

Health in South Asia

Future of Kerala depends on its willingness to learn from past

EDITOR—The Kerala model in health, cited by Bhutta et al in the theme issue on health in South Asia as replicable for South Asian countries,¹ is facing serious threats. The state has a triple burden of communicable, non-communicable, and traumatic diseases.

Stupendous growth of the private sector has resulted in skyrocketing healthcare costs. Lured by the hi tech sophistication of the private sector, people are abandoning basic principles of primary health care. Even poor people prefer private hospitals, and a major reason for sustaining poverty is healthcare cost.² The government is reducing its investments in health and education due to fiscal crises and pressure from funding and lending agencies. The opening up of the medical education sector to private entrepreneurs, lack of guidelines for the private practice of government doctors, and shortage of doctors for rural areas are all disturbing developments. Transfer of healthcare institutions under local self-governments is yet to show the desired benefits.

The state is developing a long term plan, "Health Vision Kerala 2025," and a health policy. To equip the primary healthcare workforce to face the emerging challenges,³ job responsibilities were redefined recently.

Factors that determined the successful Kerala model, among others, include historically prevalent social justice, commitment of governments to health and education, land reforms, an organised public distribution system, streamlined primary health care, and an organised labour sector. Deterioration in these determinants is likely to have strong negative impact. Kerala should learn from its past to avoid the sad plight of some other Indian states.

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- 1 Bhutta Z, Nundy N, Abbasi K. Is there hope for South Asia? *BMJ* 2004;328:777-8. (3 April.)
- 2 Sadanandan R. Government health services in Kerala—who benefits? *Econ Polit Wkly* 2001;August 11:3071-7.
- 3 Nair VM, Thankappan KR, Sarma PS, Vasana RS. Changing roles of grass-root level health workers in Kerala, India. *Health Policy Plann* 2001;16:171-9.

Sri Lanka needs to build on its strengths and gains

EDITOR—Bhutta et al and the World Bank highlight Sri Lanka as a model in achieving exceptional health status with comparatively low investments.^{1,2} However, recent data show a stagnation of gains (such as an increase in infant mortality from 15.9/1000 in 1998 to 17/1000 in 2001) and emerging challenges.^{1,3} This requires the model to be suitably modified to lower the preventable morbidity and mortality, while responding to the emerging challenges. The following examples show that Sri Lanka is deviating in an ad hoc manner from the successful model of preventive programmes at a relatively equitable grassroots level.

The preventive sector is progressively underfunded, rather than strengthened to meet the epidemic of non-communicable diseases. From 1993 to 1999 expenditure on preventive and public health declined from 10% (of total health expenditures) to 6%, and expenditure dedicated to the curative sector has been maintained around 44% to 47%.⁴

Human resource development is heavily biased towards medical officers in the curative sector rather than staff in the preventive sector, personnel, and support functions. From 1996 to 2001 the proportion of medical officers in the curative sector increased by 71% compared with a 33% increase in medical officers working in the community and a 6.5% increase in family health workers.⁵

Sri Lanka therefore requires urgent corrective action to build on its strengths and gains. Otherwise it may end up as an example of a country that dismantled its own pioneering model in an ad hoc manner.

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- 1 Bhutta Z, Nundy N, Abbasi K. Is there hope for South Asia? *BMJ* 2004;328:777-9. (3 April.)
- 2 World Bank. *World development report 1993: investing in health*. Washington, DC: World Bank 1993.
- 3 World Bank Group. *Sri Lanka data profile*. <http://devdata.worldbank.org/external/CPProfile.asp?SelectedCountry=LKA&CCODE=LKA&CNAME=Sri+Lanka&PTYPE=CP> (accessed 3 Apr 2004).
- 4 Ministry of Health, Nutrition and Welfare and Institute of Policy Studies. *Sri Lanka national health accounts: Sri Lanka national expenditures 1990-1999*. Colombo: Ministry of Health, Nutrition and Welfare 2002.
- 5 Ministry of Health. *Annual health bulletins 1996, 2001*. Colombo: Ministry of Health 2002.

