national average of 62.
- 50% Adolescent ST girls are underweight and BMI below less than 18.5.
- About 80 percent of tribal children are undernourished and suffering from anaemia.
- While 40 percent of under-five tribal children in India are stunted.

Socio-Economic Condition Of Tribals

Livelihood status- 40.6% of tribals live below poverty line vis-a-vis 20.5% non tribals.

Lack of Basic amenities- The 2011 census data shows that access to tap water, sanitation facilities, drainage facilities and clean cooking fuel is much lower among the tribal population.

Education gap- There is also a stark gap in educational status as 41% of STs are illiterate.

Sex ratio among tribals is 990/1000 as compared to national average of 933/1000.

Reasons For Poor Health Among Tribals

- ***Unhygienic and primitive practices:*** The chief causes of maternal and infant mortality were found to be unhygienic and primitive practices for parturition and no specific nutritious diet with iron, calcium and vitamins is consumed by women.
- ***Lack of Health Infrastructure:*** Though tribals are heavily dependent on public health services, there is a shortfall of public health centres, sub-centres, and community health centres by 27-40% in about half of the states. This has resulted in low access and coverage, low outputs and outcomes in tribal health status.
- ***Lack of Human resource:*** There are severe shortages in health human resources in terms of PHC doctors (33% shortfall), CHC specialists (84% shortage), health workers, nursing staff, ASHA workers and locally trained youth. The isolated locations with minimal facilities create unwillingness among the health workers.
- ***Financing of Tribal Health:*** The tribal sub plan (TSP), though started with the noble goal of complementing existing finances for tribal policies, has shown a lackadaisical response. The tribal affairs ministry has no information regarding TSP allocations of various states. Also, there is a lack of accounting of actual tribal health expenditure.

- ***Lack of Awareness and mistrust on modern medicine:*** The tribals are amenable to western systems of medicine. Hence, vaccination and immunization of Infants and children have been inadequate among tribal groups.
- ***Issues in Governance Structure:*** Lack of population level data, centralized policy formulation and implementation, near absence of tribals from the process, weak state level intervention etc. has accentuated dismal health conditions among tribals.

Way Forward

- ***Health Services to Remote Populations:*** Mobile medical camps to improve outreach in remote tribal populations would play a major role and will make availability of drugs, diagnostic facilities to tribals in remote areas.
- ***Transportation for Expectant Mothers:*** Tribal populations generally have to deal with lack of resources in tough terrains. Provision of emergency transportation for pregnant tribal women to health facilities for obstetric care is one of the major necessities of the tribal women.
- ***Health Workers from Tribal Communities:*** As tribal populations find it difficult to navigate through the complexities of medical facilities, health workers from tribal communities may become the link between the healthcare facilities and tribal communities.
- ***Other measures such as:*** Creation of National Tribal Health Council and Tribal health research cell, raising awareness of health issues, upgrading infrastructure and capacity building.

Arguments In Favour Shifting 'Health' To The Concurrent List

- ***Greater Flexibility to Centre:*** Bringing health into the Concurrent list would give the Centre greater flexibility to enact regulatory changes and reinforce the obligation of all stakeholders towards providing better healthcare.
- ***Rationalisation and Streamlining of the Multiple Acts:*** There is a multiplicity of Acts, rules and regulations, and mushrooming institutions, yet the regulation of the sector is far from adequate. With the health in the concurrent list, uniformity of acts can be ensured.
- ***Centre Expertise to States:*** The Central government is also technically better equipped to come up with the health schemes because it has the assistance of multiple research bodies and departments dedicated to the management of public health. States on the other hand do not have the technical expertise to independently design comprehensive public health policies.

Arguments Against Shifting 'Health' To The Concurrent List

- ***Right to Health:*** It is neither necessary nor sufficient to guarantee the provision of accessible, affordable and adequate healthcare for all. Besides, the right to health is, arguably, already provided for via the Constitution's Article 21 that guarantees protection of life and liberty.
- ***Challenges Federal Structure:*** Shifting ever more subjects from the states to the Centre would erode India's federal nature and impair efficiency by abandoning the principle of subsidiarity, which holds that any task should be left to the level of government best placed to do it.
- ***Trust Cooperative Federalism:*** The centre must direct its energies to designing policy that would help states deliver on their constitutional mandate to provide adequate, accessible and affordable healthcare for all.
- ***More Burden with Centre:*** The Centre has onerous responsibilities of its own, for which it struggles to find resources. Taking more functions would help neither the states nor the Centre discharge their constitutional obligations.

Encourage States: The Centre devolves 41% of the taxes it collects to the states. The Centre should encourage the states to do what they are supposed to do, while the Centre optimizes use of its own resources, focusing on its obligations.

- Health being a state subject does not preclude

the Centre offering constructive support.

- The NITI Aayog's Health Index, financial assistance through the insurance-based programme Ayushman Bharat, improved regulatory environment for healthcare providers and medical education are examples of such support that can nudge states in the right direction.

Other Suggestions By N.k. Singh

- Increase the government spending on health to 2.5% of GDP by 2025.
- Primary healthcare should be a fundamental commitment of all States in particular and should be allocated at least two-thirds of health spending.
- To have a standardization of health care codes for both the Centre and states.
- Forming an All India Medical and Health Service. Given the inter-state disparity in the availability of medical doctors, it is essential to constitute the Service as is envisaged under Section 2A of the All-India Services Act, 1951.
- Emphasized the importance of universalising healthcare insurance, as a large section of the society still remain uncovered.