Graduates from IIT, NIT to teach in rural areas

Prakash Javadekar

More than 1,200 youngsters with Ph.D and M. Tech degrees from institutions like Indian Institutes of Technology, Indian Institute of Science, Bengaluru, and National Institutes of Technology will spend the next three years teaching at 53 government engineering colleges in rural areas of districts lagging behind in technical education.

Human Resource Development Minister Prakash Javadekar told reporters on Wednesday that these teachers had already joined the colleges. The teachers will be there on a three-year contract and get paid Rs. 70,000 a month.

Later, they can either choose to stay in academics or join the corporate world.

This initiative, entailing an expenditure of Rs. 370 crore, is a result of the Centre helping state governments fill up vacancies in backward districts in 11 states where engineering students were suffering because of dearth of teachers.

“5,000 people had applied. Out of those, 1,225 were selected and they have already joined,” Mr. Javadekar said.

“As many as one lakh students in these developing states will benefit as a result of this.” Among the over 1200 candidates selected, about 300 have PhD degrees and about 900 have M.Tech degrees.

The focus is on states like Uttar Pradesh, Uttarakhand, Tripura, Assam, Bihar, Jharkhand, Odisha and the Andaman and the Nicobar Islands.

END

Ministry of Finance

"Education will be treated holistically from pre-nursery to class XII", says Finance Minister

Rs. 1, 00, 000 Crore initiative to drive research and infrastructure over the next four years

Posted On: 01 FEB 2018 1:32PM by PIB Delhi

Expressing concern over the quality of education, Union Minister for Finance and Corporate Affairs, Shri Arun Jaitley has said that education will be treated in a holistic manner from pre-nursery to Class XII. Presenting the General Budget 2018-19 in Parliament here today, the Finance Minister expressed the Government's resolve to increase the digital intensity in education. "The Government proposes to gradually move away from ''black board'' to ''digital board,'' he said. The Finance Minister underlined that a district-wise strategy for improving the quality of education is also being prepared. Emphasising the need to step up investment in research and related infrastructure in leading educational institutions, the Finance Minister announced the proposal to launch a major initiative named "Revitalising Infrastructure and Systems in Education (RISE)". Shri Jaitley said that over the next four years, a total of Rs. 1, 00, 000 crore will be invested in the initiative.

Referring to higher education, Shri Jaitley announced the launch of ''Prime Minister's Research Fellows (PMRF)'' Scheme. He pointed out that 1,000 best B.Tech students will be identified from premier institutions each year and facilities will be provided to them to undertake Ph.D in IITs and IISc with an attractive fellowship. Acknowledging the critical nature of the training of teachers during service, the Finance Minister also referred to the move to initiate an integrated B.Ed. programme for teachers.

The Finance Minister pointed to the need for best quality education to the tribal children in their own environment. "To realise this mission, it has been decided that by the year 2022, every block with more than 50% ST population and at least 20,000 tribal persons, will have an Ekalavya Model Residential School", Shri Jaitley said. He emphasised that Ekalavya schools will be treated at par with Navodaya Vidyalayas and will have special facilities for preserving local art and culture, besides providing training in sports and skill development.

Referring to the initiative of setting up Institutes of Eminence, Shri Jaitley said that more than 100 applications have been received. "We have also taken steps to set up a specialized Railways University at Vadodara", the Finance Minister said. He added that 18 new Schools of Planning & Architecture (SPAs) will also be established in IITs and NITs as autonomous schools.

Stressing the need to reach out to every household of old, widows, orphaned children, divyaang and deprived as defined by the Socio-Economic Caste Census, the Finance Minister enumerated the implementation of a comprehensive social security and protection programme. He announced that a sum of Rs.9, 975 crore has been allocated for the National Social Assistance Programme this year.

***

DSM/OK/RDS/MKV/HK

(Release ID: 1518546) Visitor Counter : 550

Read this release in: Telugu

END

Budget 2018: India is inching towards universal health coverage

Ayushman Bharat is the attractive title under which two promises of National Health Policy of 2017 have been coupled to create a new initiative in the Union budget of 2018. National Health Policy had prioritized primary healthcare as the principal component of health system strengthening and proposed that 70% of the health expenditure would be directed there. It also stated that strategic purchasing pathway would be used to procure and pay for secondary and tertiary care services from public and private healthcare providers. These two proposals have now been branded together in this year's budget, to provide the thrust engine for the nation's journey towards universal health coverage.

The budget allocates Rs1,200 crore for converting 150,000 sub-centres into active delivery points for comprehensive primary health services which encompass community-based health promotion, disease prevention, basic diagnostic and treatment services for common clinical conditions including non-communicable diseases and mental illness. While this is very welcome, the major challenge will lie in deploying the required number of skilled health personnel in these centres. Unless the allocation for the National Health Mission is substantially ramped up, non-availability of front-line health workers, mid-level care providers and allied health professionals will remain a barrier for revitalizing primary health services.

The biggest blossom in the finance minister's bouquet to the health sector is the scale up of financial protection for hospitalized secondary and tertiary care under the National Health Protection Scheme. Though this scheme was announced in the budget of 2016, the coverage remained at the level of Rs30,000 per annum per family which was provided under the Rashtriya Swasthya Bima Yojana (RSBY) which was redesigned as National Health Policy. Now the scheme is geared up to provide a coverage of Rs5 lakh per family to 100 million families. However, the allocation for this scheme is only Rs2,000 crore.

Unless the parallel schemes funded by state governments are merged in to a "single payer" mechanism under NHPS, the resources available will not match the ambition. Strategic purchasing will also demand increased capacity for defining the package of services, setting standard management guidelines, negotiating costs and monitoring quality. Otherwise unnecessary induced care will compete with appropriate needed care in hospital settings.

Another welcome initiative is the upgradation of 24 district hospitals for hosting new medical colleges in states which presently have very few. This will improve the capacity for delivering advanced care closer to home, without depending on far away corporate hospitals, while scaling up the production of doctors. The provision of financial support for patients with tuberculosis to access better nutrition is a necessary adjunct to their medical treatment and will help revive their depressed immunity.

Beyond the health sector, the Swachh Bharat Abhiyan will continue to build more toilets. The initiatives to control air pollution, identified as the second most important contributor to disease in India, include financial support for Delhi's neighbouring states for in-situ disposal of crop waste (instead of burning) and expansion of the Ujjwala scheme to provide more poor women with cooking gas connections.

K. Srinath Reddy is president of Public Health Foundation of India (PHFI). The views expressed are personal.

END

Get cracking: on implementing 'Modicare'

The NDA government lost precious time in its first three years in initiating a health scheme that serves the twin purposes of achieving universal coverage and saving people from high health care costs. It announced two years ago in the Budget a health protection scheme offering a cover of 1 lakh per family, but ultimately that did not extend beyond 30,000. Fresh hopes have been raised with the announcement of Ayushman Bharat in Budget 2018. The plan has the components of opening health centres for diagnostics, care and distribution of essential drugs as envisaged in the National Health Policy, and a National Health Protection Scheme (NHPS) to provide a cover of up to 5 lakh each for 10 crore poor and vulnerable families for hospitalisation. These are challenging goals, given the fragmented nature of India's health system. Some States already purchase health cover for the poor, but do not regulate private secondary and tertiary care services or treatment costs. The task before the Centre, which has provided 3,200 crore for the programme areas, is to now draw up an implementation roadmap.

What is 'Modicare' and how will it affect you?

Developing countries that launched universal health coverage schemes over a decade ago, such as Mexico, had to address some key challenges. These included transfer of resources to provinces, recruitment of health personnel, and purchase and distribution of medicines to the chosen units. All these apply to India. Moreover, the steady growth of a for-profit tertiary care sector poses the additional challenge of arriving at a basic care package for those who are covered by the NHPS, at appropriate costs. A national health system will also have to subsume all existing state-funded insurance schemes. This will give beneficiaries access not just within a particular State but across the country to empanelled hospitals. In the case of the local health centres that are planned under the Ayushman Bharat programme, there is tremendous potential to play a preventive role by reducing the incidence and impact of non-communicable diseases such as diabetes and hypertension. Such centres can dispense free essential medication prescribed by all registered doctors and procured through a centralised agency. But the efficiency of a large-scale health system depends on strict regulation. The early experience with state-funded insurance for the poor shows that some private hospitals may resort to unnecessary tests and treatments to inflate claims. Determination of treatment costs by the government is therefore important. This will also aid those with private health insurance, since it eliminates information asymmetry and provides a comparison point. The Centre must share details of the next steps.

The draft of Assam's National Register of Citizens is a first step, but it opens up concerns

END

The lowdown on pulse polio

On January 28, India carried out the first of its two national rounds of the Pulse Polio Campaign for 2018. The second is on March 11. These two campaigns will see a huge mobilisation of resources to give the oral polio vaccine (OPV) to around 17 crore under-five children. Why do Indian policy-makers continue to focus on polio, though the Southeast Asian region, including India, became polio-free in 2014? This is because the threat of resurgence is real and can happen in two ways. As of today, two countries — Pakistan and Afghanistan — still have circulating polio. And the polio virus can cross borders easily through adults who show no symptoms. In 2011, 10 years after becoming polio-free, China's Xinjiang province saw 21 cases of paralytic polio and two deaths. When the virus from the outbreak was sequenced, it turned out to be from Pakistan. In 2009, India exported polio to Tajikistan, where it caused an outbreak of 587 cases. Today, India's only defence against the import of polio is watertight immunisation. A small gap in immunisation among newborns can be enough for the imported virus to seep in.

The second risk of resurgence comes, ironically, from OPV itself. In rare cases, this vaccine, which contains weakened but live polio virus, can cause paralytic polio. Also, because the vaccine-virus is excreted by immunised children, it can move from one person to another. This makes OPV a double-edged sword. On the one hand, a vaccinated person protects unvaccinated people he/she comes in contact with by spreading immunity through faeces. But on the other, such circulation allows the virus to stick around and mutate to a more virulent form, raising the spectre of vaccine-derived poliovirus (VDPV). VDPV, like imported wild polio, can cause outbreaks in under-immunised population. It is for this reason that the eradication of polio worldwide requires OPV to be stopped and replaced with the Inactivated Polio Vaccine (IPV). IPV does not cause VDPV but protects children equally well against polio.

Indian researchers started experimenting with the strategy of 'pulse' immunisation in the 1980s. By then, OPV was a part of India's Expanded Programme on Immunisation, but polio burden remained high, with 1,000 children becoming paralysed each day. The success of the programme was being thwarted by low coverage of the vaccine, problems with potency and blunted immune response among Indian children. Against this background, a group of researchers, led by Vellore-based virologist T. Jacob John, championed the idea of pulse campaigns. While routine immunisation waits for parents to bring their children to the clinic, something that many parents do not do, pulse campaigns try to give a 'pulse' of vaccine to an entire population in one go. Dr. John suggested that routine immunisation worked in developed countries, because parents were motivated to vaccinate their children. But India needed a different strategy.

An early experiment in Vellore in 1978 showed that pulses delivered to a large cohort of children gave them strong immunity even when the vaccine was not so potent. This was because vaccine pulses rapidly replaced the wild-polio virus circulating in the community with the vaccine-virus. Vellore was the first Indian town to become polio-free through the pulse strategy, and the rest of India adopted the strategy in 1995.

Out of the three wild-types of poliovirus that cause the disease, the transmission of one, Wild Poliovirus 2 (WPV-2), was interrupted successfully more than a decade ago.

The two remaining viruses that are circulating in Pakistan and Afghanistan are WPV-1 and WPV-3. Once we stop these two viruses in their tracks, OPV will be phased out and replaced globally with IPV.

Priyanka Pulla

END

Look for proof

Representational image.

Policymaking, especially in health, is a complex process. Here, research that guides the process of policymaking is one of many contributing factors, the others being political aspects, interests of key stakeholders, feasibility of the policy, alignment with other policies, and consonance with the larger vision of the government. It is vital that India's health policies are based on the best available evidence-based research.

For example, a lot has been written on how the National Pharmaceutical Pricing Authority's (NPPA) decision, taken a year ago, to cap prices of advanced medical equipment, was a recipe for a public health crisis. There is now consensus that price regulation in an otherwise free-functioning market would eventually create inefficiencies. However, effects are often diffused and take time to surface.This makes finding evidence of the impact of such policies ex-post necessary, thereby providing guidance to policymakers to tweak and refine their policy goals and strategies.

In the example above, the policy was envisaged to make angioplasty procedures more accessible. But did this come about? IQVIA and the Advanced Medical Technology Association (AdvaMed), which comprises nearly 300 global medical technology companies, have released a paper to show that the NPPA's decision, to cap prices of cardiac stents, was actually bereft of economic logic. The study, conducted a year after the price cap policy came into effect, found that benefits to patients with coronary heart disease and the growth in the number of angioplasty procedures did not significantly change in this time. The study also found that the price cap on stents by as much as 85% resulted in 8-18% reduction in the overall angioplasty procedure cost for patients undergoing single vessel procedure (which accounts for almost three quarters of all angioplasty patients) in private hospitals. Patients at government-run hospitals did not benefit significantly because stents were, in any case, available at below the effective price after capping.

So, public policies need to be carefully designed. The approach by the NPPA in regulating price devices greatly underestimated the value of policy design. The study shows that the NPPA's planned actions did not result in representing a realistic and viable means of achieving improved access to affordable health care for people. There is now empirical proof that the big drop in prices due to the policy did not significantly alter the growth rate of angioplasties across hospitals of different segments in the country.

India faces a growing burden of non-communicable diseases, with cardiovascular diseases at the forefront. In this context, our reliance on any provider of safe, innovative and effective medical devices, which includes cardiac stents, cannot be undermined. By 2020, India is projected to have the highest population of youth, and, by 2027, the world's largest workforce with a billion people aged between 15 and 64 years. We need to ratchet up medical infrastructure and strengthen the health-care ecosystem so that our demographic dividend does not become a demographic disaster.

We should adopt public policies that have some empirical support and backed by scientific research. If reason and research point to the contrary, then price caps must go. We can consider alternative measures such as trade-margin rationalisation and differential pricing of medical devices, combined with categorisation, on the basis of the clinical status of patients. These long-drawn but concrete ways will increase accessibility to quality health care, boost innovation, and, most importantly, assist the government in achieving the goal of universal health coverage.

When the NPPA said that it would reconsider its decision to cap prices, it was perhaps hoping to

somehow, carefully and logically, ground its decision. There is evidence now. The NPPA must demonstrate that its actions can not only be cost effective and beneficial but also preserve incentives for innovation to make our health-care system robust in the long run.

Ashish Bharadwaj, who teaches law and economics at Jindal Global Law School, is a Director of Jindal Initiative on Research in IP and Competition (JIRICO)

Astronauts on extended space travel missions would have significant bone and muscle complications.

END

The progress India makes will have a significant impact: Yohei Sasakawa

Yohei Sasakawa.

Yhei Sasakawa, who is chairman of the Nippon Foundation, and the World Health Organization Goodwill Ambassador for Leprosy Elimination, was in India recently as part of the "The Global Appeal-2018". The event aims to end the discrimination faced by people affected by leprosy, and their families, worldwide. Mr. Sasakawa, who is also Japan's Ambassador for the Human Rights of People Affected by Leprosy, spoke to The Hindu about the challenges before India, which accounts for the largest number of cases of leprosy in the world, and his organisation's partnership in fighting the battle. Excerpts.

Leprosy is an age-old disease, described in the literature of ancient civilisations. Throughout history, people afflicted have often been ostracised by their communities and families. The first cure for leprosy emerged in the 1940s, but the important breakthrough came in the early 1980s with the introduction of a highly effective treatment, multi-drug therapy (MDT).

In 1991, the WHO set a target to eliminate leprosy as a public health problem, defining elimination as a prevalence of less than 1 case per 10,000 population. Since 1995, the WHO has provided MDT free of cost to all leprosy patients in the world. Free MDT was initially funded by The Nippon Foundation and since 2000, is being made available by donations through an agreement with Novartis. More than 17 million leprosy patients have been treated with MDT over the past 30 years.

Although the annual number of new cases has dropped dramatically since the pre-MDT days, there are still some 200,000 new cases reported around the world each year. There were 214,783 new leprosy cases registered globally in 2016, according to official figures from 145 countries in the world. Of these, 11 countries, among them India, Brazil and Indonesia, reported more than 1,000 patients, among them India, Brazil and Indonesia, with India accounting for more than 60% (135,585 cases) of all new cases.

Elimination of leprosy as a public health problem, at the national level, has been achieved by almost every country and we believe that 2018 could be a milestone year if Brazil too reaches this point. It would mean every country has now reached the elimination threshold of less than 1 case per 10,000 population.

But this does not mean that the fight against leprosy is over. That's why this year, our partnership with Disabled Peoples' International (DPI) and its Global Chair, Javed Abidi, is very significant. So far, 91 Member National Assemblies (MNAs) of DPI from around the world have endorsed the Global Appeal 2018.

The challenge is two-fold. There is the medical dimension of continuing transmission of leprosy, with some 200,000 new cases being diagnosed each year. There is also the social dimension in which stigma and discrimination impact the lives of people diagnosed with leprosy and even their families. Fear of discrimination can be a reason why people hesitate to seek treatment, which means they could be passing the disease to others and also putting themselves at risk of

developing life-long disabilities.

Leprosy affects men and women, adults and children. But factors such as gender discrimination can mean that women and girls are impacted disproportionately by the consequences of leprosy. Children accounted for around 9% of new cases in 2016 and there is now a concerted effort to reduce the number of leprosy cases among them to zero by 2020.

India accounts for the largest number of cases of leprosy in the world. It is now making concerted efforts to detect and treat cases early with special leprosy-case detection campaigns and other activities. There is also momentum to address outdated legislation that discriminates against persons affected by leprosy. The progress India makes in tackling leprosy will have a significant impact on the global situation.

There is yet no prophylactic vaccine available for leprosy, so early detection and treatment with MDT form the cornerstone of efforts against the disease. Ensuring that all cases are diagnosed and treated promptly remains a challenge among hard-to-reach and marginalised populations. Further efforts at educating the public about leprosy are needed so that people don't fear coming forward to seek treatment. Those who have been treated and cured do not face discrimination in their daily lives.

Astronauts on extended space travel missions would have significant bone and muscle complications.

END

What is pulse polio?

A child receives polio vaccine drops on the occasion of National Immunisation Day in Amritsar on January 28, 2018. | Photo Credit: AFP

On January 28, India carried out the first of its two national rounds of the Pulse Polio Campaign for 2018. The second is on March 11. These two campaigns will see a huge mobilisation of resources to give the oral polio vaccine (OPV) to around 17 crore under-five children. Why do Indian policy-makers continue to focus on polio, though the Southeast Asian region, including India, became polio-free in 2014? This is because the threat of resurgence is real and can happen in two ways. As on today, two countries — Pakistan and Afghanistan — still have circulating polio. And the polio virus can cross borders easily through adults who show no symptoms. In 2011, 10 years after becoming polio-free, China's Xinjiang province saw 21 cases of paralytic polio and two deaths. When the virus from the outbreak was sequenced, it turned out to be from Pakistan. In 2009, India exported polio to Tajikistan, where it caused an outbreak of 587 cases. Today, India's only defence against the import of polio is watertight immunisation. A small gap in immunisation among newborns can be enough for imported virus to seep in.

The second risk of resurgence comes, ironically, from OPV itself. In rare cases, this vaccine, which contains weakened but live polio virus, can cause paralytic polio. Also, because the vaccine-virus is excreted by immunised children, it can move from one person to another. This makes OPV a double-edged sword. On the one hand, a vaccinated person protects unvaccinated people she comes in contact with by spreading immunity through faeces. But on the other, such circulation allows the virus to stick around and mutate to a more virulent form, raising the spectre of vaccine-derived poliovirus (VDPV). VDPV, like imported wild polio, can cause outbreaks in under-immunised population. It is for this reason that the eradication of polio worldwide requires OPV to be stopped and replaced with the Inactivated Polio Vaccine (IPV). IPV does not cause VDPV but protects children equally well against polio.

Indian researchers started experimenting with the strategy of 'pulse' immunisation in the 1980s. By then, OPV was a part of India's Expanded Programme on Immunisation, but polio burden remained high, with 1,000 children becoming paralysed each day. The success of the programme was being thwarted by low coverage of the vaccine, problems with potency and blunted immune response among Indian children. Against this background, a group of researchers, led by Vellore-based virologist T. Jacob John, championed the idea of pulse campaigns. While routine immunisation waits for parents to bring their children to the clinic, something that many parents do not do, pulse campaigns try to give a 'pulse' of vaccine to an entire population in one go. Dr. John suggested that routine immunisation worked in developed countries, because parents were motivated to vaccinate their children. But India needed a different strategy.

An early experiment in Vellore in 1978 showed that pulses delivered to a large cohort of children gave them strong immunity even when the vaccine was not so potent. This was because vaccine pulses rapidly replaced the wild-polio virus circulating in the community with the vaccine-virus. Vellore was the first Indian town to become polio-free through the pulse strategy, and the rest of India adopted the strategy in 1995.

Out of the three wild-types of poliovirus that cause the disease, the transmission of one, Wild Poliovirus 2 (WPV-2), was interrupted successfully more than a decade ago.

The two remaining viruses that are circulating in Pakistan and Afghanistan are WPV-1 and WPV-3. Once we stop these two viruses in their tracks, OPV will be phased out and replaced globally with IPV.

Receive the best of The Hindu delivered to your inbox everyday!

Please enter a valid email address.

Astronauts on extended space travel missions would have significant bone and muscle complications.

END

Mixing work with study

Basic education has slipped in priority in the national policy matrix over the decades. The Census and several other data sets have pointed to various dimensions of the problem. Recently, the Annual Status of Education Report (Rural) 2017, published by a non-governmental organisation and containing data from 26 districts in 24 States, has some national-level findings that should cause concern.

Focussing on the 14-18 years age group, the ‘Beyond Basics’ study has tried to assess, inter alia, whether this cohort of young people is enrolled in any educational institution, whether they are both enrolled and pursuing work, how well they have been prepared in previous schooling, their access to technology, and what occupies their time. This is an important segment of the population, on the threshold of adulthood, and, importantly, political participation.

The insights from the study are based on a sample of 28,323 youth who are at different levels of development. A national-level finding is that as a group, 14.4% of youth aged 14 to 18 years are not enrolled in school or college. Yet, this figure conceals variations by age: while it is 5.3% for 14-year-olds, it rises to 30.2% at age 18. The imperative clearly is to look at factors that prevent them from being part of formal higher secondary education, of which availability and affordability of schools would be important.

Evidently, a large-scale vocational education system on the lines of the “dual” German model — classroom instruction plus apprentice training — would help raise the productivity of both individuals and the economy. ASER’s statistics indicate that overall, only 5.3% of the age group is enrolled in a vocational course, while 60.2% of out-of-school youth are engaged in some form of work. These trends underscore the need to scale up substantive skill-building programmes, making them free or highly subsidised.

