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## Capacity Building in the HEALTHCARE SECTOR



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health

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Communicable  
diseases

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Interview with  
**Shri Rajesh Tope**  
"Hon'ble Health Minister,  
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## *From the President's Desk*



Dear Members,

The pandemic has taught us many things about the world we inhabit. Probably the most important is that our economic future cannot be achieved without putting the health and wellbeing of our population at the centre of public policy. Yet, despite all the robust evidence available that good health is beneficial to economies and societies, it is remarkable how health systems globally struggled to maintain the health of populations even before Covid ... a crisis that further exposed the lacunae in our healthcare systems. These must be addressed to make society healthier and more resilient to future shocks.

Investment in health is not only a desirable but also an essential policy priority for sustained economic development. However, that is easier said than done. All of us, at least once in our lives, are likely to have experienced healthcare that was inflexible, impersonal and bureaucratic. At the aggregate level, these individual experiences add up to poor safety, substandard coordination and systemic inefficiencies – costing millions of lives and enormous expense to the exchequer. This state of affairs contributes to slowing down the progress towards achieving sustainable development. Neither Maharashtra nor India can afford it.

However, many of the conditions that can facilitate positive change are in place. Ample evidence exists that investing in public health and primary prevention delivers huge economic dividends. Likewise, digitization has made the provision of many services and products across different economic sectors safe, fast and efficient. There is no reason, why, with the right policies, this should also not happen in healthcare.

Covid has accelerated the use of digital health technologies. However, in this regard, it has also sharpened the urban-rural divide. For example, telemedicine is working relatively well in urban areas, but a lot of groundwork needs to be done before marginalized populations in rural areas experience the same benefits. Unless we are able to bring about universal access, equity and a rising quality of healthcare facilities throughout the land, we will continue to remain at the receiving end of any future pandemics.

Strategic investment in population health would make people, particularly

vulnerable groups, more resilient to health risks. The health and socioeconomic consequences of the pandemic are felt more acutely among disadvantaged groups, stretching a social fabric already challenged by high levels of inequalities. Prevention is better than cure. Building the immunity of the masses requires sharp focus on solidarity and redistribution in social protection systems to address the underlying structural inequalities and poverty-related issues. Such policy initiatives cannot succeed without strong institutional backing.

Both primary and senior-citizen healthcare need to be reinforced. Covid presents a double threat for people with chronic conditions. Not only are they at greater risk of complications and death, but also Covid creates unintended health harm if they forgo the usual care, whether due to disruption in services, fear of infections, or worries about burdening the healthcare system. Strong primary healthcare maintains continuity for these groups. Also, with the majority of Covid-related deaths occurring in senior citizens, the elder care sector is also particularly vulnerable. It calls for efforts to enhance control of infections, support and protect healthcare workers and better coordinate medical and social care for the elderly. This is not to be taken lightly.

Labour markets for healthcare also need some policy attention. Beyond the sheer weight of numbers, rigid health labour markets make it difficult to respond rapidly to demand and supply imbalances. One way to address this is through the creation of a “reserve army” of healthcare professionals that can be mobilized at short notice in emergency situations. By some accounts, a new wave of Covid is already upon us, and policymakers need to ensure that its detrimental effects are minimized.

An effective vaccine and successful vaccination of the population will provide the only real exit strategy. Both India and Maharashtra have done well in this regard, but we need to remember that success is not guaranteed and there are still some policy issues to be resolved. More support is needed for multilateral access mechanisms that contain licensing commitments. Intellectual property rights should not be a barrier to access, and allocation of scarce resources should be made strictly based on need.

The pandemic has given us insightful opportunities to learn valuable lessons for healthcare system management and resilience. It has also made it clear that those suffering most from Covid belong to the socioeconomically marginalized sections, and so it is towards them that the bulk of the state’s resources need to be diverted. Going ahead, the need is for greater focus on anticipating changes, solidarity within and across nations, a proactive approach in managing the evolving situation, and renewed efforts for collaborative action. This issue of the Digest is devoted to enlightening us on some of the underlying concerns in this vitally important area.

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# A Wake-Up Call for Multidimensional Capacity Building

## Introduction

The pandemic is a grim reminder that massive investments in scientific, technological and healthcare capacities are necessary to build resilience in times of crisis, which could occur henceforth more frequently than we think. As India grapples with another wave of the Covid outbreak, scientific breakthroughs are enabling us to understand the biology of the virus, and thus, to devise strategies to deal with its potentially dangerous health and socioeconomic implications. Scientific progress is a determinant of good health during extreme events such as wars or pandemics. Research has the potential to address structural healthcare problems in an attempt to reduce poverty and inequality. As India's economy reopens after a prolonged lockdown, its medium to long-term recovery plans should pay greater attention to scientific and regulatory challenges associated with the design of public healthcare systems. This should go beyond the immediate responses to emergent diseases. Innovative solutions and redesigned regulatory frameworks are essential to enhance systemic resilience and transform public healthcare challenges into long-term socioeconomic development opportunities.

## Economic progress extends beyond science

A key lesson Covid has taught

us is that we need to invest in strategic sectors like healthcare to safeguard national sovereignty in times of temporary global value chain disruptions. Science and technology have an initial role to play in boosting the level of production and innovation capabilities. However, what matters subsequently is enlightened government policy in implementing measures to support and incentivize industries to restructure their activities and redirect their production to the manufacturing of masks, ventilators, sanitizers, vaccines and other products responsible for combating the pandemic.

In this regard, there is need for cooperation and coordination between civilian scientists and the military. After all, we are almost fighting a war against Covid. The pandemic underscores the need for cooperation and coordination in all spheres not only within countries but also between countries. All differences should be forgotten now, as we are battling a global enemy. Multi stakeholder interactions are necessary to mobilize scientific and technological resources, and integrate them in a policy framework that will maximize their efficacy.

The experiences gleaned in healthcare should be replicated in other strategic policy areas

where industrial innovations and industry-academic interactions can play an instrumental role. This includes food/nutrition security, energy sustainability and environmental management. A visionary public policy is necessary for enabling science and technology to contribute to socioeconomic development. Greater political attention, the systematic diversion of resources to R&D, and the development of related infrastructure, is the need of the hour. It is obvious that there are plenty of shortcomings in our healthcare capabilities, and all of them need to be systematically attended to. With a new wave of Covid, and a sharp rise in cases, that becomes imperative.

## Conclusion

Covid has given rise to new and dangerous challenges for the global community, but it has also opened up innovative policy opportunities for collaboration at national and international levels. While inclusivity and sustainability have been high on the global agenda for years, such abstract concepts are often difficult for emerging economies to implement. Hopefully, Covid would have changed that, at least in the healthcare sector. Policymaking needs to focus on the socioeconomic implications of scientific R&D, as we move forward from the pandemic's challenge.

