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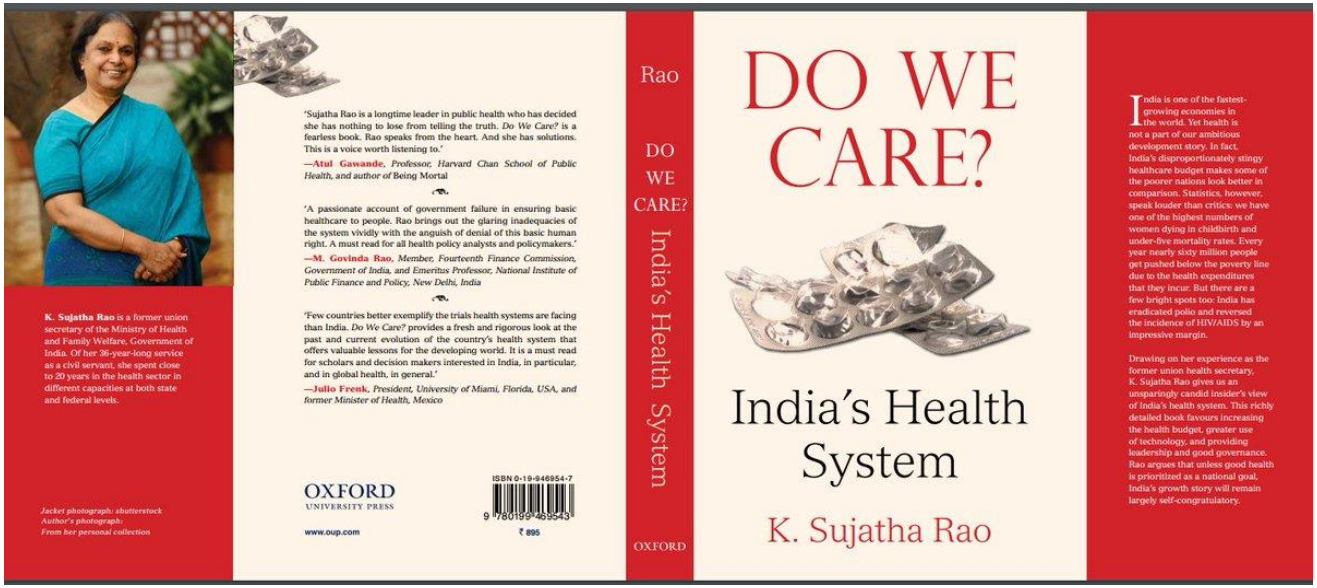
What life has taught me…

"I was unable during my ten years of office as Minister of Health to bring home the realization that health is as important as food, shelter, clothing and occupation."

Raj Kumari Amrit Kaur

Book Review


K. Sujatha Rao is a former union secretary of the Ministry of Health and Family Welfare, Government of India. Of her 36-year-long service as a civil servant, she spent close to 20 years in the health sector in different capacities at both state and federal levels.
Jacket photograph: shutterstock
Author's photograph: From her personal collection
'Sujatha Rao is a longtime leader in public health who has decided she has nothing to lose from telling the truth. Do We Care? is a fearless book. Rao speaks from the heart. And she has solutions. This is a voice worth listening to.'
—Atul Gawande, Professor, Harvard Chan School of Public Health, and author of Being Mortal
'A passionate account of government failure in ensuring basic healthcare to people. Rao brings out the glaring inadequacies of the system vividly with the anguish of denial of this basic human right. A must read for all health policy analysts and policymakers.'
—M. Govinda Rao, Member, Fourteenth Finance Commission, Government of India, and Emeritus Professor, National Institute of Public Finance and Policy, New Delhi, India
'Few countries better exemplify the trials health systems are facing than India. Do We Care? provides a fresh and rigorous look at the past and current evolution of the country's health system that offers valuable lessons for the developing world. It is a must read for scholars and decision makers interested in India, in particular, and in global health, in general.'
—Julio Frenk, President, University of Miami, Florida, USA, and former Minister of Health, Mexico
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Rao
DO WE CARE?
India's Health System
OXFORD
DO WE CARE?
India's Health System
K. Sujatha Rao
India is one of the fastest-growing economies in the world. Yet health is not a part of our ambitious development story. In fact, India's disproportionately stingy healthcare budget makes some of the poorer nations look better in comparison. Statistics, however, speak louder than critics: we have one of the highest numbers of women dying in childbirth and under-five mortality rates. Every year nearly sixty million people get pushed below the poverty line due to the health expenditures that they incur. But there are a few bright spots too: India has eradicated polio and reversed the incidence of HIV/AIDS by an impressive margin.
Drawing on her experience as the former union health secretary, K. Sujatha Rao gives us an unsparingly candid insider's view of India's health system. This richly detailed book favours increasing the health budget, greater use of technology, and providing leadership and good governance. Rao argues that unless good health is prioritized as a national goal, India's growth story will remain largely self-congratulatory.