It is in this context that the role of agriculture as a provider of jobs and prosperity must be viewed. Among those who are already working in the 14-18 age group, 79% are engaged in farming, and that too in their family farms. By contrast, agriculture as work ranked very low as an aspiration among the youth. What this appears to show is that for a significant number of youth, a useful education in agriculture, coupled with access to the formal economy for finance and marketing, could raise the quality of life. In fact, the ability of farmers to adopt technology, avail benefits offered by the government and demand stronger institutions would be enhanced, if elementary education is improved. It would also produce the additional benefit of promoting health-seeking behaviour among these youth.

At the moment, though, the education tests administered to them seem to show that they can read text, but feel challenged when it comes to solving a simple mathematical problem. They will do better if the teaching-learning process becomes engaging and effective.

Marriage is a civil contract — adultery or divorce should have only civil consequences

END

Modicare will find it tough to get out of the blocks

Soon after he announced the world's largest public healthcare scheme in the Union budget, finance minister Arun Jaitley termed it "Modicare" in a Doordarshan interview. This was not happenstance. Prime Minister Narendra Modi's electoral dance card is full. Taking ownership of a startlingly ambitious—in theory—programme aimed at the common man is apt messaging. But the problems faced by Modicare's namesake, Obamacare, in the US show how tricky the big questions in healthcare are.

India's perennial healthcare failure, with low government healthcare spending and high disease burden, make for predictably depressing outcomes. According to World Bank data, 62.4% of total health expenditure in the country was out of pocket (OOP) as of 2014, compared to a global average of a little over 18%. Shamika Ravi, Rahul Ahluwalia and Sofi Bergkvist have estimated in a 2016 Brookings Institute paper, *Health and Morbidity in India (2004-2014)* that this adds around seven percentage points to India's poverty figures. Modicare—or the National Health Protection Scheme—raises two questions. Is it the best long-term model to reduce OOP expenditure and improve outcomes? And judging by the performance of the existing publicly funded health insurance (PFHI) scheme, Rashtriya Swasthya Bima Yojana (RSBY), that it will subsume, can it be implemented effectively?

The evidence for the first question is somewhat ambiguous. European states have implemented government or government mandated insurance—first, in the 1920s, and then with a number of southern European countries following suit in the 1960s—to achieve coverage and outcomes that are among the best in the world. However, the various models used sit uneasily with India's governance realities. Germany's system, for instance, relies on high formal sector employment to partly fund government insurance managed by independent trusts. It is also placing an increasingly unsustainable strain on the exchequer. Switzerland has managed to avoid this, implementing arguably the most free market model in the world, with the government subsidizing private insurance on a sliding scale. But its per capita health expenditure is among the highest in the world. Besides, the system rests on an efficient state's ability to tightly regulate the private insurers. More recently, countries in the developing world like China have used publicly funded health insurance to achieve wide coverage. In the absence of the European states' governance capabilities, however, outcomes have been poor and OOP expenditure has not decreased.

Given this, the answer to the second question is unsurprisingly clear. RSBY has been riddled with problems. Implemented in 2008 by the United Progressive Alliance government, it aimed to cover Below Poverty Line (BPL) households, funding private insurance for inpatient coverage of Rs30,000 for five members per household. A comprehensive report by Soumitra Ghosh and Nabanita Datta Gupta, *Targeting and effects of Rashtriya Swasthya Bima Yojana on access to care and financial protection (Economic & Political Weekly, 2017)* found that the scheme had failed in both its primary objectives. It had misfired in targeting, covering only 12.7% of households among the poorest quintile at the national level. Little wonder that "almost half of the households enrolled in the RSBY actually belonged to the non-poor category." And while the scheme increased the number of admissions in insured households by 59% compared to mean inpatient care utilization among uninsured households, it failed to significantly impact OOP expenditure or reduce health-related poverty for the former.

Figuring out why the outcomes have been poor is not rocket science. At both the central and state levels, governments have lacked the capacity to regulate RSBY effectively. This has exacerbated the effect of the inevitable perverse incentives for various actors in the system such as the insurers and healthcare providers. The former, paid on a per household basis, have found it profitable to register less than the mandated five members per household or issue the registration

cards halfway through the insurance term. Effective targeting has also not been a priority. Doctors and hospitals, meanwhile, have fallen into the supplier-induced demand trap, recommending unnecessary procedures in order to claim reimbursements.

The lack of concrete information about Modicare makes it impossible to know if the design flaws will be addressed. The few details that have been released so far suggest that states will have the freedom to provide insurance via the trust model or the insurance company model. The former would perhaps be more effective based on global precedent. In theory, farming insurance out to private companies introduces competition that reduces costs, but this has not been the case in practice. On the other hand, if Modicare allows competition between private insurers and public trusts, it has the potential to improve outcomes.

Regardless, the larger problem remains. Government insurance works to improve healthcare access and outcomes—if the state has the agility, expertise and regulatory capacity to implement it effectively. India does not. This will not change by October when Modicare is launched. Healthcare lies at a confluence of inelastic demand, political sensitivity, economic consequences and ethical governance that makes the state's role crucial. With Modicare, the current government is attempting to create a narrative that gives due importance to this. That is to the good. And despite the inevitable criticism, public insurance need not cannibalize the public healthcare system. Both can function in a complementary fashion. The reality of state capacity in India, however, means that Modicare will be more about messaging than performance in the near future at least.

Should the budget have focused on upgrading the public health system instead? Tell us at views@livemint.com.

END

Deadly drug cocktails in India

Indians are big consumers of dangerous fixed dose combinations (FDCs) that are not approved by the country's drug regulator, says a study, 'Threats to global antimicrobial resistance control: centrally approved and unapproved antibiotic formulations sold in India', published in the *British Journal of Clinical Pharmacology*.

FDCs are a blend of two or more drugs to maximise drug efficacy and can promote antibiotic resistance if they are not designed rationally. Using statistics from the PharmaTrac sales database, the study found that of the 118 FDCs sold in India, only 43 were approved by the Indian drug regulator, the Central Drugs Standard Control Organisation (CDSCO), while five were approved by the U.S. and the U.K. regulators.

Seven of the FDCs that were not approved by the CDSCO were among the top 20 bestselling FDCs in 2011-12. Sixteen of these bestsellers were not approved in the U.S. and the U.K. either. For example, the second-most popular Indian FDC, a combination of ofloxacin and cloxacillin, is not approved by the CDSCO. The study also identified approved drugs that were irrational — ofloxacin and the anti-protozoa drug ornidazole were combined even though they had different dosing schedules and could worsen diarrhoea.

Around 42% of the FDCs sold in India in 2011-12 included at least one "highest priority critically important antimicrobials" as designated by the World Health Organisation. These are antibiotics that are a last resort, where loss of efficacy would have a large impact on public health. Eight of these combinations included two antibiotics, and only two of the eight were approved in India, while none were approved in the U.S. and the U.K. While the idea behind antimicrobial combinations is to reduce the risk of resistance by attacking a bacterium from two fronts, studies have shown that if the two drugs aren't carefully chosen, combinations can trigger resistance to multiple antibiotics.

In March 2016, the Union government banned 344 FDCs. The Supreme Court, while upholding the ban after appeals from pharma companies, has asked the Drugs Technical Advisory Board to examine the cases afresh. Of the 344 FDCs, the study's authors identified 16 in the PharmaTrac database. Several multinationals were found to be selling unapproved FDCs in India as well.

Marriage is a civil contract — adultery or divorce should have only civil consequences

END

Making health insurance work

It is unusual for a health programme to become the most prominent feature of a Union Budget. The previous government missed the bus when it failed to implement the recommendations of the High-Level Expert Group on Universal Health Coverage (2011). Yet, those recommendations resonate in the Budget of 2018, with commitment to universal health coverage, strengthening of primary health care (especially at the sub-centre level), linking new medical colleges to upgraded district hospitals, provision of free drugs and diagnostics at public health facilities, and stepping up financial protection for health care through a government-funded programme that merges Central and State health insurance schemes.

Whatever be the time and resources needed to fully implement these initiatives, the Budget sends a strong message that health is now in the spotlight of politically attractive policy pronouncements. From now on, no government can ignore people's legitimate aspiration to get the health services they desire and deserve. However, health care is not just a matter of health insurance, involving as it does many other elements such as the availability of a multi-layered, multi-skilled health workforce. Further, there is health beyond health care, dependent on many social determinants.

The scheme will provide cost coverage, up to 5 lakh annually, to a poor family for hospitalisation in an empanelled public or private hospital. The precursor of the National Health Protection Scheme (NHPS), the Rashtriya Swasthya Bima Yojana (RSBY), provided limited coverage of only 30,000, usually for secondary care. Though it improved access to health care, it did not reduce out-of-pocket expenditure (OOPE), catastrophic health expenditure or health payment-induced poverty. The NHPS addresses those concerns by sharply raising the coverage cap, but shares with the RSBY the weakness of not covering outpatient care which accounts for the largest fraction of OOPE. The NHPS too remains disconnected from primary care.

The NHPS will pay for the hospitalisation costs of its beneficiaries through 'strategic purchasing' from public and private hospitals. This calls for a well-defined list of conditions that will be covered, adoption of standard clinical guidelines for diagnostic tests and treatments suitable for different disorders, setting and monitoring of cost and quality standards, and measuring health outcomes and cost-effectiveness. Both Central and State health agencies or their intermediaries will have to develop the capacity for competent purchasing of services from a diverse group of providers. Otherwise, hospitals may undertake unnecessary tests and treatments to tap the generous coverage. The choice of whether to administer NHPS through a trust or an insurance company will be left to individual States.

Reduced allocation for the National Health Mission and sidelining of its urban component raise concerns about primary care, even though the transformation of sub-centres to health and wellness centres is welcome. If primary health services are not strong enough to reduce the need for advanced care and act as efficient gatekeepers, there is great danger of an overloaded NHPS disproportionately draining resources from the health budget. That will lead to further neglect of primary care and public hospitals, which even now are not adequately equipped to compete with corporate hospitals in the strategic purchasing arena. That will lead to decay of the public sector as a care provider. This must be prevented by proactively strengthening primary health services and public hospitals.

The NHPS is not a classic insurance programme, since the government pays most of the money on behalf of the poor, unlike private insurance where an individual or an employer pays the premium. However, the scheme operates around the insurance principle of 'risk pooling'. When a large number of people subscribe to an insurance scheme, only a small fraction of them will be hospitalised in any given year. In a tax funded system or a large insurance programme, there is a

large risk pool wherein the healthy cross-subsidise the sick at any given time. The NHPS will be financially viable, despite a high coverage offered to the few who fall sick in any year, because the rest in the large pool do not need it that year.

However, the NHPS will need more than the 2,000 crore presently allocated. As the scheme starts in October 2018, the funding will cover the few months before the next Budget. It is expected to require 5,000-6,000 crore to get it going in the first year and 10,000-12,000 crore annually as it scales up. It will draw additional resources from the Health and Education Cess and also depend on funding from States to boost the Central allocation. The premiums are expected to be in the range of 1,000-1,200 per annum. They may be lowered if enrolment is high but will rise if utilisation rates are high.

In all the excitement about the Union Budget's proposal of the NHPC, it is easy to forget that State governments have the main responsibility of health service delivery and also need to bear the major share of the public expenditure on health. The National Health Policy (NHP) asks the States to raise their allocation for health to over 8% of the total State budget by 2020, requiring many States to double their health spending. Will they be stimulated to do so, when the Central Budget has not signalled a movement towards the NHP goal of raising public expenditure on health to 2.5% of GDP by 2025?

The NHPS needs a buy-in from the States, which have to contribute 40% of the funding. Even with the low cost coverage of the RSBY, several States opted out. Some decided to fund their own State-specific health insurance programmes, with distinctive political branding. Will they agree to merge their programmes with the NHPS, with co-branding? Will other States, who will also contribute 40% to the NHPS, demand similar co-branding? In a federal polity with multiple political parties sharing governance, an all-India alignment around the NHPS requires a high level of cooperative federalism, both to make the scheme viable and to ensure portability of coverage as people cross State borders. For the sake of all Indians, let us hope an all-party consensus develops around how to design and deliver universal health coverage, starting with but not stopping at the NHPS.

K. Srinath Reddy is President, Public Health Foundation of India. Views are personal

Marriage is a civil contract — adultery or divorce should have only civil consequences

END

India needs a sewage system, not free toilets

A policy announcement about the Swachh Bharat Abhiyan (SBA) in the 2018 budget speech barely received any attention. Referring to the 60 million toilets already constructed, the finance minister declared the existing programme a success, and announced the intention to construct an additional 20 million toilets allotting a budget of Rs17,843 crore to this end. This has attracted little criticism or praise. The reason is that Indians are familiar with this policy; they are reminded of it daily while paying the Swachh Bharat cess. And there is little controversy over the need for greater levels of sanitation. Overall, this seems like a well-intentioned and sensible initiative.

Except for one thing. Access to free toilets has not helped resolve open defecation in India. And the SBA is unlikely to succeed in its primary task of eliminating open defecation by October 2019. The main reason is that Indians don't want free toilets, they want sewage systems. India has far higher levels of open defecation than other countries of the same GDP (gross domestic product) per capita. For example, India has a higher GDP per capita than Bangladesh, but in Bangladesh only 8.4% households defecate in the open, compared to 55% in India. Basic latrines are not that expensive, and people in countries far poorer than India build inexpensive latrines to avoid defecating in the open. Typically, as nations get wealthier, open defecation decreases. Despite increases in GDP per capita, and increase in latrine availability through the SBA, India has witnessed little decrease in open defecation.

Why do Indians, even with accessible toilets, go in the open? Especially when open defecation is killing infants, making children sick, stunting their growth.

Diane Coffey and Dean Spears' recent book, *Where India Goes*, argues that the problem is not just one of access to toilets. Even when toilets are provided for free by the government, Indians prefer defecating in the open to using basic latrines. The latrines provided by governments are often used for storage, washing clothes, and as play areas—everything except the intended use. The key reason for this is that basic latrines that need to be emptied out manually or pumped by simple machines are unacceptable to higher caste Hindus. It is considered polluting to the individual and the home, and historically associated with untouchability. The perceptions of ritual purity are particularly prevalent and persistent in rural India, with consequently the highest level of open defecation in the world.

So, Indian policymakers need to rethink the solution to this problem. It is not just a matter of access but a problem of perceptions of pollution, ritual purity, and caste. This in no way suggests that one should endorse the nonsensical and irrational caste perceptions and practices that are slowly and steadily killing and stunting Indian children. However, deeply entrenched cultural contexts must be taken into account for successful policy outcomes. India needs to change perceptions of ritual purity through education and awareness in rural areas. And if it is not possible to change perceptions quickly, India needs to think of policy solutions that can work around the perverse caste perceptions. Or pursue both paths simultaneously.

One solution is to change the SBA from a scheme providing free toilets, to one encouraging and enabling local governments to construct sewage systems. A toilet that is not connected to a functional sewage system needs to be pumped and transported, which runs counter to perceptions of ritual purity. A toilet that flushes away human waste into the sewage and waste management system solves the problem. If there is a functional sewage system, it is relatively low cost for households to build a toilet in every home that is connected to the sewage system. At the current levels of development in India, a much smaller proportion of the population will actually need a government subsidy to construct a toilet.

Building a sewage system is no easy task and raises classic collective action problems. All citizens do not face the costs equally when some streets and neighbourhoods are dug up for years on end. But everyone reaps the benefits of having a functional and sanitary waste disposal system. So this is a problem of concentrated costs and dispersed benefits, which leads to policy inaction.

There is a secondary problem of political incentives when it comes to building sewage systems. It takes years to build sewage systems, and local politicians face all the costs upfront, and the benefits are far in the future. Disgruntled citizens and voters complain about the digging of neighbourhoods for years, causing much nuisance to their daily lives. However, a different legislator or corporator may reap the benefits of better health outcomes far in the future. So, this is also a problem of immediate costs and distant benefits.

Both these problems essentially act as disincentives of the political class to take action to solve the sanitation problem. Providing free toilets is easier to achieve, and also easier to measure as a success at the distribution level, if one ignores the fact that they are not used for the intended purpose.

The SBA has minimal chance of success in the near future. Even if the government builds free toilets without any leakage or corruption, India will at best have 80 million new toilets that a large proportion of Indians do not want to use, and simultaneously high levels of open defecation. The government needs to rethink the solution to the problem of open defecation and focus on providing public goods like sewage systems instead of free toilets.

Shruti Rajagopalan is an assistant professor of economics at Purchase College, State University of New York, and a fellow at the Classical Liberal Institute, New York University School of Law.

Comments are welcome at views@livemint.com

END

The unjoined dots

It is unusual for a healthcare scheme to become one of the most talked about provisions of a Union budget. In the past, finance ministers have, at best, made cursory references to universal health coverage in their budget speeches. But while presenting the Union Budget for 2018-2109, Arun Jaitley broke this tradition when he introduced “the world’s largest government healthcare related programme”. He was talking about a new publicly-funded healthcare insurance scheme, the National Health Protection Scheme (NHPS). “Ten crore familes will get Rs 5 lakh per year to cover secondary and tertiary hospital expenses,” the finance minister said. Given that this amount is more than 16 times the Rs 30,000 provided to BPL families by the Rashtriya Swasthya Bima Yojana (RSBY), usually for secondary care, the insurance scheme announced in the budget does signal a significant departure in healthcare policy. But the NHPS’s success in providing universal health coverage will hinge on the adequacy of primary medical services — the Achilles heel of the country’s healthcare system.

In a country where a health crisis is often a precursor to financial catastrophe for the poor, the salience of a healthcare financing scheme cannot be overstated. But according to a study last year, in the international journal, Social Science Medicine, the RSBY did not lead to any significant reduction in out-of-pocket health expenses by its beneficiaries. The one strand running through the several reasons for this failure is that the country’s healthcare infrastructure is not up to the mark. According to the Union Ministry of Health and Family Welfare’s Rural Health Statistics (RHS) 2016 Report, the country has a 22 per cent shortfall in primary health centres (PHCs). More than 80 per cent of the posts of specialists in community health centres in rural India are vacant, according to the report. More than 40 per cent of the PHCs do not have ambulances to transport the critically ill to community and tertiary-care facilities. Primary and community health centres are crucial to needs of patients who do not require hospitalisation — tuberculosis patients, for example. The RSBY did not address their requirements. The NHPS, too, remains disconnected from primary healthcare.

A weak primary healthcare system could burden tertiary care. In other words, the NHPS could drain government resources, which could, in turn aggravate the neglect of primary healthcare facilities. The government intends to pay for the hospitalisation of the new scheme’s beneficiaries through “strategic purchasing” arrangements with private healthcare providers. But there are currently no protocols for diagnostic tests for the beneficiaries of publicly-funded insurance schemes — a well-known criticism of the RSBY was that private hospitals often took advantage of the insurance coverage of patients by prescribing unnecessary tests. The success of the NHPS will require the government to join several dots. On current evidence, it seems that it hasn’t thought the challenge through.

END

AYUSH

Government set up quality control regulations and validations of herbal medicines

Posted On: 06 FEB 2018 3:31PM by PIB Delhi

Central Government has published Ayurvedic pharmacopoeia containing quality standards of 645 single Ayurvedic drugs and 202 compound formulations; Unani Pharmacopoeia containing quality standards of 298 single drugs and 150 compound formulations and Siddha pharmacopoeia containing quality standards of 139 single drugs. Standardised 985 Ayurvedic Formulations, 1229 Unani Formulations and 399 Siddha Formulations are published in respective Formularies. Development of standards of ASU medicines is a ongoing process taken up by Pharmacopoieal Commission of Indian Medicine & Homeopathy and Pharmacopoeia Committees. Central and State Drug Laboratories for testing of ASU medicines are in place and as of now 55 laboratories are approved under the provisions of Drugs & Cosmetics Rules, 1945. It is mandatory for the manufacturers to adhere to the prescribed requirements for licensing of manufacturing units & medicines including compliance to Good Manufacturing Practices (GMP) and quality standards of drugs given in the respective pharmacopoeia. Proof of safety & effectiveness required for issuing manufacturing license for various categories of ASU medicines is prescribed in Rule 158B of the Drugs & Cosmetics Rules, 1945. Accordingly, the Licensing Authorities/Drugs Controllers appointed by the State Governments are empowered to grant or renew license for manufacturing of ASU medicines and to take necessary action against the defaulters acting in contravention of the legal provisions.

Herbal medicines as such are not defined in the Drugs & Cosmetics Act, 1940 and Rules there under. However, Ayurvedic, Siddha and Unani (ASU) medicines made from herbal/plant materials and other ingredients are regulated in the country through exclusive quality control provisions given in the Drugs & Cosmetics Act 1940 and Rules there under. Instances of fake such medicines have been reported, which are defined in chapter IV A of the Drugs & Cosmetics Act, 1940 as spurious, misbranded and adulterated types along with the penal provisions for the defaulters. Complaints of substandard medicines are forwarded to the respective State Regulatory Authorities for taking action in accordance with the legal provisions.

Reports of testing of ASU drugs received in this regard from some of the states and central laboratory during 2017-18 are as under-

State	**No. of drug samples taken for testing**	**No. of samples not qualified**	**Action taken in accordance with the provisions of Drugs & Cosmetics Act and Rules.**
Kerala	570	15	Prosecution action and Departmental action are being taken against the defaulters
Chhattisgarh	50	03	Action was taken as per recommendation of Screening Committee formed as per Govt. of India.
Chandigarh	432	Nil	-
Delhi	2346	19	08 cases are under process in Court.

Gujarat	76	00	----
Himachal Pradesh	487	44	Action has been taken as per Drugs & Cosmetics Act, 1940 and Rules 1945.
Odisha	53	Nil	---
Karnataka	1056	29	• Failed batches of medicine are withdrawn from the Market. • Show cause notices issued and manufacturers instructed not to issue the failed batch of medicines. • Sale of failed batches of medicines banned.
Tamil nadu	1255	39	Show cause notices issued.
Telangana	315	Nil	
Tripura	146	Nil	
Uttarakhand	138	34	Show cause notices issued.
Pudducherry	16	Nil	
Central Pharmacopoeia Laboratory of Indian Medicine (PLIM)	07	01	Test Reports submitted to Hon'ble Court.

This information was given by the Minister of State (Independent Charge) for AYUSH, Shri Shripad Yesso Naik in written reply to a question in Rajya Sabha today.

RJ/SK

END

Nod for 24 new medical colleges, more seats

Location for the medical colleges will be identified in the selected areas.

The Cabinet Committee on Economic Affairs (CCEA) chaired by Prime Minister Narendra Modi, on Wednesday, gave its approval for setting up 24 new medical colleges in underserved areas, increasing the under and post graduate medical seats by 18,058 and adding 248 nursing and midwifery schools.

This is to be done at a total estimated cost of Rs. 14,930.92 crore up to 2019-20.