# Capacity Building in the Healthcare Sector in India

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## Introduction

The healthcare sector in India is a spectrum of contrasting landscapes. At one end of the spectrum are the glittering and glassy corporate hospitals delivering high tech - high cost medical care to the affording, mostly urban Indian. At the other end are the neglected health posts in the remote reaches of the “other India”, trying desperately to live up to their identity as health sub-centres, waiting to be transformed into shrines of health and wellness. India began with a glorious tradition of public health, as seen in the references to the descriptions of the Indus Valley civilization (5500–1300 BCE) which mention “Arogya” as reflecting “holistic well-being.” Surgeons like ‘Sushruta’ and Physicians like “Charaka” were world renowned epitomes of Indian healthcare systems. The Chinese traveller Fa-Hien (tr.AD 399–414) took this further, commenting on the excellent facilities for curative care at the time. The British brought allopathic treatment into India, and Medical colleges started in 1835. Today, we are

we are a country of 1300 million people who present an enormous diversity, and therefore, an enormous challenge to the healthcare delivery system.

In post-Independence era till 1990, Indian healthcare was mainly dominated by large public hospitals run by governments and public sectors like Corporations, ESIS, Railways etc. and small nursing homes run by private individual practitioners. It was after the 1990s when liberalisation took place, that the government allowed privatisation of higher education and health. This was the time large, multi-specialty corporate hospitals started growing in India. Over the years, government health expenditure reduced and public health did not cope with the needs and started crumbling down due to manpower shortage, poor amenities and inadequate budgets.

## Current Challenges of Healthcare in India

1. **Access to healthcare:** We see a contrast in urban and rural accessibility. In urban areas,

more than 50% population lives in slums or chawls. These are mainly catered to by the public or small private healthcare facilities. A city like Mumbai has a huge network of Municipal tertiary medical college hospitals, peripheral secondary hospitals, maternity homes, dispensaries and health posts along with State Government run hospitals. This results in the availability of public healthcare within a 1.2 km of home for most individuals. In addition to this, there are private dispensaries, nursing homes and trust/Corporate hospitals. However, in rural areas, only 37% of people are able to access indoor health facilities within a 5 km distance, and only 68% are able to access out-patient facilities. This is the reason why rural and urban poor health parameters such as MMR, IMR are worse than overall urban parameters of health.

## 2. Awareness of health:

Lacunae in the awareness about important issues regarding their own health are common findings in various studies in the Indian population.

**3. Human Resource in healthcare:** India has a shortage of healthcare manpower in numbers as well as distribution. This is discussed below.

**4. Inadequate public funding for health.**

Government only spends 1.3% of GDP on health. This is far less than other developed countries. The private sector accounts for most of the health expenditures in the country (approximately 3- 3.5% of GDP). Most of the budget is spent on salaries of healthcare workers. There is an urgent need for scaling up of the budget to 2% of GDP and taking it to more than Rs.1, 00,000 Crores.

**5. Affordability or the cost of healthcare:**

It is common knowledge that the private sector is the dominant player in the healthcare arena in India. Almost 75% of healthcare expenditure comes from the pockets of households, and catastrophic healthcare cost is an important cause of impoverishment.

**6. Accountability or the lack of it:**

With increasing concern on the quality of healthcare provided and costs involved, there is a need for making healthcare personnel and systems accountable for the proper delivery of healthcare. Ethics in healthcare should be a hotly discussed issue, within the profession, rather than outside it.

**What needs to be done for capacity building in Healthcare?**

Capacity-building is defined as the “process of developing and strengthening the skills, instincts, abilities, processes and resources that organizations and communities need to survive, adapt, and thrive in a fast-changing world.” An essential ingredient in capacity-building is transformation that is generated and sustained over time from within; transformation of this kind goes beyond performing tasks to changing mindsets and attitudes.

**Capacity Building in Healthcare Human Resource**

**Doctors:** In India, we have approximately 9 lakh practicing allopathic doctors (including general physicians, specialists and super specialists). As per the data provided by Union Minister of State for Health in the Rajya Sabha in March 2019, there is one doctor for every 1,445 Indians for an estimated population of about 135 crores. This is lower than the prescribed norm of one doctor for 1,000 people by World Health Organization (WHO). He also mentioned that besides these allopathy practitioners, there are 7.88 lakh Ayurveda, Unani, Siddha and Homeopathy (AYUSH) doctors in the country. Assuming 80 % availability, it was estimated that around 6.30 lakh doctors practicing in

these systems of medicine were available for service. If you add AYUSH doctors (approximately 6.3 lakhs) then the gross ratio becomes one per 860 population, which is less than one per 1000 recommended doctors. This exceeds the recommended WHO norms. Unfortunately, there is a gaping unequitable distribution of qualified doctors in the country. The rural population is mostly catered to by AYUSH doctors who also treat many of the urban slum population. The doctor to population ratio is widely different between states; Bihar and North-eastern states like Nagaland have very few doctors.

As per a “Times of India” report dated September 2, 2018, Delhi, Karnataka, Kerala, Tamil Nadu, Punjab and Goa have more than 1 doctor for a population of 1000. The density of doctors in Tamil Nadu is 4, in Delhi it is 3, in Punjab and Goa, 1.3 and in the states of Karnataka and Kerala, the density is 1.5 doctors for every 1000 persons. Given the rate at which the population is growing, this is going to be inadequate. Though the government is making attempts to increase medical colleges which have almost doubled in last 10 years, this is unlikely to help us cope with the need for doctors in the country. To give an example, a country with a magnitude like that of India’s, needs 6.5 crores



of surgeries per year, (major and minor). Currently India does around 2.6 crore of surgeries (Global Surgery – Lancet 2015). That means, 60% of the needed surgeries are not done in India due to access, affordability and reluctance from patients. This leads to suffering by the patients. The surgeon density in India is 2.5- 3 per lakh population as compared to 54, 35, and 34 in Germany, Brazil and USA respectively. In view of this, the government has increased the number of seats in MS General Surgery in last three years from 2400 to 3600 seats per year mainly in government hospitals. We have a population of 130 crores in 2019, for which we have approximately 40,000 registered surgeons. (We do not know how many are currently practicing surgery). With the increase in the number of seats and medical colleges, we hope to have approximately one lakh surgeons practicing in India by 2050. However, the population in India at that time is likely to reach up to 210 crores and the need for surgeons will be approximately 195000 (populationpyramid.net), and hence the gap will continue.

Going into the deeper aspects of surgery, India has approximately 30000 new carcinoma of pancreas patients diagnosed every year. 75% of them are usually inoperable and advanced cancer patients where surgery

is not advisable. So only 7500 patients require surgery per year. However, surgeons who are capable of doing these surgeries are less and the number of curative surgeries done (such as Whipple's operation) are only 3000 across India per year, i. e. more than 50% of the patients are not able to get this surgery due to access and affordability. This is true with other diseases as well. Hence there is a need to develop physicians for tomorrow, keeping in focus the disease burden in India and equitable access and affordability.

