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Indian Medical Parliamentarians' Forum
Newsletter

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Dear Friends,

On behalf of the IMPF, we are pleased to release the IMPF Newsletter, Budget Session 2017 issue. The IMPF Newsletter is circulated widely amongst Members of Parliament and other stakeholders. We hereby acknowledge all the responses and suggestions that we have received on alarming issues of public health in India.

At a glance:

We take this opportunity to welcome the new National Health Policy 2017 (NHP 2017), which was approved by the Union Cabinet on 15 March, 2017. The new NHP offers renewed measures to address much known deficiencies of public health sector in India. It is set to increase the public spending to 2.5 percent of GDP by 2025, from the current 1.15%. The NHP 2017 also proposes free diagnostics, free drugs, and free emergency and essential health services in all public hospitals, which will accelerate access to free and affordable medicine and treatment for patients.

In this issue, we highlight the issues of eradicating Leprosy, Tuberculosis, issues related addressing NCDs and HIV / AIDS.

We express our sincere thanks to all the contributors who have made this newsletter more informative. We look forward to working with you in the future as we continue to carry forward our responsibilities in more productive way.

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The problem of tuberculosis in India

Tuberculosis (TB) is a treatable disease yet in 2015 it killed 1.8mn people globally, and has killed more people than any other infectious disease in history (WHO TB Factsheet, 2016). India carries an undue burden in respect of tuberculosis, contributing to a quarter of cases worldwide. As a signatory of the WHO End TB strategy, India must ensure that the elimination of TB. The Revised National TB Control Programme (RNTCP) implements mechanisms to achieve this goal.

Tuberculosis is an infectious disease caused by the bacteria 'mycobacterium tuberculosis'. It is spread between persons as a result of one coughing, sneezing or spitting and another ingesting the bacteria. Long term exposure to the bacteria or a weakened immune system can result in infection. For example, those suffering from HIV/AIDS and diabetes are at risk. 'Active' TB means the patient is suffering from TB and should seek medical attention. Whilst 'latent' TB means that inactive TB bacteria are in one's body, this is carried by roughly 1/3 of the global population.

Diagnosing TB is difficult and expensive. Sputum collection testing is a common, inexpensive method used in India. However, it lacks sensitivity and fails to detect TB in children. The 'Genexpert' technology is a welcome development. It uses sputum samples and provides results within 2 hours. Such equipment is of limited availability and access is determined according to geographical location. The availability of such technology must be increased to achieve a national standard of care.

The Directly Observed Treatment Short Course (DOTS) strategy is not without flaws. TB treatment requires daily medication for 6 months. Completing the full course is imperative to prevent Multi-drug resistant TB (MDR-TB), the treatment of which is invasive and arduous. The 'pill-in-hand' tool has been developed to monitor and ensure patients' adherence to treatment. Patients must free-phone the number printed inside each pill casing. A database is updated noting that the patient is adhering to the treatment plan on receiving a call. SMS technology can be used to contact the patient or the healthcare provider regarding an individual's treatment. Whilst such a system is laudable, Jose Luis Castro (Executive Director of the International Union Against Tuberculosis and Lung Disease), noted that the majority of TB medication was 'invented before astronauts walked on the moon'. Research and development is imperative to create new treatments that are more efficient and reduce the risk of MDR-TB.

Collaboration and commitment between stakeholders including the government, health providers, NGOs and individual citizens is imperative to eliminate TB. The India TB Caucus, launched on the 8 March 2017 is a commendable advance. This focus group consists of parliamentarians who are committed to championing the TB cause. They seek to raise awareness not only amongst fellow parliamentarians, but also within their respective constituencies thereby increasing resources and capital to address TB. Supported by The Global TB Caucus, there is the potential to bring TB narrative to the forefront in India, with the result of eventual elimination. The mobilisation of such stakeholders is important and indicates a movement in the correct direction but the pressure must not cease there.