According to a release issued by the Health Ministry, “The government is looking at continuation of the ongoing scheme to establish 58 new medical colleges attached with existing district/referral hospitals already approved under Phase-I by 2019-20. Selection and establishment of 24 new medical colleges will be under Phase-II by 2021-22.’’

Also the locations of the proposed 24 new medical colleges in Phase-II will be selected within the identified underserved areas in challenge mode.

An amount of Rs. 5,587.68 crore is proposed for the ongoing scheme under Central share during Phase-I. Phase-II entails an amount of Rs. 3,675 crore to be spent till 2021-22 as Central share out of which an amount of Rs. 2,600 crore is proposed to be spent till 2019-2020.

“It has been planned to ensure at least one medical college for every three to five Parliamentary Constituencies and at least one Government medical college in a State,’’ noted the Health Ministry. The government is looking at an increase of 10,000 UG seats by 2020-21 and 8,058 PG seats (4,058 in Phase-I by 2018-19 and 4,000 in Phase-II by 2020-21).

The Cabinet has also given the green signal for setting up 112 Auxiliary Nursing and Midwifery (ANM) Schools and 136 General Nursing Midwifery (GNM) Schools by 2019-20 in underserved districts.

END

Biologics, patents and drug prices

The global sales of the world's best-selling prescription drug, Humira, continue to grow even after the expiry of the patent over its main ingredient, adalimumab, a biologic used for the treatment of arthritis. By 2020, AbbVie Inc, makers of Humira, expects its sales to touch $21 billion — a figure that will surpass India's pharmaceutical exports for that year. But success has its price. In 2015, faced with the imminent expiry of the patent for Humira's main ingredient, AbbVie reassured investors that the "Broad U.S. Humira Patent Estate" — a list of 75 secondary patents in the U.S. for new indications, new methods of treatment, new formulations, and the like — would take care of the problem.

But what was the problem? Patents offer their owners market exclusivity for a limited period of time. For medicines, this exclusivity should last as long as the primary patent — which relates to the active pharmaceutical ingredient (API) of the medicine — is in effect, typically 20 years. The end of patent exclusivity is referred to as a patent cliff, because drug prices fall steeply afterwards — by as much as 80% — owing to generic competition.

But the threat of this precipitous fall in profits drives pharmaceutical companies to find new ways to postpone their exclusivity by filing secondary patents for derivatives and variants of the API, such as a physical variant of the API, a new formulation, a dosage regimen, or a new method of administering the medicine. The secondary patents prop up before the expiry of a primary patent thereby stretching the exclusivity beyond 20 years, a practice that is called "evergreening". This strategy is most lucrative when employed in the context of so-called blockbuster medicines, which reap annual revenues exceeding $1 billion.

The Humira patent estate now comprises secondary patents. While it is hard to comprehend how real estate can grow, the genius of patent law allows the intellectual property estate to expand by filing more secondary patents. Over the years, AbbVie has increased the price of Humira in the U.S. by 100%, while steadily filing a large number of secondary patents. While the complexity of biologics – drugs made from complex molecules manufactured using living cells — allows for filing more patents, the patent laws too play a role. The U.S. recognises and encourages secondary patents. India, however, does not, which means that while Humira costs $1,300 (85,000) in the U.S., the same treatment costs only $200 (13,500) in India, thanks to the rejection of secondary patents on Humira by the Indian Patent Office (IPO) and the consequent introduction of cheaper versions.

The rejection of a secondary patent for Novartis' Glivec, a crucial leukaemia cure, was famously upheld by the Supreme Court of India in 2013, while the same was granted in the U.S. Consequently, the cost of a monthly dose of the medicine in the U.S. was 1.6 lakh, while the cost of the generic was 11,100 in India. Likewise, Spiriva, a medicine for asthma, enjoys patent protection until 2021 in the U.S., largely due to secondary patents. All of these secondary patents were rejected in India. As a result, while the monthly cost of the medicine in the U.S. is over 19,100, it costs a mere 250 in India.

In our study of more than 1,700 rejections for pharmaceutical patents at the IPO spanning the last decade, we identified a subset of applications that sought protection in the form of secondary patents for blockbuster medicines. Our study sheds new light on how Indian patent law helps thwart evergreening practices by pharmaceutical companies. Secondary patents for several blockbuster medicines have been rejected by the IPO dramatically expanding access to medicines for important health problems such as cancer, AIDS, asthma and cardiovascular diseases.

None of this would have been possible without some remarkable innovations in Indian patent law.

To be deemed patentable, applications for secondary patents have to clear significant hurdles. As per Section 2(1)(ja) of the Patents Act, the product in question must feature a technical advance over what came before that's not obvious to a skilled person. Because secondary patents for pharmaceuticals are often sought for trivial variants, they typically fail to qualify as an invention. Further, when a medicine is merely a variant of a known substance, Section 3(d) necessitates a demonstration of improvement in its therapeutic efficacy. The provision also bars patents for new uses and new properties of known substances. This additional requirement is unique to Indian law, and along with Section 2(1)(ja), ensures that bad patents stay out of the system.

We found that secondary patents were rejected largely due to the stringent thresholds imposed by Sections 2(1)(ja) and 3(d). Section 3(d) is not our only defence against secondary patents. It is complemented by other exceptions to patentability: Section 3(e) ensures that patents for combinations of known substances are allowed only if there is synergistic effect, while Section 3(i) ensures that no exclusivity can be claimed over methods of treatment. Together, Sections 3(d), 3(e) and 3(i) have been instrumental in rejecting close to 1,000 secondary patents for pharmaceuticals we studied.

These provisions also extend to biologics, the new big players in the therapeutics marketplace. More lucrative than small molecule medicines, biologics are no stranger to the lure of secondary patenting for extending patent terms. For instance, a quarter of the secondary patents for Humira, a biologic, are directed towards new uses and methods of treatment. Thanks to the provisions in the patent law, Humira enjoys no patent protection in India, since AbbVie restricted their Indian filings to only cover their secondary patents.

Blockbuster medicines are crucial to the success of public health. But they have been gamed, and rendered inaccessible to the people and governments who need them. In order for these medicines to be accessible, there can be no surer way than to enact strong standards that put bad patents where they belong.

Feroz Ali is the IPR Chair Professor at IIT Madras and Sudarsan Rajagopal is a London-based patent analyst. Their report, available at www.accessibsa.org, was prepared as a part of a Shuttleworth Foundation project on access to medicines

Marriage is a civil contract — adultery or divorce should have only civil consequences

END

Is Ayushman Bharat a game changer?

India is presently in a state of health transition. Infectious diseases such as tuberculosis, malaria, dengue, H1N1 pandemic influenza and antimicrobial resistance remain a continued threat to health and economic security. At the same time, the country is having to confront the emerging problem of chronic non-communicable diseases such as cardiovascular diseases, diabetes, cancer which are now the leading cause of mortality.

This epidemiological transition is being fueled by social and economic determinants of health, as well as by demographic changes such as an ageing population, by environmental factors such as climate change, and by factors such as globalization, urbanization and changing lifestyles.
As a result, the health infrastructure is already under severe strain. Moreover, the high cost of health care and out of pocket expenditure force families to sell their assets, pushing nearly 60 million people every year into poverty.

The New Initiative

To address these challenges, Finance Minister Arun Jaitley on February 1 unveiled the world's largest government-funded health programme called National Health Protection Scheme (NHPS), covering 10 crore families or approximately 50 crore population, with Rs 5 lakh insurance cover per family per year. The scheme is for secondary and tertiary healthcare, mainly for hospital care.

This flagship scheme is likely to benefit more than 37% of the population, meaning that nearly all the poor and vulnerable families will be covered. The government will require Rs 12000 crore for it's implementation, with cost shared on a 60:40 basis between central and state governments.

Mr Jaitley further announced setting up or converting some 150,000 subcentres in the country into so-called "health & wellness" centres which will offer a set of services including maternal and child health services, mental health services, vaccinations against selected communicable diseases, and screening for hypertension, diabetes, and some cancers. The sub-centres which at present cater to a population of about 5000 people each and are manned by two paramedical staff.

The Ayushman Bharat programme is apparently driven by two main aims: 1) to strengthen primary health care which has been lacking in the country and 2) to offer finacial protection from catastrophic expenditure, often encountered once a family member is sick and needs long-term health care.

Implementation is Key

The scheme, if implemented properly could be a game changer by enhancing access to health care including early detection and treatment services by a large section of society who otherwise could not afford them. The identification of beneficiaries can be done by linking with Aadhar and similarly following up for services received and health outcomes achieved, thereby helping to monitor and evaluate the impact of the programme.

Ultimately, NHPS could help country move towards universal health coverage and equitable access to healthcare which is one of the UN Sustainable Development Goals or SDGs.

This new scheme builds on the already existing Rashtriya Swasthya Bima Yojna or RSBY – a health insurance scheme for the below poverty line families, with entitlement of upto Rs 30,000 per annum for diseases requiring hospitalization. However, given that states are expected to agree for 40 per cent share under the NHPS and that health being a state subject, state ownership and

commitment will be critical for the success of the programme.

The Finance Minister has made a budget allocation at Rs 52,800 crores for the health ministry, up from Rs 47,352 crore during the previous year signifying an increase of 11%, yet as percentage of the GDP, it is still among the lowest in the world. In addition, government plans increase the levy of health cess from 3 to 4%. According to health minister J P Nadda, Rs 2000 crore has been allocated as of now.

It is clear that the NHPS scheme, which primarily offers support for clinical services such as hospitalization, is unlikely to help fix the broken public health system in the country. The most critical issue remains the limited and uneven distribution of human resources at various levels of health services, with up to 40 per cent of health worker posts lying vacant in some states. Most primary health care centres suffer from perennial shortage of doctors and even district hospitals are without specialists.

Without addressing the human resouce situation, public sector health care will remain of poor quality and largely unacceptable, forcing patients to go to the private sector. Therefore, it seems as if NHPS is likely to benefit private parties more than government health services. This will ultimately be unsustainable and even detrimental for the poor for whom the scheme is intended.

To maximise benefits, it may be wise to establish a link among various health initiatives announced in the budget and also with related programmes such as the National Health Mission.

Clarity is also needed on what services will be provided by government health facilities and for which conditions patients will have to use private parties and what mechanisms are being thought of. There is a need for uniformly pricing systems for various health interventions, including diagnostics and medicines, and making them transparent by displaying them in hospital premises.

Moreover, a continuum of care system also needs to be established by linking institutions or hospitals, with health centres and the community. Community engagement is thus crucial in planning and implementation of the programme and in ensuring that the health and wellness centres and the primary health centres are responsive to the needs of the community.

For the success of the programme, effective implementation is the key. For this an independent body or unit may be set up within the ministry of health & family welfare to plan, coordinate, and provide technical backstopping to states, including in capacity building and development of standards and guidelines for the programme. Such a unit will ensure uniform and systematic approach to programme implementation across the country.

Finally, the scheme is innovative and path-breaking in the history of public health in India, which may have a transformative impact if implemented in an effective and coordinated manner. The enduring interest and level of discussion in the media does reflect the wider realization in the country that only healthy people can build a strong and prosperous nation.

END

Social enterprise uses capitalism for uplift

It is the profit motive that has driven capitalism over the years, and successfully too. However, a free enterprise model has been less-than-successful in driving social uplift.

The face of entrepreneurship has changed over the years to accommodate non-traditional enterprises and tap markets that are not yet exhausted, with even technological advancements opening up hitherto unknown channels of delivery.

Social entrepreneurship has evolved over the years and given us innovative and profitable ideas that address social problems. With more ideas being incubated and funds flowing into social enterprise, the subcontinent, which already has successful examples such as Amul, Barefoot College, Grameen Bank, etc., has the ability to create many more socially relevant enterprises.

Given that the hub of businesses is guided by economies of scale and is therefore, understandably, centred on cities, the gains of liberalization and globalization have been absorbed mostly at the city level. The consequent shrinkage of income opportunities in rural areas has led to sustained emigration.

In the wake of large-scale migration to urban places, which adds pressure on the overburdened social infrastructure of cities, identification of local enterprises is a crucial way of providing sustainable livelihoods in rural areas.

A localized, self-sustaining social enterprise, through forward and backward linkages, not only has the potential of addressing a contextual problem but also of providing meaningful, continuous employment to the local populace for whom self-employment, many a times at subsistence level, and informal employment are the norm.

According to a 2011 study published by International Proceedings Of Economics Development And Research, 94% of women workers are engaged in the informal sector.

Social enterprises have time and again demonstrated ways of empowering women at the grassroots level by providing them with income-generating activities, adding to a rise in rural household incomes—whether it’s engaging local women in the production of local handicrafts in which they have a comparative advantage, or building capacities of women to formalize and manage their self-help groups. By making women economically independent, these enterprises contribute to a tacit shift in power within existing societal norms.

However, in order to be relevant to rural areas, it’s important that social enterprises are supported through a market-based model of financing rather than a philanthropic one to ensure their sustainability.

A great positive of social enterprises is the opportunity they afford to people to acquire new skill sets and enhance existing ones. As enterprises adapt themselves to newer products/services, the people involved also adapt and learn new skills. Furthermore, usage and adaptability of ever-changing technologies help improve the existing processes of enterprises, and build efficiency and the social well-being of people, thereby enhancing value for all.

Technological developments also create the need and channels for newer services. The collective effect this has on people associated with enterprises is a shift from traditional enterprises to modern ones.

A big roadblock for social enterprises is obtaining funding and the right backing for the business. Since the enterprise is not “traditional”, and is often a pilot venture, market feedback is not readily available. That is why formal lenders remain apprehensive while lending to such ventures.

The scenario is changing steadily due to fewer restrictions and an increased risk appetite in the formal lending environment, but it isn’t growing fast enough. Fortunately, the start-up boom in India has provided a big fillip not just to conventional capitalist ventures but also social enterprises.

The advent of impact investing and of vehicles of finance other than traditional debt and equity channels does look promising because they mitigate the aforementioned challenges. For instance, development and impact bonds that provide a return against actual results to lenders have the potential to be a capital tool, thereby attracting funds to support social ventures.

Not only are these kinds of bonds changing the face of philanthropy, they are also making it worthwhile for investors to support social causes. According to Intellecap, in 2000, a capital of $1.17 million was injected into social enterprises in India; in 2011, this figure rose to $250 million per annum.

Another issue many social enterprises grapple with at a nascent stage is the weak formal structure of the organization. Many such organizations begin with just an “idea” and individuals driving these usually require handholding at the initial stage.

One of the ways for companies to address these challenges, aside from offering training on skills to budding entrepreneurs, is to offer mentorship support—a way of sharing lessons, insights and foresight gathered through work experience.

The question that perhaps we as a society must ask is what that “new capitalism” should look like. We are surely in a new era of socially relevant economics; the true test will be how nimbly we respond to the idea of change.

Jaivir Singh is vice-chairman of the PwC India Foundation and chairman of the School for Social Entrepreneurs, India.

Comments are welcome at theirview@livemint.com

END

India’s public healthcare system needs far more investment

The tragic story of several people having been allegedly infected with HIV by a fake medical practitioner using one unsterilised syringe in Uttar Pradesh’s Unnao is plausible, even believable, and highlights the massive lacunae in the public healthcare system, especially in rural India. Data from the National Health Profile 2017 shows that India has a little over one million (allopathy) doctors to treat its population of 1.3 billion people. Of these, only around 10% work in the public health sector. To put it in perspective, this means that there is one government allopathic doctor for every 10,189 people, one government hospital bed for every 2,046 people and one state-run hospital for every 90,343 people. To make matters worse, a 2016 World Health Organization (WHO) report on India’s healthcare workforce found that only one in five doctors in rural India is qualified to practise medicine. The report pointed out that 31.4% of those calling themselves allopathic doctors were educated only up to Class 12 and 57.3% doctors did not have any medical qualification.

In such a scenario, it is hardly surprising that people who cannot afford private healthcare (if at all it is available), end up falling prey to either quacks or tricksters. The lack of doctors, coupled with a glaring lack of regulation, leaves millions of people with little or no option when it comes to healthcare. A new bill seeking to replace the Medical Council of India with a national medical commission contains a proposal to provide cross learning pathways between allopathy and traditional medicine and non-allopathic modes of healing. Perhaps this could ease the burden on allopathic doctors and provide better care to those in need.

Over the past two decades, successive governments have promised to raise India’s public health expenditure to 2.5% of the GDP, yet the current spend hovers at 1.4%. No lessons appear to have been learned from the Gorakhpur tragedy of August 2017 in which several children died of a lack of oxygen, because a hospital had failed to pay its dues to a supplier. The public health crisis that India currently faces can only be solved by strong political will and far greater investment in primary healthcare. Until then, stories like that horror in Unnao will be the norm rather than the exception.

END

Kerala, Punjab, T.N. in good health

A shot in the arm:A child being vaccinated at a Primary Health Centre in Malappuram, Kerala. Immunisation coverage was one of the aspects covered by the NITI Aayog report.K.K. Mustafah

Kerala, Punjab and Tamil Nadu were the top rankers in NITI Aayog's latest Health Index report which has, for the first time, attempted to establish an annual systematic tool to measure and understand the heterogeneity and complexity of the nation's performance in the health sector.

The document, developed by NITI Aayog with technical assistance from the World Bank and in consultation with the Ministry of Health and Family Welfare, indicates that Jharkhand, Jammu and Kashmir and Uttar Pradesh showed the maximum improvement in indicators such as Neonatal Mortality Rate, Under-five Mortality Rate, full immunisation coverage, institutional deliveries, and People Living with HIV (PLHIV) on Anti-Retroviral Therapy (ART).

The report was released on Friday by Amitabh Kant (CEO of NITI Aayog), Preeti Sudan (secretary, Ministry of Health and Family Welfare) and Junaid Ahmad (country director, World Bank).

Another report in June

The next report will be released in June this year and district hospitals too would be ranked. "We would rank 730 district hospitals based on their performance. We want to encourage the good performers and name and shame those who aren't," said Mr. Kant.

Manipur registered maximum incremental progress in indicators such as PLHIV on ART, first trimester antenatal care registration, grading quality parameters of Community Health Centres, average occupancy of key state-level officers and good reporting on the Integrated Disease Surveillance Programme (IDSP).

Lakshadweep showed the highest improvement in indicators such as institutional deliveries, TB treatment success rate, and transfer of National Health Mission funds from the state treasury to implementation agency.

"Kerala ranks on top in terms of overall performance but sees the least incremental change as it had already achieved low levels of Neonatal Mortality Rate, Under-five Mortality Rate and replacement level fertility, leaving limited space for any further improvement," noted the report.

"Common challenges for most States and Union Territories include the need to focus on addressing vacancies in key staff, establishment of functional district cardiac care units, quality accreditation of public health facilities and institutionalisation of human resources management information system. Additionally, all larger States need to focus on improving the Sex Ratio at Birth," Mr. Kant said. "This Index is expected to nudge States towards further achieving a rapid transformation of their health systems and population health outcomes."

END

India Health Fund to boostresearch on TB, malaria

The India Health Fund (IHF), an initiative by Tata Trusts, in collaboration with the Global Fund has come forward to financially support innovations and technologies designed to combat tuberculosis and malaria.

The IHF aims to support new products and strategies that impact the entire lifecycle of TB and malaria, from prevention to post-cure recovery. It has recently invited project proposals.

“The IHF aims to support individuals and organisations with already germinated innovative strategies, services, products, such that they become sustainable and scalable solutions in addressing TB and malaria. It is not a fellowship to do research from scratch,” said Jayeeta Chowdhury, programme head-IHF, Tata Trusts.

While not disclosing the quantum of funding earmarked for the initiative, Ms. Chowdhury said a “large partnership building is under way” and it is a “long-term exercise” aligned with the country’s goal of eliminating TB by 2025 and malaria by 2030.

“IHF will promote innovative solutions such that they are widely accessible and are affordable,” she added.

Tough challenge

TB and malaria pose long-standing health challenges for India.

The two diseases account for over 4.23 lakh deaths and around 15 million lab-confirmed cases every year.

The quantum of funding might increase in the future depending on new partners joining the IHF initiative. “Effort will be made to expand the partnership and have a wider base of donors/investors,” Ms. Chowdhury said.

Four research areas

The four areas of research for which applications are invited are: use of technology and data science to strengthen surveillance of TB and malaria, inform early warning systems, and improve early detection and prompt treatment; promotion of robust molecular diagnostic facilities feasible for primary healthcare in low-resource settings; innovations on effective communication strategies that will prevent transmission of TB and malaria, and enable people to protect themselves from the diseases, and, finally, research on innovative approaches to vector surveillance.

The last date for submission of applications is March 19. More details can be found at *www.indiahealthfund.org*.

Rama was born normal. By the time she was six, her life underwent catastrophic events — blindness, breathing problems, asthma, growth problems.

END

AYUSH

Government takes measures to promote Yoga and Ayurveda across the world

Posted On: 09 FEB 2018 5:15PM by PIB Delhi

Ministry of AYUSH undertakes various measures to promote international cooperation for development of AYUSH systems of Medicine including Yoga and Ayurveda such as (i) Signing of Country to Country Memoranda of Understanding (MoUs) on 'Cooperation in the field of Traditional Medicine'; (ii) 'Setting up of AYUSH Academic Chairs in Foreign Universities/Institutes' (iii) Signing of MoUs for 'Undertaking Collaborative Research' to enhance the acceptability of AYUSH systems at International level (iv) Setting up of AYUSH Information Cells in the premises of the Indian Missions/ICCR Cultural Centres for dissemination of authentic information. (v) Organization / participation in International exhibitions/ conferences/ workshops/ seminars/ road shows/ trade fairs, etc. to create awareness amongst the local population; (vi) Providing incentives to AYUSH drug manufacturers/ entrepreneurs/ AYUSH institutions, etc. for (a) participating in International exhibitions/ conferences/ workshops/ seminars/ road shows/ trade fairs, etc. for generating awareness amongst the participating public about the AYUSH systems of medicine and; (b) registration of AYUSH products with regulatory authorities of the foreign countries.

Funds allocated to promote Ayurveda, Yoga and other AYUSH systems of Medicine across the world during last three years are as below:

Year	2015-16	2016-17	2017-18
Funds allocated	850 Lakhs	1400 Lakhs	1528 Lakhs

The data on the number of foreign tourists who visited India for AYUSH system of medication is not maintained by the Ministry of AYUSH

To increase the awareness about the AYUSH systems and promoting the wider use of AYUSH products, the Ministry of AYUSH has been taking up various activities as mentioned above in reply to part (a) of the question.

This information was given by the Minister of State (Independent Charge) for AYUSH, Shri Shripad Yesso Naik in written reply to a question in Lok Sabha today.