Research cannot be funded when health itself has low priority

EDITOR—In the theme issue on health in South Asia Sadana et al analysed the lack of health research in South Asian countries.¹ Health is given the least priority in annual budgets. In a country such as India, which has a population of over 1 billion, the health budget is less than 2% of the total budget. This obviously affects the delivery of primary care, so where would be the funding for research?

The health system in South Asian countries is run mainly by the private sector. The private sector is driven by economics, so funds for research are again low. Vast numbers of patients go through the private health sector. Only proper collection of data would provide the clinical data that could then be used to devise protocols for managing different illnesses. Thus in the long run a healthier population would result. This would also decrease the burden on the health system of these countries.

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- 1 Sadana R, D'Souza C, Hyder AA, Mushtaque A, Chowdhury R. Importance of health research in South Asia. *BMJ* 2004;328:826-30. (3 April.)

Community worker programmes may be occasional local solution

EDITOR—In the South Asia issue Moazzem et al criticise the promotion in developing countries of a Western style of health services based on personalised curative treatment administered by doctors and hospitals regardless of the entirely different disease pattern and socioeconomic conditions of most people.¹ On these grounds they call for national community health worker programmes.

We contend that personalised curative care is pivotal because diseases generally require clinical skills for control, and



patients demand alleviation of avoidable death, suffering, and anxiety related to illness.

Committed community health workers may sometimes be a useful link between communities and professional services. But in Africa, they were unable to substitute for professionals in delivering first line health care—unlike medical assistants, who with a few years' training may replace doctors in deprived areas. They generally offered solutions to problems for which communities already had an answer—for example, drugs available on markets.² Community health workers could not deal with many disease control interventions together (mass drugs administration, surveillance, health education, water and sanitation, and vector control).

We challenge the link made by the authors between reduction in infant mortality and the activities of community health workers. This indicator is sensitive to numerous social and economic factors.³ It decreased from 1970 to 2000 in all developing countries, with or without community health workers.

Community participation is pivotal in collaboratively managing publicly oriented health facilities,⁴ which are badly needed for disease control and patient centred care. Participation can enhance their responsiveness and utilisation rates. With adequate funding and managerial contracts, governments and international aid could promote such democratisation and quality health care.

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- 1 Moazzem Hossain SM, Bhuiya A, Khan AR, Uhaa I. Community development and its impact on health: South Asian experience. *BMJ* 2004;328:830-3. (3 April)
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- 3 Van Lerberghe W, De Brouwere V. Assessment of appropriate child care at district level: how useful are mortality rates? *Trans R Soc Trop Med Hyg* 1989;83:23-6.
- 4 Unger JP, Marchal B, Green A. Quality standards for health care delivery and management in publicly-oriented health services. *Int J Health Plann Manag* 2003;18:579-88.

Roll on health in Africa issue

EDITOR—Highlighting the poor health of people in the developing world is one of the roles of a general medical journal.¹ While reading Editor's choice for the Health in South Asia issue,² I had to remind myself that I was reading about South Asia, not West Africa. Be it communicable diseases, non-communicable diseases, maternal and infant mortality, the catastrophe of HIV and AIDS, or the paltry allocation to the health sector by governments, the picture is similar—as the *BMJ* will expose when it visits Africa.

Similarly, the effects of rapid urbanisation to the detriment of rural development, where

most Africans live, can be seen in the rise of fatal road traffic crashes, congestion and overcrowding, stress, depression, and anxiety. Factors such as the prevailing illiteracy, which feeds ignorance, poverty, superstition, voodoo, and black magic, compound the awful statistics of morbidity and mortality across all ages and both sexes in Africa.

