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"National Rural Health Mission: Institutional Reform and Institutional Limitations," T. Sundararaman. *India in Transition*, May 21, 2012 (https://casi.sas.upenn.edu/iit/sundararaman)

India in Transition

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Is India's Public Health System Ready to Face the COVID-19 Pandemic?

BY T. SUNDARARAMAN
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क्या भारत की सार्वजनिक स्वास्थ्य प्रणाली कोविड-19 की विश्वव्यापी महामारी का सामना करने के लिए तैयार है? (/hindi/iit/india%E2%80%99s-public-health-system-ready-face-covid-19-pandemic)

INDIA IN TRANSITION

Special COVID-19 Series

Suddenly, within just six weeks, the pandemic is upon us.

The first case of COVID-19 in India was reported on January 29th and reached 100 cases by March 14th. As of today, there are over 5,000 cases and 166 deaths (and counting (https://www.mohfw.gov.in/)) due to COVID-19. At first glance, this is not alarming, as it works out to just 3.6 cases and 0.11 deaths per million; one of the lowest infection and mortality rates anywhere in the world. The Indian media, and many Indian and world leaders, have hailed Prime Minister Modi for his boldness in going all in for an early and strict nation-wide lockdown, and have attributed these low rates to his strategy. Comparisons have been drawn with the situation in Europe, and claims made (including by the prime minister himself), that despite such nations having far better health systems, India has achieved better control of this crisis. Others have attributed the “success” to protection afforded by India’s hot climate, or some form of genetic or acquired resistance.

Such declarations could be premature and misleading. We are still in the early days of the pandemic, and new cases are continuing to increase each week. Furthermore, India has one of the lowest testing rates in the world, which skews the legitimacy of the low numbers. Additionally, while most nations list mild and moderate cases (and as many as 50 percent of all infected personal could have no symptoms), India does

not test people unless they have a clear history of contact. If community transmission is ongoing, India's actual number of cases could be five times higher than reported. India's death reporting system functions sub-optimally in most states, and only one in four death reports mention the cause of death. Many of these deaths happen at home. The sensible thing to do would be to prepare for an epidemic on the safe assumption that COVID-19 will treat Indians just like it does any other ethnicity and nation.

The Legacy of Health Sector Reforms

The problem with strengthening health systems to respond to an outbreak is that the best time to begin is at least ten years beforehand. Learning from this pandemic, we can list a few important tasks India should have carried out and reflect on why we did not do them earlier.

Saving lives during the COVID-19 pandemic requires good quality intensive care with advanced ventilator support. There must be public services that have the technical capacity to provide this. But in most states, such capacity is far too limited due to a policy introduced under an earlier generation of health sector reforms, and revived recently, where the main effort is to limit public services to a very select and minimalist package of services and leave the rest to the private sector. Most of the district hospitals, and even medical college hospitals outside the main metropolises, are just not equipped to provide the sort of intensive care that this disease requires, and it will be quite a challenge to build them up.

Inadequate Public Investment in the Health Sector

Public hospitals and health care facilities must have a built-in excess capacity in infrastructure design, in number of beds and equipment, and even in staffing. Thus, in times of need, they can be quickly stretched to handle the extra load. Most public hospitals are, however, designed the other way around—just the minimum required—and sometimes not even that. Those hospitals that provide a larger package of services are over-crowded and over their capacity.

Under the National Health Mission, from 2005 to 2012 there had been an increase in public health expenditure that went into strengthening public health infrastructure and service delivery—but even then, there was not enough expansion of the total services provided. Under the current regime, health care has been given very low priority. Commenting on the low allocations to health in the Union Budget 2016–17 in a 2016 *Economic & Political Weekly* issue, we had warned

(https://www.epw.in/journal/2016/16/budget-2016%E2%80%9317/no-respite-public-health.html): “The finance ministry is apparently responsive only to the needs of the industry, defense, and economic growth rates. Without sounding alarmist, it would be useful to remind the ministry that chronic and sustained under-financing of public health systems over the last four years has now reached such critical levels that there is a serious threat to health security of the nation as well as to its economic growth—not only in the long run, but also in the immediate—not only for the poor, but for everyone.” Post lockdown, the Government of India announced an additional Rs. 15,000 crore to strengthen public health services immediately. This was most welcome, but the government should have provided this annual increment in funding over the last four years to reach its own policy targets.