RJ/SK

END

AYUSH

Encouragement of Ayush Medicines

Posted On: 09 FEB 2018 5:13PM by PIB Delhi

Central Council for Research in Homoeopathy, an autonomous body under the Ministry of AYUSH has signed a Memorandum of Understanding (MoU) with Royal London Hospital for Integrated Medicine, United Kingdom on Cooperation in the field of Research and Education in Homoeopathic Medicine. The MoU aims at strengthening & developing co-operation in the field of Research & Education in Homoeopathic Medicine at International level. This encompasses joint research projects; exchange of information; organisation of seminars/workshops etc.

This information was given by the Minister of State (Independent Charge) for AYUSH, Shri Shripad Yesso Naik in written reply to a question in Lok Sabha today.

RJ/SK

END

NITI Aayog

NITI Aayog releases “Healthy States, Progressive India” Report

Kerala, Punjab & Tamil Nadu ranked on top in terms of overall performance

Jharkhand, Jammu & Kashmir, and Uttar Pradesh ranked top three States in terms of annual incremental performance

Posted On: 09 FEB 2018 1:55PM by PIB Delhi

NITI Aayog released today a comprehensive Health Index report titled, “Healthy States, Progressive India” at a function in the capital today. The report ranks states and Union territories innovatively on their year-on-year incremental change in health outcomes, as well as, their overall performance with respect to each other. The report was released jointly by the CEO, NITI Aayog; Amitabh Kant, Secretary, Ministry of Health & Family Welfare; Preeti Sudan and World Bank India Country Director, Junaid Ahmad. It is the first attempt to establish an annual systematic tool to measure and understand the heterogeneity and complexity of the nation’s performance in Health. The report has been developed by NITI Aayog, with technical assistance from the World Bank, and in consultation with the Ministry of Health and Family Welfare (MoHFW),

States and UTs have been ranked in three categories namely, Larger States, Smaller States, and Union Territories (UTs), to ensure comparison among similar entities. The Health Index is a weighted composite Index, which for the larger States, is based on indicators in three domains: (a) Health Outcomes (70%); (b) Governance and Information (12%); and (c) Key Inputs and Processes (18%), with each domain assigned a weight based on its importance.

Among the Larger States, Kerala, Punjab, and Tamil Nadu ranked on top in terms of overall performance, while Jharkhand, Jammu & Kashmir, and Uttar Pradesh are the top three ranking States in terms of annual incremental performance. Jharkhand, Jammu & Kashmir, and Uttar Pradesh showed the maximum gains in improvement of health outcomes from base to reference year in indicators such as Neonatal Mortality Rate (NMR), Under-five Mortality Rate (U5MR), full immunization coverage, institutional deliveries, and People Living with HIV (PLHIV) on Anti-Retroviral Therapy (ART).

Among Smaller States, Mizoram ranked first followed by Manipur on overall performance, while Manipur followed by Goa were the top ranked States in terms of annual incremental performance. Manipur registered maximum incremental progress on indicators such as PLHIV on ART, first trimester antenatal care (ANC) registration, grading quality parameters of Community Health Centres (CHCs), average occupancy of key State-level officers and good reporting on the Integrated Disease Surveillance Programme (IDSP).

Among UTs, Lakshadweep showed both the best overall performance as well as the highest annual incremental performance. Lakshadweep showed the highest improvement in

indicators such as institutional deliveries, tuberculosis (TB) treatment success rate, and transfer of National Health Mission (NHM) funds from State Treasury to implementation agency.

The Health Index report notes that while States and UTs that start at lower levels of development are generally at an advantage in notching up incremental progress over States with high Health Index scores, it is a challenge for States with high Index scores to even maintain their performance levels. For example, Kerala ranks on top in terms of overall performance but sees the least incremental change as it had already achieved a low level of Neonatal Mortality Rate (NMR) and Under-five Mortality Rate (U5MR) and replacement level fertility, leaving limited space for any further improvements.

However, the incremental measurement reveals that **about one-third of the States have registered a decline in their performance in 2016 as compared to 2015**, stressing the need to pursue domain-specific, targeted interventions. **Common challenges for most States and UTs include** the need to focus on addressing vacancies in key staff, establishment of functional district Cardiac Care Units (CCUs), quality accreditation of public health facilities and institutionalization of Human Resources Management Information System (HRMIS). Additionally, almost all Larger States need to focus on improving the Sex Ratio at Birth (SRB).

Linking this Index to incentives under the National Health Mission by the Ministry of Health and Family Welfare underlines the importance of such an exercise. The report also notes that rich learnings have emerged in the first year and these will guide in refining the Index for the coming year and also address some of the limitations. It notes that there is an urgent need to improve data systems in the health sector, in terms of terms of representativeness of the priority areas, periodic availability for all States and UTs, and completeness for private sector service delivery. This Index is expected to **nudge States towards further achieving a rapid transformation of their health systems and population health outcomes.**

Health Index has been developed as a tool to leverage co-operative and competitive federalism to accelerate the pace of achieving health outcomes. It would also serve as an instrument for “nudging” States & Union Territories (UTs) and the Central Ministries to a much greater focus on output and outcome based measurement of annual performance than is currently the practice. With the annual publication of the Index and its availability on public domain on a dynamic basis, it is expected to keep every stakeholder alert to the achievement of Sustainable Development Goals (SDGs) Goal number 3.

The process of index refinement involved inputs from the States and UTs, national and international sector experts, and development partners. Data submitted by the States & UTs was validated by an Independent Validation Agency, following which index values and ranks were generated on the web portal (http://social.niti.gov.in), and certified by the Independent Agency.

Presentation of Health Index

FAQ health Index

AKT/HS

(Release ID: 1520074) Visitor Counter : 0

END

To battle malnourishment, start a mass awareness campaign

Nobel laureate Amartya Sen has always maintained that “hunger is quiet violence”. Proof of this comes in the latest Urban Hungama Report, a survey on the nutrition status of children in the 10 most populous cities in India, carried out by the NGO, Naandi Foundation. The findings should be worrying to policymakers as urbanisation is growing and, with it, the problems of how best to cater to the interests of children.

The most alarming finding is that 22.3% of the children surveyed were stunted; 30.6% of the stunted children are in Delhi, the nation’s capital. The education of the mother has a bearing on the situation of the child. 35.3% of the children of mothers with five years of schooling or less were stunted. In the case of mothers who were more educated, the corresponding proportion was 16.7% .

When India began the National Family Health Survey, its stunting and wasting statistics (among children) were on a par with Thailand. Today, Thailand has all but overcome the problem; we have made only slow and uneven progress. What we lack is the proper data for planning and intervention. The need of the hours is a mass awareness campaign on the lines of the pulse polio one which produced excellent results. Since urban areas are considered better-off, the problem of stunting and wasting among children in these places has rarely been thought of as a serious problem. But it is. Even educated mothers, it was found, did not know the difference between giving their children food and giving them the right nutrition.

An undernourished child cannot easily be differentiated from a healthy one until she suffers from full blown malnutrition. So the problem remains unnoticed and neglected. If sub-Saharan Africa has fared better on malnutrition than India, it can only be put down to the fact that women’s voices there are stronger.

Unless the mother is involved in nutrition projects, progress will continue to be indifferent. At least in enlightened self-interest, governments both at the Centre and states should address this issue. We talk of the demographic dividend which we can reap but the economic consequences of stunting and wasting in children can be devastating. In a country which has surplus food grain and which guarantees the right to food for all, it is morally, politically and economically unacceptable that children are denied the right nutrition for entirely avoidable reasons.

END

Neglected but treatable

In the public health context, neglected tropical diseases (NTDs) have been consistently and alarmingly under-emphasised despite being widespread among low-income populations in developing tropical regions (Africa, Asia, and the Americas). The diseases that are most prevalent in India include lymphatic filariasis, soil transmitted helminthiases, trachoma, visceral leishmaniasis, dengue, rabies, cysticercosis and Japanese encephalitis. India also bears a high burden of intestinal worm infections (hookworms, whipworms and Ascaris worms).

Extensive activities under two significant public health campaigns will roll-out in February and address the problems of intestinal worms (or soil-transmitted helminth) and lymphatic filariasis. While on National Deworming Day (February 10) children between ages 1 to 19 through schools and anganwadi centres would have been dewormed in order to improve their nutritional status and well-being, the Lymphatic Filariasis Programme will reach out to those above two years, by using health workers across select endemic districts to administer anti-filarial drugs. Both programmes involve the distribution of drugs free of cost through periodic rounds of mass drug administration(MDA) and their effectiveness depends on when these drugs are consumed by the high-vulnerability population.

Their success also depends on clear communication strategies as many a time the benefit of such programmes is not understood by many. In the case of the filariasis programme, MDA is needed to reduce infection in a community to levels below the threshold at which vectors cannot spread parasites from person to person. This happens only if a large part of the population, including those who have not contracted the disease, consumes the drugs.

The WASH strategy

The potential of water, sanitation and hygiene (WASH) strategies, a critical component of prevention and care for all NTDs, has yet to be realised. Provision of safe water, sanitation and hygiene is one of the five key interventions in the global NTD road map. However, the WASH component has received little attention; the potential to link efforts on WASH and NTDs has been untapped. Focussed efforts on WASH are a must especially in NTD control where transmission is closely linked to poor WASH conditions, examples being soil-transmitted helminthiasis, schistosomiasis, trachoma and lymphatic filariasis.

Emerging evidence suggests that NTDs significantly impair response to standard childhood immunisations. Both antenatal and childhood parasitic infections have the ability to alter levels of protective immune response to routine vaccinations. Successful NTD programmes can prevent immunomodulation caused by parasitic antigens during pregnancy and early childhood and also improve vaccine efficacy.

In the disease fight, several countries have made extraordinary progress; 20 countries and 499 million people were no longer in need of MDA for lymphatic filariasis, as of 2016, and 10 countries have now eliminated it as a public health problem across the Pacific-African regions ahead of the global target year of 2020. Lessons learnt from Sri Lanka and the Maldives in the South Asian region are what can help India prioritise and intensify efforts to eliminate filariasis.

On December 14, 2017, Uniting to Combat NTDs, a collective of dedicated partners working together to defeat 10 neglected tropical diseases, released its fifth report to highlight the progress made in the NTD fight. The report indicates the potential of an NTD-control programme that is community-based. It also looks at how it can provide a gateway to universal health coverage as it reaches marginalised populations through well-trusted health workers who provide quality, free-of-

cost drugs to the population. India’s commitment towards NTD elimination is critical to meet the global target of elimination of intestinal worm infections and lymphatic filariasis by 2020.

Dr. N.K. Ganguly is a former Director General of the Indian Council of Medical Research, New Delhi. Dr. Rahul Srivastava

is a public health expert based in New Delhi

Rama was born normal. By the time she was six, her life underwent catastrophic events — blindness, breathing problems, asthma, growth problems.

END

States of health: On NITI Aayog's first Health Index

Unsurprisingly, States with a record of investment in literacy, nutrition and primary health care have achieved high scores in NITI Aayog's first Health Index. **Kerala, Punjab, and Tamil Nadu are the best-performing large States**, while Uttar Pradesh, Rajasthan, Bihar, Odisha and Madhya Pradesh bring up the rear. Health-care delivery is the responsibility of States; the Centre provides financial and policy support. Being able to meet the Sustainable Development Goals over the coming decade depends crucially on the States' performance. Yet, health care is not a mainstream political issue in India, and hardly influences electoral results. The Index, with all its limitations given uneven data availability, hopes to make a difference here by encouraging a competitive approach for potentially better outcomes. For instance, with political will, it should be possible for Odisha to bring down its neonatal mortality rate, estimated to be the highest at 35 per thousand live births — worse than Uttar Pradesh. A dozen States with shameful under-five mortality rates of over 35 per 1,000 live births may feel the need for remedial programmes. What the Index shows for the better-performing States such as Kerala and Tamil Nadu is that their continuous improvements have, overall, left little room to notch up high incremental scores, but intra-State inequalities need to be addressed.

Topping NITI Aayog Health Index may deprive Kerala of incentives

Coming soon after the announcement of a National Health Protection Scheme in the Union Budget, the Index uses metrics such as institutional deliveries, systematic reporting of tuberculosis, access to drugs for people with HIV/AIDS, immunisation levels and out-of-pocket expenditure. The twin imperatives are to improve access to facilities and treatments on these and other parameters, and raise the quality of data, including from the private sector, to enable rigorous assessments. At the same time, as NITI Aayog points out, data on other key aspects such as non-communicable diseases, mental health, governance systems and financial risk protection lack the integrity to form part of a good composite index. Both the Centre and the States have the responsibility to scale up their investment on health as a percentage of their budgets, to be more ambitious in interventions. While the NHPS may be able to address some of the financial risk associated with ill-health, it will take systematic improvements to preventive and primary care to achieve higher scores in the Index. As the experience from countries in the West and now even other developing economies shows, socialisation of medicine with a reliance on taxation to fund basic programmes is the bedrock of a good health system. If the NITI Aayog Health Index leads to a mainstreaming of health on these lines, that would be a positive outcome.

The draft of Assam's National Register of Citizens is a first step, but it opens up concerns

END

Hardly a gamechanger

The National Health Protection Scheme announced in this year's Budget has generated a lot of debate. The government has committed itself to "providing coverage up to 5 lakh per family per year for secondary and tertiary care hospitalisation" for 10 crore poor families, with approximately 50 crore people as beneficiaries. As only 2,000 crore in 2018-19 has been allotted to finance this scheme, various government functionaries have come up with estimates between 10,000 to 12,000 crore as its actual cost. We wish to take the debate beyond the money required and look at other crucial issues.

First, the government's target group seems to be the bottom 40% (50 crore) of the population. A good starting point would be to look at the insurance coverage that this section already has.

Making health insurance work

An analysis of the National Sample Survey (NSS) 71st round (2014) unit record data for "Social Consumption in India: Health" shows that only 11.3% of the bottom 40% (10.5% covered by government insurance) population has any insurance coverage as against 17.9% for the top 60% (14.3% covered by government insurance). In other words, just to bring the entire 40% of the population under health insurance is a huge task, with fiscal implications. As latest official data for 15 States show, starting from 2008, only 66% of the target below poverty line population has come under coverage of the Rashtriya Swasthya Bima Yojana (RSBY), the government-run health insurance programme for the poor In 2017-18, the government allocated only 1,000 crore for RSBY, covering roughly 10% of the bottom 40% of the population.

We estimate, on the basis of National Sample Survey data, that the total cost of medical expenditure (including reimbursements) for hospitalisations incurred by the bottom 40% was 14,286.82 crore in 2014, with the average cost of hospitalisation being only 8,081 in the same year. With 5 lakh coverage (if we assume that most of the hospitalisation cost will be reimbursed) then the premium which needs to be paid would be much higher than the government's estimate.

The problem, however, is in terms of the rate of hospitalisation and reimbursement of expenses that insurance companies pay, as seen in the table.

Three observations are crucial in reading the table. First, the rate of hospitalisation for those covered under some kind of health expenditure support is higher than those without any cover, for the bottom 40% as well as the entire population. If the new health scheme announced in the Budget brings more people under insurance, then the rate of hospitalisation will show significant improvement.

Therefore, over and above the money needed for insurance premium, adequate medical infrastructure needs to be created for the scheme to work; given that there has not been much allocation for it in the Budget. In the absence of such allocation, private health-care demand will rise, possibly leading to an increase in the cost of private health care. Second, reimbursement as a percentage of medical cost of hospitalisation in government schemes is abysmally low, especially for the bottom 40% of the population. Only 4.5% of total hospitalisation expenses are reimbursed to the bottom 40% and 11.9% for the entire population.

Get cracking: on implementing 'Modicare'

This raises questions about the efficacy of government schemes. Even with the meagre coverage of 30,000 (RSBY), the proportion of hospitalisation cost reimbursed is low. There is no guarantee

that increasing coverage will improve this.

Third, the proportion of hospitalisation cost reimbursed is much higher for insurance schemes directly bought by households than government ones. In the case of insurance being paid by the government, insurance companies are most often unwilling to pay the reimbursement as compared to when a household pays. This could be a result of low premiums paid by the government or a general apathy towards honouring the insurer's commitment when the payers are not the actual patients but the government.

The percentage of hospitalisation cost reimbursed is low for health insurance schemes and most of them only cover hospitalised treatment. Generally, a majority of health insurance schemes do not cover the cost of a non-hospitalised outpatient visit. For health insurance schemes, what essentially happens is that the government pays the premium to insurers which in turn pay the hospitalisation expenses.

Given the state of government medical care in India, a significant proportion (more than 50%) of the population opt for private facilities. Thus, health insurance creates a larger market for private players. A sudden expansion of the government-funded insurance market may aggravate the problem of hospital-induced demand for medical care such as an unnecessary hospital stay, diagnostic tests and surgeries unless supply-side conditions are improved and the entire health sector brought under regulation. The Budget declaration is quite silent about these complementary steps.

Ayushman Bharat: the big budget scheme

The moot point is actually an old one. If the government is serious about providing health care to even the bottom 40% of the population, it should not only increase its current budgetary allocation substantially but also strengthen the health infrastructure at all levels which includes a strong regulatory mechanism. Neither the Budget nor the National Health Policy 2017 shows any clear and convincing direction of heading in this path.

Subrata Mukherjee is Associate Professor, Institute of Development Studies, Kolkata and Subhanil Chowdhury is Assistant Professor at the same institute

Marriage is a civil contract — adultery or divorce should have only civil consequences

END

Is India ready for NHPS?

The National Health Protection Scheme (NHPS) is based on four assumptions and one hope: One, creating an effective demand to trigger private investments in supply deficit areas, two, enabling tapping of the 30 per cent unutilised capacity in private hospitals for the poor, three, covering 10 crore families with Rs 1,200 per family is affordable, and four, strengthening Wellness Clinics at the 5,000 population level will reduce hospitalisation. The hope is that, in this process, impoverishment will reduce and premature deaths will be averted.

Positioned as the big idea whose time has come, the NHPS attracted attention and health was the breaking news of the day. The discourse, however, has centred round the gap between policy intention and actual fund allocation.
The first assumption will take over five years or more to fructify, but partially, since revenue centres for hospitals are diagnostics and drugs not inpatient treatment. More investment into health is required to enhance access, but if it is only in the private sector, it will also increase out-of-pocket expenses. Regarding the second assumption, the benefits will go to the urban poor. Evidence from the RSBY shows that 25 per cent of people who availed services got impoverished meeting the indirect costs of hospitalisation.

The third assumption requires closer analysis. The NHPS provides cover for services that southern states are already providing within an average per capita outgo of less than Rs 50,000 despite the ceiling of an assured sum of Rs 2 lakh. Offering a higher ceiling for the same set of services will only help the hospitals game the system and is no solution to the crisis of inadequate human resources that the private hospitals also face. Technology can help neutralise this factor somewhat but will entail costs. In this environment of scarcity, the “government” patients are already competing for attention with those paying two times more for services — domestic and foreign. In other words, maintaining uniform quality is emerging as an issue in the current multi-payer system running alongside conditions of scarcity and an absence of regulatory oversight.

Besides, uptake will be low as the northern states have severe supply deficiencies — so poor that Bihar and UP abandoned midway the modest RSBY that provided a Rs 30,000 cover for secondary care. Taking these factors together, the allocation of Rs 12,000 crore for the NHPS is ample in the short term, but will treble as supply and service utilisation increases and gallop when coverage extends to outpatient care as well.

As for the fourth assumption, indicating a commitment to primary health care is not enough. All governments since Independence have been doing so. The sum of Rs 2,000 crore for Wellness Clinics is peanuts and will help strengthen less than a fifth of the relatively better functioning ones of the 1.5 lakh facilities. Besides, the primary health care system also consists of primary health centres and community health centres. This three-tier system is expected to prevent disease, provide timely medical attention, treat and manage chronic diseases like hypertension, diabetes, mental health and old age diseases. But due to chronic underfunding, substantial vacancies and shortage in human resources, lack of infrastructure and the rapid decline in public health capacity to cope with the complexity of the infectious diseases, barely a fifth of the 30 and odd services are being provided, explaining for the community’s continued trust in quacks and their apathy to seek care from these centres.

Policy intention that prioritises comprehensive primary health care implies committing an investment of Rs one lakh crore for providing basic healthcare alongside its social determinants, namely water, food, hygiene, environmental sanitation and behavioural modifications. Countries like Brazil, Japan, China, Sri Lanka made such investments and have conclusively demonstrated a reduced disease burden, lengthened life expectancies, one-third reduction in emergencies and

hospitalisation and averting of avoidable morbidity. Clubbed together, they add up to huge savings. Besides the fiscal argument, such a strategy also makes sense for half the country's population, that accounts for 35 per cent of the deaths related to malnutrition, TB, neonatal causes and respiratory infections that are preventable and treatable at low cost.

The Burden of Disease Report of 2016 shows the wide disparities between the north and south. Kerala for example, has a female life expectancy of 78.7 while Assam has 63.6. Or the epidemiological transition ratio — the shift from communicable to non communicable diseases — is 0.16 for Kerala while it is 0.74 in Bihar explaining for the 33 per cent health loss in northern states due to communicable diseases. This is significant as only few suffering from communicable diseases need hospitalisation. Even in the south, the disease burden due to non-communicable diseases can be substantially reduced with lifestyle modifications. In other words, the incidence of kidney failure requiring dialysis can be reduced if diabetes and alcohol intakes are moderated. Credit, then, lies not in providing Rs 1.5 lakh per year per person for dialysis but not having such a high demand in the first place. The tragedy of India is that all this is known. Yet we continue to neglect building a robust primary health care system.

The NHPS, however, raises a more important issue: The decisive redefinition of the role of the state from being a service provider to a financier. Separating the provisioning and financing increases costs, but makes the service providers and the state more accountable. This is the theory. But if the internal dynamics, as mentioned briefly, are not stitched together, such separation can also end up with the private sector getting fatter (what with the rapid infusion of FDI in our premier hospitals) and more parasitical on government finances and undermining the public sector that is the recourse for the poor without necessarily enhancing welfare or social gain.

In other words, if shoddily designed and implemented, the NHPS can metamorphose into a situation of riding a tiger that government will be unable to dismount later. Future implications of pushing the country into such an irreversible situation that can entail high social costs require a serious discussion in Parliament. Can our politicians go beyond partisanship? Do they care?

END

Price cap on hip implants awaited

After price caps on cardiac stents and knee implants, a cap is now eagerly awaited on hip implants, which too are highly priced due to excessive profiteering by manufacturers, distributors as well as healthcare providers.

“The price control on all implants has been widely discussed. The cap on hip implants is also likely in the process,” said orthopaedic surgeon Ram Prabhoo, president of Indian Orthopaedic Association.

Knee implants

Following the price cap on knee implants, the most widely used cobalt chromium implant now costs Rs. 54,720, while the ones using titanium and oxidised zirconium cost Rs. 76,600. The high-flexibility implant has been capped at Rs. 56,490 while the revision knee surgery has been capped at Rs. 1,13,950. The prices exclude GST. “Patients have benefited tremendously,” said Dr. Prabhoo, adding that capping the price of orthopaedic implants was extremely tedious as there were many components and materials involved.