A few diseases are now treated by different methods. Cardiac diseases are now treated mainly by Interventional angioplasty by cardiologists rather than bypass surgery. Hence we should now increase number of cardiologists instead of CVTS surgeons. Secondly, availability and access needs to improve in rural and semiurban areas. This would need infrastructural development and is discussed below.

**Nurses** - Nurses are two-thirds of health workforce in India. Currently India has only 1.7 nurses (global is 2.5/1000) available per thousand population. The ratio of hospital beds to population is 0.98/1000 against the global average of 3.5 beds/1000 population (WHO). India stands at 67th rank in 133 developing countries with regard

to number of doctors and 75th rank with respect to number of nurses. The Physician Nurse ratio is not satisfactory. Thus, International Nurse is 1:3 whereas India has 1:1. The country needs 2.4 million nurses to meet the growing demand (FICCI report, 2016). The HLEG (High Level Expert Group) report on UHC (Universal Health Coverage India) 2011 is increased reliance on a cadre of well-trained nurses. The role of nurses is evolving and changing. Nurses can perform health assessment, actively support patients and families in all settings, create innovative models of care, and enhance work processes to raise quality, lower costs and improve access for our society. This will allow doctors to focus on complex clinical cases. The number of registered nurses/midwives was 6.7 lakhs in 1998 and has reached 22,10,000 nurses/midwives in 2020. (1.7 per 1000 population)

From 2000 to 2016, ANM schools have increased from 298 to 1927, GNM schools from 285 to 3040, B.Sc. colleges from 30 to 1752, and M.Sc. colleges from 10 to 611. Although the increase is significant still there is gap between demand and supply. India needs public health nurses like ANMs (Auxiliary nurse midwives) and thousands of female health supervisors (ASHA & USHA). They are responsible for implementing

all national and state health programmes at ground level. Shortage of nurses and its impact on the Indian healthcare delivery system remains a major concern to this day.

**Paramedical** - Paramedics are health professionals who are present to assist doctors in overall diagnosis and care of the patients and management of health facilities. Their primary role is to provide pre-hospital medical care to the patients. In a developing country like India there is acute shortage of skilled and trained healthcare professionals. At present, **India requires 64 lakh paramedics** to cater to the increasing need in the health sector. Currently, there is a dearth of such trained professionals, which can only be compensated with increased world-class training and education in paramedical sciences.

Over all there is a rising demand in terms of manpower for tertiary and quaternary care, which requires specialized and highly skilled resources including doctors, nurses and other paramedical staff.

### **Strengthening of healthcare facilities**

In addition to increasing the trained human resources, India needs to develop a multi-tiered network of health infrastructure along with up-to-date equipment and adequate funding for running the same.

The current budgetary allocations by Central and State governments are inadequate and they need to be increased immediately. There is urgent need for scaling up of budget to at least to 2% of GDP and taking it to more than 100000 crores. One must ensure that while building a network of affordable primary, secondary and tertiary healthcare facilities, attention is also given to provide adequate access to rural and urban poor populations of India.

### **Economics dilemmas in healthcare**

- Tax to GDP ratio and healthcare spending - India in the 1990s reduced tax to GDP ratio in the country but simultaneously reduced spending on healthcare and education. This resulted in a tremendous growth of the private sector and weakened public sector. This resulted in increase in out of pocket expenses for the common man for health and education.
- Spending on tangible progress – The government always wants to spend on tangible progress such as highways, coastal roads, airports, water projects rather than spending on education and health. Good health, though not tangible, is important for the country's overall productivity.
- Spending on Insurance

schemes rather than building health infrastructure - Over the last 10-15 years, all over India, states are spending on health insurance through various schemes such as Mahatma Phule Arogya Yojana, PM Arogya Yojana etc. Though some sectors of society benefit from these schemes for curative treatments, the preventive aspects of health are neglected. Most of the benefit goes to private sector which earns money through volumes. One may argue that this huge amount may be spent on building and running health infrastructure over time and be beneficial for the general public at large in the future. However this is not attractive to politicians as well as to the community and is hence not followed in many states.

### **Health vision 2030**

The future of healthy India lies in mainstreaming the health agenda towards development of a strong framework of sustainable development and strengthening primary, secondary and tertiary healthcare services for the rural and urban population. National Health Policy 2017 recommends setting up new Medical Colleges, Nursing Institutions and AIIMS's in the country by the government, standardization

of quality of clinical training, revisiting entry policies into educational institutions, ensuring quality of education, and continuing nursing education. It also recommends on the job support to healthcare providers, especially those working in rural areas using tele tools and other appropriate training resources, strengthening human resource governance, and regulation of protocols and practices.

The coronavirus disease-2019 (COVID-19) was an unanticipated and unexpected public health emergency which had social, economic, mental and political implications. Everyone went through a period of pain and despair when there was agony, suffering and many deaths. There were shortages of beds, ICU, isolation facilities and medicines. Human resources were also inadequate and had to be mobilized. In fact, in the initial phases of Covid 19, the lacunae in public health system of India were evident. However public systems responded very well and healthcare infrastructures like jumbo centers were developed, resources like ventilators, PPE kits were mobilized and made available to healthcare professionals as well as to frontline workers. Doctors and nurses were trained in the new protocols and treatment methods. This stabilised and standardised the

management of Covid-19 and weekly mortality rates decreased from 7% to less than 0.5%. In spite of a massive vaccination program, the spread of disease has been rapid in March 2021. However the second wave in March 2021 has lower mortality and morbidity.

### **Need For Strengthening of Preventive Healthcare Services**

This should make policymakers realise that there is a need to look at health policy and capacity building in healthcare more seriously in the coming years. Covid has exposed weaknesses in our system and the need to remain prepared for more such emergencies. Building competent doctors and skilled nurses is the need of the hour. Everyone also realised the strengths of public health in India where, the government took immediate public health measures for the containment, reduction and prevention of Covid-19.

The development of jumbo facilities and a massive vaccination programme are other examples of our strength. Hence, the government must continue to develop and maintain the public health sector for tackling such emergencies in the coming years. AYUSH health professionals can work as complementary to the allopathic system in a preventive approach. A national level well-

co-ordinated response was seen in increasing the national capacity for the production of medical equipment, drugs, diagnostic, and preventive kits. *Atmanirbhar Bharat* was a much-needed impetus to the indigenous industries related to essential medical supplies, pharmaceuticals, and vaccines including new vaccine development.

Covid also made us realise that we should focus more on treatment rather than prevention. There is a need of a dedicated cadre for public health in India. One should use this opportunity to build health facilities and preventive health programs. We should aspire for a healthcare system in which most people do not have to pay out-of-pocket for most healthcare needs. Resources are always a key issue in consideration of universal healthcare and especially so in India, where the proportion of GDP spent on healthcare is low compared to other middle-income countries. However emphasizing prevention, strengthening of health infrastructure network, increasing human resources and producing own cheaper consumables will make healthcare accessible and affordable to the common Indian citizen.