The problem of TB in India is complex, largely underrepresented and misunderstood. The elimination of TB will be an arduous task requiring an accelerated effort and sustained commitment from a variety of stakeholders over a sustained period. The current focus and rate of decline in relation to TB requires acceleration if the 2035 target is to be achieved. Holistic efforts encompassing research and development, awareness campaigns and improved access to healthcare facilities are required to eliminate TB in India.

- Dr. Boora Narsaiah Goud
Member of Parliament

Mental Healthcare for Social Integration: A Hidden Emergency

Mental health discourse has come a long way. The institution-wide ostrich approach taken previously, has progressed to the point where these same institutions encompass and understand mental disorders as a health issue. This is increasingly important, as WHO estimate that 20% of India's population will suffer from some form of mental illness by the year 2020. However, one must not over estimate the progress made thus far, serious hindrances to appropriate care are in existence, and hence the level of care afforded to patients is still somewhat inadequate.

As per NIMHANS, Bengaluru there are more than 7 crore mentally ill people in India and less than 4000 doctors to treat them. Such medical professionals are concentrated in metros or two-tier cities. This scenario is exemplified by numerous other issues that result in mental health treatment being insufficient. NIMHANS estimates that there are at least 35 lakh Indians who require hospitalisation for mental illnesses. These patients are left untreated or are subject to inadequate medical infrastructure and specialists. Of the 40 institutions capable of treating such patients, only 9 are equipped to treat children. Moreover, many of them are institutions with obsolete infrastructure with patients kept in solitary confinement.

Barely 1-2% of the health budget is dedicated to mental health, in comparison to 10 –12% in developed countries. Given the stigma associated with any psychiatric illness, many of those suffering continue to live with mental illness in the shadows, away from public view validating mental health issue as a "*hidden emergency*" as per WHO.

The current budget is not enough to address the burden faced by the mental health system. Additionally, the current Mental Healthcare Bill, 2016 which was passed by Rajya Sabha last year clashes with the existing Mental Health Act, 1987.

One further issue lies in the fact that the scope and mandate of the definition of mental health care has succumbed to the limitation of biomedical and psychiatric care. Such a response has resulted in a significant socio-economic cost of bearing a mental disorder. The impact on those suffering from an illness and the importance and necessity of psychotherapy and counselling is consistently overlooked.

By addressing mental illness from a holistic perspective and by empowering mentally ill persons, the Bill seeks to remove the stigma attached to mental illness. It seeks to secure equal treatment for both with mental and physical illness.

Irrespective of how progressive the new bill is, it fails to go far enough in the direction of reform. The bill only recognises the role of psychiatrists in the treatment of a mental illness. It fails to acknowledge the roles of counsellors and psychologists who work with patients suffering from mental and emotional distress. While mental illness is a 'substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life'; mental retardation is characterised by 'incomplete development of mind of a person,' which is not included as 'mental illness'. This differentiation seeks to highlight the fact that *Mental illness is not an intellectual disability, unlike mental retardation*. Mentally ill people are intelligent, and can take up regular employment, which could motivate them to lead a productive life. Whilst this distinction is important, it does not exonerate the current Bill for excluding the mentally retarded from the ambit of mental healthcare.

However, whilst the Bill mandates insurance companies to provide medical insurance for the mentally ill on the same grounds that they would issue insurance for physical illnesses, counselling services would probably not be covered even in the new insurance schemes.

- Dr. Dharam Vira Gandhi
Member of Parliament

Eradicating Leprosy and Its Social Stigma

"Leprosy work is not merely medical relief; it is transforming frustration of life into joy of dedication, personal ambition into selfless service"

- Mahatma Gandhi

To honour Mahatma Gandhi, Anti-Leprosy Day is celebrated internationally on January 30. Gandhiji had emphasised the elimination of this predominantly misunderstood disease from India. He made selfless endeavours for the treatment of people suffering from this malady and also to mainstream them in our society. WHO defines leprosy or Hansen's disease as a chronic infectious disease caused by *Mycobacterium leprae*, an acid-fast, rod-shaped bacillus. The disease mainly affects the skin, the peripheral nerves, mucosa of the upper respiratory tract, and the eyes.