At present, a hip implant costs anywhere between Rs. 40,000 (for a basic cemented implant) and Rs. 1.80 lakh (for a fourth-generation ceramic head implant). Revision implant surgery costs between Rs. 3 lakh to Rs. 4 lakh.

‘Has worked well’

“A price cap on the knee implants has worked extremely well. We feared that high-end implants would be phased out, but because of a clause put by the NPPA (National Pharmaceuticals Pricing Authority), the stocks could not be withdrawn. Over the past few months, more patients have opted for surgeries,” said Pradeep Bhosale, joint replacement surgeon at Nanavati Hospital, which has seen a 40% rise in the number of knee-joint replacements since the price cap was introduced.

“Joint replacements are not treated as emergencies. A large number of patients keep suffering in pain due to the high cost of treatment. These patients are now coming forward,” said Dr. Bhosale.

With increasing incidences of diabetes, osteoporosis, osteoarthritis, obesity and increased awareness of the benefits of arthroplasty (joint replacement), it is estimated that India is likely to witness a 15-20% growth in this segment by 2030. According to the NPPA, an estimated 1.5 to two crore Indians require orthopaedic surgery interventions, but they either remain undiagnosed, or are diagnosed but unable to afford the high cost of implants.

Joint replacements are not treated as emergencies. A large number of patients keep suffering in pain due to the high cost of treatment

Pradeep Bhosale

Joint replacement surgeon,

Nanavati Hospital

END

National Health Protection Scheme will not help its intended beneficiaries

It has been a fortnight since the Union finance minister announced the government's vision of Ayushman Bharat, or the National Health Protection Scheme (NHPS), assuring 100 million families of coverage of up to Rs5 lakh for secondary and tertiary care.

Meanwhile, in a welcome departure from previous years, health has emerged as the central topic of post-budget analysis and critique. Media newsrooms have been brimming with policymakers, academics, industry executives and politicians explaining the details and mechanics of the NHPS. Valuable viewpoints, evidence and analysis have surfaced in plenty, laced with a mix of admiration and scepticism, and as a result, the NHPS has been labelled many things—visionary, populist, pro-private insurance market, suboptimal solution for universal health, scaled-up version of old schemes, pre-election gimmick, and more.

Conspicuous by its absence in these debates has been the voice of the customer—the reaction of those belonging to the 100 million households meant to be relieved by the NHPS of the financial hardship of paying for healthcare.

The National Council of Applied Economic Research labels them "Deprived Households". The annual income of these households lurks below Rs1.5 lakh. Their homes, whether urban or rural, are in locations defined by wretched living conditions. And the people who call them home float freely between carefully-combed poverty zones separated by invisible poverty lines. Some 135 million households fall in the deprived category, constituting 56% of the total households in India. And yet, there has appeared not a single report highlighting their opinion.

This article doesn't either. It is an attempt to zoom in on the lives of such "deprived" households and their surroundings. It is a theoretical exercise to predict their likely reaction to the NHPS, based on the established correlation between economic capacity, health-seeking behaviour, and the gamut of risk factors endangering well-being and health in the bubble of deprivation.

On an average, the medical expenses of such deprived households with low income capacity hover between 5-6% of total expenses. The pursuit of health may trap them in medium- or long-term therapy regimens, pulling this single-digit proportion into a catastrophic range of 10% or above. Hence, the majority of them do not report sickness, until rendered inactive to work and earn, either by injury or the flare-up of a chronic condition.

For rural dwellers, seeking health is not even a matter of choice if the nearest medical touch point (public or private) lies miles away. There are still others, who don't trust the quality of available care to be worth dwindling family finances. Will the NHPS announcement let such families shed these inhibitions and change their health-seeking behaviour?

In the last two decades, many states have seen an epidemiological transition, with non-communicable diseases such as heart problems, stroke and depression imposing a greater economic and human burden on society than infectious diseases and nutritional deficiencies. That said, whichever state the deprived households may be located in, it would be safe to assume that the epidemiological profile of the low economic strata will mirror that of the poorest states (Empowered Action Group or EAG states) due to similarities in environmental and behavioural risk factors.

The top ailments adding the maximum burden of disease in EAG states include ischaemic heart diseases, lower respiratory tract infections such as bronchitis and asthma, chronic obstructive pulmonary disorder, tuberculosis and diarrhoeal diseases. Most of these are chronic conditions

that require regular outpatient consultations to manage disease prognosis. Hospitalization is a one-off event.

Eighty per cent of the time, the out-of-pocket expenditure of patients within this strata is, therefore, on outpatient clinics that don't come under the ambit of NHPS.

Therefore, for deprived households, the NHPS holds limited value. It cannot deliver on the grand claim of complete health for them. It will not reduce the ever-increasing monthly medical bills that go towards managing the chronic diseases they are most susceptible to. It will not bring an iota of change in their health-seeking behaviour. That can happen only if the expenditure on health, which has hovered around 1% of gross domestic product (GDP), doubles in the near future to improve access and quality of healthcare to the last mile.

No doubt, insurance of Rs5 lakh per annum would be a comforting thought if one needs hospitalization and surgical intervention (provided in-patient admissions claims processing and reimbursement-related processes do not themselves become added stress factors). Such events may be few and far between.

It might be too early for opponents of this scheme to lay a wreath at its funeral, but the lackadaisical thought that has gone into crystallizing it misses the point that the epidemiological profile of its target strata will most likely exclude a majority of them from benefiting.

The scheme must expand its scope to share expenditure on outpatient services for long-duration chronic diseases to achieve Ayushman Bharat.

Sheetal Ranganathan is vice-president of life sciences and healthcare operations at a research and consulting firm, and a commentator and columnist covering global health and science.

Comments are welcome at theirview@livemint.com.

END

Real-time data sharing among rural health workers can save lives

Smartphones and tablets are no longer the preserve of technoparks and financial districts. According to a Telecom Regulatory Authority of India report from 2017, there are a little over 500 million mobile subscribers in rural India, of whom 109 million own smartphones. In 2016, the Boston Consulting Group reported that 70% of rural internet users use social networks while 30% use chat applications with search, purchases and other motives figuring in the list.

Digitization has crept into their work as well. It is no longer uncommon to see a teacher in a far-flung government school using a digital solution to track student attendance, or a farmer consulting an app for crop-specific information. From my own experience, WhatsApp is an increasingly popular project management tool in rural India. The government is not a laggard in this respect either with several innovative products such as the Swachh App by the ministry of drinking water and sanitation that acts as a real-time monitoring tool for sanitation coverage in rural areas.

The situation is no different in public health. I am personally aware of at least six applications catering to the three women frontline health workers alone—ASHA (accredited social health activist), AWW(*anganwadi* worker) and ANM (auxiliary nurse midwife). These three women drive delivery of health and nutrition services in villages across India. In my last column, I introduced three of them—Vimla, Manju and Priya, respectively. Applications catering to these women each serve as remarkable personal digital assistants. The ANMOL-ANM online app for ANMs was developed by the ministry of health and family welfare, with support from the United Nations Children's Fund. It enables ANMs to carry out functions such as growth monitoring, logistics planning and reporting in an informed manner. The common application software developed by the women and child development ministry for AWWs and now part of the National Nutrition Mission is another excellent example. It enables real-time access to information about the health of women and children in high malnutrition burden districts.

Replacement of myriad, voluminous registers with smart, hand-held devices is welcome. It makes workers' lives easier and everybody knows they urgently need that help. It improves the quality of data they produce. The elephant in the room, though, is yet to be addressed. As we discussed last week, the fundamental problem in rural healthcare delivery is that India's Vimlas, Manjus and Priyas do not share data with each other. This need not be the case.

As I had hinted, there is good news. A seamless digital solution shooting information between the three workers' devices exists. This "integrated AAA app" is a useful job aid for each of the workers, that helps them perform their tasks more effectively. The more significant factor is that the integrated app, enables these devices to talk to each other. The workers now have a common database to work with and can serve beneficiaries as a cohesive unit.

This has important real-world applications. Take the case of Sarita, a 25-year-old woman. Manju, the AWW, notices that Sarita shows signs of pregnancy. When she checks the relevant box in her version of the integrated app, it is relayed instantly to the other workers, Vimla and Priya. Vimla, the ASHA, visits Sarita's house and mobilizes her to visit the local *anganwadi* centre for the monthly village health and nutrition day. There, Priya the ANM, confirms Sarita's pregnancy and records her information in her app. Based on Sarita's low haemoglobin level, the app automatically tags her as a high-risk pregnancy. This information again flows instantly to the ASHA (Vimla) and AWW (Manju) so that they can offer counselling, as required. Early identification and commencement of counselling enabled by instantaneous communication between the three workers could thus save lives. And this is just one such use case.

In spite of the clear case for an integrated app, why should single-user personal digital assistants

rule the roost? It might be explained by workers belonging to different ministries—ANMs from health and AWWs from women and child development with ASHAs working with both ministries on an incentive basis. There are some encouraging signs with positive noises about inter-ministerial convergence. Rajasthan has showed the way with the health, and women and child development ministries working together on the AAA model and its evolution.

The integrated app has been tested extensively in the field with the three workers, cutting across ministerial barriers. Their feedback has been incorporated and the product is at an advanced stage of trial.

This is deadly serious business. Lives are at stake. The need of the hour is for administrators across the country to get our frontline workers (and their data) to talk to each other in real time.

Ashok Alexander is founder-director of Antara Foundation. His Twitter handle is @alexander_ashok.

END

Can sanitation reduce stunting?

The missing piece: “If campaigns to change behaviour are not initiated to tackle the problem of open defecation, Indians will continue to defecate in the open even if they get toilets for free.” An eco-friendly public toilet in Bengaluru. G.R.N. Somashekar

Studying the impact of sanitation on stunting is tricky, and the much-awaited results of two ambitious new trials published this year show why.

The trials, which implemented water, sanitation and hygiene (WASH) interventions in Bangladeshi and Kenyan villages for two years, were an effort to prevent stunting (low height for age) seen in children under two years in developing countries. Specifically, the WASH interventions included replacing poor-quality toilets with improved ones, chlorinating drinking water, and promoting handwashing — all in an attempt to protect toddlers from the faecal pathogens that are believed to interfere with their growth. But when the trials ended, disappointingly, the researchers found these children were not taller than those who did not receive these interventions. The findings are a setback to the hypothesis that improving sanitation can thwart childhood stunting. But how big a setback they are is disputed.

One point of view is that even though Bangladesh and Kenya see childhood stunting, they are dramatically different from countries such as India on a critical count. India is the only country today in which over 50% of the rural population still defecates in the open. Bangladesh, while close to India in population density, brought down open defecation rates from 42% in 2003 to just 1% in 2016.

This critical difference was apparent in the two trials as well. Only around 3-9% of the participants in the trial in Bangladesh, and less than 5% in the trial in Kenya, defecated in the open at the start of the experiment. Most people already had toilets, albeit poor-quality ones, which the trial improved. It is likely that the children sampled were exposed to lower levels of faecal pathogens in the first place, which is why the trials didn’t impact stunting, says Dean Spears, an economist at the Research Institute of Compassionate Economics (RICE). He argues that the only thing the trials show is that upgrading from a basic toilet to an improved toilet, along with other WASH interventions, didn’t make children taller. “But it is not as informative for someone focussed on India’s policy challenges, because the policy challenge in India is open defection,” he says.

Others say the new trials raise doubts about the link between sanitation and stunting in India too. Wolf-Peter Schmidt, an epidemiologist at the London School of Hygiene and Tropical Medicine, points out that even in countries like Bangladesh, poor-quality toilets can cause heavy faecal contamination. Stephen Luby, an epidemiologist at the Stanford Woods Institute for the Environment and lead investigator in the Bangladesh study, says that the villages in his study saw high rates of both contamination and stunting. Yet the WASH improvements made no difference, which means that other factors could be driving stunting. “This heightens concerns that similar mechanisms underlie the association between open defecation and stunting in India,” he says.

Stunting is a complex problem. Children in richer South Asian countries are shorter on average than those in poorer Sub-Saharan African countries, and no intervention so far has closed this gap. Even though prenatal health, breastfeeding and diet, among dozens of factors, have been implicated in stunting, trials to encourage breastfeeding or supplement the mother’s and child’s diets have come up short. Simultaneously, researchers have homed in on an alternative hypothesis: that poor sanitation plays a greater role in stunting, because faecal bacteria and parasites deprive the child of nutrition.

Evidence for this hypothesis has piled up over the decades. Studies in Gambian children in the 1990s showed that intestinal inflammation, possibly caused by exposure to faecal germs, is correlated with stunting. Among animals, baby mice infected with *Escherichia coli*, a faecal bacterium, grew slower, and showed signs of such intestinal inflammation when dissected. In 2013, Mr. Spears analysed data from 65 countries and found that much of the height variation among those regions could be explained by differences in open defecation rates. The study also showed that open defecation had a stronger impact on height when population density was higher, as is the case of India and Bangladesh.

The problem is that most of the data which show that children in households with poor toilets are more likely to be stunted comes from descriptive studies. Descriptive studies have a downside: they can show association but not causation. “The concern with these studies is that they may be explained by some other difference between households with nice toilets and those without,” says Mr. Luby. This is why randomised control trials (RCTs), like the ones in Bangladesh and Kenya, matter.

But this is where researchers run into another stumbling block. It is extremely hard to conduct RCTs on sanitation. Since 2010, some six groups, including three in India, have experimented with sanitation approaches to tackle stunting. Nearly all failed because they were unable to convince enough people to use toilets in the first place. One RCT in Mali, in 2015, did increase toilet use by 30% and saw a small increase in child growth. But RCTs need to be replicated before their findings can be extrapolated to other countries, says Amy Pickering, one of the study’s authors who is from Tufts University. Another predicament is that for WASH interventions to be truly effective, more than one generation of families may need to adopt them. Most trials do not last longer than two years, given how expensive and logistically challenging they are.

India’s Swachh Bharat Abhiyan (SBA) is an example of how difficult it is to change people’s sanitation habits. Even though the SBA aims to eliminate open defecation by 2019, data from the 2015-16 National Family Health Survey show the campaign hasn’t changed much since it began. “Almost halfway through the SBA, open defecation remained quite common in rural India and its distribution across districts looked pretty similar to 2011,” Mr. Spears says. In *Where India Goes*, Mr. Spears and RICE demographer Diane Coffey argue that programmes like the SBA that focus on constructing toilets can’t do much in the face of deep-rooted cultural beliefs about open defecation because they presume that people do not build toilets for financial reasons. If behavioural change campaigns are not initiated to tackle the problem, Indians will continue to defecate in the open even if they get toilets for free.

Against this background, the Bangladesh study is significant because it did succeed in changing participant behaviour. It provides critical information for countries that have already eliminated open defecation. They may now want to weigh the merits of sanitation against other interventions like nutrition. What the trials mean for India is a tougher question. For an RCT to test the link between open defecation and stunting, it must figure out first how to get Indians to stop open defecation. Several researchers have tried this, but have come up dry.

priyanka.pulla@thehindu.co.in

NPPA calls for cap on prices of secondary cardiac devices

Even as stent prices were brought down earlier this week, exorbitant profiteering in devices like catheters, balloons and guide wires used in angioplasty procedures continue to keep the cost of cardiac procedures at a higher range.

The National Pharmaceuticals Pricing Authority (NPPA), during a series of meetings to reduce stent costs, acknowledged that the costs of these secondary devices are at times more than that of the stent. The Authority has already written to the Health Ministry to categorise these devices as essential medicines so that their prices can be capped as well.

‘Grossly exorbitant’

“The cost of cardiac catheters, balloon catheters and guide wires used in the procedure remains grossly exorbitant and leaves very high margins and scope of profiteering,” states the NPPA’s minutes of the meeting, adding that the Authority has taken note of this and decided to upload the data in the public domain.

The Authority also mentioned that it had received several complaints from health activists and cardiologists, who revealed that many hospitals were reusing catheters, balloons and guide wires after serialisation, and charging patients at the same rate as new ones or with some concession.

“The benefit of reduced stent prices will reflect in patients’ bills only when some of the corporate hospitals stop this unscrupulous extraction of money,” said a cardiologist from Mumbai.

A stenting procedure involves puncturing the artery with the help of a needle, which costs about 300. A sheath is then inserted into the artery, followed by a guiding catheter, which costs up to 6,000. A guide wire that costs about 6,000 is then placed, followed by a balloon to dilate the artery. A balloon costs anywhere up to 12,000. It is after this last step of dilation that a cardiac stent is placed. While these costs are rough estimates from a charitable trust hospital, doctors say that hospitals charge up to two to three times more for the devices. The NPPA has now made it mandatory to list the prices for these devices separately.

Expensive packages

“The overall cost of an angioplasty package, including the required two days of stay, should ideally not exceed 1.2 lakh. This is still a ballpark figure and it should vary with a lower grade of room, institute etc.,” said Mumbai-based cardiologist Dr. Dev Pehlajani. He said charitable trust hospitals have cut down costs but corporate hospitals have worked around the packages with profits in mind.

This is the first time tandospirone has been shown to reverse the deficit in brain neurogenesis induced by heavy alcohol consumption.

END

A deepening crisis

The more necessary it seems, the less likely it gets. That is the story of public spending on education. In 1966, the Kothari Commission had said in its voluminous report that India should aim at spending 6% of its GDP on education. More than half a century later, we are spending less than 3% of our GDP on education. D.S. Kothari's recommendation gives us a symbolic measure of the importance given to education. At the time the commission chaired by him was drafting its report, India was passing through a difficult period. Famines, wars and political uncertainty were taking their toll. The economy was stuck in sluggish growth, and the idealism of the freedom struggle was waning.

Conditions are rather different today. By any standards, India is more prosperous today and people's aspirations are higher. Education is valued across different sections and strata. Despite this favourable social climate, education has failed to become a matter of national concern. Every year, the Union Budget indicates that it is not a high priority although it is loudly announced to be so. This year's Budget is no different. It offers a marginal increase on different routine expenses and reduction on some. There is no sign of funds to enable institutional recovery after a prolonged period of damage caused by financial cuts in higher education. In elementary education, supply of funds for improvement in quality is no more certain. No funds are in sight to sustain the bold dream of making the Right to Education a sustainable reality.

In his Budget speech, the Finance Minister referred to the importance of teacher education. This was a welcome reference and somewhat rare too. Teacher training constitutes a relatively invisible, low-status sector of the system. It seldom receives high-level attention. A few prestigious colleges that were set up under British rule a century ago have lost their sheen. In the discourse of policy too, teacher training stays on the margins. And the current popular term 'public policy' does not cover teacher education at all. Some years ago, its inner reality was revealed by a commission appointed by the Supreme Court under the chairpersonship of the late Chief Justice of India, J.S. Verma. The report of this commission brought to public attention the dismal state of teacher education, especially the corruption that has seeped into the regulatory system put in place in the mid-1990s. Rampant commercialisation and rigid bureaucratic control combined to stifle any possibility of academic growth in teacher education. The Justice Verma Commission offered several good remedies to improve the regulatory structure, and for a little while it seemed as if things were moving forward. But the progress could not be sustained.

The Finance Minister made a special mention of the four-year integrated B.Ed. (Bachelor of Education) programme as a way forward for achieving quality in teacher training. The big question that has remained unanswered since the commission submitted its report is whether the Central government will spend the money the sector needs. So far, the indications have been that teacher education will have to pay for its own growth. What the government is willing to invest in is mainly the in-service part of the sector. Pre-service courses like B.Ed. continue to have a huge market outside public institutions, like departments of education in universities. The long history of the four-year integrated B.Ed. course in the confines of the Regional Institutes run by the National Council of Educational Research and Training (NCERT) offers the hope that it may perhaps do well in the broader world as well, but that hope is contingent on a big, presently daunting question.

That question is whether the government is aware of its responsibility towards higher education. Teachers for all levels are directly or indirectly affected by institutions of higher education. A nursery teacher needs to benefit from current knowledge in child psychology, and someone teaching language in primary classes must know how to leverage contemporary knowledge about how children learn reading or how to impart bilingual skills. The secondary teacher is directly affected by conditions in undergraduate colleges. If they have no science labs and adequate

faculty, the graduates who opt for school teaching as a career can hardly do justice to the adolescents who choose to study science. These are reasons why the degraded state of undergraduate education limits the potential impact of training on a schoolteacher's academic capacity.

Barely a decade ago, the Yash Pal report on renovation and rejuvenation of higher education presented a bleak picture of undergraduate education and offered recommendations for improving it. Implementing these recommendations will need increased public spending. Above all else, it will call for an institutional recovery road map. Neither extra money nor a recovery plan is in sight.

It is a legitimate question why India does not worry about its educational crisis or why it does not invest more public funds in education. One way to seek an answer is to look back. In the first few decades following Independence, resources were limited and they were used for other, more immediate needs. Then, for a little while, it seemed as if education might become a priority because social demand for it had increased. However, before this demand could acquire a political voice, the state got seduced by the option to privatise education. Now, we are in an advanced stage of that fascination. Any suggestion is welcome provided it avoids arguing for more funds from the public exchequer. How long this viewpoint will continue to shape public policy in education is anyone's guess.

But one thing is certain. The damage our institutional apparatus has suffered over the last three decades has begun to hurt our long-term national economic interests and social goals. We need to recognise that growing inequality and dissonance among youth are a consequence of malnourished institutional experience. The United Nations discourse of sustainable development should remind us that our national aspirations might get a jolt if we fail to prioritise education.

Krishna Kumar is a former Director of the NCERT. His latest book is an edited volume titled 'Handbook of Education in India'

END

WHO issues new guidelines to curb surge in caesarean sections

Doctor checking health belly status of Indian pregnant mother. | Photo Credit: Getty Images

The World Health Organization (WHO) on Thursday said it has revised a benchmark used by health professionals worldwide in caring for women during childbirth because it has caused a surge in interventions like caesarean sections that could be unnecessary.

Since the 1950s, a woman progressing through labour at a rate slower than one centimetre of cervical dilation per hour has been considered “abnormal”, said Olufemi Oladapo, a medical officer with the World Health Organization’s department of reproductive health.

When doctors and other care providers confront labour moving slower than that rate, “the tendency is to act”, either with a caesarean section or with the use of drugs like oxytocin that speed up labour, leading to the “increased medicalisation” of childbirth, he said.

In its new guidelines, the WHO called for the elimination of the one centimetre per hour benchmark.

“Recent research has show that that line does not apply to all women and every birth is unique,” Dr. Oladapo told reporters in Geneva.

“The recommendation that we are making now is that that line should not be used to identify women at risk of adverse outcome,” he added.

While rates of interventions like c-sections vary among regions, WHO has seen what it considers a worrying rise in such practices worldwide.

Interventions that were once used to manage complicated childbirths have become commonplace, the agency warned.

“Pregnancy is not a disease and child birth is a normal phenomenon, where you expect the woman to be able to accomplish that on her own without interventions,” Mr. Oladapo said.