DO WE CARE?
PART I

India's Health System:Challenges and Constraints

1. Evolution of System
2. Health Financing
3. Governance: Impacting the Health System

DO WE CARE?
PART II

Implementing Policy: Successes, Failures, and the Road Ahead

4. Scaling up to Reverse HIV/AIDS Epidemic
5. Revitalizing Rural Primary Health Care:The National Rural Health Mission
6. Making Our Future

India does not need any more reports. What is needed is sheer hard work to implement recommendations already available.

India has gone further away from the letter and spirit of the Constitution, hasn't she?

Moribund Primary Health Care System

The Primary Health Care system has all but collapsed. Among 19 major States.

Andhra Pradesh incurred the lowest expenditure of Central grants (National Rural Health Mission and disease control programmes) as proportional to its total health spending during 2011;

Health is Wealth

The link between health, development and wealth is very strong.

Neglect of health entails real costs to the economy —

Household expenditures incurred on buying drugs rather than nutritious foods

Investments for hospitals rather than factories that generate jobs and impair growth due to reduced productivity and so on.

Professor Jeffrey Sachs, Chairman, Commission on Macroeconomics and Health (CMH) ,2000

The conundrum of health and wealth

Health is wealth; only wealthy can access health services easily.

Like the parable of gold coins, the one who has will be given more, one who has little, that little will be taken away!!

Is it true?

Multidimensional Poverty Indices capture poverty in terms of the consequential deprivation or ‘the clustered disadvantage’

Health is a privilege that entails maintenance

Tripod of robust health care

1. Equity,
2. Efficiency
3. Quality

To stay focussed on *doing the simple things right in the first instance* so that disparities reduce and the poor reap the benefits in real terms.

‘Minimum government and maximum governance’

It could imply a government reneging from its duty to provide primary health care, both preventive and curative, and universal access to public goods like *piped water*, nutrition and sanitation.

Private care must supplement, not substitute public care

Universal Health Coverage

The doctrine of UHC guarantees cashless access to a defined package of quality health services to all citizens.

National Health Assurance (NHA)

In seeking the maximisation of the health and well-being of every individual, the NHA subsumes the essentiality of access to those elements that constitute the foundation of good health — **tap water** (where conveyance of contamination is reduced by 99 per cent), **a toilet and sewerage system, environmental hygiene, nutrition and basic primary care** — and in the process, reduce 90 per cent of all morbidities and a substantial proportion of mortality

Rajiv Arogyasri Health Insurance Scheme

While it showed an overall reduction in out-of-pocket expenditure and increased hospitalisation, it had limited impact in reducing impoverishment or indebtedness among the two lowest quintile groups.

Travails of inpatients!

Forced hospitalisation for outpatient care, increasing the risk of hospital acquired infections and higher indirect expenditures that the poor cannot bear.

Who benefits and what gets neglected?

A. Cardiac, cancer and kidney failure (38 per cent of patients or 0.5 per cent of population)
B. Lower respiratory infections, diarrhoeal diseases, tuberculosis (TB), ischemic heart diseases and malaria

Strengthening the system to offer best possible care

To ensure patient well-being and value for money, standard treatment protocols and guidelines need to be developed; costing of procedures undertaken, monitoring systems for quality such as rates of survival, hospital acquired infections and readmissions developed and regulations enforced alongside establishment of grievance redress systems, with fair compensation and penalties against malpractice.

Better alternative to RAS..

Scaling-up the National Rural Health Mission's efforts to revive the primary health-care system would be far cheaper and more sustainable than buying care from private hospitals.

Better alternative…

Scaling-up the NRHM's efforts to revive the primary health-care system; incentivising lifestyle changes; universalising access to social determinants; revamping and embedding the primary care system within the community; increasing investments in public sector hospitals, along with improving incentive structures, employing requisite staff and upgrading infrastructure would be far cheaper and more sustainable than buying care from private hospitals

How Medical Education was converted into ‘business’

Archaic and outmoded rules, regulations and eligibility conditions requiring a capital base of more than Rs.150 crore have made the establishment of medical colleges a business proposition

Recommended architecture of MCI

Four Independendent Boards

1. Curriculum development,
2. Teacher training, and standard setting for undergraduate and post-graduate education;
3. Accreditation and assessment processes of colleges and courses for ensuring uniformity in standards; and
4. The registration of doctors, licensing and overseeing adherence to ethical standards.

Remedy

Since medical education is in ***the concurrent list of the Constitution,*** the Central government needs to leverage that power to bring in some discipline.