source:leprosysociety.org

Leprosy is a major public health issue in India. Around 58% of the new leprosy cases around the world are identified in India. But this does not suggest that the disease is incurable. The Multi-Drug Therapy (MDT), introduced by the WHO, has been successful in significantly lowering the occurrence of leprosy, especially among Indians. From time to time, the government has formulated several policies with the objective to wipe out this disease from our country. The Ministry of Health and Family Welfare instituted the National Leprosy Eradication Programme and the Central Leprosy Division and earmarked them with the task of providing medical facilities, civic amenities and other assistance measures to leprosy patients. Additionally, It such programmes encourage voluntary reporting of cases. Under the Special Leprosy Case Detection Campaign, 2016 more than 32,000 cases were diagnosed and put on treatment. Further, the WHO has launched a global strategy to eradicate leprosy by 2020 and India, being a member of the WHO is obligated to adhere to such targets.

More than 85% of persons affected by Leprosy are non-infectious and non-contagious, while over 99% of the world population has a natural immunity to Leprosy. Still, people suffering from this disease are buried into a social stigma of discrimination and bigotry. Furthermore, several domestic laws are discriminatory to leprosy patients as they violate Article 14 of the Indian Constitution which the guarantees the right of equality. Under its 256th report, the Law Commission of India has listed several laws as discriminatory to the leprosy sufferers. In several family laws, *virulent and incurable form of leprosy* constitutes as a valid ground for divorce. In the State Beggary Acts, leprosy sufferers are labelled in the same category with a person suffering from lunacy. The Life Insurance Corporation Act, 1956 charges high premium rates from leprosy sufferers on account of higher risk to their lives. In several other Indian legislations certain rights and privileges to such persons are denied on account of leprosy.

Legislative intervention is necessary to re-draft these laws in the light of the recent developments in the medical treatment of leprosy and also to ensure the elimination of discrimination against persons affected by leprosy. There is an additional need to create social awareness about this disease. People must be made acquainted with the actuality that leprosy is not only entirely curable but also non-infectious to a large extent. These efforts might aid the patients of leprosy to lead their life with dignity and self-respect. On January 29, 2017, the Indian Prime Minister Narendra Modi commented, "As a country, we have to leave no stone unturned to not just reach the last mile but also to work together to eliminate the social stigma attached with this disease,"

- Dr. Kirit Premjibhai Solanki
Member of Parliament

Ending HIV/AIDS in 2030

"AIDS exceptionalism" refers to treating or giving HIV / AIDS the status of being exceptional. In other words, HIV / AIDS is a special disease, requiring exclusive responses and resources.HIV / AIDS was made exceptional at the international level with the adoption of UNSC Resolution 1308 in July 2000, calling for "urgent and exceptional actions" to mitigate the threats posed by HIV / AIDS. Being the first disease discussed in the UNSC, the exceptional status of HIV / AIDS brought about unprecedented levels of international funding allocated primarily in developing countries where responses for HIV / AIDS have historically been scarce or non-existent.

With the increase in international financial assistance from 2000 onwards, HIV / AIDS responses have intensified in many developing countries. Whilst the AIDS exceptional approach was warranted in earlier stages of responses in the national level, it has been increasingly ineffective over time. An overwhelmingly policy preference towards HIV / AIDS has resulted in the sidelining of other health threats in developing countries. More importantly, a stagnating and even declining trend of HIV / AIDS international financial assistance has been anticipated. Investigations show that most European donor governments have reduced their financial commitments since 2012. Without renewed commitment from international donors and increased commitment from recipient governments, the sustainability of future national HIV / AIDS programmes is in doubt.

In response to the changing global health agenda, over 90 percent of the countries are prioritising the integration of HIV / AIDS in existing health-related systems. This shift implies that international funding organizations have exerted a tremendous influence on the priority of health issues in the developing world. India is no exception. The integration of HIV / AIDS interventions and primary healthcare systems has taken place in India from 2010 onwards. For instance, six components of the NACP-III merged with the NRHM in 2010, namely, ICTC, PPTCT, blood safety, STI services, condom programming, and ART. Integrating HIV / AIDS responses into the umbrella health system is ongoing in the NACP-IV; all the service delivery units except the TIs have been set up within the health care system.

