Turning gold into platinum: a supplement to guest editorial on "Ministry of Public Health"

SN Deshpande[1]*, VL Nimgaonkar[2]

[1] Professor, Department of Psychiatry, Centre of Excellence in Mental Health, Atal Bihari Vajpayee Institute of Medical Sciences-Dr Ram Manohar Lohia Hospital, New Delhi, India
[2] Professor, Department of Psychiatry and Dept. of Human Genetics, University of Pittsburgh, Pittsburgh, PA, US

Corresponding Author:
SN Deshpande, MD
Department of Psychiatry, Centre of Excellence in Mental Health
Atal Bihari Vajpayee Institute of Medical Sciences-Dr Ram Manohar Lohia Hospital
New Delhi, India
E-mail: smitadeshp@gmail.com

Dr. Ravinder Singh indeed articulated an urgent need for a new, robust Indian public health law based on principles of prevention and promotion by empowering communities. He avers that the current framework of laws is inadequate to deal with new and emerging healthcare emergencies and indeed, even basic healthcare needs. He calls for a comprehensive public health law. He proposes that a new Ministry be formed by integrating modern principles of public health with the ancient Indian indigenous systems of medicine which are currently housed under the AYUSH ministry, which will be the implementation agency for this law. This change, he states, will include expanding the basic medical degree to combine all aspects of medical health, encompassing social, spiritual, mental and medical components of healthcare system (integration at ministry level and college level).

While we agree with Dr Singh's premise, we propose a more ambitious target: an Integrated Healthcare Service (IHS) that along with providing comprehensive treatment facilities, emphasizes preventive health and incorporates disparate sections of the healthcare system currently embedded in several different agencies. We suggest that the Indian government work for a holistic healthcare service whose implementing agency will be the Indian Healthcare Service, housed in a much larger Ministry of Holistic Health. Our proposal is aligned with patterns of comprehensive health care offered in all developed countries barring the USA. The current COVID-19 pandemic has taught us that healthcare workers need to work in tandem- starting from the community healthcare worker and Accredited Social Health Activist (ASHAs) to nurses, doctors and other healthcare staff such as social workers, counsellors, therapists etc.

The National Health Service (NHS) is now said to be 'a religion of the United Kingdom', (2) – a testimony to the healthcare this service provides. Other healthcare services such as the Scandinavian and German systems as well as those in South Korea and Singapore proved their worth in this ongoing pandemic. In Thailand, the Universal Healthcare Model has been widely acclaimed (3). Even in the USA, calls for an efficient publicly funded health service on the lines of the NHS-UK are growing (4).

Preventive and promotive- and even curative- healthcare services are indeed inadequate in India, leading to regular, annual rise in infective diseases such as malaria (India has 4% of the global malaria burden) (5), dengue, and difficulty in controlling long standing diseases such as Hansen's disease (leprosy, largest number of new cases in the world) (6) or tuberculosis (highest burden) (7). On the other hand, India's elimination of small pox and polio, and its control of HIV are due to the dedication of its limited public healthcare staff. Paradoxically, the healthcare budget of both central and state governments is often skewed to tertiary healthcare services and national institutions rather than basic healthcare for all. The system is complicated by the fact that health is both a State and a Union subject leading to grey areas.

So where should the young recruitee of the Indian Healthcare Service begin from? The rural population in India formed about 68.84% of the population according to Census 2011 [8]. Healthcare in rural areas is in a parlous state, by all accounts. We do have a model from other group 'A' services of the Government of India, wherein young inductees begin their service from rural or district areas. Similar rules could be adopted here too, with a time bound rate of transfers, transparent rules of service etc. The Government of India has already resolved to upgrade all district hospitals to medical college status. The IHS would be a good beginning to oversee this upgrade.

Who will pay? An IHS would need a significantly higher budgetary allocation. Including expenditure on medical and public health, family welfare and water supply and sanitation, the Indian government planned to spend only 1.6% of its Gross Domestic Product (GDP) in its proposal for the FY20 budget- a tiny rise from 1.5 percent in FY1999 (9). For the IHS, perhaps the AYUSHMAN BHARAT scheme could be expanded to include other paying citizens who could then add to the Indian Health Services kitty.

How will healthcare change? The Indian public healthcare systems need to adopt a life cycle approach by preventing and treating disease, promoting health, improving re-integration into society by improving rehabilitation services, mitigate disability and improve quality of life 'from womb to tomb'. The IHS could be an umbrella service for all healthcare needs and could act as vertical for treatment, prevention and rehabilitation needs of Indian citizens. The World Health Organization recognises that there can be no life without health. We need to recognize that too and provide a national Healthcare Service which could prove a beacon for the world.

Disclosure statement

To the best of our knowledge, no conflicts of interest exists among authors.

References

1. "Does India need Ministry of Public Health?-Lessons Learnt from COVID-19 and Road Ahead" by Ravinder Singh, Scientist C, NCD, Indian Council for Medical Research, New Delhi, India.
2. Warner J. The NHS - Britain's national religion - doesn't have a prayer [Internet]. The Telegraph. Telegraph Media Group; 2014 [cited 2020May20]. Available from: http://www.telegraph.co.uk/news/nhs/10959391/The-NHS-Britains-national-religion-doesnt-have-a-prayer.html
3. Sumriddetchkajorn K, Shimazaki K, Ono T, Kusaba T, Sato K, Kobayashi N. Universal health coverage and primary care, Thailand. Bulletin of the World Health Organization 2019; 97:415–422.
4. About PNHP [Internet]. PNHP. [cited 2020May20]. Available from: https://pnhp.org/about/
5. Ghosh SK, Rahi M. Malaria Elimination in India-The Way Forward. J Vector Borne Dis. 2019;56(1):32–40.
6. Sengupta U. Elimination of leprosy in India- An Analysis. Indian J Dermatol Venereol Leprol. 2018;84(2):131–136.
7. Singh S, Kumar S. Tuberculosis in India: Road to Elimination. Int J Prev Med. 2019;10:114.
8. Censusindia.gov.in [Internet]. [cited 2020May20]. Available from: https://censusindia.gov.in/2011-provresults/paper2/data_files/india/paper2_1.pdf
9. Economic Survey 2020: Expenditure on healthcare continues to be flat [Internet]. Moneycontrol. MoneyControl; [cited 2020May20]. Available from: https://www.moneycontrol.com/news/economy/policy/economic-survey-2020-expenditure-on-healthcare-continues-to-be-flat-4888481.html

doi: 10.38205/imcr.010204