

Convocation Address at the 41st Annual  
Convocation of the All India Institute of  
Medical Sciences  
New Delhi, India, 12 September 2013

Excellencies, graduates and honourees, faculty, scientists,  
distinguished guests, ladies and gentlemen,

It is a great honour to address you from a campus that houses India's most elite medical college, its best post-graduate training programmes, its world-famous research facilities, and its teaching hospital and centres for specialized tertiary care.

These treatment facilities attract patients from all over India and abroad, who stream here, in the thousands every day, seeking the miracles of modern medical care. They usually find those miracles, big or small, at very low cost or, for the poor, at no cost at all.

This policy aligns with my own personal conviction. The poor deserve the very best medical care because they have been given so little else in life.

Health is a nation-building strategy. The students and scholars who will be receiving degrees, awards, and prizes today are India's investment capital for building a better future.

You are the elite, and the elect, with the talents, skills, and knowledge needed to spearhead improvements throughout India's health system. You are a leading light, and much more.

You are a symbol of the spirit and aspirations of modern Indian society. A symbol of this government's desire to cultivate talent, reward excellence, and reach for the world's highest standards. In other words, you are a symbol of India's aspirations to stand shoulder-to-shoulder with the giants.

I doubt there are many medical graduates, anywhere in the world, who have benefitted from such a privileged education. You have a first-rate tight-knit faculty, with an enviable student-to-teacher ratio.

You have been immersed in an environment that stimulates creativity and innovation, often with a distinctly Indian touch.

As noted in the 56th AIIMS Annual Report, clinical research conducted here is finding new therapeutic applications for medicinal plants, especially for the management of chronic diseases. Such research is a good way to bring this country's rich heritage of traditional medicine into the family of modern therapies, backed by rigorous scientific evidence.

As students, you have witnessed cutting-edge technology performed in state-of-the-art facilities. Staff at the All India Institute of Medical Sciences can perform robotic surgery, treat the foetus, reattach amputated limbs, transplant organs, and manage cancer with the latest medicines and technologies.

You have also witnessed the health needs of the very poor.

As you receive your degrees, awards, and prizes, your years of concentrated study and learning, those textbooks, classes, and long nights in the library, are now formally transformed into the start of especially promising careers. Opportunities will open and you will make a number of choices.

Many of you will begin to practice the art and science of medicine. You will experience some setbacks and surprises, and probably bouts of self-doubt. You will be wrong sometimes, but eventually right more often than not, as you will never stop learning. This, too, is part of your training.

But here is one thing fairly certain. Most of you will encounter severely malnourished children, especially as so many of these small patients need to be treated in hospital. Their management is a medical problem, a medical emergency, and it is a social problem, a social emergency.

These tiny patients are visibly wasted, apathetic, and despondent. They rarely cry. Why waste energy crying when it brings no comfort? When picked up, they may respond with a monotonous bleating sound, but no tears will fall. Nearly starved, they have lost their appetite for living. They do not smile.

WHO has long stressed the importance of giving these children much more than first-rate medical care. They need extra stimulation, extra cuddling, extra toys, and bright colours around their cots as a way of preventing permanent mental and emotional impairment.

This is not a costly intervention, but it is by no means a real solution. Managing a severely malnourished child can be both a highly rewarding and a heart-breaking experience. Doctors have the tremendous reward of quite literally bringing these children back to life, watching them gain weight, smile and thrive. You release them to their homes, to the same environment. And they relapse. You see them again, likely with their siblings. It never ends.

Nor can you always blame an ignorant parent. When asked what the child should be eating, many mothers can give you a textbook answer: green and leafy vegetables, meat, fish, fruit, milk, and milk products.

“And what did your child eat today?”

“Rice gruel.”

“And what did your child eat yesterday and the day before?”

“Rice gruel. Rice gruel. Rice gruel is all we have to eat.”

This is poverty. This is misery.

And this is my first wish for you. That during the course of your careers, the number of India's severely malnourished children, of girls and pregnant women with severe anaemia, will diminish to the vanishing point.