*Stay safe and stay healthy !*

# Capacity Building for Evidence-Informed Health Policies

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## Context

Healthcare services are important and unique in many respects. They form an important part of the economy, involve multiple contact with citizens during lifetime, traverse across other sectors, have evolved rapidly through use of technology, are influenced by supplier-induced demand and involve matters of life and death. The COVID-19 pandemic has exposed the weakest link in the chain of healthcare services, i.e. the health system. The health system, which provide these services, have close interactions with technical, social, economic and political dimensions of healthcare. Hence, effective healthcare service is not only effective clinical care but also includes effective application of the principles of administration, management, epidemiology, economics, law and ethics. Health policies guide the programmes delivered by the health systems, and hence have to take a holistic approach to improve health services.

The objectives of a health system includes providing services, capacity building, financing and governance. All these four objectives are interlinked, and governance can be considered as an overarching objective, which influences outcomes in each of the other three objectives. Good governance is about efficient management of resources to achieve equitable outcomes. Global evidence on health outcomes and healthcare financing suggests that more than *what* amount of money is being spent (say, as a % of GDP); it is *how* the money is being spent, which determines the performance of the health systems and health outcomes. For example, the United States of America (USA) has the highest spending on healthcare in the world (approximately 18% of its GDP), but also has one of the lowest life expectancies among the OECD nations. Countries, which have achieved good health at low cost, e.g. Sri Lanka, Cuba, etc., have all focused on public-

funded, well-managed primary healthcare as well as the social determinants of health, i.e. education (especially among women), nutrition, sanitation and strong community engagement.

What emerges from these empirical evidences is that health outcomes are influenced by a multitude of determinants and health systems need to evolve as adaptive systems responding to changing epidemiological, demographic, economic, social and political dimensions. Global evidence also suggests that a data and evidence-informed approach to health planning and health policy contributes to good governance and facilitates efficient and equitable health outcomes by the health system. COVID-19 has also highlighted the need for evidence-informed policy and health research relevant to health systems and policy. To meet this challenge, it is important that the capacity of those already working or wishing to work in health systems be built

in a holistic way based on the above-mentioned dimensions. It is in this function of capacity building for holistic evidence-informed policy making and programmes, that academic institutes within the country can play a critical role. In this context, this article shares the process of development and learnings of an innovative capacity development programme for evidence-informed health policy offered by the Tata Institute of Social Sciences, Mumbai.

### The TISS Model

The type of research that generates evidence relevant for health systems and policy differs from academic theoretical research in the fact that although guided by theory, it is more action-oriented and problem-solving in nature. It is also context-specific and time-sensitive as problems and their solutions can change with place and time. The findings of this research also need to be communicated differently than academic writing since the audience are not academicians but programme managers in the health system or policy makers at the state or national level. Hence, such research requires to meet the standards of scientific quality in a short time frame combined with effective communication (using non-technical jargon)

techniques for dissemination of findings.

To meet the above requirements, a unique and innovative capacity building programme has been developed by the School of Health Systems Studies (SHSS) at the Tata Institute of Social Sciences (TISS), Mumbai. It is the only programme of its kind in the entire South Asian region, which integrates the disciplines of epidemiology, health policy, economics, finance, social sciences, ethics, health systems research, economic evaluation and health technology assessment (HTA) in a public health curriculum. This two-year Masters programme called the MPH in Health Policy, Economics and Finance (HPEF) was developed in collaboration with the London School of Economics and Political Science (LSE) and approved by the University Grants Commission, Ministry of Education, Government of India, in 2010. Capacity building of faculty was achieved by collaboration with faculty from the LSE through a generous grant received by the Dorabji Tata trust. To address the gap in research in India in the areas of health policy, economics and finance, the Centre for Health Policy, Planning and Management (CHPPM) was also

created within SHSS with the mandate to work on evidence-informed health policy in the Indian subcontinent.

The conceptualization to implementation of the MPH (HPEF) programme took 18 months and was completed through a series of consultations and brainstorming sessions with a wide range of stakeholders. The stakeholders included representatives from academic institutes across India, state government representatives from different states, Non-Governmental Organization (NGO) representatives and members of civil society. This two-year Masters programme is a unique blend of classroom teaching and field-based work contributing to evidence-informed health policy. The programme follows a step ladder model by first training the learners in foundation and basic courses grounded in the Indian ethos and context, followed by public health courses, quantitative and qualitative research, health economics, financing, ethics, etc., and thereafter the specialized courses in health policy analysis, economic evaluation, systematic reviews, HTA and applied economics and financing. Apart from knowledge generation, the course provides the learners



with the opportunity for skill development in writing policy briefs and communication strategies relevant for policy makers, which provide a more effective communication tool for policy makers and programme managers in the health system.

In the second year, the learners have to complete an internship called the Field Practicum<sup>1</sup> within the semester, wherein they are placed with either the central ministry or various state health systems across India or NGOs working towards improvement of health systems and policies. The Field Practicum agencies provide an opportunity for the learners to apply the knowledge learnt for doing situation and gap analyses, and provide actionable pragmatic recommendations on a public health issue, which is contextually relevant and addresses a need in the health system and policy. The output of the Field Practicum is a report and a policy brief written in a language understandable to policy makers and programme managers. Hence, it is an example of a proactive academia directly engaging with the state and non-state actors based on the principles of stakeholder engagement and using explicit scientific methods for generating evidence on actionable

recommendations for relevant prioritized public health issues.

**Key features and lessons** from this model:

1. **Continuous consultative engagement** with state/national level policy makers, programme managers, NGOs, etc., (from conceptualization to report writing) ensures ownership and better acceptability of the findings.
2. Application of principles of **co-assessment and appraisal** with all stakeholders (**including the community**) involved.
3. **Quality assurance and Incentivisation for quality:** Quality of work is ensured through continuous faculty mentoring throughout the programme. Also, the report is evaluated independently for 10 credits (equivalent to five courses) and is a compulsory requirement for the MPH degree, with prizes given for best policy briefs and reports.
4. **Time-sensitive** as the report and policy brief have to be created within 18 weeks of start of this exercise.

5. **Policy brief writing** ensures conversion of complex academic jargon into a language more easily understood by decision makers (state health secretary, programme managers, NITI Aayog, etc.).

In addition to accepting fresh graduates (national and international), this MPH programme also accepts nominations from state governments for mid-level working professionals in their health systems. It also provides flexibility in programme completion especially for working professionals to complete the programme within five years of enrolment. The programme undergoes review every three years wherein feedback is taken from graduated learners, state and national level representatives, NGO representatives and representatives from other academic institutes. This ensures that the programme and its content are aligned with the changing technical, economic, social and political contexts.

This model has received international recognition, and the learnings of this MPH programme have been shared

in invited talks in international conferences in Thailand, Iran, UK, Germany and India, and has resulted in the creation of the **SMART framework for capability development**<sup>2</sup> for Health Intervention and Technology Assessments (HTA). The SMART principles are **Simple, Mixed methodology, Academic Institutionalization, Relevance to context and Timely**, and are critical for sustainable and effective capacity building for evidence-informed health policies. Recognising this contribution, CHPPM-TISS has received membership to HTAsialink, an international network of organizations working in the field of HTA and evidence-informed health policies.