“However, what has been happening over the last two decades is we have been having more and more medical interventions being applied unnecessarily to women and we have situations where several woman are getting too many interventions that they do not need.”

While cautioning against any one-size-fits-all benchmarks, the new WHO guidelines say that for a woman delivering her first child, any labour that does not extend beyond 12 hours should be considered normal.

For a subsequent pregnancy, the figure drops to less than 10 hours.

This is the first time tandospirone has been shown to reverse the deficit in brain neurogenesis induced by heavy alcohol consumption.

END

Ministry of Chemicals and Fertilizers

India’s biggest Annual Conference on Pharma Industry and Medical Devices - India Pharma 2018 and India Medical Device 2018 - begins at Bengaluru

‘Namo-Care’ to turn India into largest Pharma manufacturer in the world in three years: Shri Ananthkumar

New Pharmaceuticals Policy on the cards to ensure effective implementation of ‘Namo-Care’; Major reforms to be initiated in the Drug Price Control Order

Expect $65 billion Pharma and $12 billion Medical Devices industry to double in next five years: Shri Ananthkumar

Minister urges the Industry to take up the Challenges of implementing Namo-Care in coordination with Make in India initiative of the Government

Posted On: 15 FEB 2018 4:00PM by PIB Delhi

“Ayushman Bharat health insurance scheme announced by the Government, popularly called as ‘Namo-Care’, has the potential to turn India into the largest pharma manufacturer of the world in about three years”, Union Minister of Chemicals & Fertilizers and Parliamentary Affairs, Shri Ananthkumar, said while inaugurating the third edition of India Pharma 2018 and India Medical Device 2018, International conference and exhibition in Bengaluru today. The three-day event is being organized by Department of Pharmaceuticals (DoP), Ministry of Chemicals and Fertilizers, in collaboration with Federation of Indian Chambers of Commerce and Industry (FICCI). India Pharma & India Medical Device Awards were announced at the event to honour excellence and innovation in the field of pharmaceuticals and medical devices.

Addressing the distinguished gathering industry stalwarts and international drug regulators, Shri Ananthkumar said that Ayushman Bharat will lay down an ambitious framework for Universal Health Coverage by giving assured Affordable and Quality health cover of Rs. 5 lakh per annum to about 50 crore poorest of people in India. The Government will start rolling out Namo-Care in the next three months with the same speed and efficiency as highly successful initiatives like Mudra Yojana, Ujjwala Yojana, UjalaYojana and neem coating of urea.” With this ‘Giga Health Reform’, the Government expects the $65 billion Pharma and $12 billion Medical Devices industry to double in next five years. “Can we produce affordable pharma products and medical devices of global standards? That is the real challenge”, the Minister added.

Shri Ananthkumar added by saying, “Namo-Care cannot be effectively implemented in the currently fragmented ecosystem of the pharma industry. The Government accordingly intends to come up with a New Pharma Policy which will unify and synergize its various components of Pharma and medical devices sectors, such as Drug Price Control Order (DPCO), manufacturing, R&D, financing, quality control, drug control, price control and medical devices. The pharma and medical devices industry has to take up the Namo-Care challenge in coordination with the Make in India initiative of the Government to ensure 360 degree Health Security for All. I have given it the ‘3A formula’ – Availability, Authenticity and Affordability – without compromising upon the Quality”, the Minister added.

The event saw a roundtable session of pharma and medical devices CEOs with Shri Ananthkumar, to discuss Government policy and challenges facing the industry. The Minister informed that during the interaction the CEOs have been exhorted to partner with the Government to find joint solutions for challenges facing the pharma and medical devices sector and ensure ‘Affordable and Quality Healthcare for All’ in the country, which is the theme of this conference.

Addressing the audience, Minister of State for Chemicals & Fertilizers , Road Transport and Highways , Shipping , Shri Mansukh L. Mandaviya, said that rapid growth in the pharma industry, especially in bulk drugs and APIs, is essential to ensure availability, accessibility and affordability of medicines for the masses. The Minister said that Government of India has been taking steps to ensure affordable and quality health care for all, like over 3150 Pradhan Mantri Janaushadhi Kendras being made functional across the country; 100% FDI in Greenfield projects and 75% in Brownfield projects in Pharma sector have been permitted through automatic route; transforming NIPERs into Innovation Hubs to promote R&D in pharma sector, inter alia, to serve the last man in the society, the Minister said.

A host of dignitaries were present at the inaugural ceremony of the event, including Shri Jai Priye Prakash, Secretary DoP, Shri Suddhansh Pant, JS DoP, along with senior officers of the Ministry and stalwarts of the pharma and medical devices industry and government officials from India and abroad. Hundreds of delegates, including 50 Hosted Delegates from other nations and over 10,000 business visitors, are attending the event. Over 300 companies and 50 start-ups are showcasing their products. More than 90 eminent industry leaders would speak at various sessions spread over three days.

Over 20 international drug and device regulators are set to meet with Indian regulators at the venue. Ministerial delegations from CIS and BIMSTEC countries are also attending the event. A key highlight of India Pharma & India Medical Device 2018 is a workshop by World Health Organization on “Regulatory System Strengthening and Prequalification updated by WHO.” A conference will also be organized by NASSCOM on “Digital Transformation through Innovation in Pharmaceutical, Medical Devices and Healthcare Industries.”

Themed around ‘Affordable, Quality Healthcare,'the three day conference has back to back sessions to discuss topics like Discovering Innovative Medicines in India; Making India a Part of Global Supply Chain in Medical Devices; Opportunities, Challenges and Regulatory Requirements in the Development of Biologics; Opportunities & Challenges for Stem cells & Regenerative Medicine; Emerging Global Trends in Self Care and Relevance of OTC Regulatory Framework for Indian Public Healthcare System; aSub-sectoral Approach to Make in India; and Moving towards API Self Sufficiency.

*****

PP/VM

(Release ID: 1520651) Visitor Counter : 0

END

Case histories: On National Health Protection Scheme

The government's intention to launch the world's largest health insurance programme, the National Health Protection Scheme, raises an important issue. Should the focus be on the demand side of health-care finance when the supply side, the public health infrastructure, is in a shambles? Experience with insurance schemes, such as the Centre's Rashtriya Swasthya Bima Yojana and Andhra Pradesh's Rajiv Aarogyasri, show how demand side interventions can miss the mark. While the RSBY and Aarogyasri did improve access to health-care overall, they failed to reach the most vulnerable sections. At times they led to unnecessary medical procedures and increased out-of-pocket expenditure for poor people, both of which are undesirable outcomes. These showed that unless the public health system can compete with the private in utilising funds from such insurance schemes, medical care will remain elusive for those who need it most. Policymakers behind the NHPS, which will cost the government around 5,000 crore in its first year, must take heed.

Both RSBY and Aarogyasri are cashless hospitalisation schemes. While both benefited people living below the poverty line, over-reliance on private hospitals and poor monitoring watered down their impact. According to one Gujarat-based study, a majority of RSBY insured patients ended up spending about 10% of their annual income during hospitalisation, because hospitals still charged them, unsure as they were when they would be compensated. A study in Andhra Pradesh found that beneficiaries spent more from their own pockets under Aarogyasri. They spent most of their money on outpatient care, and Aarogyasri didn't tackle this adequately. Possibly the most problematic fallout was mass hysterectomies done in Andhra Pradesh. Between 2008 and 2010, private hospitals removed the uteri of thousands of women unnecessarily, to make a quick buck. Thus, perverse incentives can drive the private sector to sabotage schemes that are not well monitored. The second problem with over-reliance on the private sector is that it limits the reach of such programmes. Evidence from RSBY and Aarogyasri shows that as distance from empanelled hospitals grew in Andhra and Gujarat, fewer people benefited from them — most empanelled hospitals are private and urban. Scheduled Tribe and rural households typically missed out, while richer quintiles of the population benefited. There can be much gained from the NHPS if the government views it as the first step towards universal health care, rather than a panacea to all of India's health-care woes. The second, and a long-awaited, step is to reform the public health system. Without this, an insurance scheme, no matter how ambitious, will be a band-aid.

The draft of Assam's National Register of Citizens is a first step, but it opens up concerns

END

Not a prescription for the poor

The National Health Protection Scheme (NHPS) is being hailed as the biggest takeaway for the aam aadmi in this year's Budget. Given the noise that is being made around it, one is led into believing that the government has brought the nation into the next generation of health security. Quite expectedly, the Opposition, led by the Congress, has dubbed it "as nothing but a pack of lies". As there are a few elections this year before the big and major one, the battle lines are being drawn. So, given this impasse in public discourse, how will anyone be able to judge it accurately? The only real way to judge the potential of the NHPS is to review the empirical evidence pertaining to some of the existing publicly-funded health insurance schemes, particularly the Rashtriya Swasthya Bima Yojana (RSBY).

At the outset, it should be pointed out that the RSBY was rechristened the NHPS in 2016. The Budget promised to provide insurance coverage to an estimated 50 crore poor beneficiaries through the NHPS. There are two problems with this claim. First, the RSBY which was launched in 2008, was initially designed to target only the Below Poverty Line (BPL) households. However, even after nine years of its implementation, only half the BPL families have been covered, according to government data. Further, there is a huge discrepancy between the coverage figures in government data and estimates from surveys. In the 71st round of the National Sample Survey (NSS), 11.1% of the population was covered by the RSBY and State health insurance schemes in 2014 but according to the Insurance Regulatory and Development Authority, the population coverage of these schemes was 16.4%.

A key reason for this discrepancy is the creation of bogus beneficiaries by insurance companies to earn premium subsidies from the government. Another reason is that while insurance companies have been given the premium subsidy for covering all eligible households in the respective States, the insurer reached out to only a fraction of the eligible population. For example, in 2016, only 2.45% eligible families were enrolled under Maharashtra's Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) in 2016. Enrolment was also found to be very low in the Chief Minister's Comprehensive Health Insurance Scheme, in Tamil Nadu, as shown in the NSS data.

The second problem is related to the identification of poor households. According to the NSS data for 2014, among the poorest quintile, 12.7% of households received RSBY coverage, which accounted for 25.9% of all the RSBY enrolled households. On the other hand, about 36.52% of households enrolled in the RSBY were actually drawn from the richest 40% of the sample households. Further, almost half the households enrolled in the RSBY actually belonged to the non-poor category. The targeting process in RSBY has been fraught with exclusion errors.

It is important to underscore the fact that insurance coverage does not automatically translate into utilisation. According to the programme data, the hospitalisation rate was found to be as low as 1% among RSBY-insured individuals, compared to a national average of 2.6% for the general population as of 2014. The RSBY is not an exception in this regard. The utilisation rate of other insurance schemes is also very low. For example, the MJPJAY recorded a utilisation rate (calculated as the proportion of eligible persons with at least one in-patient claim during the year) of just 0.12% in 2013-14 and 0.18% in 2014-15.

There is no evidence that the RSBY/NHPS has caused a reduction in out-of-pocket expenditure. Two very recent impact evaluation studies have reported that the RSBY has hardly had any impact on financial protection. Proponents of the NHPS might argue that the insurance coverage was limited in the RSBY, leading to patients incurring payments for hospitalisations. So, in

‘Modicare’, the benefit package has increased coverage substantially. However, the increase in allocations is unlikely to effectively address the problem of out-of-pocket expenditure.

There are two reasons. First, international experience in publicly funded health insurance in unregulated private health-care markets suggests that in countries where the benefit package was expanded by raising only the insurance limit, private hospital care providers responded by substantially increasing the price of services. So, this kind of increase would actually mean a larger transfer of public money into private hands. This was also evident in recent actions by many private hospitals which withdrew from the RSBY as they were apparently not happy with the package rates. Hence, it is just a matter of time before private hospitals empanelled under the NHPS ask for higher package rates as seen in Karnataka or Andhra Pradesh where private network hospitals have threatened to pull out if their demands for higher rates are not met.

Second, given the fact that out-patient care, the single largest contributor to out-of-pocket spending, is not included in the benefit package of the NHPS, the increase in the insurance limit will not be of much help. Moreover, in the absence of strong and effective government regulations for insurers and providers, well-recognised market failures such as supplier-induced demand will ensure that eligible families exhaust full coverage with little improvement in their well-being.

Soumitra Ghosh is Assistant Professor, Centre for Health Policy, Planning and Management, School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai

Marriage is a civil contract — adultery or divorce should have only civil consequences

END

is the price control of stents essential?

What did the regulator do?

The National Pharmaceuticals Pricing Authority (NPPA), India's drug pricing regulator, has further brought down the cost of drug-eluting stents (DES) from Rs. 29,600 to Rs. 27,890, while marginally increasing the cost of bare-metal stents from Rs. 7,400 to Rs. 7,660.

The move comes a year after the NPPA slashed stent rates by nearly 85%. Price control, it said, "is necessary under the failed and exploitive market system characterised by exorbitant, irrational and restrictive trade margin."

The NPPA said it was "immediately necessary to fix the ceiling prices of coronary stents in order to protect public interest." Coronary stents are used to open narrowed arteries, reduce symptoms like chest pain and treat a heart attack.

How will it help?

Doctors say the move will help more people opt for DES that are technologically better and more advanced. In just one year after price regulation, the use of bare-metal stents has been reduced by 30% and replaced by DES.

Bare-metal stents have a significantly higher rate of restenosis (the recurrence of abnormal narrowing of an artery or valve after corrective surgery) and the need for target vessel revascularisation or restoration of perfusion to a body part or organ that has suffered ischemia compared with all DES. "Affordability matters," NPPA Chairman Bhupendra Singh said.

The new order also allows transparency and better government control and audit ease. With this order, patients will have the option to get a stent and accessories from outside the establishment, and manufacturers are allowed only 8% trade margin. Also stents selling lower than the ceiling rates cannot go up in price now after the new order.

The Indian Medical Association has noted that "this is a bold move by the NPPA."

Dr. K.K. Aggarwal, immediate past president of the IMA, said: "Cardiac-related diseases are rising in India. Poor accessibility to quality health care and high pricing is a major deterrent for people seeking medical care. Price capping will minimise the expenditure in the health sector and allow more people to benefit from it."

Doctors also say the move sends a strong message to private players that profiteering at the cost of life is unacceptable. "This has also brought back attention to the needs of the patients and is now encouraging people to opt for better treatment plans and most importantly break the nexus of unethical pricing," Dr. Aggarwal noted.

The NPPA also decided against the request of multinational stent makers for a new category for advanced stents.

Was there a need?

A core committee, which examined the issues relating to the essentiality of coronary stents, observed in its report to the government in April 2016 that there is a very high incidence of coronary artery disease (CAD) in India associated with high morbidity and mortality; and CAD has

become a major public health problem.

The NPPA held meetings with eminent cardiologists, who said the price cap had resulted in more angioplasties and fewer bypass surgeries. The NPPA also met stakeholders on February 5 and 8.

At a meeting held on February 13, the NPPA said it examined all available information/data of coronary stents supply chain and all relevant options for price fixation of coronary stents before announcing the new rates, which will be valid till March 13, 2019.

“This is being done to prevent the cardiac stents market from falling back to its old archaic state... and an extraordinary failed market system,” the NPPA noted.

What lies in store?

Based on available data from official sources and manufacturers/importers, the NPPA is now analysing the trade margins in the cardiac guidewire/balloon catheter and guiding. The analysis by the authority notes that profit margins are as high as 400% in this area and thus may need government intervention for cost optimisation. The NPPA has sought comments and views of stakeholders in this matter.

Bindu Shajan Perappadan

END

Vice President's Secretariat

Educational institutions must provide varied & rich learning experiences to students: Vice President

Addresses Platinum Jubilee Celebrations of Rouzathul Uloom Association

Posted On: 17 FEB 2018 3:51PM by PIB Delhi

The Vice President of India, Shri M. Venkaiah Naidu has said that educational institutions must provide varied and rich learning experiences to students. He was addressing the Addresses Platinum Jubilee Celebration of Rouzathul Uloom Association at Farook College in Kozhikode, Kerala today. The Minister for Local Administration, Kerala, Shri K.T. Jaleel and other dignitaries were also present on the occasion.

The Vice President said that we need to lay a strong foundation in the early years of schooling in order to become lifelong learners. What is important is the ability to be curious, to observe, analyze, synthesize, draw conclusion, test hypothesis, and advance continuously the frontiers of knowledge, he said.

The Vice President said that educational managers, teachers and researchers should help build a system that has “equity” and “quality” as the two guiding principles. He further said that each child is important for us and each moment we spend with the child and young person is precious. It has tremendous potential - potential to inspire, the potential to catalyze creative, positive thinking, the potential to change individuals, families and countries for the better, he added.

The Vice President said that education is an emancipatory tool and it liberates us from dependence, restores self-confidence and enhances self-esteem. If we don’t expand access to good education, we shall have widening gaps between different sections of our society which might negate economic progress, he added.

Following is the text of Vice President's address:

"I am privileged to be among the finest creative minds of the world assembled here for this inaugural function of the 8th Theatre Olympics at this historic Red Fort. The journey from Delphi (Greece) in 1993 to Delhi in 2018, completes 25 years and we are proud to host this important cultural event at this momentous time.

Art and cultural ties have united humanity from time immemorial. Ancient civilizations like the Greek, Roman, Babylonian, Egyptian and Indus Valley civilizations have enriched the cultural capital of the world. There is a fascinating diversity in the themes and presentation but the emotions conveyed appeal to all human beings across the globe.

The seven colours of the rainbow are different and beautiful but underneath the difference is a common origin. Which is why art has united and connected various cultures and continents.

The theatre Olympics is yet another initiative to connect countries and cultures and enrich our collective consciousness. Since it started in Delphi in 1993 and now it is being held in the equally historic city of Delhi, let me recall the great contribution made by two of the most ancient cultures in the world. Greek culture is replete with great philosophers like Plato, Socrates and Aristotle as well as dramatists like Sophocles, Aeschylus and Euripides. Theatre was an important and integral part of Greek civilization. Around the 4th century BC regarded as the Golden Age of Greek drama, the centre-piece of the annual festival "Dionysia" was a competition between three tragic playwrights at the Theatre of Dionysus.

Ancient Indian civilization also had a grand tradition of performing arts.

Bharata Muni's Nya stra written around 5th century BC is an ancient encyclopedic treatise on the performing arts. Drama, in this ancient Sanskrit text, is an art to represent every aspect of life and imitate what happens in the lives of people (Avasthanukrutir Natyam) in order transport the audience to a state of joyful consciousness.

As the commentator Abhinavagupta says, the performing arts temporarily suspend us from the ordinary world and takes us into another parallel reality full of wonder.

In the Indian thought, life is an integrated whole into which Dharma (Righteousness), Artha (Wealth), Kama(Desire) and Moksha (Emancipation) are inextricably interwoven.

Similarly, there are nine aesthetic experiences called "Nava rasas" which can transform the inner state and where the beauty of art lifts us into higher consciousness.

From amateur village clubs to professional theatre groups, from folk and tribal theatre to highly sophisticated modern and post-modern theatre, India has witnessed a distinctive theatre tradition, dominating the society's cultural space. The theatre traditions of our country are our culture's enduring legacies. Our theatre is one of the oldest in the world, going back to 2500 years. Coming down to the present from the ancient times, the common roots of our apparently different genres of theatre tell the story of a cultural synthesis which distinguishes our civilization. Regardless of our diversities of language, religion or region, theatre in India is a common form of performing art and all states have a rich history of theatre tradition.

In fact, diversity has been the defining feature of our country's reality. Play wrights and artistes, writers and poets have captured the essence of this reality in their creative pursuits in the past and, continue to do so today. This has given a distinct identity to Indian creativity. And, this Theatre Olympics showcases and celebrates our unique cultural identity.

Theatre, as I understand, is a powerful medium, where the practitioners may use different locales and different languages, to convey an idea, to entertain or enlighten and focus on a societal issue. The theatre performers have the power to transcend regional and cultural barriers and address the larger humanity. Often, the themes such as poverty, hunger, oppression, atrocities, wars and displacements which are common to all societies capture the imagination of the theatre directors. I feel that these themes could be creatively used through theatres to bring about social change and transformation by retrieving hope from hopelessness, optimism from despair and joy from seemingly endless sorrow.

Sisters and Brothers,

Art is a mirror of the society and is reflection of the lives of people. It is a creative transformation of the stories of ordinary lives into an extraordinary art form.

Art forms touch human hearts like no other impulse. It can produce different aesthetic responses in the viewers. It can move them to tears, make them laugh heartily, make them feel angry about an issue, make them feel disgusted about some reality. There are a whole lot of emotions it can generate. However, art is an expression of certain values inherent in a culture.

There are certain values that are universal like the desire for friendship, yearning for peace and harmony. Art can help us to sublimate many raw emotions or as the Greek dramatists called it, undergo “catharsis” in which our thoughts get purified. The Indian tradition also emphasized the need for art to keep in view the impact which should serve the larger objective of “good to humanity” (Vishwa shreyah kaavayam).

Sisters and Brothers,

It is a matter of great happiness that the Logo of this Theatre Olympics has been designed as “Flag of Friendship”. It brings to my mind a beautiful song composed by a contemporary Indian Saint, Paramacharya Chandrashekhara Saraswathi and which echoes the timeless Indian vision of the whole world as one family.

“Maithreem Bhajatha Akhila Hrith Jethreem”

(Cultivate Friendship and Humility, which will conquer the Hearts of Everyone)

This is a message that India has been giving the world for many centuries. It is probably a message that is most relevant in a world that is torn with narrow, fractured vision. I am hopeful that the theatre Olympics will keep the flag of peace and friendship flying high and melt the hardened, icy hearts and flood our world with the rejuvenating rivers of love and oceans of compassion.

I welcome all the artists from around the world and I am hopeful that you will share with each other different facets of your artistic excellence and take away pleasant memories of your stay here.

My compliments to the Ministry of Culture, Government of India, and the country’s premier theatre institute, the National School of Drama and its Chairperson, the distinguished playwright and theatre director, Mr. Ratan Thiyam, for organizing this mega theatre event.

My greetings to all the theatre personalities present here from as many as 35 countries participating in this theatre extravaganza.

Thank You, Jai Hind!"

***

AKT/BK/RK

END

Doctors for rural India

Nearly 600 million people in India, mostly in the rural areas, **have little or no access to health care**. A widespread disregard for norms, a perpetual failure to reach targets, and an air of utter helplessness are what mark the state of rural health care today. One can add to this another fact: the country is short of nearly five lakh doctors.

Among the range of measures that have been suggested in the past decade is a rather promising proposal which has been sidelined. If properly implemented, it may provide rural India with a lasting pool of primary care physicians.

A few years ago, the Union Health Ministry drew flak when it put forth a proposal to train a new cadre of health professionals. Under this plan, these professionals, after undergoing a short term, 3-3.5 year course in modern medicine, were to serve the health needs of the rural population, with a focus on primary care.