The time has come to ***strengthen the regulator first*** by having the MCI Board include all stakeholders and have the members appointed through a rigorous selection process by an autonomous body like the Union Public Service Commission. This will ***end the nomination process of the ministry and the consequent conflict of interest.***

Once appointed, the regulator can be allowed to enforce its own rules and regulations.

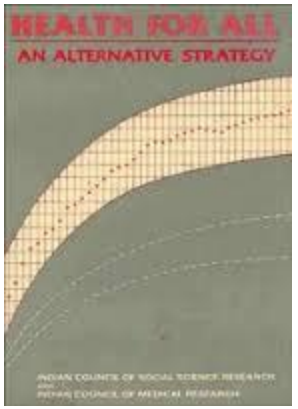
What needs to be done is known, but sadly how to do it is not.

Governments, at the Centre and in the States, need to allow people with field experience and practical knowledge of the health system to contribute their expertise.

What is also needed today more than ever is the need to listen to the ground — as patients, women in villages, front line workers, the hapless doctor in the PHC, all have a different story to tell. We cannot afford any more blundering!

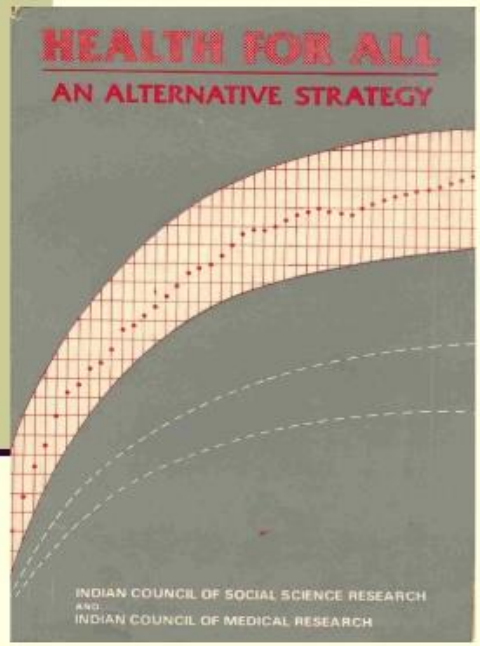
HEALTH SITUATION IN 1980

The overall picture is a mixture of light and shade, of some outstanding achievements whose effect is unfortunately more than offset by grave failures.



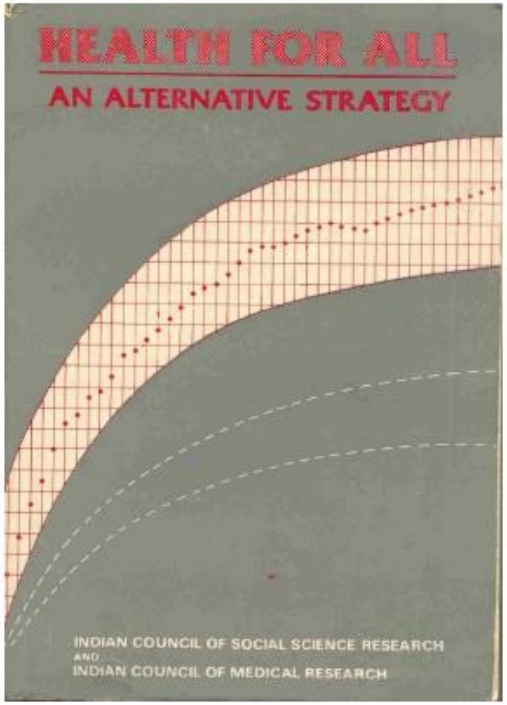
Health for All – the Prescription of ICMR and ICSSR – 1981

For a mass movement post Alma Ata



- "Reduce poverty, inequality & spread education
- Organise poor & underprivileged to fight for their basic rights
- Move away from the counter productive Western model of health care and replace it by an alternative based in the community
- Provide community health volunteers with special skills, readily available, who see health as a social function"

1981- Health for All – An Alternative Strategy
The Prescription of ICSSR and ICMR in India



- **"A Mass movement to reduce poverty inequality and spread education.**
- **Organize poor and underprivileged to fight for their basic rights**
- **Move away from the counter productive western model of health care and replace it by an alternative based in the community ….."**

- (Dr. N.H.Antia was member secretary of this committee)

HEALTH FOR ALL: AN ALTERNATIVE STRATEGY

I The Approach

1. Wanted: An Alternative Health Policy
2. Health, Development and Family Planning

II Supportive Services

3. Nutrition
4. Improvement of Environment
5. Health Education

HEALTH FOR ALL: AN ALTERNATIVE STRATEGY

III The Alternative Model: General Principles and Organization

6. The Alternative Model: General Principles
7. The Alternative Model: Organization

IV The Alternative Model: Some Specific Aspects

8. Health Services for Women and Children
9. Control of Communicable Diseases
10. Personal and Training
11. Drugs and Pharmaceuticals
12. Research