### Conclusions

The TISS model of capacity building for evidence-informed health policy is a dynamic, flexible, innovative model that continues to evolve. In the last 10 years, over 200 policy briefs on a wide range of context-specific prioritized public health issues have been created by the MPH (HPEF) programme students for state health systems across India, national level decision makers and NGOs working with

the health systems. Being an integral component of an academic programme, there is no cost to the government/NGO for this exercise. Hence, it is an extremely cost-effective model for evidence generation for policy/programme assessment from the health systems perspective. Also, many learners have found future employment in the Field Practicum organizations and continue the application of their learning, which benefits the health systems. While the TISS programme is able to develop capacities of 20-25 learners in a year, there is a need for more such programmes in India in this niche area. The SMART model is a useful framework that can be used by other academic institutes in India and other low and low-middle income countries (LMICs) for designing their own capacity building programmes in this area.

Evidence-informed health policy is not a one-time exercise. It is a continuous process, which is relevant to all stages of policy making (from agenda setting to implementation) and requires good quality evidence coupled with engagement of all stakeholders, especially the

community. This makes the process scientific and systematic, sensitive to grass root reality, creating a bottom-up approach and increasing the likelihood of acceptance of decision or policy and its implementation. While academic institutionalization of such programmes ensures capacity building of young graduates and professionals, it is also important that decision makers and programme managers recognise the value of this evidence and act on it for improving health system performance and outcomes. Although a global crisis, the current pandemic also provides an opportunity to reflect on the gaps and shortcomings in the health systems and use evidence effectively for health policy decisions to create efficient, equitable and sustainable health systems.

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# Emergency Medical Services and Scope for Improving Quality of Patient's Life in Pre-hospital Phase

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Emergency Medical Services (EMS) is considered as the first and most important step in pre-hospital emergency medical care. An EMS system comprises of agencies and organizations (both private and public), call-centres, communications and transportation networks, hospitals and trauma centres, and specialty care centres. All these systems should be efficient and effective for improving quality of life for patients with serious illness and injuries. It's all about best management of time with suitable essential treatment.

## Global view

Internationally there are many ideal examples of how EMS should function. When we talk about EMS, the National Health Services (NHS) from United Kingdom (UK) comes first in front of our eyes. UK has well-defined best practices for EMS, implemented across the country by NHS, who have led guidelines for every step for improving quality of EMS. Besides UK, many countries in

Western Europe and even US and Canada are known for their best practices towards EMS. High quality EMS also comes with higher quality infrastructure and communication standards. Most developed countries provide a Government funded EMS, which can be run on national level. As compared to developed countries with proper emergency systems in place, there is no single system which could play a major role in managing emergency medical services in India. There is a fragmented system in place to attend to the emergencies in the country.

## Time is a muscle

The 'Golden Hour' and the 'Platinum Ten Minutes' illustrate the importance of EMS all over the world. It is a well-accepted fact that a patient who receives basic care from trained professionals and is transported to the nearest healthcare facility within 15-20 minutes of an emergency has the greatest chance of survival. Time

management is the back bone of medical emergency. Certain organs like brain and heart need extraordinary time management for their well-being, especially in crises. Brain cannot survive (with its full functionality) even for 4 minutes without proper oxygenation and heart cannot live if oxygenation is hampered for more than 8-9 minutes. In case of emergency, it is essential to take care of these organs with the best of time management and medical treatment. One needs extraordinary services with trained team of doctors and paramedical staff and also latest technology and equipment to support this emergency management.

## Where are we today?

With a 1.3 billion population, India is the second most populated country in the world. The most basic EMS are provided as a transport operation only, simply to take patient from incident to nearest medical treatment center. This is still true in many parts of our country.

India needs to have a centralized body which provides guidelines for training and operations for Emergency Medical Services. Many states have already initiated various models of EMS mainly involving timely transportation of emergency cases. Today EMS is fragmented and not accessible throughout the country. EMS is a relatively new concept here and EMRI (Emergency Medical Response Institute) is the most dominant player established since 2005. They have established their services in 17 different states (including Union Territories). Each state is trying to offer better and better pre-hospital services for the citizens, but state level developments at times are an obstacle in providing better EMS to the needy.

### **Are we ready for this?**

Emergencies typically occur in cases like road accidents, cardiac problems, stroke, convulsions etc. Paramedics provide first aid to the patient i.e. pre-hospital care and shift the patient to an appropriate facility. EMS can be provided in two forms—treatment to **in-patients** and **pre-hospital services**. We are far better in in-patient services in most of the states. Pre-hospital medical services include ambulatory services, transportation of the patients to or from places of treatment and

acute medical care. Infrastructure is the foremost issue in rural parts of the country, with heavy compromise on systems and communication and IT processes, power conditions, efficient trained caregivers and high level of discipline. Situation in urban India is also not very different, where average time for an ambulance to reach varies between 25-40 minutes (against average of 8-9 minutes in UK)

We should have national guidelines of improving quality of EMS standards. Every service provider must follow National Ambulance Code. Unfortunately, the quality of cardiac ambulances and services are primitive. Telemedicine plays a high priority role in EMS. Technology has its own value in increasing pace of treatment. In many countries, cardiac ambulances are capable of effectively managing the emergencies irrespective of the transportation challenges to a great extent, mainly because they have most advanced equipment, trained paramedics and quality infrastructure to provide all the necessary amenities to the patient.

### **Technology and Emergency Care**

Advanced patient handling solutions like motorized stretchers, Bi-Phase Defibrillator

with advanced patient monitor, portable ventilator, Oxygen delivery system etc. can do a major job of stabilizing patients with serious cardiac problems. Some of these devices are designed to communicate patient's data over WIFI or cellular network to the nearest hospital. Patient ECG and other essential vitals can be sent in just few seconds to the base location. Doctors in emergency care area are well informed about patient's condition even before the patient physically arrives in the hospital. This give huge time benefit for the caregivers in emergency department. At times when the patient need to be taken into the Cath Lab for stenting, early diagnosis of patient's ECG has immense value for better outcome. This "Door to Balloon" concept has saved many lives and given quality life to the patient. The quality of Cardio-pulmonary Resuscitation (CPR) is also a crucial stage in reviving patient from Sudden Cardiac Arrest (SCA). Today there are devices which can monitor the quality of CPR and tell whether the quality is effectively helping patients or not. Such devices should be an integral part of the EMS ambulances. All these increase the survival rate and overall quality of EMS.