Such short-term courses aren't new in the Indian health-care scenario. In the 1940s, primary care physicians — who were trained under short-term courses, and broadly termed Licentiate Medical Practitioners (LMPs) — would deliver quality services in the rural sector until the Bhore Committee (1946) recommended abolishing them in the idea that India would produce enough MBBS doctors.

Breathing life into health care in India

The committee made certain laudable recommendations in connection with the public health system. Back then, however, nobody could have anticipated the country's miserable failure in achieving most of the targets prescribed by the committee, even years after Independence. While a profit-driven, private health-care sector continued to denude the public health system of its qualified physicians, its medical education system kept losing touch with the actual health needs of the country.

Starting a short-term course in modern medicine can provide an opportunity to design a medical curriculum that is much more relevant to the nation's needs. Its entry requirements could be based less on sheer merit and more on an aptitude for medical service and preference should be given to applicants from within the community. Further, a provision for learning in the vernacular languages can be made.

Short-term courses in modern medicine have been consistently equated with producing "cheaply made, poor quality doctors". However, one begs to differ with this. LMPs cannot be called quacks if they be adequately trained in their field (primary care) and have a well-defined role in health care. The present MBBS curriculum includes a good amount of superfluous detail, including subjects such as forensic medicine, that is of little relevance to primary care physicians. Here, we should also note that even though nurse practitioners and pharmacist medical practitioners may be capable of serving the same functions as LMPs, they cannot be expected to make up a lasting pool of dedicated grass-rootlevel physicians.

Another concern is that the rural population would be made to feel like second class citizens by appointing a lower tier doctor to treat them. This can be put to rest by not letting LMPs replace MBBS doctors but instead work in a subordinate capacity.

A few changes in the public health system can be envisioned here: LMPs be employed in sub-centres where they perform both clinical and administrative functions at the sub-centre level. This would also allow easier access to primary and emergency care and keep the post of medical

officer for MBBS doctors, thereby deterring any competition between the two cadres of physicians.

Medical officers (MBBS) could be employed in primary health centres (PHC), and new recruits imparted mandatory further training of a sufficient duration in basic clinical specialties. Also, inpatient facilities at PHCs can be scaled up. PHCs should deal with cases referred to them by sub-centre LMPs and also supervise their work.

This has many advantages. With LMPs working at the grass-root level, a single PHC would be able to handle a bigger population, allowing for more resources to be concentrated on individual PHCs for manpower and infrastructure development and also for increasing the remuneration of medical officers.

Ancillary responsibilities can be taken off an MBBS doctor and their skills put to better use. Quality emergency and inpatient attention can be made available at the PHC-level. Today, less than a handful of PHCs provide inpatient care of significance. Concerns about the clinical and administrative incompetence of fresh MBBS graduates appointed as bonded medical officers can be put to rest.

LMPs could be allowed to take up a postgraduate course in primary care as an option to study further. Those with a postgraduate qualification could choose to move higher up in the public health system, establish their own practice, find positions in hospitals, or serve as faculty in medical colleges training LMPs.

Therefore, reviving LMPs can help address the dearth of trained primary care physicians in rural India. The logistical entailments of implementing this idea would require separate deliberation.

Soham D. Bhaduri, a medical doctor based in Mumbai, is the Editor-in-Chief of 'The Indian Practitioner'

Positive developments are taking place with regard to female genital mutilation

END

Vaccine can prevent TB infections in adolescents

The results will be announced on Tuesday at the 5th Global Forum on TB Vaccines in Delhi.

A clinical trial has provided encouraging new evidence that TB vaccines can prevent sustained infections in high-risk adolescents. The results will be announced on Tuesday at the 5th Global Forum on TB Vaccines in New Delhi.

Subunit vaccine

In the Phase 2 trial conducted in South Africa, revaccination with the Bacille Calmette-Guerin (BCG) vaccine significantly reduced sustained TB infections in adolescents. An experimental vaccine candidate, H4:IC31, also reduced sustained infections, although not at statistically significant levels.

However, the trend observed for H4:IC31 is the first time a subunit vaccine has shown any indication of ability to protect against TB infection.

The study was conducted to evaluate the safety and immunogenicity of the vaccine regimens, as well as their ability to prevent initial and sustained TB infections among healthy adolescents in the Western Cape Province of South Africa.

Ann Ginsberg, MD, PhD, Chief Medical Officer at Aeras and a member of the organising committee for the 5th Global Forum on TB Vaccines, said: “We and our partners will share a range of new data at the 5th Global Forum on TB Vaccines, highlighting the scientific progress being made to develop potential new vaccines against TB, the world’s leading cause of death from an infectious disease.”

According to the World Health Organisation, about one-third of the world’s population has latent TB infection, which means people have been infected by TB bacteria but are not (yet) ill with the disease and cannot transmit the disease. People infected with TB bacteria have a lifetime risk of falling ill with TB of 10%. People ill with TB can infect 10-15 other people through close contact over the course of a year. Without proper treatment, 45% of HIV-negative people with TB on average and nearly all HIV-positive people with TB will die.

Mark Hatherill, MD, Director of the South African Tuberculosis Vaccine Initiative (SATVI) at the University of Cape Town, and the study’s principal investigator, said: “We are pleased to have performed the first-known randomised, placebo-controlled prevention-of- infection trial for TB and to have demonstrated that vaccination has the potential to reduce the rate of sustained TB infection in a high-transmission setting. While neither vaccine proved to be statistically significant in preventing an initial TB infection, we are extremely encouraged by the signals observed for both vaccines in preventing sustained TB infections.

“We believe the results from this novel trial design will provide significant scientific benefit to the field in understanding TB infection, and based on this positive signal, we look forward to testing the potential of such vaccines to prevent TB disease among uninfected adolescents in a larger, more traditional prevention-of-disease clinical trial.”

END

Education must mould a strong character and inculcate ethical and moral values among students: Vice President

Vice President's Secretariat

Education must mould a strong character and inculcate ethical and moral values among students: Vice President

Ensure that the environment at home as well as in schools is de-stressed;

Inaugurates Platinum Jubilee Celebrations of R.A. Podar College of Commerce and Economics

Posted On: 19 FEB 2018 12:30PM by PIB Delhi

The Vice President of India, Shri M. Venkaiah Naidu has said that education must mould a strong character and inculcate ethical and moral values among students. He was addressing the gathering after inaugurating the Platinum Jubilee Celebrations of R.A. Podar College of Commerce and Economics, in Mumbai today. The Minister for Housing Department, Maharashtra, Shri Prakash Mehta and other dignitaries were present on the occasion.

The Vice President called on parents, teachers, schools and colleges to ensure that the environment at home as well as in schools is de-stressed. He further said that it is unfortunate that many a time the parents fail to recognize the warning signs or fail to understand the mental stress their wards are coping with. This important subject was close to the heart of Prime Minister, Shri Narendra Modi, who has even penned a book titled 'Exam Warriors' on how to overcome the anxiety and stress caused by exams, he added.

The Vice President said that converting country's vast pool of human resources into a "demographic dividend" is a big challenge before everyone. He further said that we must use it as an advantage to propel India's growth trajectory to be among the top three economies in the world in the coming years. Education must develop the overall personality of an individual in a truly holistic manner by enabling them to make informed choices on their careers and at every stage in their later part of the lives, he added.

The Vice President said that education must empower and enlighten the youth, improve their analytical skills and make them to explore new vistas, discover and innovate. He further said that merely adding more and more buildings without providing quality as well as inclusive education will not enable the creation of the 'New India'. Education must not only be accessible but affordable too and it must empower and Enlighten people apart from providing employment, he added.

Following is the text of Vice President's address:

"I am extremely pleased to inaugurate the Platinum Jubilee Celebrations of this prestigious college, which has catered since its inception to the educational needs of different sections of this vibrant city and produced eminent personalities in different fields.

I am told that former Chief Justice of India, R.C. Lahoti, cricketers Farokh Engineer and Ravi Shastri, film actor, Shilpa Shetty, carnatic vocalist and composer, Bombay Jayashree and President of the Institute of Chartered Accountants of India, Nilesh Vikamsey are some of the well-known alumni of this college.

Dear students! India is one of the fastest growing large economies with a predominantly young population. A big challenge for the country is to convert this vast pool of human resources into a “demographic dividend” and propel India’s growth trajectory to be among the top three economies in the world in the coming years.

As you all are aware, millions of graduates in various disciplines come out of the portals of our higher education institutions every year. But the big question we all need to ask ourselves is—Are we producing holistic students with sound knowledge in their disciplines and the life skills needed to face the present-day competitive world or are we merely producing millions of degree-holders who are unemployable?

Education is not meant only for degrees and employment. Education must develop the overall personality of an individual in a truly holistic manner by enabling them to make informed choices on their careers and at every stage in their later part of the lives. At the same time, education must mould a strong character and inculcate ethical and moral values among students.

It must transform them into mature individuals with empathy and a humanistic worldview and not just modern-day computer geeks. Education must empower and enlighten the youth, improve their analytical skills and make them to explore new vistas, discover and innovate.

In fact, the education system needs a total overhaul from the primary education to higher levels so that learning becomes a joyful experience and students are not subjected to exam stress and needless tension. Over the years, we have been witnessing the disturbing trend of students committing suicide due to their inability to cope with the stress and pressure of exams. Parents, teachers, schools and colleges have a huge responsibility in ensuring that the environment at home as well as in schools and schools is de-stressed.

It is unfortunate that many a time the parents fail to recognize the warning signs or fail to understand the mental stress their wards are coping with. I am glad that this important subject is close to the heart of Prime Minister, Shri Narendra Modi, who has even penned a book titled ‘Exam Warriors’ on how to overcome the anxiety and stress caused by exams.

Another aspect I would like to flag is the need to provide quality education rather than focusing on numbers. No doubt, expansion of educational infrastructure is important. But merely adding more and more buildings without providing quality as well as inclusive education will not enable the creation of the ‘New India’. Education must not only be accessible but affordable too.

We have to collectively strive to eradicate poverty, agrarian problems, illiteracy, caste divisions, religious fundamentalism and gender discrimination, among others, to usher in the ‘New India’ as envisaged by our freedom fighters. Also, the rural areas cannot be allowed to lag behind the urban

areas and all the amenities found in urban areas must be created in small towns and villages.

This is needed absolutely to create equal opportunities for people living in rural areas and prevent migration so that cities are not turned into inhabitable concrete jungles.

Dear students, we have a rich culture which recognizes the value of knowledge and learning. In our culture, the Guru, who is the knowledge-giver is venerated. India was once known as 'Vishwaguru' and our ancient universities like Takshashila and Nalanda were famous centres of learning which attracted learners from across the globe.

Today, India once again has the chance to emerge as a knowledge hub in the world. But to achieve that, we need to overcome many formidable challenges by fully empowering the vulnerable sections, youth and women through education, knowledge and skills. Literacy plays a vital role in overcoming various challenges, empowering people and transforming communities.

I was truly impressed with vision and mission statements of your college. The Vision ''Samaani va aakooti samaanaa hridayaani vaham' (one in mind and one in heart) highlights the meaning of the verse that God has created us all equal, while Mission states "Nahi gnyaanen sadrasham pavitramiha vidyate'(there is nothing in this universe as pure as knowledge) and that it needs to be shared and exchanged freely, without any inhibition.

These thoughts must permeate every action of us in creating the New India of equal opportunities for all.

JAI HIND!

***

AKT/BK/RK

(Release ID: 1520883) Visitor Counter : 0

Read this release in: Urdu , Tamil

END

Experts urge more funds to tackle tuberculosis crisis

Only 63% of the patients infected with TB are currently under treatment.

Stating that tuberculosis (TB) has become a national crisis in India, the Health Ministry assured the TB community that eliminating the disease by 2025 had the ‘highest level of commitment from the Prime Minister Narendra Modi’s office.’

Senior Health Ministry official Sunil Khaparde, who heads the TB programme voiced the assurance at the opening day of the 5th Global Forum on TB Vaccines in New Delhi.

Nearly 4.2 lakh Indians die of TB every year. Out of the 10 million cases globally, India shoulders the maximum burden with 2.8 million cases. According to Health Ministry data, only 63% of the patients infected with the airborne disease are currently under treatment. Further, 1,47,000 patients are resistant to first and second line TB medicines. At the current rate of progress, global targets to eliminate TB by 2030 will be missed by a 150 years.

Against this backdrop, Dr Soumya Swaminathan, deputy director general of the World Health Organisation (WHO) said that globally, governments need to invest more in TB research and development to meet the global targets.

WHO representative to India Hendrick Bekedam added that TB vaccine was a global public health good, which meant governments need to invest if they want to own it later.

END

Infant mortality: 6 lakh Indian children died in their first month in 2016, says UNICEF

A neonatal intensive care unit in Mysuru. File | Photo Credit: The Hindu

India ranks 12th among 52 low-middle income countries having highest infant mortality rates with over 6 lakh children dying within the first month of their birth in 2016, a report by the United Nations Children's Fund says.

With the neonatal mortality rate being recorded at 25.4 deaths per 1,000 live births in 2016, India ranked below Sri Lanka (127), Bangladesh (54), Nepal (50) and Bhutan (60) but was above Pakistan, which was ranked among the lowest in the list with 45.6 deaths per 1,000 live births, according to the report released on February 19.

Babies born in Japan, Iceland and Singapore have the best chance of survival, while newborns in Pakistan, the Central African Republic and Afghanistan face the worst odds, the report stated.

"While we have more than halved the number of deaths among children under the age of five in the last quarter century, we have not made similar progress in ending deaths among children less than one month old," said Henrietta H. Fore, UNICEF's Executive Director. "Given that the majority of these deaths are preventable, clearly, we are failing the world's poorest babies."

Globally, in low-income countries, the average newborn mortality rate is 27 deaths per 1,000 births, the report says.

In high-income countries, that rate is 3 deaths per 1,000. Newborns from the riskiest places to give birth are up to 50 times more likely to die than those from the safest places.

However, a Health Ministry official said India has shown impressive progress in reduction of under-five mortality, nearly meeting its MDG target, with a 66% reduction in under-five deaths during 1990 to 2015.

India's progress has been far better than the world's, the global decline in the under-five mortality during the MDG period was 55%, the official said, adding the number of annual under-five deaths in India has gone below one million for the first time in 2016.

Ensuring gender equity with equal focus on boys and girls and addressing gaps in quality of care are now going to be the next frontiers for newborn survival. The issue of neglect of the girl child is much broader and needs interventions beyond health, to also address the social norms and cultural practices.

"There is an urgent need to intensify our combined efforts to further bridge this gap and ensure equitable access to care for the newborn girl. There is a need to create a social movement involving all stakeholders — government, professional bodies, civil societies, media, political leaders and communities — truly leaving no one behind," UNICEF India representative Yasmin Ali Haque said.

For the first time, UNICEF has come out with rankings based on their newborn mortality rate (the number of deaths per 1,000 live births).

It helped heal scratch wounds in 24 hours

END

Beyond physical access to schools

India has around 1.1 million elementary schools with 200 million children enrolled in them. About 96% of the habitations now have elementary schools within a 3km radius. In the last two decades, enrolment has been driven primarily by private schools. We see a mass exodus of students from government schools, resulting in the growth of small and tiny schools in both urban and rural areas. In 2015-16, there were about 250,000 elementary schools with an enrolment of 30 or less, out of which 78,300 have less than 15 students, according to Udise (unified district information system for education) data. Nearly 7,200 schools have zero enrolment. India stares at a huge dysfunctional public school system with small, tiny and empty schools scattered across the country.

Small schools compromise quality and efficiency by imposing enormous costs on providing physical and human resources, and for measuring and monitoring schooling outcomes. Many studies have shown that small schools lead to increase in per-child expenditure, create distributional inefficiencies, poor schooling quality, and breed schooling inequality among social groups. The per child expenditure on teacher salary in tiny schools (20 or fewer students) is about Rs78,000, almost eight times the average government schools, making them unviable in the long run.

Multi-grade teaching is common in small schools due to the difficulty in meeting teacher demands and increased cost, compromising schooling quality. In addition to completing the curriculum, teachers are expected to handle a multitude of administrative tasks, such as monitoring midday meals and maintaining attendance records. Teachers are also used for election duties and surveys. The burden of school management and administration is much higher in small schools than large schools. Moreover, teacher absenteeism further compounds the problem.

Aser (Annual Status of Education Report) surveys from 2005-14 have indicated a learning-level crisis in India in reading and mathematics. Due to low teaching inputs and infrastructural support, children in small schools are likely to have poor learning outcomes. Parents even from relatively poor backgrounds tend to avoid small schools if alternatives are available.

A closer look at small and tiny schools reveals startling realities about the challenges they face. In a pilot study in Karnataka (conducted with K. Vaijayanti of the Akshara Foundation), we came face to face with several small schools and the challenges faced by their teachers and students. Small and tiny government schools could be seen in almost every district we visited, although the geographical spread and density of schools varied considerably between rural, urban and tribal areas.

In a government higher primary school in Vagata (about 40km from Bengaluru city), in Bengaluru rural, the total enrolment in classes I-VII declined from 134 in 2014-15 to 96 in 2016-17 . The school register of 2017-18 showed even lower enrolment, of 82 students. On the day of our visit, only about 60 students were attending classes. These students were mostly children from the Scheduled Castes or Muslim community. The upper class has largely left the public school system. Four teachers have been appointed to the school, out of which three were present on the day of the visit. The head teacher was busy managing school affairs, effectively leaving only two teachers to teach seven classes.

The story of this school repeats in many small schools in the surrounding area. Teachers quote multiple reasons for this dwindling enrolment, such as availability of low-cost private schools in the surrounding area, rise in admissions under the “right to education” quota in private schools, and parental demand for English-medium schools. They lament that empty rooms leave them with no

motivation to teach. For the remaining few students, a single teacher is expected to teach 15-20 subjects for three to five classes, along with other administrative duties.

Changing perception about public schooling is essential for its survival. Restructuring the school systems by consolidating small schools in close proximity would bring efficiency by pooling students and teachers, without compromising access. This would result in better utilization of resources, and monitoring. The school management committees should be made functional with the effective participation of parents in monitoring school activities, and empowered to take financial decisions. The medium of instruction, instead of being strictly vernacular, can combine with English from the early stages.

There are a few examples where the trend of dwindling enrolment has been reversed, largely when concerted efforts were made to make schools functional. Within the government school systems, Navodaya Vidyalayas and Kendriya Vidyalayas have better teaching and infrastructural resources, show better learning outcomes, and continue to remain in demand. Where government and civil society have worked hard to make schools functional with adequate infrastructure, teachers have adopted sound pedagogical practices. Scaling and replicating such initiatives needs careful restructuring of the entire schooling system.

Shivakumar Jolad is an assistant professor at IIT, Gandhinagar.

The author would like to thank Sagar Atre for careful reading and comments.

END

Ministry of Health and Family Welfare

Shri J P Nadda addresses Global Digital Health Partnership Symposium at Australia

Digital health has great potential towards reducing inequity in provisioning and distribution of healthcare resources and services: J P Nadda

Posted On: 21 FEB 2018 12:00PM by PIB Delhi

“Digital health has great potential towards reducing inequity in provisioning and distribution of healthcare resources and services and it can greatly facilitate proactive treatment for disabled patients, children with developmental delays and deformities and people suffering from mental health illnesses and for those suffering from stigmatic infections such as HIV/AIDS, leprosy and tuberculosis.” This was stated by Shri J P Nadda, Union Minister for Health and Family Welfare during his address at the Global Digital Health Partnership Symposium at Sydney, Australia, today. The Union Health Minister spoke on the topic: The role of digital health in supporting improved health outcomes in India.

Mr. Michael Keenan, Minister of Human Services, Australia, Mr Jim Birch AM, Chair, Australian Digital Health Agency, Professor Robyn Norton, Co-founder and Principal Director of the George Institute for Global Health, Professor Ian Jacobs, President and Vice-Chancellor, UNSW Sydney, along with delegates from other countries were also present at the event.

Addressing the participants, Shri Nadda said that it is evident from experiences of various countries that well-designed digital health systems and services can reduce medical errors and cost of care while improving health system efficiency. “We have seen many sectors benefitting from digital revolutions in the past such as retail, banking, logistics etc. The next decade of digital revolution is going to be seen in healthcare; in fact, digital revolution is long overdue in healthcare which can transform the way our physicians, nurses, field staff and hospitals work to deliver care,” Shri Nadda stated.

The Union Health Minister informed the participants that the National Health Policy (2017) of India clearly articulates the healthcare aspirations of people of India with three distinct goals. “The first goal is to ensure district-level electronic database of information on health system components by 2020, which largely means moving away from paper-based data collection and recording in public health system to use of sophisticated computerized tools for improving functioning of hospitals and health system. The second goal is to strengthen the health surveillance system and establish registries for diseases of public health importance by 2020, where we intend to create registries to support epidemiological profiling of diseases to be better informed for targeted health interventions. The third goal pushes us to work for establishment of federated national e-health architecture, setting-up of health information exchanges and national Health Information Network by 2025,” Shri Nadda elaborated.

Speaking about various strategic initiatives taken by the Union Health Ministry, Shri Nadda said that Integrated Health Information Platform (IHIP) is intended to establish first Health Information

Exchange by connecting various Hospital Information Systems from 10 Indian States. He also highlighted the work done by the Ministry in building Registries. “We have started building registries for health facility and have given unique identification numbers to more than 200 thousand public health facilities. Incorporation of health facilities from private sector is ongoing. Creation of registries for patients and providers is also planned to be taken-up under IHIP,” Shri Nadda added.

The Union Health Minister further said that the Health Ministry is in process of setting-up a National Digital Health Authority, a statutory body for creating frameworks, regulations and guidelines for interoperability and exchange of digital information. The Authority is also intended to promote adoption of eHealth standards. It will soon be set up through an Act of Parliament which would also address issues related to health data privacy and security. Shri Nadda also gave an overview of Health Data and Information Standards and Tele-medicine.

Reiterating India’s commitment towards Digital Health, Shri Nadda said that modernization of healthcare through digital technology is an important public policy agenda and India is committed to modernizing its health facilities and services using digital technology. “Under the Digital India Programme of Government of India, we are giving lot of focus on use of ICTs for improving service delivery and Health Ministry has rolled out large scale IT systems in different areas of healthcare ecosystem such as public health management, hospital information system, supply chain management, online services, tele-medicine, programme monitoring, mHealth etc,” Shri Nadda stated.

Stressing on the need of building collaborations, the Union Health Minister said that cyber security and protection of privacy of patient health data are major areas where cooperation from various countries would be required. “This area also requires collaboration with industry and academia to come-up with sustainable strategies to fight cybercrime. Similar collaborations would also be required when we intend to use Artificial Intelligence and Machine Learning in hospitals or in community settings for use by health workers,” Shri Nadda said.

