Fighting tomorrow's public health battle

The "India: Health Of The Nation's States" report, released last week, makes two things abundantly clear. The first is that the lack of such a granular, state-wise assessment of India's public health scenario and trends in a common framework until now has been an inexplicable failure on the part of previous governments. The Narendra Modi government has done well to rectify the lack. The second is that the nature of the country's health challenges has changed sharply over the past couple of decades and is going to continue changing.

The latter should not come as a surprise. Global precedent shows that a country's health profile changes as its economy and level of urbanization grow. The threat posed by communicable diseases such as tuberculosis and malaria, maternal, neonatal and nutritional diseases—collectively termed infectious and associated diseases in the report—declines, and the burden of non-communicable diseases (NCDs) grows. India is no different, even if the rapidity and extent of the change are startling.

In 1990, the total disease burden of infectious and associated diseases in the country, measured using the metric of disability-adjusted life years (DALYs), was 61%. The burden of NCDs at the time was 30%. Cut to 2016 and those numbers have just about flipped: infectious and associated diseases account for 33% of the disease burden while NCDs account for 55%. This trend is going to continue to play out as India's socio-economic contours change. In roughly the same period that the report covers—the past quarter century—two thirds of the deaths globally have been because of NCDs. The World Health Organization predicts that over the next decade, NCD deaths will increase by 17% globally. And in high-income countries, generally speaking, they account for 80% or more of deaths. All of this leads to two conclusions.

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The first is the need for decentralized health policymaking. There is wide divergence between the health profiles of various regions and states in India. While infectious and associated diseases now account for less than half of the disease burden in all the states, the transition happened as early as 1986 and as late as 2010 depending on the state in question. Likewise, the NCDs burden covers a substantial range—from 48% of the state disease burden to 75%. Drill deeper and it gets even more complicated. The burden due to specific diseases within the NCDs and the infectious and other diseases groups differs substantially. This is true not just between groupings of economically similar states—say, industrialized states like Maharashtra and Gujarat, and Empowered Action Group states like Uttar Pradesh and Madhya Pradesh—but between similar states as well. This divergence, naturally, extends to the risk factors that cause various diseases. In the face of this reality, Centre-dominated health policymaking—save in its broadest contours such as increasing insurance coverage, setting standards for public sector health institutions and deciding drug policy—must inevitably diminish the effectiveness of state response.

The second takeaway is the nature of state response will have to enter relatively new territory. According to the report, "The leading individual cause of death in India in 2016 was ischaemic heart disease... The other NCDs in the top 10 individual causes of death included chronic obstructive pulmonary disease, stroke, diabetes, and chronic kidney disease." Risk factors such as dietary risks, high blood pressure, high blood sugar and tobacco use rank correspondingly high.

In a journal article *Beyond Carrots And Sticks: Europeans Support Health Nudges*, Lucia A. Reisch, Cass R. Sunstein and Wencke Gwozdz note that tools such as nutritional standards, fiscal measures and hard regulation such as banning advertisements for certain products have been less effective globally than hoped for in addressing such risk factors. Instead, they note: "Increasing research evidence suggests that a key to changing nutritional and activity patterns is the purposeful design of living and consumption environments—the so-called choice architecture."

In other words, nudges, brought into prominence in recent years by the work of Nobel Prize winning economists like Daniel Kahneman and Richard H. Thaler. An increasingly large number of countries are incorporating this in policymaking; the UK's Behavioural Insights Team is perhaps one of the most well-known attempts.

Building an effective choice architecture can require direct government action. Urban planning is perhaps the best example of this. Ensuring that citizens lead a more physically active life would directly address a number of risk factors for NCDs. That means ensuring ease of access from everything to pedestrian access to public transport and communal green spaces. Effective architecture will require bringing private enterprises on board in other instances—from displaying health information and advice in stores to appropriate food labelling, high salt warnings and product placement in stores.

This sort of broad and diffuse response will not be easy to implement. And certainly, addressing the weak fundamentals of India's health system is critical. But NCDs are called lifestyle diseases for a reason. Evidence from developed economies shows that addressing them requires inducing basic changes in the manner citizens live their lives, effective health systems notwithstanding. Achieving this without straying into state paternalism and heavy-handed regulation—an ever present risk in India—is going to be tricky but essential for fighting tomorrow's health battle.

Can nudges effectively address India's growing NCD burden? Tell us at views@livemint.com

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