I know that this is among the ambitions of the government of India, as expressed through the establishment of the National Rural Health Mission and as set out in its Twelfth Five Year Plan. That Plan further acknowledges the need for public policies that address the broader social determinants of health. Treatment by the best doctors in the best hospitals will not tackle the root causes of ill health, with poverty being the deepest root of all.

Graduates and honourees,

Sometimes a single statistic can tell a story, about now and about the big trouble that is on its way.

Of the estimated 346 million people worldwide who suffer from diabetes, more than half are unaware of their disease status. For many of these people, the first contact with the health services will come when they start to go blind, need a limb amputation, experience renal failure, or have a heart attack.

This is my second wish for you. That patients with chronic diseases will benefit from screening and early detection services, and reach you at a stage when your care can help prevent acute events, help prevent long hospital stays, huge medical bills, and an early death.

For this wish to come true, several changes are needed. Schemes for financial protection are needed. People who have to pay out-of-pocket for care tend to delay visiting a health centre until their condition has advanced to the stage that it is extremely difficult, if not impossible to treat.

To catch these diseases early, primary health care must be strengthened to include screening and early detection services, backed by a good referral system. Medical education can help by increasing the career appeal of family and community medicine.

India's health system is doctor-centred, yet the country faces a crippling shortage of doctors. India has around a million rural medical providers who are unregistered, unlicensed, and often unqualified. They are the last resort for millions of the rural poor living at the end of the road, at the end of the rope.

India's health system must also cope with the extraordinary growth of care provided by private practitioners. Many private hospitals are corporate enterprises driven by profits, with neither the quality of care nor its costs subject to regulatory control. Their predominance in the health system stimulates the overuse of services, tests, and hospital beds, contributing greatly to waste and inefficiency, and furthering the problem of catastrophic medical bills.

India is famous as the world's pharmacy, as the biggest supplier of high-quality low-priced generic medicines that form the backbone

of affordable care throughout the developing world. Yet in this country, the price of essential medicines has been progressively soaring for years. Fuelled by these rising prices, out-of-pocket payments for health care have become one of the leading causes of direct debt and poverty in India. These are not just bills for expensive treatments and long hospital stays. Even the cost of essential medicines can drive a household living on the margins over the brink and into poverty.

At least some of the people who flock to this Institute, expecting miracles, hoping to be kept alive, will have sold their assets, their livestock, perhaps even their ancestral land. This is the strength of the will to stay alive, even if it means poverty for the entire household.

This is my third wish. That the interventions you prescribe as best for your patients will never be a cause of their financial ruin. That no patient will be lost to follow-up because of an inability to pay. That the potential of your training to do great good will never be blocked by poverty.

That day may not be so far away.

The government of India is acutely aware of all the problems I have described. In January 2011, Indian researchers, including many from this Institute, published a series of papers in the Lancet.

Papers, commentaries, and editorials argued that a failing health system may be the biggest obstacle to further progress in this country. They concluded that India needs a policy of universal health coverage, led by government, as the foundation for continuing national development.

In November of that same year, a High Level Expert Group, instituted by the Planning Commission of India, published its report on universal health coverage for India. That report concluded that the goal of UHC for India was entirely feasible and affordable. Many of its key recommendations were incorporated in the country's Twelfth Five Year Plan.

India's health care system has multiple untapped opportunities to reduce waste and inefficiency, whether through tighter regulatory control of health providers and products, or through use of the

country's innovative IT sector to introduce hospital information systems and electronic health records. Doing so frees resources to expand service coverage.

Apart from my wishes, I also have some heart-felt advice. Never forget your humanity, or that of your patients. They are people, not just a collection of specialized body parts. They have unique life-stories, linked to their place in families, communities, and societies, with women and girls often occupying the lowest place. These circumstances have a profound impact on illness and healing. Remember: Of the seven deadly sins identified by Mahatma Gandhi, science without humanity is one.

Graduates and honourees, ladies and gentlemen,

The problems I have described are not unique to India. Not at all. In a world of radically increased interdependence, health everywhere is being shaped by the same powerful forces, like demographic aging, rapid urbanization, and the globalization of unhealthy lifestyles. Under the pressure of these forces, chronic diseases have displaced infectious diseases as the leading cause of mortality worldwide.