In spite of all the work done in

the area of EMS, the question still arises, is this meeting the requirements of EMS in India? The answer is still no. Though there has been a considerable improvement in emergency services in India, there is still a long way to go before a comprehensive EMS is implemented across the country. Yet numerous deficiencies like patient handling trainings with advanced equipment, Advanced Life Support (ALS) devices, and patient data transmission to get immediate assistance from in-hospitals teams before patient getting admitted etc. are still fragile in the emergency services

across many part of the country. For aspiring to an optimum EMS service, we have to define rigorous protocols and execute them to the core.

Another important thing missing, and which is certainly needed in the long-run, is a body to regulate the EMS in the country.

### Conclusion

The importance of a reliable EMS cannot be overstated, especially in India where the government has the responsibility of caring for a majority of the population. It can be argued that a nation of more than a billion people has

been deprived of a decent EMS for far too long now, and it is high time the government takes definitive action. The success of a few services are evident enough of the need for EMS and what it will take to ensure that it works perfectly. In a healthcare system that is experiencing the benefits of involving private players, a public-private partnership framework could be the right way forward for policy-makers. At a time when the emphasis on preventing damage is greater than ever, the provision of pre-hospital care will be the key to ensure that lives are not lost due to avoidable circumstances.

## Economic Feeds

- *India is in the midst of a second wave of the pandemic. Covid infections have been rising for the past few weeks, since bottoming out in early February. The coming few weeks are predicted to be critical for the country as new strains of viruses seem to be driving this wave.*
- *India has crossed the 60 million mark in Covid vaccinations, led by people over the age of 60. This comes in the wake of experts warning that the second wave of infections was likely linked to a lack of testing and contact tracing. However, the burden of the pandemic is rising.*
- *India and America have agreed to revamp their strategic energy partnership to focus on greater collaboration in cleaner energy sectors, including biofuels and hydrogen production. Advantage will be taken of advanced US technologies and India's growing energy market.*
- *Salvage teams have finally freed a huge container ship stuck for nearly a week in the Suez Canal. This ends a crisis that had clogged one of the world's most vital waterways and held up billions of dollars a day in global maritime commerce.*
- *RBI is exploring developing its own blockchain platform. India's upcoming digital currency will aim to minimize transaction settlement processes, making transactions more cash-like and giving the RBI tighter control over the functioning of the financial system.*



# A Tour through the Medical Tourism Scenario in Maharashtra

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Many people are new to the concept of medical tourism. This is partially true due to the present scenario that exists in this industry. Firstly, what is medical tourism? It refers to the process of traveling to other nations or cities to receive medical treatment. When the travel is done across international borders, it is called *International Medical Tourism*. When the travel is within the same country it is called *Domestic Medical Tourism*.

Earlier this referred to the travel undertaken by the people from lesser developed nations to developed nations that had available superior medical services. This scenario is now changing. It is very common for people from developed regions and nations such as those from Europe, the USA, and Canada to travel to countries such as India, Thailand and Malaysia to name a few. People just don't travel to another country because the

treatment might not be available to them in their country. The travel isn't restricted from lesser developed nations to more developed nations. Cheaper rates, quality of services, time taken to receive the treatment at home, no waiting to receive the treatment, to explore a new country or city, opportunity to visit their birth nation etc. are just a few of the reasons for the growth of medical tourism.

India is becoming one of the hubs for medical tourism with more and more people coming to India for treatment. Pre-Covid times, tourism in India was expected to grow to a total market size of USD 9 billion, acquiring over 30% of the global medical tourism market share. India already ranks in the top 10 countries for medical tourism because of its healthcare infrastructure.

With treatment costs as low as one-tenth of those available in

the USA or UK and a network of the second largest accredited facilities in the world, India truly is poised to acquire the center stage in medical tourism. Already India was showing a growth rate of 30% in medical tourism (pre-Covid) with more than 8 lakh patients per year.

Reasons for the growth of medical tourism in the country:

- Low cost of treatment
- State of art medical facilities
- Strong pharmaceutical market
- Affordable travel and living
- Ease in communication (Knowledge of English knowledge)
- Reputed healthcare professionals
- Relaxation in medical visa rules

- Quality nursing facility
- Traditional healthcare therapies and treatment
- An extensive network of roads, railways, and airways

This enables us to attract patients from countries like the USA, CIS nations, Middle East, African nations, Maldives, Mauritius, and other Southeast Asian countries. In India, Maharashtra is emerging as one of the most prominent locations for medical tourism. It has a share of 31% of India's medical tourism market. It ranks number one internationally and fifth in the domestic medical tourism market. The State is constantly nurturing the medical tourism ecosystem, thus becoming a preferred destination for medical and wellness treatment. Maharashtra witnesses an estimated average annual inflow of nearly 5 lakh domestic and international medical tourists.

This is primarily owing to its competitive pricing, quality of healthcare and medical treatment, range of procedures, better infrastructure, skilled manpower, ease of communication, and low living costs. The state has numerous numbers of JCI and

NBAL accredited hospitals that ensure quality standards at the international level. Ease in the process of getting E-Visa, M-Visa, and MX-Visa that allows multiple entries and long-term stay also make the state a lucrative location for medical treatments. It is becoming a reputed destination for treatments and surgeries such as Orthopaedic and Joint replacement surgeries, Cardiological Bypass, IVF treatments, Cosmetic Surgeries, Dental Implants, Cancer therapy, Ophthalmic Surgeries, Bariatric surgery, and organ transplant. Hospitals in Maharashtra are equipped with advanced information technology (IT) and they are making effective use of it to benefit from holistic healthcare delivery and processes.

Maharashtra provides end-to-end solutions for any patient coming for their treatment. With the availability of vast numbers of wellness and recovery centres across the state, the patient along with their family have the luxury to recover to their perfect health while enjoying the picturesque view that these places provide. These places offer alternative treatments such as Ayurvedic Yoga, meditation, and natural therapies. Maharashtra has

realized the importance of medical tourism and is actively working for policies that favour the same. The policy aims at providing the best of services to its patients and their families, while bringing other stakeholders together, efficiently and transparently.

The government has also launched a couple of other initiatives such as the Maharashtra Infrastructure Development and Support Act (MIDAS), and has granted tourism activity an industry status. This facilitates tourism to gain from all the benefits and incentives earned by other industries. MIDAS empowers Maharashtra Tourism Development Corporation (MTDC) to be a special planning authority to procure and provide land available at various tourism estates, without needing approval from the Maharashtra Industrial Development Corporation (MIDC).

The Government also launched the Medical Tourism Council of Maharashtra (MTCM) in November 2003, in collaboration with the Federation of Indian Chambers of Commerce and Industry (FICCI). The State's Tourism Policy has laid down the

objectives for medical tourism to give a fillip to the sector. The MTCM is aimed at exploiting the potential of the State and will have tie-ups with various hospitals and hotels to provide affordable and easily accessible facilities to tourists availing medical treatment. It aims to set up a special task force to put together suggestions for drafting the necessary policies for the promotion of medical tourism in Maharashtra. It is also evaluating engagement and association with partner countries to provide an impetus to the growing industry.