At the 2016 high-level meeting at the United Nations General Assembly, India pledged to follow targets to fast track the pace of progress towards ending HIV / AIDS as a public health threat in the next five years, and ending the epidemic by 2030. To fulfill the commitment, the government of India is funding its HIV / AIDS programmes. Indian HIV / AIDS programmes are less dependent on foreign monetary assistance than they had been previously. This is evident from the fact that two-thirds of the budget for the NACP-IV is provided by the government of India and comes from the domestic budget. To ensure sustainability of the HIV / AIDS interventions, the continuous integration of HIV / AIDS programmes into larger health system is required. However, health care has never been a priority in India per se. Despite rapid economic development over the past two decades, public expenditure on healthcare as a proportion of GDP is among the lowest in the world. Health expenditure in India was merely 1.3% in 2015-16, while countries such as Norway, Canada, and Japan allocated over 9% of GDP to health. Budget allocation to public health care should be increased in order to achieve the goal of ending AIDS in 2030.

Despite the prevailing advocacy of HIV / AIDS interventions in an integrative manner, there has been a consistent push to maintain the exceptional status of HIV / AIDS as a unique global health challenge. It is argued that certain levels of AIDS exceptionalism should be maintained when we perceive ending HIV / AIDS as a means to an end: if we can end HIV / AIDS, we can end other pressing developmental problems, including poverty and gender inequality, in India.

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Bringing Public Health to Centre Stage

Non-Communicable Disease is a Serious Public Health Issue

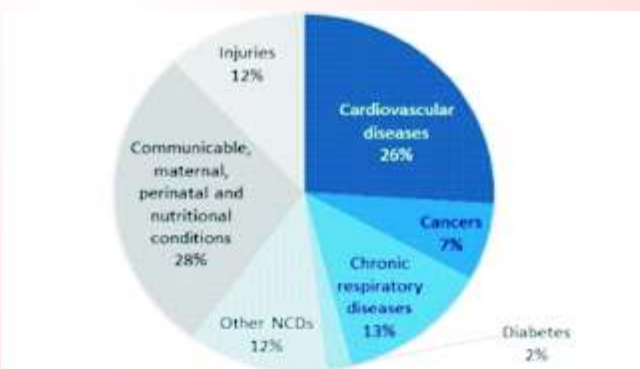
Given our policy directions as under the Sustainable Development Goals (SDGs), it is now of utmost importance to *ensure healthy lives and promote well-being for all at all ages.*

The SDGs highlight the significance of inter-sectionality amongst *economic, social* and *environmental change* which now needs hard focus. Sustainable development can be considered to be '*transformative development thinking*' which encourages individuals to bring holistic *human development* in to focus.

Deaths from infectious diseases such as diarrhoea and malaria have declined due to access to safe water and sanitation. Better access to immunization, insecticide-treated mosquito nets and essential medicines has also contributed to such decline. However, non-communicable diseases (NCDs) such as stroke, heart disease, cancers and chronic respiratory disease, amount to nearly two-thirds of the total global deaths caused by unhealthy environments.

The World Health Organization (WHO) estimates that by 2020, NCDs will account for 80% of the global burden of disease, causing 7 / 10 deaths in developing countries, about half of them resulting in premature death. As per WHO, it is estimated that the global NCD burden will increase by 17% in the next ten years.

In India, NCDs contributed to an estimated 61% of all deaths in 2014 (WHO, 2014), which also signals a "tomorrow pandemic" to combat.



Causes of death in India (2014) (own graph, source: WHO, 2014)

The transition from infectious diseases to NCDs in developing countries has been driven by several factors, often indicative of *economic development*. The impact of globalization and urbanization in low-and-middle-income countries (LMICs) has accelerated the growing burden of NCDs. The rise of NCDs has been driven primarily by four major risk factors: tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets. WHO noted that most NCD deaths are preventable, yet health systems are inadequate or non-responsive to combat the threat of NCDs in developing countries.

