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ASIA EDITION

"Health workforce training is a big area as there are shortages in Australia and India"

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The inaugural India chapter of the Indo-Pacific Global Health Case Competition was recently organised jointly by the University of Melbourneâ??s Faculty of Medicine, Dentistry and Health Sciences and the Australia India Institute, marking a new frontier for universityâ??s existing Indo-Pacific Global Health Case Competition held annually in Melbourne. During the event, student teams showcased innovative, evidence-based strategies to improve vaccine access and uptake among those living with disabilities in India. BioSpectrum Asia took this opportunity to interact with Professor Nathan Grills, Academic Director India for the Faculty of Medicine, Dentistry and Health Sciences and Fellow of the Australia India Institute at the University of Melbourne about how Australiaâ??India health partnerships are driving innovations, and what are the challenges.

How are Australia–India health partnerships driving innovations in the non-communicable diseases sector?

We have had a number of partnerships in diabetes research with CMC Vellore and in tobacco control with the Public Health Foundation of India. Together with PHFI we undertook work to support the India Government as it developed some of the world’s best laws limiting advertising on tobacco packaging and replacing it with graphic warnings. This contributed to smoking rates continuing to decrease in India which will save millions of lives in India given that smoking kills up to a half of long term users. Such innovations are only possible when we collaborate and utilise our shared expertise.

What are the current challenges facing the healthcare ecosystems in India and Australia, and how these challenges could be jointly solved?

Health workforce training is a big area as there are shortages in Australia and India. A reliance on professional doctors and allied health workers needs to be supplemented with training and support for grassroot community and disability workers. This is what the Government of India's rehabilitation council of India and the University of Melbourne have been doing to develop a community based inclusive development programme. This course is now training thousands of grassroots disability workers across India. These workers help provide disability support in areas where access to doctors and therapists can be limited.

Other challenges are around ballooning health budgets both in India and Australia. This is partly associated with ageing populations and an associated epidemic of non-communicable disease. But if used wisely, I think virtual healthcare can help minimise costs and control the budget explosions. It can also allow healthcare to be increasingly delivered at home and less in the expensive hospitals that are staffed by highly paid professionals. Acute care might be best done in hospital but chronic care is definitely not.

Please share your views on how technology can strengthen the healthcare sector in the next five years.

I think technology will make affordable and high quality healthcare more readily available right down to the district, block and Panchayaat level. I think technology will also make healthcare more accessible - especially to those in rural areas, people experiencing poverty and those with disability. We have been working alongside E-Sanjeevani which facilitates hundreds of thousands of consults every day. It is the future of healthcare in India! Virtucare, a Melbourne led initiative with partners including CDAC Mohali, George Institute, CBM, PHFI, PRASHO and EHA, has been working with E-Sanjeevani to maximise disability inclusion in systems and digital platforms. The accessibility score of E-Sanjeevani is now close to 100% as they have specifically focussed on this issue with the support of this project. This means people with disability can benefit from the world's largest telehealth system.

How are India and Australia cooperating in disability research and policy development?

We are cooperating with the Indian government in training community disability workers as outlined above. The Community Based Inclusive Development (CBID) course trains thousands of community disability workers (Divyang Matra) each year. The MoU in disability between Australia and India, signed in the presence of the President of India, has facilitated this cooperation. Alongside this we have been cooperating on strengthening inclusive telehealth and promoting telerehab programmes. If digital health is to benefit everyone, including people with disability, then we need to intentionally plan and include approaches that maximise inclusion. To this end we have been working with PRASHO and an expert advisory group to develop best practice to do this. Under the MoU and supported by the Australian High Commission and CBM we have also done a body of work exploring insurance programs to support people with disability. We have shown that investing in disability actually has a good return on investment.

What were the key takeaways from the inaugural India Chapter of the Indo-Pacific Global Health Case Competition, and what is the future outlook?

11 leading institutes in India came together to show how seriously they are about tackling complex global health issues of our time and their willingness to facilitate their students to learn and apply their learning to create innovative solutions. The future of health in India is in good hands. The quality of the presentations demonstrates a high level of competence and passion. It also shows that the leading universities in India are producing graduates that have the right skills and values. This case also challenged the students to develop solutions that were inclusive of people with disability. A number of students expressed how this really opened their eyes to the needs of people with disability. Finally, it shows the importance of transnational education where we can learn together and share ideas and projects that provide world class learning opportunities.

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