The Government has championed a public-private sector partnership (PPP) model at both central and state levels to improve healthcare infrastructure and provide efficient services and innovative delivery models. E-Visa facilities will be introduced for medical tourists visiting India, which will benefit Maharashtra. For promoting medical tourism facilities, the Government is addressing insurance payment issues of different countries and also strengthening its policies on medical insurance to be availed by patients. All these policies are in the right direction to make sure that the medical tourism

market continues to grow. But there is still a long way to go. A centralized organization or body is required which can provide all of the services and facilities that a patient might require under one umbrella itself.

A patient when traveling to a foreign city or country would already be so focused on the treatment that they would not wish to further take the burden of other responsibilities at that time. They would appreciate it if someone can help them with the accommodation process, to help them with their dietary requirements, a translator if required, a local SIM card, and transportation. These are very basic needs that might look trivial but can become a big headache for someone who has come for medical treatment. A platform is required wherein someone sitting outside in a different country can safely browse customized treatment packages as per their needs. They should have an assurance about the prices mentioned for those treatments. Currently, most of the medical tourism service providers give a rough estimate for the cost which tends to increase as the patients arrive for the treatment. But if a platform

can provide price surety, it could boost medical tourism for that particular country or state.

When you travel somewhere, it is common to ask a friend or acquaintance or a family member for guidance, and if someone is present in that location to help you as and when required it is advantageous. That is what is required for medical tourism too. People would appreciate an organization, a body, or someone who can be there for them. Help them with their doctor appointments, provide them 24x7 guidance and support, assist in the hospital admission process, and assist in day-to-day activities. In brief, someone who makes their life easier for them. The future of medical tourism lies in converting traditional medical tourism to medical value tourism. Many competitors in the world can provide quality treatments that are quite similar to the ones offered in India but not many can provide holistic end-to-end services. It is a race, and the first organization that can master this and provide the most hassle-free service to its patients will win the race. They would have the power to shift the scales in their favor and become the market leaders in medical tourism.

# Interview with Shri Rajesh Tope

## Hon'ble Health Minister, Government of Maharashtra



**1. Covid has brought into focus the need for healthcare reforms that promote universal access to affordable care. How far has Maharashtra succeeded in this regard?**

**Answer:** The Covid pandemic has been the most unprecedented public health crisis in our lifetime. As far as the state of Maharashtra is concerned, we tried to look at it as an opportunity to improve the public health system and bring about the reforms that were long overdue. We have taken several steps to enhance and strengthen the state's healthcare system in multiple ways.

- Ranging from augmentation of infrastructure, human resource and installation of equipment in hospitals dedicated to COVID to scaling up immunization and COVID vaccination programmes, Maharashtra state has improved on a lot of such avenues.

- To reduce the out-of-pocket expenditures the state government has made the insurance scheme *Mahatma Phule Jan Arogya Yojna* (MPJAY) available to the whole population of the state in hospitals that are empanelled with MPJAY. Also, 10% of the total beds in private charitable hospitals are reserved for poor patients so they can avail treatment free of cost. An additional 10% beds in these hospitals are being reserved for economically vulnerable patients for their treatment at subsidised rates. There was also a lot of talk about high treatment costs charged by private hospitals for COVID management. To address issues related to this, we have also established a grievance redressal mechanism so that bills by private hospitals can be kept in check.
- 85 percent and still counting, of the state's population is covered under the Mahatma

Jyotiba Phule Jan Arogya Yojana (MJPJAY) making Maharashtra the first state to introduce free and cashless insurance cover to its entire population. Over 1,000 hospitals come under this scheme which empower the lower strata of the society.

- Benefits of Pradhan Mantri Garib Kalyan Scheme are being given to the employees of the health department since 30<sup>th</sup> March 2020 who have unfortunately lost their lives while assisting the state in management of COVID-19. 123 such applications have been received, 53 out of them have been given the amount of ₹ 50 lac and other applications are currently under scrutiny.
- A memorandum is signed to include government, semi-government employees and white ration card holders in the scheme in a bid to prevent private hospitals from overcharging patients.

- Rates of COVID tests, HRCT, masks have been reduced over time and they have now been fixed. For instance, RT-PCR rates (site collection) have come down from ₹ 4500 to ₹ 700 and Rapid Antigen Test at the collection site costs ₹ 600. Similarly, rates for different types of masks and HRCT have been fixed across the state.
- In the first phase of the pandemic, we trained almost 90,000 staff at different levels in the healthcare system. This includes ASHA, Health Assistants, Staff Nurses, Health Workers, and Community Health Officers among others. Further, to build capacities of others, training on various aspects of pandemic prevention, control and treatment were repeatedly carried out through the course through online mediums. These include training on ventilatory management, respiratory management for doctors, interpersonal communication for frontline health workers etc.
- Lastly, considering the fact that urban areas have largely been the epicentre of the pandemic, we are looking at focusing on urban health in

a more holistic way than ever before. Structural changes have been proposed in the system and they soon will be in place.

Several such healthcare reforms have been taken by the state to ensure Universal Health Coverage and to promote universal access to affordable care.

**2. Which are the biggest bottlenecks being faced in ensuring that the citizens of Maharashtra do not remain vulnerable to the pandemic? How are they being overcome?**

**Answer:** To control the spread of the disease, the responsibility has to be shouldered by the citizens as well as the government. One of the biggest reasons for the spread is that of non-compliance of COVID appropriate behaviour. This is seen across society – people do not seem to be wearing masks, they don't seem to follow physical distancing. A sense of complacency seems to be setting in. When the government has recognised that a blanket lockdown cannot be a sustainable solution, it is the people who have to understand their bit of responsibility. To ensure this,

we are focusing on awareness activities all over again and to put the onus of infection prevention on people themselves, we have launched the '*mi jabaabdaar*' (I am responsible) campaign. Additionally, officials are visiting random places such as malls, bazaars etc. and imposing fines on those who are violating the rules of masks and physical distancing. This has helped us identify the frequent offenders and imposing fine hopefully is sending across a strong message in the communities that they have to be strict with their Covid-appropriate behaviours – for themselves, their families and their communities at large.

Another important intervention, especially in the second wave is the vaccination drive. We have a huge population to cover and that is going to take time. Time is a factor that cannot be controlled beyond a point but we are now increasing the eligibility and larger sections of the population are going to be vaccinated. Another issue is that of vaccine hesitancy. Some media reports and fake news are contributing to it. We are constantly focusing on awareness generation activities to reinforce that the vaccines are safe and that people should voluntarily go and get the vaccines.



**3. Maharashtra is now facing a new wave of Covid. How is the government planning to deal with it in view of all the experience gleaned in the past year?**

**Answer:** During the first wave of the COVID-19 pandemic in Maharashtra, we observed a gradual rise in the number of cases. From the first cases reported in Maharashtra i.e., on 9<sup>th</sup> March 2020 it took 186 days till the peak of the curve on 11<sup>th</sup> September with 24866 reported cases in a day. However, observations from the second wave of COVID-19 show a sharp rise in the growth rate of cases and we have already surpassed the single-day peak of the first wave.