The Need for Self-Reliance in Health Technologies.

The prime minister has repeatedly pointed out that even the nations known for universal health coverage with high standards of health care were struggling to cope with the pandemic. The huge requirement in select health commodities and equipment that a pandemic response needs would be a challenge for any nation however robust its infrastructure. Adequate test kits for a new virus, ventilators, and personal protective equipment (PPE) for its staff are the main requirements. It is worth noting that some nations, notably China, South Korea, Germany, and Iceland were able to move very fast and get these supplies going. These are the nations that went for an intensive testing regime and kept their lockdowns very limited. But India, reputed as the pharmacy of the third world, with an immense manufacturing capacity of its own, has been unable to scale up the production of test kits, PPEs, or ventilators. In these areas, the nation had become completely import dependent. Its limited manufacturing capacity in these areas was also focused on the export market. So now when the need is at its peak, imports have dried up. The production in every country is prioritized for its own needs. Belatedly, in the last two weeks that exports were prohibited, new manufacturers have been identified, certified for production, and orders placed. If the pandemic escalates as anticipated, the nation is in deep trouble. It is time to step back from free trade fundamentalism and factor in considerations of self-reliance, health security, and health sovereignty as guiding principles for developing manufacture in health commodities.

As India’s health system preparedness is going to take longer, an early development of medicines or vaccines could be a huge boon to its predicament. But here, too, India must have the political will to do whatever it takes to become self-reliant in

production within the shortest time.

It is worth noting that some states that have been investing in building up their public health care services are relatively better placed to cope with the needs of hospital care and outreach services. Kerala, which had an innovative program called "Aardram" to strengthen the quality and comprehensiveness of its health care services, is one such example. Though it has an older and more vulnerable population, it is able to respond much better to the crisis. Other states like Bihar, Uttar Pradesh, or Jharkhand—where the gaps are high—are the least prepared to face this crisis, and their ability to close these gaps in such a short time would be difficult, if not impossible. Much of the Centre's attention had gone into building systems of purchasing care from the private sector through insurance mechanisms. But these have little relevance to addressing the crisis. The only forms of engagement considered are placing select private hospitals under a public authority as a form of expanding government capacity to respond to health care needs.

Lockdowns Buy Time but at a Great Social Cost

The praise of the lockdown, and the projection of social distancing as the one and only strategy have drawn attention away from the failures in health systems' preparedness, both of the past and the present. India's lockdown may have been bold, but we do not know whether it was effective. We do know that it was brutal for most of India's working population who have no social security, job assurance, or savings and were forced into a desperate migration to return to their home villages. There have been many incidences of violence and violations of rights with regards to these migrants. The relief measures for unorganized workers are far from adequate, and in a nation under lockdown, don't even reach those who need it most. Those working in agriculture have been seriously affected. Small enterprises have collapsed. And there are major concerns that the lockdown of essential health services needed for saving mothers and children and combatting old killers like tuberculosis, water-borne diseases, and non-communicable diseases could seriously compromise overall health outcomes.

For a large part of the population living in overcrowded homes in dense slums, staying at home is not social distancing. And for another large part of the population forced into migration or captured and forced to huddle in temporary camps, social distancing has actually decreased. The current strategy of testing is not enough to provide data on whether the lockdown has helped. But even if the lockdown had been effective, there can be little doubt that the disease incidence will spiral upwards

once it is lifted. At best, the lockdown has bought time for preparing health systems at a very great cost. And we can ill afford to have repeated lockdowns; the sort of problems that lockdowns create in a nation where the majority are part of the organized work force are only exacerbated. Strong social security nets cannot be compared with the sufferings of a population where the majority are in unorganized sectors, mostly in precarious livelihoods, living on the edge without any effective social security or health care.

And so India will have to fall back on the strengthening of public health services. The best time for doing so was ten years ago. The next best time is now.

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