Budgetary Implications for Public Health in India: The allocation to healthcare has increased moderately from around 38,343 crores to 47, 353 crores which makes up 8% of the budget. While the government announced that 1.5 lakh health sub-centres will be upgraded to wellness centres, India has neither the manpower nor the resources to affect this as per Public Health Foundation of India (PHFI).

"Fifteen per cent of our health burden is related to mental illness. While healthcare gets one percent or so of the country's GDP, mental health gets around one per cent of that. We need an innovative approach to the health budget," said Dr. Soumitra Pathare, Co-ordinator, Centre for Mental Health Law and Policy, Pune.

The government is seeking to eliminate kala azar and filariasis by end of 2017, leprosy by 2018 and measles by 2020. However, the budgetary challenges towards addressing public health issues, especially NCDs leave the outcome questionable.

Given the rapid increase in NCD related mortality globally, especially in the developing world, there is a dire need to address the challenges posed. NCD related mortality carries a great challenge, not just for human development, but in addressing the development agenda at large. Such mortality not only makes lives hollow but also fractures the growth of economy and efficiency of the workforce. The SDGs' objectives to combat poverty, hunger, malnutrition, environmental degradation, well-being of the people, and so forth, are intertwined with reducing mortality. Development for the people and by the people cannot be achieved without ensuring so. Hence, a serious, comprehensive, more integrated and holistic approach is required, notably, India being a growing economy needs to pay great attention to bring public health to centre stage.

- Gajendra Singh Shekhawat
Member of Parliament

News Boxes

India TB Caucus launch

The India TB Caucus was launched in New Delhi on 8 March 2017. The Caucus is part of a Global TB Caucus that is present in over 130 countries. The Indian Caucus is comprised of elected representatives committed to ending TB in India. 28 Members of Parliament from Lok Sabha, Rajya Sabha and 4 MLAs attended the Caucus, committing themselves to the cause. It seeks to work both collectively and individually to end TB through raising awareness of the disease, and tackling associated issues such as the social stigma and isolation. Prof. P.J Kurien, Deputy Chairman Rajya Sabha is the agreed patron of the caucus. The co-chairs are as follows: Hon. Dr Kirit Premjibhai Solanki MP (Lok Sabha), Hon. Dr. Boora Narsaiah Goud MP (Lok Sabha), Hon. Mr. Majeed Memon MP (Rajya Sabha), and Mrs Viplove Thakur MP (Rajya Sabha).

Discussion followed and 3 overarching goals were agreed upon: (1) To advocate for increased resources for TB prevention and care. (2) For representatives to raise the issue of TB within their own networks and ensure that TB remains to be an urgent political priority. (3) To sensitize families and communities, addressing the stigma and isolation issues associated with TB and to ensure accessibility to diagnosis and treatment to every patient.

The Union against TB and Lung Disease facilitated this launch in partnership with Centre for Legislative Research and Advocacy, Indian Association of Parliamentarians for Population and Development, REACH, Global Coalition against TB, Global Health Strategies, and Aequitas under the Challenge TB project.

National Health Policy 2017

The National Health Policy2017, which proposes to ensure the highest level of health and well-being to every citizen of the country, was approved by the Union Cabinet. The new policy will replace the previous one framed in 2002. Highlights of the policy are:-

1) It envisages providing larger package of assured comprehensive primary health care through the Health and Wellness Centre's. Primary health care packages include care for major NCDs [non-communicable diseases], mental health, geriatric health care, palliative care and rehabilitative care services.
2) It aims to raise public healthcare expenditure to 2.5% of GDP from current 1.4%, with a focus on primary healthcare.
3) It proposes free diagnostics, free drugs and free emergency and essential healthcare services in all public hospitals
4) It aims to allocate major proportion of resources to primary care and intends to ensure availability of two beds per 1,000 population distributed in a manner to enable access within golden hour [the first hour after traumatic injury, when the victim is most likely to benefit from emergency treatment].
5) It aims to strengthen health systems by increasing access to quality services and technology and reducing costs to eliminate financial barriers.
6) The policy lists quantitative targets regarding life expectancy, mortality and reduction of disease prevalence.

