

# Preface

In pursuance of the recommendations made by the Commission on Macroeconomics and Health, India established the National Commission on Macroeconomics and Health (NCMH) in March 2004. The main objective of the NCMH was to establish the centrality of health to development and make an evidence-based argument to increase investment in health. The Terms of Reference of the NCMH were mainly centred on identifying a package of essential health interventions that ought to be made available to all citizens and also list systemic constraints that need to be addressed for ensuring universal access to this package of services. The NCMH was also to indicate the resources required and targets that ought to be achieved by 2015.

One of the Terms of Reference of the NCMH was to come up with a baseline of the estimated prevalence of diseases in India, particularly those that disproportionately affect the poor now or have the potential to do so in the future. Based on such estimations, the Commission was to indicate targets that could be achieved within a specific time-frame. Accordingly, the NCMH invited leading experts in the country to assist in identifying those diseases/conditions that were responsible for high levels of mortality and morbidity and, if unchecked, could have ruinous implications for a majority of households in India. The experts were also given three other tasks: (i) to project the disease burden in a decade from now, assuming the current status quo in terms of policy attention and investment levels; (ii) identify the proximate, direct and indirect causal factors that, if tackled adequately, could substantially reduce disease incidence and thereby enhance welfare; and (iii) provide a minimal standard treatment protocol listing the interventions that ought to be undertaken at different levels of care to avert death and reduce progression of disease. This information was to enable us to cost the interventions and arrive at the quantum of investment required to achieve the aspiration of universal access to essential health interventions.

The experts identified 17 diseases/conditions that public policy needed to take note of on priority. The list included both the set of pretransition diseases or diseases of underdevelopment as they disproportionately affected the poor more and post-transition diseases or diseases of affluence, normally referred to as lifestyle diseases, which are believed to affect the rich more. Based on an exhaustive literature review, the experts attempted to provide a baseline of disease prevalence today and causal analysis indicating the various

direct and indirect factors that contributed to the persistence of these diseases. Surprisingly, we found it difficult to provide even current-level estimates for diseases/conditions that are being implemented with substantial donor funding under the National Health Programmes. We, therefore, could not come up with any estimates for malaria or other vector-borne diseases, reproductive health, several childhood diseases such as respiratory infections, etc. Even for tuberculosis (TB), arriving at any projections for 2015 under the emerging scenario of the rising HIV/AIDS epidemic was impossible. For these reasons it was difficult to come up with any specific targets to be achieved within a limited time-frame.

Likewise, we were unable to find any studies or research which provided evidence demonstrating the efficacy of specific interventions under a programme in Indian conditions and among different population groups. This inhibited us from being able to identify those sets of interventions that ought to be accorded high priority to achieving an end goal, for example, reduction in infant mortality, or maternal mortality or malaria incidence, etc.

The second lesson that this exercise threw up was the high levels of prevalence of non-communicable diseases such as asthma, chronic obstructive pulmonary disease (COPD), hypertension, diabetes, mental problems, injuries, etc. Some household surveys also conclusively suggested that these diseases affected the poor as well as the not-so-poor segments of the population. These conditions and diseases have received no policy attention as they have been believed to be of little consequence to the poor. That is no longer true. In fact, there is an urgent need to pay attention to formulate appropriate policy responses to these diseases—their prevention as well as treatment—as these diseases are very expensive to treat, well beyond the means of the poor and most lower middle classes and occupational groups in the informal sector. Non-attention carries the implication that in the absence of any social insurance or risk protection, the poor either die for want of care or get impoverished when they do attempt to seek care. Since these diseases affect the younger age groups, the stress to such families could be immense, necessitating a public policy response—either by improving its public provisioning by providing free treatment and/or by having social health insurance policies in place.

A more cost-effective approach to disease containment is to prevent its occurrence in the first instance. Prevention can be achieved by well-organized health education and health information dissemination campaigns at the local level and

through effective use of the mass media; by enforcing regulations and using financial incentives to modify behaviour towards health-enhancing habits such as a healthy diet, exercise, use of seat belts or helmets, reducing dependence on alcohol or tobacco, etc. Several diseases such as diarrhoea can also be drastically reduced by enhancing access to safe water or promoting the habit of washing hands with soap, diseases like polio or measles can be altogether eliminated by immunization campaigns which are equally inexpensive. Clearly then, it is in this area of prevention of diseases and promotion of good health values that public policy should pay attention to.

The experts gave us their unstinted support. We would like to thank all authors and reviewers for having taken time from their busy schedules to help us. We would also like to thank several experts who attended our consultation meetings and gave us the benefit of their advice. To each of them we owe a debt of gratitude. We do hope that the work done will stimulate further research and enable evidence-based policy formulation. If that is indeed done, the efforts put in will not have been in vain.

K. SUJATHA RAO  
Secretary  
NCMH  
New Delhi