HEALTH FOR ALL: AN ALTERNATIVE STRATEGY

V IMPLEMENTATION

13. Administration, Finance and Implementation

14. Issues and Conclusions

VI Appendices

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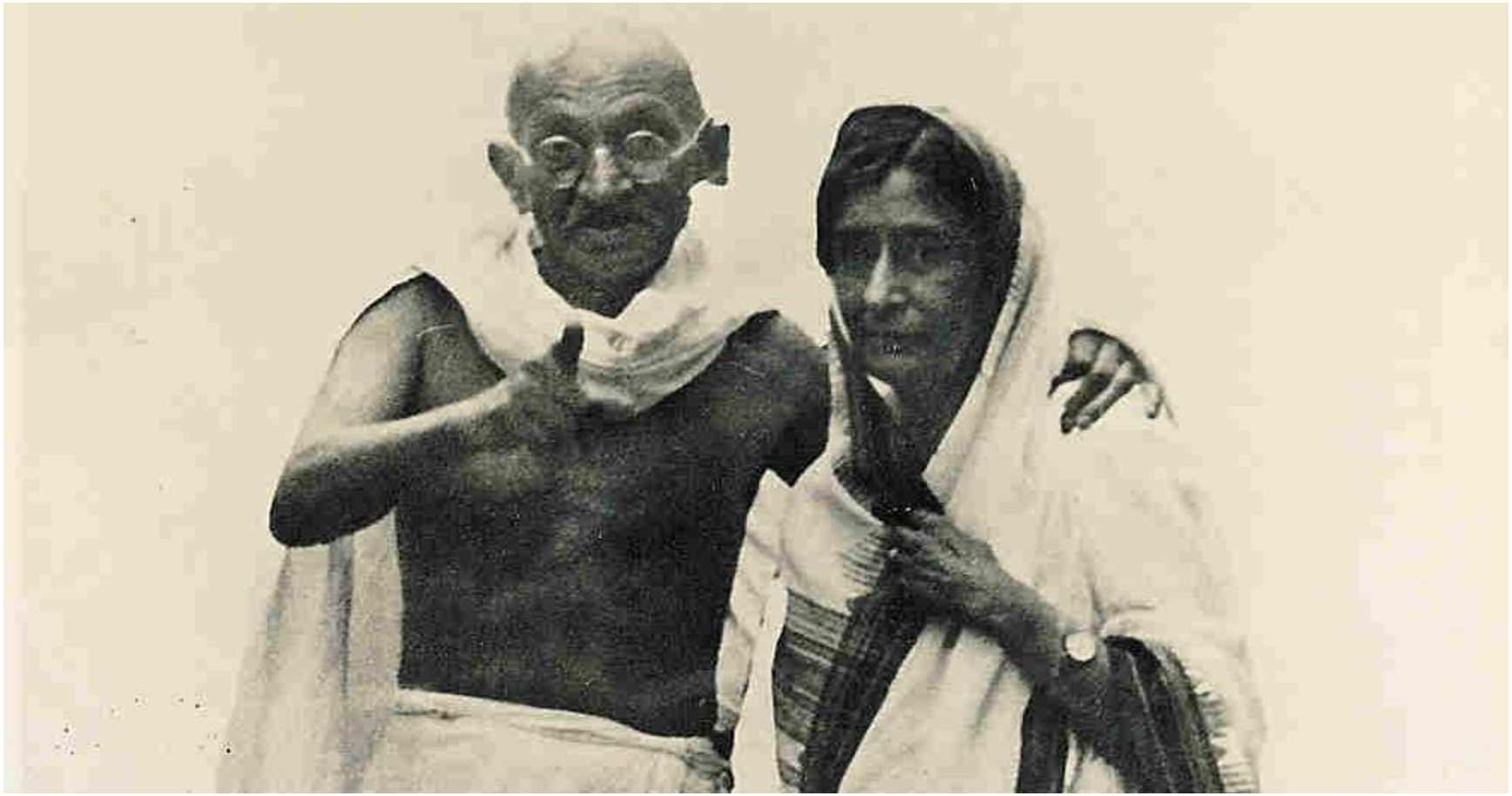

Princess Amrita Kaur

(1889-1964)

Women's Rights activist, Freedom fighter, Social Worker

Participated in 'Quit India' & 'Salt Satyagraha'

First woman cabinet minister of free India

WORK as a Minister of Health:

Establishment of AIIMS, New Delhi

Chairperson of Red Cross Society for 14 yrs

Initiated 'Tuberculosis Association of India' &

'Central leprosy teaching & research institute

Founded 'Amrit Kaur college of nursing' &

'National sport club of India'

Social service is an art and a science for it deals with human relations.

It is my firm belief that no one who has political ambition should be in charge of health or education in any government.