***

MV/SK

(Release ID: 1521218) Visitor Counter : 0

Read this release in: Tamil

END

Saving lives: on mortality rate

A new country-wise ranking of neonatal **mortality rates** — the number of babies dying in their first month for every thousand live births — gives India cause for both hope and shame. Shame, because the report, produced by the United Nations Children's Fund (Unicef), ranks India behind poorer countries such as Bangladesh, Nepal and Rwanda. Hope, because the ranking shows that financial resources are not the biggest constraint in improving this health indicator; political will is. According to the report, titled "Every Child Alive", while average newborn mortality in low-income nations is nine times that of high-income ones, several countries buck the trend, showing a way forward for India. For example, Sri Lanka and Ukraine, which like India are categorised as lower-middle income economies, had a neonatal mortality of around 5/1000 in 2016. In comparison, the U.S., a high-income economy, did only slightly better with a rate of 3.7/1000. Meanwhile, Rwanda, which falls in the lowest income group of less than $1,005 per capita, has brought down its mortality rates from 41/1000 in the 1990s to 16.5 through programmes targeted at poor and vulnerable mothers. Money matters, but intent matters more.

India saw the 31st highest newborn-mortality rate, at 25.4 deaths per 1000 in 2016, while Pakistan had the highest. Coming in after 30 countries is no comfort, however, because a small mortality rate can translate to numerous deaths when the birth-rate is high. This means India lost 640,000 babies in 2016, more than any other country. How can we chip away at this staggering number? The report points out that the most powerful solutions are not necessarily the most expensive. The 10 critical products that hospitals must stock to save newborns include a piece of cloth to keep a baby warm and close to the mother to encourage breastfeeding. The list also includes antibiotics and disinfectants, the use of which can stave off killers like sepsis and meningitis. But other solutions will need greater investment. The biggest cause of death is premature birth, while the second is complications like asphyxia during delivery. Preventing these would mean paying attention to the mother's health during pregnancy and ensuring she delivers in a hospital attended by trained doctors or midwives. India has programmes such as the Janani Suraksha Yojana for this, but must expand its reach in laggard States like Uttar Pradesh and Madhya Pradesh. Then there are factors outside the healthcare system, like female literacy rates, that make a big difference to healthcare-seeking behaviour. But changes in education levels will come slowly. Despite these challenges, progress is within reach. States like Kerala and Tamil Nadu show that by focussing on these factors, newborn deaths can be brought to fewer than 15 per 1000 in Indian settings. It's time for the rest of India to follow suit.

The draft of Assam's National Register of Citizens is a first step, but it opens up concerns

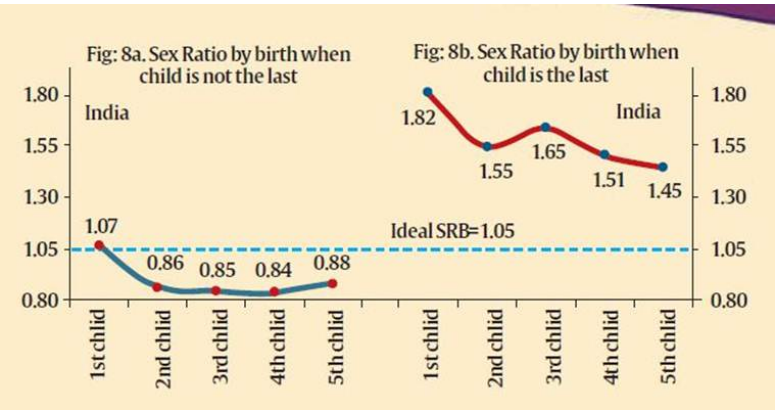
END

Unwanted: 21 million girls

(Written by Seema Jayachandran)

A number can make us pay attention to a societal problem. India has 63 million “missing women.” That stark number makes it harder to ignore the shortage of girls in India. The 2018 Economic Survey gives us a powerful new number: India has twenty-one million “unwanted girls”. This number describes the girls who are born but not treated well. Crafting a new statistic that brings a spotlight to this problem will be an important legacy of the Economic Survey.

“Missing women” are the girls and women who would be alive today if parents were not aborting female foetuses. Girls getting less food and healthcare add to this count by raising female mortality. Amartya Sen woke us up to this problem in 1990 with an article titled “More Than 100 Million Women Are Missing”. He counted the missing women across several countries such as India, China and Pakistan. Many people knew the problem existed, but Sen’s number, called out in the title of his article, made the problem salient.



The population census enumerates everyone in a country, which allowed Sen, and others after him, to quantify missing women based on the sex ratio of the population. Today, there are 63 million fewer women counted in the Census in India than there naturally should be. Once we have

quantified the problem, we can track whether it is improving or worsening. We can benchmark India against other countries. We can make state-wise comparisons and see that Haryana and Punjab, and, more surprisingly, Telangana, have a large missing women problem.

“Unwanted girls” are girls who are alive but likely disfavoured by their parents. They receive less healthcare and schooling, with life-long effects on their well-being. It is not news that many parents favour boys over girls. What we lacked was a statistic that quantified the scope of the problem. Now we have it: Twenty-one million unwanted girls under the age of 25 in India. These girls are more precisely described as “less wanted” children. They are daughters that parents gave birth to when they were really hoping for a son. We cannot know if their parents would be happier without the girl; what we can surmise is the parents were disappointed to have given birth to a girl.

How do we detect this “less wantedness” or “unwantedness”? Here is a common pattern of childbearing. A couple wants to have two children, ideally one son and one daughter, but it’s especially important to them to have at least one son. If they have two daughters in a row, they will keep having children until they get a son. (Meanwhile, if they have two sons in a row, they might regret having no daughter but not enough to expand their family.) A son might arrive on the third birth, and their children will be girl, girl, then boy.

It might take two tries: Girl, girl, girl, then boy. Notice that in both cases, the last child in the family is a boy. If we aggregate all families, we’d notice that the sex ratio of the last child (SRLC) is male-skewed. SRLC is thus a revealing measure of parents wanting sons. A subtle but important point is that these fertility “stopping rules” do not skew the populations’ overall sex ratio. I used the SRLC measure in my research to show that the fervent desire for sons in India is not a feature of all less economically developed societies. For example, in the historical US, there wasn’t a male-skewed SRLC.

The Economic Survey built on this work and took it further. Its analysis revealed that even Kerala and Assam have a male-skewed SRLC; if we only tracked missing women, these states would look problem-free. Importantly, the report also calculated the India-wide total of 21 million. In the figure below, taken from the report, the right panel shows that last children are disproportionately male. The left panel shows that non-last children are more female; that’s because the child being female led the parents to keep having children in their quest for a son. The 21 million unwanted girls can be calculated using the left panel: They form the gap between what would occur naturally — the dashed horizontal line at a sex ratio of 1.05 — and what we actually see.

Many couples have a girl when they were hoping for a boy. If the girls are nonetheless treated equally, this would not be much of a problem. Unfortunately, girls get fewer resources than boys. The stopping behaviour means that girls tend to grow up in larger families. Even if parents treat their children equally, girls are disadvantaged by being in families with fewer resources to spend per child. Moreover, parents who passionately want sons, unsurprisingly, favour them once born. Boys are more likely to get immunisations. India shows a gender gap in stunting compared to other parts of the world, consistent with girls consuming less nutritious food. One study found that one year after parents were advised that their child needed surgery to correct a heart defect, 70 per cent of the boys but only 44 percent of the girls had undergone the surgery.

This is why having 21 million unwanted girls is unacceptable. I am hopeful that by alerting us to the size of the problem, the Economic Survey will spur efforts to fix it. But we need to be smart in how we track progress. A decline in the number of unwanted girls isn’t necessarily progress. Unwanted girls arise when parents keep having more children to obtain a son. Couples are becoming more reluctant to have large families and are gaining better access to ultrasound. “Trying again” might give way to more sex-selection. It will not be progress if we achieve fewer unwanted girls at the cost of more missing women.

The goal is for both numbers to come down. The way forward is to improve women's earnings opportunities so that dowries are lower and women have more say in family decision-making. Better options for people to support themselves in old age, such as a good pension system, would make having a son less paramount to couples. We also need more efforts that take on society's norms and try to reshape them so that people start valuing daughters as much as sons. The writer is associate professor, department of economics, Northwestern University and led the study that put the figure on 'unwanted girls'.

(The writer is associate professor, department of economics, Northwestern University and led the study that put the figure on 'unwanted girls')

END

Restructuring the public school system

Indian public schools are seeing a systemic decline in enrolment, resulting in the massive growth of small and tiny government schools. According to a recent article by economist Geeta Kingdon, 419,000 (40%) of government schools had total enrolment less than 50, and 108,000 schools (10.3%) were “tiny” schools with enrolment of less than 20. Although the Indian public school system has addressed the problem of access, it has failed to withstand competition from private schools. These failures of the public school system call for an overhaul of the structure of schooling in India, especially at a time when the new education policy (NEP) is being drafted by the Kasturirangan committee.

Physical access to neighbourhood schools is now a reality, with 96% of the villages having an elementary school within a radius of 3km. However, physical access does not ensure adequate learning. Ten years of annual survey of education report (Aser) surveys and national achievement surveys by the National Council of Educational Research and Training (NCERT) have revealed a nationwide learning crisis. The first to exit dysfunctional public schools are those from better socio-economic classes, and the disadvantaged suffer. Studies have revealed that students drop out mainly because schools are not attractive physically and pedagogically. Better learning outcomes need functional schools—not just mere physical access.

The right to education (RTE) Act has defined norms for providing functional access such as pupil-teacher ratio, teacher qualification and infrastructure facilities such as availability of toilets, drinking water, library and playgrounds. However, in addition, we need enough teachers and staff per school, subject teachers in the higher grades, and pedagogical support for the teaching-learning process to make the schools functional.

The complex school organization structure across different levels, such as primary, upper primary and secondary schools, and multiple managements (within government and private) break the continuity in schooling, leading to higher dropout rates. There is no need to have separate primary-only schools when the constitutional mandate is completion of primary and upper-primary classes up to class VIII. With universalization of secondary education on the table, schools from primary to secondary should be integrated and secondary education should integrate vocational education to provide gainful employment.

Composite schools can be created through vertical integration across levels and a consolidation of neighbourhood schools to increase school size, ensure better rationalization of teachers and avoid multi-grade teaching. Consolidation brings efficiency, provides better facilities, trained teachers, more comprehensive curriculum, broader extracurricular activities and diverse social experience.

Many states such, as Andhra Pradesh, Rajasthan, Odisha, Himachal Pradesh and Maharashtra, have attempted to consolidate the schools (under names such as school rationalization, mainstreaming, amalgamation and integration) at the primary and upper-primary levels. Rajasthan has undertaken school mergers on the largest scale. About 17,000 schools were ordered to be merged, out of which 12,944 primary and 1,728 upper-primary ones had been merged as of 2016. However, these attempts have been made without adequate study of the need for consolidation and its impact on children in local communities.

School location decisions have to consider the optimal match of schooling demand with supply in the neighbourhood without compromising functional access. The following guiding principles could be followed for consolidation and restructuring: 1. Create before you destroy—construct a functional school infrastructure and appoint teachers in the consolidated school prior to shutting down schools; 2. No child left behind—school consolidation should not result in denial of access to

any child; all possible transportation options should be explored, in case consolidation leads to difficulty in physical access; 3. Consult before consolidation—consolidation must be done with the consent of the community through consultations, and the alternative must include consensus on school location, transportation, etc.; 4. Vertical integration—school consolidation should ensure vertical integration across different levels.

Current norms for neighbourhood limits for schools are at different levels: primary schools within 1km, upper-primary schools within 3km and secondary schools within 5km. A common norm for all levels of schooling, with adequate flexibility to suit local conditions, could ensure vertical integration. Administratively, this requires the merger of Sarva Shiksha Abhiyan (SSA) and Rashtriya Madhyamik Shiksha Abhiyan (RMSA) at the Centre (which the ministry of human resource development is contemplating), and primary and secondary education bodies under the departments of education in states.

The Central and state governments should act as facilitators for consolidation and desist from taking a one-size-fits-all approach. Consolidation should be a local exercise—best decided by local authorities. The state governments should act as facilitators to the process of school rationalization by providing technical and financial support and capacity-building of local authorities.

Shivakumar Jolad is an assistant professor at IIT, Gandhinagar.

The author would like to thank Sagar Atre for careful reading and comments.

END

Asians, Europeans genetically prone to severe dengue,;Africans best protected iin this respect: study

The dos and don'ts when it comes to dengue.

Scientists have identified gene variants that make people of Asian and European ancestry more prone to developing severe dengue.

Dengue fever is endemic to tropical and subtropical regions of East Asia and the Americas, but the virus responsible for the disease has recently spread to North America and Europe due to the introduction of its vectors — mosquitoes of the Aedes genus — into these regions.

The dengue virus can lead to a wide spectrum of illness, ranging from classic dengue fever (DF) to the potentially-fatal dengue shock syndrome (DSS).

Ethnic diversity has long been considered as one of the factors explaining why the severe forms of dengue are more prevalent in Southeast Asia than elsewhere, as previously shown in epidemiological research, yet the phenomenon has never been explained by human genetics.

Researchers, led by Anavaj Sakuntabhai from National Center for Scientific Research (CNRS) in France, studied the genetics of 411 patients admitted with dengue virus infection to three hospitals in Thailand between 2000 and 2003.

The study, published in the journal *PLOS Neglected Tropical Diseases*, identified two genes related to blood vessel inflammation that confer risk of severe dengue, and four genes related to metabolism that affect risk of classic dengue fever.

Further experiments showed that variations in the genes led to observable changes in cellular dynamics.

A comparison with the genetic databases of individuals of African and European origin showed that the prevalence of these variations varies based on ethnic ancestry.

“The particular genetic risk conferred by these genes indicates that Southeast and Northeast Asians are highly susceptible to both phenotypes, while Africans are best protected against severe dengue,” said Mr. Sakuntabhai.

“Europeans, on the other hand, are less susceptible to classical dengue fever but more susceptible to severe dengue fever,” he said.

This research offers insights that can help understand the pathophysiology of this infectious disease and develop new therapeutic approaches

END

Report Summaries

Women's Healthcare: Policy Options

Report Summary (636 KB)

- The Committee on Empowerment of Women (Chairperson: Ms. Bijoya Chakravarty) submitted its report on 'Women's Healthcare: Policy Options' on January 3, 2018.
- **Synergy between the central and state policies:** The Committee noted that synergy between the central and state policies will bring changes in women's healthcare. For example, the Committee observed that transportation of expectant mothers to the nearest delivery points still remains a hard task in view of (i) difficult geographical terrains, (ii) lack of transportation facilities, (iii) natural calamities, (iv) security threats, curfews, hartals, among others. In this regard, the Committee recommended that the central government must discuss with states to build 'pre-delivery hubs', preferably close to the delivery points to take care of such transportation issues. Further, it observed that such hubs would help reduce the out-of-pocket expenses of poor and marginalised families and also reduce maternal deaths.
- **Functioning of Rastriya Swasthya Bima Yojana:** Rastriya Swasthya Bima Yojana (RSBY) is an insurance scheme for the below poverty line families as well as certain categories of unorganised workers. It aims to reduce their out-of-pocket expenditures on health and increase their access to healthcare facilities. The Committee noted the following issues with RSBY's implementation: (i) exploitation of poor beneficiaries at the hands of private hospitals empanelled under RSBY (in the form of avoidable surgeries, wrong diagnosis, etc.), (ii) low enrolment percentage of households under RSBY indicating lack of awareness among the targeted population, and (iii) varied feedback with regard to quality and accessibility of hospitals. The Committee recommended a mechanism for oversight across all the districts in the country where RSBY is implemented. Further, the Committee also recommended that data pertaining to RSBY be made freely available on public platforms.
- **Demand for Accredited Social Health Activists (ASHA):** ASHA workers provide support in tracking the health of pregnant women, help them avail benefits (such as Janani Suraksha Yojana entitlements), and aid the grassroot implementation of health programmes. The Committee noted that ASHA workers across the country do not have fixed wages and that they have demanded a fixed wage component within their remuneration in many states. In this context, the Committee recommended a proposal for assured monthly wages not less than Rs 3,000. Further, the Committee also highlighted other issues regarding the training of ASHAs such as dearth of competent trainers, infrastructure, and equipment.
- **Need for food fortification:** The Committee noted prevalence of anaemia among women in rural areas to be worse than in urban areas. This is despite the implementation of National Food Security Act, 2013, Mid-Day Meal scheme, and the Public Distribution System. In this context, the Committee observed that the government priority has been on the issue of increasing the availability of food alone, rather than ensuring nutritional aspects of it, through approaches like food fortification. The Committee recommended that fortification of cereals with iron must be taken up with priority since (i) it does not alter the quality and nature of foods, (ii) can be introduced quickly, and (iii) can produce nutritional benefits for populations in a short period of time.

- **Unsafe abortions:** The Committee stated that unsafe abortion is a leading reason for the high percentage of abortion related deaths in the country (eight percent of all maternal deaths per year). It observed that the reasons for it could be the following: (i) awareness about abortion being low, and (ii) women must seek legal recourse if the pregnancy has gone over 20 weeks to terminate the pregnancy; however, a slow judicial process ensures that the pregnancy crosses the legal limit and the woman is unable to get the abortion done, thus, pushing her to the quacks in both rural and urban areas. The Committee recommended amending the Medical Termination of Pregnancy Act, 1971 to raise the permissible period of abortions to 24 weeks with this bar not applying to unborn babies having serious abnormalities. Further, it recommended removing the provision where only married women can get an abortion thereby allowing anyone to get an abortion.
- **Mental health of women:** The Committee noted that due to societal stigma and ignorance, mental illnesses suffered by women fail to get recognised. In this regard, the Committee recommended creating awareness and providing possible remedies to help de-stigmatise mental health issues.

END

Don’t discount WaSH: on the link between sanitation and stunting

The recent article “**Can sanitation reduce stunting?**” (*The Hindu*, February 15) brought forth an important and interesting debate on sanitation that has been attracting considerable traction among health, nutrition and social researchers and policymakers around the world, more so in the lower and middle income (LAMI) countries. The article touched upon many dimensions and possible reasons to explain why Water, Sanitation and Hygiene (WaSH) trials in countries like Kenya and Bangladesh ended, disappointingly, with no palpable reduction in stunting among children.

Problem of open defecation

While these countries are dramatically different from India, and open defecation remains a persistent problem despite sustained and concerted efforts under the Swachh Bharat Abhiyan (SBA) campaign over the last few years, the very fact that over half (about 52%) of rural India still defecates in the open is still a reason why it may be too early to quash or discount SBA. The campaign is beyond mere construction of toilets. The importance it accords to cleanliness, hygiene and sanitation can go a long way in India’s fight against not only stunting (low height for age) but also many other forms of malnutrition.

Link between sanitation, stunting questioned

Stunting is driven by multiple factors, one of which is inflammation. Inflammation is a normal biological response of body tissues to stimuli such as disease-causing bacteria (pathogens), but ironically repeated exposure to high doses of bacteria that are not linked with diseases or diarrhoea also cause inflammation. Children living in environments where hygiene is poor and open defecation is common are regularly exposed to high doses of bacteria that will not cause diarrhoea or frank gastrointestinal infections, but certainly stimulate low-grade chronic inflammation, as observed in one of our studies wherein 2- to 5-year-old children had higher total bacterial count and inflammatory markers compared to those reported from other countries. Inflammation down regulates growth factors, and thus impairs normal growth in children. Mothers with inflammation in the gestation tissues had smaller babies in our study.

When the effect of poor sanitation is obviously passing on from one generation to the other, it might take at least a generation to adopt WaSH interventions before their outcomes can be seen. Therefore, short-term trials like the ones in Kenya and Bangladesh are bound to show little or no effect. In addition, in India, where the baseline, unlike in those countries, is so large (over 50% of open defecation against 1% in Bangladesh) even small improvements can demonstrate significant and palpable changes. For that matter, the difference in prevalence of open defecation in urban (7%) and rural (52%) India is large and the figures of stunting are much lower in urban children than among their rural counterparts. This difference may not necessarily establish the cause-and-effect relationship but it certainly indicates that toilets and sanitation are important factors associated with stunting.

The Bangladesh way

It is indeed true that mere building of toilets cannot prompt people to use them as there are a lot of social, cultural and behavioural aspects attached to it. What we need to learn from Bangladesh is how **they have managed to bring down open defecation** to less than 1% by 2016, from a whopping 42%, in a little over a decade. Bangladesh’s sanitation victory definitely did not come easy. A huge chunk of public and charity money was spent on building toilets, and campaign volunteers slogged to change public attitudes and habits. Children were used literally as whistle-

blowers and agents of change while door-to-door campaigns were carried out. It was done in a dogged campaign in mission mode supported by 25% of the country's overall development budget. Given its vastness, diversity and varied views, India may take time to change, but let us not think all is pointless with WaSH, and nothing is working.

R. Hemalatha is Director, National Institute of Nutrition, Hyderabad

Positive developments are taking place with regard to female genital mutilation

END

Cutting school syllabus by half shouldn’t come at the cost of learning

The announcement by Human Resource Development Minister, Prakash Javadekar, that the syllabus of National Council for Educational Research and Training (NCERT) books for classes 1 to 12 will be slashed by half is welcome, but also raises some vexing issues. The government’s emphasis on digitisation and slimmer textbooks will help reduce the weight of schoolbags. These changes may be in place by 2019. Mr Javadekar said the school syllabus at present was more than that of B.Com and BA courses. The burden of course work left teachers with little time to impart life skills and inculcate creativity among students.

But the reduction of the quantity of course syllabi should not come at the cost of learning. As it is, the comprehension levels of students across the country are below par. The recently released Annual Status of Education Report for 2017 said 40% of students between the ages of 14 and 18 surveyed in rural schools in 24 states across the country couldn’t tell the time from a clock and 57% couldn’t do basic mathematics. It is not hard to understand why. Our education system has not focused enough on learning outcomes. It has not kept up with advances in technology. Improving the quality of our students may involve enhancing the quality of our educators. Of the 20 lakh teachers which were to be trained in 2015 under the Right to Education Act, only five lakh have been trained so far. There is a clear mismatch in the supply and demand for educators with 70 lakh teachers teaching close to 26 crore students in 15 lakh schools across the country.

So, merely dropping chapters from books might not be enough. It needs to be augmented by greater rigour in the evaluation process. An element of competition among students through regular assessments is desirable to improve their learning abilities. To its credit, the government has brought back board examinations for class 10 in 2017 and is planning to introduce a Bill in the Parliament to restore examinations and detentions. In 2017, the Right to Education Act was amended to incorporate a competency-based evaluation study covering 2.2 million students across 110,000 schools to understand what a child should be learning in various classes. One of the recommendations of the T.S.R. Subramanian committee, entrusted with preparing a new education policy for India, is compulsory certification for teachers in government and private schools, with the provision for renewal every 10 years based on independent external testing. Lighter textbooks with relevant course work and better teachers could well be the recipe for improved learning outcomes.

END