News from here and there

Legalization of medical marijuana leads to drop in prescription painkiller and anti-depressant usage in USA

American states which had legalized medical marijuana have had a decline in the number of Medicare prescriptions and associated Medicare spending on said prescriptions for drugs such as opioid painkillers and antidepressants. This finding has been published by Bradford and Bradford from the Department of Public Administration and Policy at the University of Georgia in the journal *Health Affairs* (Medical marijuana laws reduce prescription medication use in Medicare Part D. *Health Aff* 2016;**35:**1230–6). The study examined data from Medicare Part D from 2010 to 2013 to analyse the effect of legalization of marijuana on doctors' clinical practice and its role in reducing the cost of public health expenditure. The reduction in the number of prescriptions was seen for drugs used to treat anxiety, depression, nausea, pain, psychosis, seizures, sleep disorders and spasticity, all of which can be treated by marijuana as an alternative, while prescriptions for drugs such as blood-thinners, which cannot be replaced by marijuana, stayed the same.

Medical marijuana, which acts on totally different receptors to opioids and is not associated with fatal overdoses, is currently classified as a Schedule I drug by the federal government in the USA. This disallows it from being technically prescribed by doctors and is not covered by insurance companies. Drug Enforcement Agency USA is currently considering a proposal to re-classify medical marijuana as a Schedule II drug, thereby putting it in the same class as morphine and oxycodone, which would allow physicians to prescribe it and make insurance coverage a possibility. Ashley C. Bradford and W. David Bradford, the authors of the study, also analysed the effect of medical marijuana on prescriptions covered by Medicaid, the federal–state health insurance programme in the USA for low-income people. The results of this separate study will be published soon though early analysis suggests a drop in prescription payments was seen there as well.

When asked for his comment on the subject, Dr Jeremy Johnson, Emeritus Consultant in Palliative Medicine and Director of Education and Research at Karunashraya, Bengaluru said, 'The analgesic, anxiolytic, anti-emetic and euphoric properties of cannabis have been known for over 5000 years and exploited well in certain communities. Its use became popular in the 19th century following a publication by W.B. O'Shaunghessy, in 1838, in the *Transactions of the Medical and Physical Society of Bengal*, "On the preparation of the Indian Hemp or *ganjah*". With the discovery of cannabinoid receptors and the endo-cannibinoid system, there has been a burgeoning interest in this arena in the past 10–15 years. An increasing number of publications in medical literature have confirmed the beneficial effects of cannabis, or some of its specific medicinal extracts, particularly with regard to post-chemotherapy vomiting and anorexia, and muscle spasms in certain neurological conditions. There is also increasing evidence that cannabinoids may help as an adjunct to opioids in cancer-related pain. The finding of Bradford and Bradford should therefore not be so surprising, given that in many painful conditions the dose and frequency of opioids have been shown to have decreased with concurrent use of cannabinoids. However, caution needs to be exercised in attempting to link cause and effect! Many other factors may come into play, not least the current backlash in the USA against opioid medication such as oxycodone because of its previous inappropriate and sometimes indiscriminate over-prescribing with subsequent increasing problems of addiction.'

MAHARRA HUSSAIN, *Dubai, United Arab Emirates*

Assured health services for all Indian citizens proposed in the draft National Health Policy 2015

According to the Press Trust of India (25 July 2016), the Ministry of Health and Family Welfare has prepared a cabinet note on the draft National Health Policy 2015 (NHP). This note will be sent to the Union Cabinet after the health minister signs it. The draft NHP 2015, which has been pending for the past 2 years, aims to provide assured health services to all citizens as a right. The cabinet note talks about guaranteed health services and not health as a fundamental right, since the latter is believed to have legal consequences.

The draft NHP 2015 is the third in the NHP sequence, after NHP 1983 and NHP 2002. The first NHP was formulated in the setting of international consent on the health for all (HFA) objective to be achieved through the strategy of primary healthcare. NHP 2002 was initiated along with the economic liberalization policies and adoption of the Millennium Development Goals (MDGs). The draft NHP 2015 was initiated when, in recent years, the United Nations and other international bodies reviewed the progress made so far with regard to the MDGs and proposed two strategies: Health in All policies and Universal Health Coverage.

NHP 2015 visualizes improved performance of the healthcare system and identifies four key areas for attention:

1. *Changing health priorities:* India is projected to attain MDGs with respect to maternal and child mortality. However, the rate of maternal deaths, at 0.55% of all deaths and 4% of all female deaths in the 15–49 years age group, is still too high and this must be further reduced. Also, many other health needs, including infectious diseases and the growing problem of non-communicable diseases receive little public attention.
2. *Advent of a robust healthcare industry:* This is expanding at a compound annual growth rate of 15%. This is twice the growth rate of all services and thrice the annual economic growth rate.
3. *Devastating effects due to healthcare expenses:* This is a key contributor to poverty. The drain on family income due to healthcare costs neutralizes both gains from increase in income and also government schemes aimed at reducing poverty.
4. *Increased economic growth:* This has increased the available monetary capacity and thus, India needs a new health policy that is responsive to these and related changes.