Nearly everywhere, health budgets are shrinking, public expectations are rising, and costs are soaring. At the same time, the benefits of the world's growing wealth are not evenly distributed. According to the OECD, social inequalities are at their highest level in more than half a century.

Something has gone wrong.

The promises and expectations voiced by many economists and political analysts have not been borne out by reality.

Globalization was embraced as the rising tide that will lift all boats. This did not happen. Instead, it tended to lift the big boats but sink or swamp many smaller ones.

Trade liberalization was put forward as the sure route to prosperity for the developing world. In reality, it is economic suicide to ask a country with an immature economy to open itself to global competition.

India and China have lifted millions of their people out of poverty, but they liberalized trade only after their own economies were mature. Just one example makes the point. In the Americas, the country with the most liberal trade policies is Haiti.

The international banks encouraged debt-ridden countries to reduce spending on social services, resulting in sharp cuts in publically-financed health services. Market forces, we were told, would then operate to expand coverage.

This never happened. Instead, coverage shrank as did the overall use of publically-funded health services, also for preventive care. Private providers stepped in to pick up the slack, but only for those who could pay.

User fees were put forward as a way to recover costs and reduce the overconsumption of care. This did not happen. Instead, user fees punished the poor.

Numerous countries watched their government-run health services fall into disarray, forcing impoverished people to pay private practitioners high fees for routine care, while the best care and services were reserved for the privileged few.

This is inequality.

Ladies and gentlemen,

Our world is out of balance as never before. The gaps, between and within countries, in income levels, opportunities, and health outcomes are greater today than at any time in recent decades. The difference in life expectancy between the richest and poorest countries exceeds 40 years. Annual government expenditure on health varies from as little as \$1 per person to nearly \$7,000.

A world that is dangerously out of balance is neither stable nor secure.

Fourteen years ago, Professor Amartya Sen, Nobel Laureate in Economics, addressed the World Health Assembly, the supreme governing body of the World Health Organization. He explored the question of how health relates to development.

As he noted, understanding development requires understanding the relation between incomes and achievements, between the possession of material commodities and the development of human capabilities, between our economic wealth and our ability to live life as we would like.

He strongly challenged the notion that economic growth is the be-all, end-all, cure-for-all. Economic growth, all by itself, will never solve social problems.

I entirely agree. Growth in GDP is not the real measure of a nation's progress. What matters most is the rate at which economic wealth is translated into less poverty, more opportunities, and better health.

Too many models of development assumed that living conditions and health status would somehow automatically improve as countries modernized, liberalized their trade, and experienced rapid economic growth. But history tells us that the equitable distribution of benefits happens only when the right public policies are in place.

Decades of experience tell us that this world will not become a fair place for health all by itself. Health systems will not automatically gravitate towards greater equity or naturally evolve towards universal coverage.

Economic decisions within a country will not automatically protect the poor or promote their health. Globalization will not self-regulate in ways that ensure fair distribution of benefits. International trade agreements will not, by themselves, guarantee food security, or job security, or health security, or access to affordable medicines.

All of these outcomes require deliberate policy decisions. Decades of experience also tell us that universal health coverage is one of the most powerful social equalizers among all policy options.

India is a country of vast contrasts, but also of vast untapped potential. If a fragmented and commercialized health system is holding back progress, India has the intellectual capacity and practical know-how to solve that problem. Pressure from especially vocal activists and civil society organizations, in the world's largest and arguably most vibrant democracy, will help that happen.



Most countries that have achieved universal health coverage have needed three to four decades to do so. Members of the High Level Expert Group on Universal Health Care are confident that India can do this within 10 years.

This is the potential, the promise, and the unflagging optimism of amazing India.

This is the spirit I see in the bright young faces gathered here to be honoured today, in your caps and gowns, the pride and promise of India.

May all your dreams come true. May all my best wishes speed you on your way.

Thank you.

2,559 words