News from here and there

2020 designated as the International Year of the Nurse and the Midwife

The World Health Assembly has designated 2020 as the International Year of the Nurse and the Midwife. The WHO, the International Confederation of Midwives (ICM), the International Council of Nurses (ICN), Nursing Now, the United Nations Population Fund (UNFPA), among others, have charted out a year-long programme to celebrate the work of both nurses and midwives, to emphasize the demanding conditions that they often have to face, and to campaign for increasing investments in the workforce of nurses and midwives.

The World Health Day will be celebrated on 7 April 2020. It is to draw attention to the current status of nursing and midwifery globally. A series of recommendations will be made by the WHO and its partners to strengthen the workforce of nurses and midwifes. The tagline is 'Support Nurses and Midwives'.

Up to 50% of the global health workforce is made up of nurses and midwives. More than 50% of the global shortage in healthcare workers is among nurses and midwives. This is particularly so in Southeast Asia and Africa. The WHO has estimated that an additional 9 million nurses and midwives will be required by the year 2030 for countries to reach Sustainable Development Goal 3 on health and wellbeing.

A crucial role in health services is provided by nurses and midwives. They have devoted their entire professional lives to care for mothers and children; to give health advice and lifesaving immunizations; to taking care of older adults. To put it succinctly, they are indispensable for the daily health needs of all people.

A considerable share of the female workforce consists of nurses and midwives. While 41% are women across all employment sectors, this rises to 70% in the healthcare and social sectors. If Health for All is to be achieved, there need to be adequate numbers of well-trained, educated, regulated, and well-supported nurses and midwives, whose pay and recognition will be proportionate with the quality of care and services that they provide. Thus, there need to be adequate investments in the nursing and midwifery occupations.

A report by the United Nations (UN) Level Commission on Health Employment and Economic Growth has said that investments in the health and social sectors for education and job creation will ensure a triple return in superior health outcomes, global health security and economic growth that is all-encompassing.

The World Health Assembly resolution WHA64.7 (2011) calls on the WHO and all Member States to reinforce nursing and midwifery. A host of measures have been enumerated, including utilizing their expertise and making them a part in the development of human resources for health-related policies.

The report 'Global strategic directions for strengthening nursing and midwifery 2016–2020' has set out four goals to improve global health using the contributions of the nursing and midwifery workforce. These are:

1. To make certain an educated, motivated and proficient workforce is available within receptive and effective health systems in different settings and at all levels.
2. To optimize effective leadership, management, governance and policy development.
3. To take full advantage of the capacities and potential of nurses and midwives via professional mutual partnerships, education and continuing professional development.
4. To mobilize political will into building a valuable evidence-based nursing and midwifery workforce.

Since its inception, the WHO has aspired to give the nursing and midwifery workforce a voice. This workforce will play a crucial role in being the bulwark for improving health outcomes. With the escalating Covid-19 pandemic, this is only too true.

P.M. NISCHAL, *Thiruvananthapuram, Kerala*
ORCID ID: 0000-0003-3491-5500

WHO raises questions on actual versus perceived benefits and harms of mass screening programmes

The WHO Regional Office for Europe published a guide 'Screening programmes: A short guide. Increase effectiveness, maximize benefits and minimize harm' in February 2020. This initiative was produced under the overall guidance of Bente Mikkelsen, Director of the Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe, and financially supported by a grant from the Government of Germany.

The guide seeks to highlight awareness on potential benefits versus harm, and ethical and commercial dilemmas while conducting mass evidence-based screening programmes in the general population. The decision to publish this report follows the trend of increased focus on preventive measures that countries in the WHO European region have adopted in recent years. The report, while not a comprehensive guide on policy-making and implementation for screening programmes, raises questions on utilization of screening tests as a public health intervention to improve population health, especially screening programmes not based on available scientific evidence, and may potentially harm the general public and the state treasury by the burgeoning costs of testing. The report highlights the relevance of a 1968 WHO report by Wilson and Jungner as the gold standard for determining whether a screening programme is appropriate but urges a relook at existing screening programmes, especially those for non-communicable diseases, to assess whether they are truly effective, acceptable and affordable.

MAHARRA HUSSAIN, *United Arab Emirates*

Proposal to privatize secondary-level healthcare in India

The National Institution for Transforming India, the premier policy-making body commonly known as Niti Aayog has released a 250-page document on 'Scheme to link new and/or existing private medical colleges with functional district hospitals through PPP' (private–public partnership) for feedback. The

draft of this document was prepared in 2017 and involves private companies in public partnership to take over district hospitals for running, maintenance and upgradation. It also suggests using district hospitals as teaching hospitals for private medical colleges. The government will pay for salaries and upgradation. Outpatient services shall remain free, as earlier, but inpatient facilities will be payable based on economic eligibility of the patient.