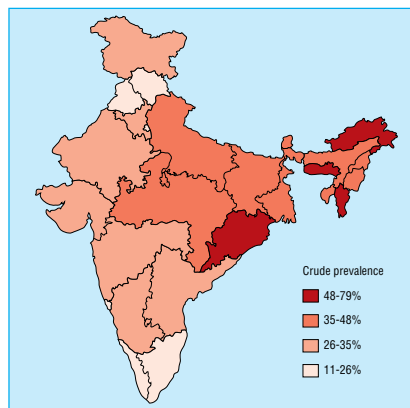
In most African countries hard data will be difficult to collect but the lamentable state of health in the continent is there for all who live there (or visit) to see. One further similarity is that South Asia and Africa are emerging from centuries of colonisation and plunder by their colonising masters. Some will say it is harsh to judge their poor performance or make comparisons with the colonising countries, only 50 years after independence, while the colonisers have enjoyed centuries of uninterrupted development and growth. I can't wait for the *BMJ* to throw its searchlight on health in Africa, to reveal all.

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Competing interests: JA is managing editor of *BMJ* West Africa edition and trustee-director of the Nigerian Medical Forum, a UK registered charity, both of which have keen interest in seeing to improvements in healthcare planning and delivery in West Africa since 1991. Neither position attracts a salary, but his travel expenses are often partly refunded.

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- 2 Smith R. Editor's choice. Towards a global social contract. *BMJ* 2004;328:0. (3 April).

Patterns and distribution of tobacco consumption in India



Unadjusted prevalence of adults aged 18 and above who smoke or chew tobacco in 1998-9 by Indian state

Study should be interpreted cautiously

EDITOR—The article by Subramanian et al on patterns and distribution of tobacco consumption in India is interesting and informative but raises issues.¹

The second national family health survey collected data from more than 90 000 ever married women aged 15-49 years in India, covering all states. The data

on the consumption pattern of paan masala, tobacco, smoking, and alcohol among household members aged 15 years and above were collected. However, no direct interviews were conducted of the adult men in the household (the information was collected by the women interviewed). In view of the above, under-reporting is a strong possibility as the women interviewed might not be aware of the consumption of tobacco outside the household. Also, because of the social stigma attached with the consumption of tobacco women might be under-reporting to the interviewers.

Hence this study may not be a true reflection of current consumption of tobacco among the adult men in India. To our knowledge it is, however, the best data set available on the prevalence of consumption of paan masala, tobacco, smoking, and alcohol in the country.

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- 1 Subramanian SV, Nandy S, Kelly M, Gordon D, Davey Smith G. Patterns and distribution of tobacco consumption in India: cross sectional multilevel evidence from the 1998-9 national family health survey. *BMJ* 2004;328:801-6. (3 April)

Impact of religion was not considered

EDITOR—Subramanian et al have confirmed in their study what we in the field have suspected for a long time¹: tobacco consumption in the South Asian communities based in the United Kingdom reflects what is happening in their countries of origin.²

Smoking and tobacco chewing is still a matter of health inequalities, and the strategy adopted by the UK Department of Health in tackling health inequalities has raised the profile of smoking cessation in addressing these health inequalities in the South Asian communities.³ South Asian communities have the highest smoking rates.⁴

However, what Subramanian et al have not looked at closely is the issue around religion and tobacco use. In 2001 the UK census was the first one of its kind to ask about religion. We now find that Sikh Punjabis who had been included within the Indian category have the lowest tobacco consumption rates both in the United Kingdom and in India on account of a decree set on 13 April 1699 (*Baisakhi*) in the Sikh Commonwealth of North India, which banned tobacco use through a baptism ceremony called the Amrit ceremony.⁵ On 13 April 2004 some one million Sikhs refreshed their vows not to smoke in this year's *Baisakhi* baptism. The Sikh leaders have taken a strong position against tobacco and have banned its sale around the Golden Temple in Amritsar.

If the World Health Organization's framework convention on tobacco control treaty and its application is handed to the many Indian religious groups, then, like the Amrit ceremony in Punjab, they could tackle