
COVID-19 and Healthcare in India:
Call for Building up System Level Resilience

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Abstract

COVID-19 has posed unprecedented challenges for the health sector. The long-standing weaknesses of the Indian healthcare system stand exposed. The article briefly discusses the vulnerabilities of the healthcare system in India and the ways to address them. It calls for using the present challenge as an opportunity to learn and resolve to reorganize the healthcare system with built-in resilience at the micro, meso, and macro levels. This will augment the system's capacity to deliver everyday benefits and positive health outcomes in times of crisis, yielding the 'resilience dividend'. It emphasizes that there is a need to implement the learning from the pandemic and take steps to adapt and transform the Indian healthcare system.

Keywords: COVID-19; Health; Public Health; Healthcare; Resilience

Humanity is waking up to the call for disaster preparedness. There is an increasing awareness that resilience needs to be built into health systems. Sudden disease outbreaks and catastrophes can cause substantial human suffering and economic losses. If health systems are ill-equipped to deal with such situations, the affected populations can be very vulnerable.

Until very recently, the world was confronted with the challenge posed by the spread of the novel SARS Cov-2 caused COVID-19, a cardiopulmonary disease with a more than 2% mortality rate. The pandemic is far from over. The World Health Organization (WHO) declared COVID-19 a Public Health Emergency of International Concern (PHEIC) on January 30, 2020. The same day India reported its first confirmed case. Since then, 19,268 deaths out of 6,53,896 confirmed cases were reported as of July 5, 2020 (08:00 IST). The economic and socio-psychological effects of the crisis have been profound. For the health sector in India, it has posed unprecedented challenges, and its long-standing weaknesses stand exposed.

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There is a need to reorganize the Indian healthcare system with built-in resilience at the micro, meso, and macro levels. This will augment the system's capacity to deliver everyday benefits and positive health outcomes in times of crisis, yielding the 'resilience dividend'.³ Building a resilient health system has also been recognized as an ethical imperative.⁴

Health system resilience is defined as the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganize if conditions require it. According to Kruk et al., resilient healthcare systems are 'aware, diverse, self-regulating, integrated and adaptive.

The Report of the Commission on Global Health Risk Framework for Future identifies six actions to build resilient public health systems: revising public health law/policy framework, strengthening public health infrastructure, building partnerships, using research evidence to inform decisions, engaging and communicating with communities and establishing a Public Health Emergency Operations Centre (PHEOC).

Building up a Resilient Healthcare System in India

Building resilience is context-dependent and iterative, needing advanced assessments of system capacities and weaknesses, investments in vulnerable components of the system before a crisis, reinforcements during the emergency, and a review of performance after a crisis. The following actions are needed to address vulnerabilities in the Indian healthcare system and make it resilient:

1. Revising public health law/policy framework

The Constitution of India enlists public health under the State List. Only a few Indian states have been able to introduce effective public health legislation. Attempts to enact a comprehensive national act covering all aspects of public health in the form of the National Health Bill- 2009 have remained unsuccessful. For dealing with infectious disease outbreaks, the colonial Epidemic Diseases Act of 1897 (EDA) has been repeatedly used by the states, down to the recent COVID-19 outbreak. The Public Health (Prevention, Control, and Management of Epidemics, Bio-terrorism, and Disasters) Bill drafted in 2017 is pending.

For want of a comprehensive law, allied laws have also been used to respond to the Covid-19 outbreak. The Indian government has taken recourse to the Disaster Management Act by declaring COVID-19 as a notified disaster. It has been pointed out that, "There is no clarity in the Standard Operating Procedures (SOP) that would be adopted by the National Centre for Disease Control (NCDC), where the situation is not classified as a 'disaster' but as an 'outbreak' or a 'potential outbreak'.

It is unclear how the different ministries would be mobilized by MoHFW, in the case of an imminent outbreak that is yet to be declared an emergency. The enabling provisions to take control measures across all relevant ministries, in case of an outbreak to mobilize different authorities under the multiple laws governed by different ministries, need to be identified.” There is a need for a comprehensive national law covering various aspects of health system governance.

2. Increase budget outlay for public health:

As per the National Health Profile-2019 (NHP-2019), India’s public expenditure on health now stands at 1.28 percent of the GDP, which is way lower than the average expenditure by countries categorized as the “poorest”. It is even lower than other Southeast Asian countries like Nepal, Sri Lanka, Bhutan, Indonesia, and Thailand.