The aim is to increase the workforce of doctors, fill the gaps in medical education and ensure delivery of modern quality healthcare. The agreement with stakeholders will be for 60 years with applied conditions. The district hospital beds will be divided into regulated beds and market beds. Patients will be divided into free and all others (paid). These free patients are already covered under Ayushman Bharat (a health insurance project launched by the Central government in 2018), hence hospitals shall receive payments from government for all these patients.

There are 734 districts in India. About 200 district hospitals have more than 300 beds. District hospitals are crucial healthcare providers to a large number of patients and are also centres for implementation of all national programmes.

The Jan Swasthya Abhiyan (JSA) and other health associations have opposed the PPP model as it is against the National Health Policy and People's right to free healthcare. The PPP model is in vogue in Gujarat and Karnataka. The Niti Aayog does not seem to have paid attention to the fact that thus far there has been ineffective and unaccountable PPP experience in tertiary care. Further, the number of doctors is not less; it is the distribution which is unequal with them being concentrated in urban parts of the nation with a scarcity in rural areas and those with a difficult terrain. The need is to reform and invest in the existing healthcare system instead of partially selling it off.

Public healthcare facilities are availed mainly by people from the low-income groups or those who have no income along with women and children. Rural and remote areas are predominantly dependent on it. The Indian public health sector serves 18% of outpatients and 44% of inpatients. Middle and upper class individuals prefer private healthcare services. The private healthcare sector provides almost 80% of curative care and expenses come directly from patients' pocket. Privatization of healthcare will lead to 20% of the poor population bereft of healthcare.

The public healthcare system is plagued with numerous drawbacks. The total healthcare budget in India is merely 1.6% of the gross domestic product, which is one of the lowest in the world. Lack of accountability is corroding our health system and reluctance of health workers to serve in the periphery as there are no facilities and dissatisfaction with the system leaves remote corners of the country under poor or no care at all.

The draft will be under the purview of the states to decide whether to accept, modify or reject the same.

JYOTI PRIYADARSHINI SHRIVASTAVA
Gwalior, Madhya Pradesh
ORCID ID 0000-0002-0032-3681

Draft policy on rare diseases initiated in India

A National Policy on Rare Diseases was finalized and posted on the health ministry website on 13 January 2020. The policy draft which was open for comments or remarks up to 15 February 2020, from the general public and stakeholders, aims to lower the incidence of rare diseases based on an integrated preventive strategy.

A rare disease is defined as a condition that affects less than 200 000 people, according to the National Organization for Rare Disorders (NORD). Rare diseases, also called orphan diseases, affect a small percentage of the population. (Readers may also want to revisit the news item, Hussain M. 'Research' theme for Rare Disease Day 2017, *Natl Med J India* 2017;**30:**117.) These diseases are to be covered for treatment under the umbrella scheme of Rashtriya Arogya Nidhi and are divided into the following three groups:

Group 1. Disorders amenable to one-time curative treatment

1a. Disorders amenable to treatment with haematopoietic stem cell transplantation such as Lysosomal Storage Disorders, etc. and

1b. Disorders amenable to organ transplantation such as metabolic liver diseases and autosomal recessive polycystic kidney disease, etc.

Group 2: Diseases requiring long-term/lifelong treatment having relatively lower cost of treatment and where benefit has been documented in the literature and annual or more frequent surveillance is required

2a. Disorders managed with special dietary formulae or food for special medical purposes such as phenylketonuria, homocystinuria, etc.

2b. Disorders that are amenable to other forms of therapy (hormone/specific drugs) such as the medication NTBC (2-(2-nitro-4-trifluoromethylbenzoyl)-1,3 cyclohexanedione) for tyrosinemia type 1, etc.

Group 3: Diseases for which definitive treatment is available but the challenges are to make optimal patient selection for benefit, because of very high cost and lifelong therapy.

3a. Based on the literature, sufficient evidence for good long-term outcomes exists for disorders, such as Gaucher disease, Hunter disease, etc.

3b. Disorders for which the cost of treatment is very high and either long-term follow-up studies are awaited or has been used in a small number of patients such as cystic fibrosis, Wolman disease, etc.

There are some concerns around the policy. It offers up to ₹1 500 000 under an umbrella scheme as one-time payment (which is insufficient to cover the cost of treatment—as the treatment of rare diseases is expensive) and there is no clarity on long-term financial assistance. Also, part of the policy is to set up digital platforms for voluntary monetary donations from individuals and corporates. The policy states that voluntary donations would be transferred to the individual itself but for long-term solutions, it may be not a good idea to depend on donations. The policy based on individual donation is also a new concept and hence, there are queries raised about its sustainability. Finally, the commercial drug market may not find it a viable proposition because of the relatively small target population and the often prohibitively expensive drugs. To overcome this problem, an incentive-based policy to promote research and development of cheaper drugs in the field might improve the overall condition.

The policy is a welcome change, provided it delivers long-term benefits to the needy and offers a long-term solution.

ANIKA SULANIA, *New Delhi*