To identify the COVID patients early on, we have increased our testing multifold. The state is testing over 1.25 lac people a day. We are also going to the communities where we have found a high number of cases and testing the population there using rapid tests, so that we understand the level of transmission and intervene in time.

Contact tracing and containment activity are the two key interventions in such times. Taking the lessons from the first wave, we have been focusing on

these two exercises currently to find as many high-risk contacts of each known Covid patient, thereby identifying and testing these contacts early.

To cope with the steeply rising number of cases, we are using the predictive model that we used in the first wave to predict the possible number of patients who will need hospitalization. This is helping us in augmenting infrastructure capacities of hospitals in districts where we are expecting a rise of patients in the next two weeks. Weekly analysis of COVID-19 data, a system that we established during the first wave, is helping us identify priority districts that need attention and support in the following week. This helps us direct our interventions to specifically these districts.

As far as the treatment of critical patients is concerned, we now have our detailed protocols ready and our staff is much better trained now. This is helping in identifying initial warning signs that naturally help us start the interventions early, saving patients' lives. Even the post-COVID management protocols are in place that will be of help in this second wave.

**4. Are there plans to boost the existing healthcare**

**facilities throughout Maharashtra? If so, could some of the details be shared?**

**Ans-** Maharashtra accounts for 60 plus percent of active cases in the entire country. Projections of cases are calculated on a weekly basis by considering the recent trends of all covid indicators. Subsequently districts are conveyed and instructed to increase their infrastructural capacity. Revival of deactivated COVID healthcare facilities is ordered. Along with discussions with IMA and several private doctors, hospitals which are ready to be converted to a covid facility fully or partially are also being done on a war footing in order to boost the strength of the existing facilities .

**5. Of all the states in India, Maharashtra has been affected most by Covid. How helpful is the Central assistance in dealing with the pandemic, and what steps could be taken to enhance its efficacy?**

**Answer:** The central functionaries have been instrumental in assisting the state counter the second wave of COVID-19. We are following the various protocols of testing, tracing and treatment given

by the Government of India officials and they have provided regular support right from the beginning. We have received help in terms of infrastructure such as ventilators to augment hospital capacities and additional funds received from GoI have been extremely helpful.

Recently a team from National Centre for Disease Control (NCDC) Delhi, visited the state to assess the current conditions and reasons for such a drastic increase in the growth rate in Vidarbha region of the state. Regular video conferences are being conducted with the experts from the Centre in order to understand and improve our existing capabilities.

**6. How satisfactorily is the vaccination drive in Maharashtra proceeding? Is it likely to improve the situation considerably in the coming months?**

**Answer:** Vaccination in Maharashtra has been going on a war footing. Intensive drives are being conducted in all districts. As on 23<sup>rd</sup> March 2021, a total of 50,51,339 people have been vaccinated. A total of 4,52,581 healthcare workers and 2,14,792 frontline workers have been vaccinated with the

second dose till 23<sup>rd</sup> March 2021. Over 3,000 vaccination sessions are being conducted on a daily basis. About 1,60,333 60+ years beneficiaries have been vaccinated so far with the first dose and 42,790 population with co-morbidities and 60+ age have been vaccinated. Additional age groups will soon be included in the vaccination eligibility criteria in a staggered manner and we are speeding up the vaccination drive to cover as much population as possible.

**7. The loss of jobs, incomes and health insurance associated with Covid will greatly stress the existing healthcare facilities in the state. How does the government propose to deal with it?**

**Answer:** One cannot shy away from the fact that lockdown has had major impacts on employment and incomes. Its social costs have been great. It is very well anticipated that the loss of income will put a burden on the existing healthcare facilities, especially the government ones. That is the very reason we included the whole population under the Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) in all empanelled hospitals in the state. 10% of the total beds in

private charitable hospitals are reserved for poor patients and an additional 10% beds in these hospitals are being reserved for economically vulnerable patients for their treatment at subsidised rates. Private hospital bills are being audited at discharge and hence the bills are kept in check.

**8. Is the state government having any outreach teams to speedily deliver needed information, supplies and services to vulnerable sections of the population in times of emergency?**

**Answer:** With respect to creating awareness, we have developed a huge amount of communication material and distributed it to the population through our frontline workers. ASHAs, Anganwadi workers, MPWs and District Extension and Media officers have been instrumental in our outreach activities. They are conducting interpersonal communication sessions with community members on a regular basis. Social media has been extremely helpful in disseminating necessary information to community members. We have partnered with Facebook which has been extremely helpful to increase our outreach. Regarding the field teams for contact tracing

and containment activity, we have augmented our capacity as the second surge started and we have roped in additional staff for these field teams. For outreach activities, our 'My family, my responsibility' campaign proved critical as it involved community members in checking the population for symptoms and creating awareness among community members.

**9. Healthcare workers have suffered a lot due to Covid-19. What steps will you be taking to improve their working conditions in the post-Covid period?**

**Answer:** Healthcare workers have been the backbone of the system during the pandemic and also were at a great risk. We ensured that all healthcare workers on COVID duties got enough off-time and institutional quarantines were arranged for them, which has not only been helpful but also appreciated by healthcare workers. We hope to keep this in mind when we move past the pandemic and focus on other diseases. There have been immense learnings from the pandemic and we have already identified a few things that will help improve the working conditions of healthcare workers. We are aiming to improve our

ICU and emergency care norms very soon. Similarly, we are trying to include in-house training for healthcare workers at all levels.

We have also learned a lot about infection prevention control (IPC) practices. Ensuring that the necessary equipment is available for healthcare workers will be another key deliverable from our side in the future. We have also seen that rotational shifts of medical and paramedical staff, although has always existed in the past, were more effectively done during the pandemic. We aim to continue this and further improve upon this. Incentives in terms of awards and accolades, and also in monetary terms have proved to be motivational for healthcare staff and we will continue this practice further.

**10. Are there any overseas best practices that you think we need to adopt in our healthcare sector to preempt unforeseen events like pandemics? If so, which ones would be the best?**

**Answer:** As far as the COVID-19 pandemic is concerned, we have learned a lot from countries such as the UK. When the scare

of new strains of the virus spread across the world, we were doing the Whole Genomic Sequencing (WGS) of about 5% of the samples to check if there have been any mutations. We are reporting regularly to ICMR on this front. Whether the variations found here are significant and responsible for the spread remains to be correlated clinically and we will have more information in the times to come.

India has historically lagged a bit in terms of using technology in dealing with public health issues. We have made significant improvements on this front and partnering with international organisations during the Covid pandemic has helped us to a great extent. We will continue to develop these capacities and use tech platforms in public health systems.

Robust health information systems are key to identify epidemics/pandemics early. We are currently in a process to ensure that we have close to real-time data for localised epidemics and platforms such as IHIP. This platform will also have all health data integrated on to a single platform and will help us deal with future crises of this kind, if any, in a better way.



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