The principal aim of NHP 2015 is to update, elucidate, reinforce and highlight the government's role in shaping the healthcare system in all its dimensions, including, investing in health, organizing and financing the healthcare services, preventing

disease and promoting good health through cross-sectoral action, technologies, human resources, medical pluralism, increased knowledge base, financial protection and regulation and legislation.

K. Sujatha Rao, former Secretary of Health and Family Welfare, Government of India, said, 'A key aspiration in the BJP manifesto is the institution of a National Health Assurance Scheme in India under which all citizens will be guaranteed health services irrespective of the ability to pay for them. In May 2014, the Ministry of Health and Family Welfare constituted a committee of experts to work out a roadmap for the implementation of NHP. The committee submitted its report in September 2014. A close analysis brought out the following three issues: (i) a substantial imbalance between supply and demand with over half the country's rural areas bereft of doctors and facilities; (ii) the wide divergence in the epidemiological status in the country with a dominating demand for non-communicable diseases in states like Kerala and an overwhelming need for basic medical care for maternal and child health in states such as Uttar Pradesh or Bihar that also have poor access to the underlying determinants such as nutrition, water and sanitation; and (iii) the distorted growth of the health system, skewed further with the ill-planned introduction of government-sponsored health insurance schemes that provide cashless treatment of hospital care, more particularly surgeries and therefore more akin to the USA where the health system is fragmented, hospital- and curative-driven, with low focus on primary care.'

She added, 'The committee made detailed recommendations ... guaranteeing full and free access to comprehensive primary care dominantly by the public sector and the not-for-profit private sector ... access to secondary care and a selected four conditions for tertiary care free of cost for 60% of the population, alongside government making concurrent investment in strengthening and enhancing quality of its own hospitals. All the above set of recommendations need enhanced government spending which has been stagnating at about 1% of the gross domestic product (GDP). Internationally, the benchmark for providing universal health coverage for essential services is estimated to need US$ 85 per capita. India is currently spending US$ 17 per capita for all healthcare. Besides money, another key barrier is the acute shortage in human resources—doctors, nurses and allied services. This issue cannot be addressed by merely opening more colleges but needs deep reforms. So whatever the NHP proposes and our politicians aspire, it is more useful if the strategies for the future are driven by evidence and ground realities than by fantasies and unrealistic expectations. Above all, what the country needs is to have a vision and the basic aspiration that all lives matter.'

P.M. NISCHAL, *Bengaluru, Karnataka*

WHO report on distribution of health workforce in India shows gaps in the system

The WHO report on the distribution of the health workforce in India (Anand S, Fan V. *The health workforce in India. Human Resources for Health Observer Series No. 16*. Geneva:World Health Organization; 2016. Available at *www.who.int/hrh/resources/16058health_workforce_India.pdf?ua=1*; accessed on 21 Jul 2016) brought to light several interesting observations. The study was based on the year 2001 census and had included 9 separate health worker categories. The study revealed that health workers constituted 2 069 540 of a total population of 1 028 610 328 in the year 2001. Of these health workers, 39.6% were doctors, 30.5% were nurses and midwives, and 1.2% were dentists. Other categories of health workers (pharmacists, ancillary health professionals, and traditional and faith healers) constituted 28.8% of the total workforce.

Of all doctors, 77.2% practised allopathic medicine and the remaining 22.8% were doctors of Ayurvedic, Homeopathic, Unani systems, etc. The national density of doctors was 79.7 per 100 000 population. The national density of nurses and midwives (61.3 per 100 000); and dentists (2.4 per 100 000) was lower. A majority of health workers (59.2%) were in urban areas where 27.8% of the population resided while 40.8% were in rural areas where 72.2% of the population resides.

The study also yielded information about the qualifications of doctors in India. It showed that many individuals claiming to be 'doctors' did not possess the requisite professional qualifications. Among allopathic doctors, 31.4% were educated only up to the secondary school level. As many as 57.3% of non-allopathic doctors did not have a medical qualification (58% of 'doctors' in urban areas had a medical degree, while only 19% of those in rural areas possessed such a qualification). Among nurses and midwives, 67.1% had education only up to the secondary school level. The study provides an overview of the gaps in the health workforce in India, the distribution of doctors practising allopathy and other systems of medicine, provides evidence regarding the rural–urban divide and also brings into focus the issue of persons without prescribed qualifications practising medicine.

Dr P. Krishnaprasanthi, President, Indian Medical Association, Tirupati Chapter, said, 'The fact that a considerable proportion of doctors in India did not possess the requisite professional qualifications questions the credibility of monitoring systems in public health. The greatest grievance of poor people is their inability to get quality healthcare in spite of paying huge amounts of money from their pockets. The rural–urban disparity indicates the dire need for strengthening the existing systems of primary healthcare along with innovative improvizations, such as integrating telemedicine and specialty consultations, which will help improve the quality of integrated systems of medicine.'

ALLADI MOHAN, *Tirupati, Andhra Pradesh*