Source: http://mohfw.nic.in/showfile.php?lid=4275

Taxing Tobacco Products

Tobacco related diseases pose as an enormous loss to society and present a challenge to country's health care system. The tobacco consumption pattern in India leads to 8-9 lakh deaths each year. According to WHO Report on the Global Tobacco Epidemic, 2015- 19% of the male youth and 8.3% of the female youth use tobacco and 18.3% of adult males use tobacco in compared to 2.4% of adult females.

In the Union Budget 2017-2018, the duty on cigars and cheroots have been hiked to 12.5 per cent or Rs 4006 per thousand,. There has been a 3 per cent increase in duty on 'pan masala' products. The duty on other unmanufactured tobacco has gone up to 8.3 per cent from 4.2 per cent. For 'pan masala' products containing tobacco or 'gutkha', the hike is from 10 per cent to 12 per cent. Duty on non-filter cigarettes of length not exceeding 65 mm has been raised to Rs 311 per thousand from Rs 215. The aim is to discourage tobacco use through higher prices in the interest of public health and safety.

Source: http://www.phfi.org/images/pdf/tobtax_in_india_an_empirical_analysis.pdf

Highlights of 2016 Global Nutrition Report

The Global Nutrition Report acts as a report card on world nutrition. It assesses the progress in meeting Global Nutrition Targets established by the World Health Assembly. Maharashtra, Madhya Pradesh, Uttar Pradesh, Odisha, Gujarat and Karataka are the only states who have launched a nutrition mission focusing the 1,000-day post conception period with a commitment to improving inter-sectoral coordination in order to improve child nutrition.

Out of the six states only Odisha and Uttar Pradesh have measurable targets for nutritional outcomes. The targets set by Uttar Pradesh and Odisha are based on older data and do not align with the global nutrition targets. All states require new, updated data to report the current status of nutrition and set new targets which cover all six globally agreed target indicators. National governments should establish SMART (specific, measurable, achievable, relevant, and time bound)national targets for stunting, wasting, exclusive breastfeeding, low birth weight, anemia, childhood overweight, adult obesity, diabetes, and salt reduction by the end of 2017 and should establish more subnational targets. National nutrition plans should develop and incorporate nutrition outcome and input targets for major administrative regions.

Source: http://ebrary.ifpri.org/utils/getfile/collection/p15738coll2/id/130355/filename/130566.pdf

National Strategic Planning for Eliminating Tuberculosis

The NSP for TB elimination 2017–25 seeks to work towards elimination of TB in India by 2025. It articulates the steps required to move towards TB elimination and provides goals and strategies for the country's response to the disease during the period 2017 to 2025. Additionally, it aims to direct the attention of all stakeholders on the most important interventions or activities that the RNTCP believes will bring about significant changes in the incidence, prevalence and mortality of TB.

For achieving the goals of the NSP 2017 – 2025, the following components of the programme will be addressed on priority:-

1. A scheme to address patients seeking care in private sector with suitable incentives for doctors and providing free of cost medicines to TB patients going to a private doctor / institute.
2. Development of a system to diagnose existing cases of TB and delivery of drug kits to patients on compliance to treatment regimen.
3. Availability of rapid molecular tests in diagnostic facilities that are also available to patients referred by private doctors or institutes. Initiating customized SMS services to individual patients on a regular basis reminding them about their treatment regimen.
4. Establishment of nutritional support to TB patients, including financial support through DBT mode.
5. India TB Control Foundation is proposed to improve financial sustainability in the TB sector and mobilise additional resources to accelerate TB control efforts.

Source: http://www.tbcindia.nic.in/WriteReadData/NSP20Draft%2020.02.2017%201.pdf

India TB Caucus launch, New Delhi

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