3. Strengthen the public health workforce and infrastructure

a. Public health workforce

The NHP-2019 report states that there is only one allopathic government doctor for every 10,926 people in India. WHO recommends a doctor-population ratio of 1:1000 while the current doctor-population ratio in India is only 0.62:1000. The Rural Health Statistics 2018-19 reveal that the sub-centers and Primary Health Centers (PHCs) are short by 10,916 Auxiliary Nurse Midwife (ANMs) and 98,063 male health workers. It has been suggested that the ASHA workers get fixed remuneration rather than paltry incentives.

The workforce crisis should be met quantity-wise, but is important to address qualitative gaps like inadequate training, inequitable deployment of the healthcare workforce, and low morale in healthcare service delivery. It is high time that India develops and executes a concrete workforce-strengthening strategy. Using data from NHP-2019, it has been reported that there are 0.55 beds per 1000 population available in India. Twelve states lie below the national level figure. Bihar has just 0.11 beds available per 1000 population. Even the country’s capital Delhi has 1.05 beds per 1000 population.

The role of primary health care is central to achieving health and well-being for all. During disease outbreaks, it is considered to be both- the ‘radar screen’ to pick up the initial cases and the delivery system to execute an effective response strategy.⁶ In India, the Primary Health-care Centers (PHCs) lack health resources- both human and material even for effective day-to-day functioning. There is a resolve to establish 1,50,000 Health and Wellness Centers (HWCs) by upgrading the existing PHCs and Sub-centers.

It is to be seen if the problems of a shortage of skilled and committed workforce, poor infrastructure, and implementation bottlenecks can be overcome. Regarding the attempt to work towards the attainment of universal health coverage (UHC) through the Ayushman Bharat Programme (2018), there are concerns that it will promote secondary and tertiary healthcare at the expense of primary healthcare.

b. Surveillance and information systems

The National Centre for Disease Control (NCDC) is the nodal agency in the country for disease control and surveillance. The Integrated Disease Surveillance Programme (IDSP) was launched in 2004 with the objective of strengthening and maintaining a decentralized laboratory-based IT-enabled disease surveillance system for epidemic-prone diseases to monitor disease trends and detect and respond to outbreaks in early rising phases. Weekly reports are released by the IDSP based on data from Surveillance units at the district (DSU) and state (SSU) levels. Although the reporting of outbreaks by the states has increased quantity-wise, there is a need to improve the quality of outbreak reporting and investigations. Besides, there is a serious shortage of trained workforce.

c. Laboratory capacity

Diagnostic capability is the key to disease control; more so during disease outbreaks. The National Institute of Virology, Pune is the designated nodal laboratory, also coordinating the testing of samples for COVID-19. As of June 30, a total of 764 government and 292 private laboratories were operational for coronavirus testing. Beginning with a low level of testing, India has slowly come far. Nevertheless, laboratory capacity is still inadequate and there is a need to expand it.

4. Building partnerships

Partnering with other public, private, and non-profit organizations is critical to healthcare. One of the biggest challenges in the current pandemic times has been partnering with the private sector. Private healthcare is unaffordable for the majority of the population.

5. Engaging with communities

Community engagement is crucial for healthcare systems. It is all the more important for outbreak preparedness and response. In the context of the COVID-19 pandemic, there has been an effort to adopt the Participatory Disease Surveillance (PDS) framework by introducing the Aarogya Setu.¹⁵ However, caution needs to be exercised to address participation from digitally isolated populations, ensure the reliability of data, and consider ethical concerns such as maintaining individual privacy.

6. Establishing a Public Health Emergency Operations Center (PHEOC)

Global inter-connectedness of the world has raised the importance of PHEICs manifold. The need for a PHEOC has been recognized internationally to strengthen health systems worldwide to rapidly detect and effectively respond to PHEICs. In 2012, WHO established the Public Health Emergency Operations Centre Network (EOC-NET) to identify and promote best practices and standards for EOCs and provide support to EOC capacity building in the Member States.

A PHEOC integrates traditional public health services into an emergency management model. It supports and is a component of existing national disaster management authorities or entities. It must be part of a comprehensive program of public health emergency preparedness, planning, and capacity building. India is one of the member states and is also participating in the Global Health Security Agenda (GHS) which was launched in 2014 by WHO, US Centre for Disease Control and Prevention (CDC), and other partners. However, the efforts in the direction of implementing the GHS need to be further strengthened.

Conclusion

The COVID-19 pandemic in 2019, and subsequent recurrent waves have made the importance of healthcare more explicit than ever. Further, the pandemic has taught the importance of preparedness to be woven within the healthcare system. It is important to carry out honest self-assessments, make realistic plans, identify gaps in implementation, and fix them. To conclude, there is a need to treat the pandemic as a wake-up call and resolve to understand the vulnerabilities of the healthcare system in India, implement the learning from the pandemic, and take definite steps to adapt and transform the system to make it resilient.

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