India needs a renewed health-care system

The new Health Minister needs to focus on the core lessons from the pandemic and rebuild trust in public health

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India has a new Union Health Minister after the recent cabinet reshuffle. So, what does the new Health Minister need to learn from previous experience, and what unfinished tasks need to be taken forward? As citizens, how should we expect the Government to perform better on the public health front, given the lessons of the COVID-19 pandemic? If the Union Health Ministry acts upon the following health system lessons, this would not only enable improved handling of COVID-19, but would also have widespread positive impacts extending much beyond the COVID-19 situation.

Two States and a comparison

For any population, the availability of functional public health systems is literally a question of life and death. This is evident by comparing two States which currently have the highest number of COVID-19 cases in India – Maharashtra and Kerala. Their per capita gross State domestic product (GSDP), reflecting the overall economic situation in each State, is similar. However, their COVID-19 case fatality rates are hugely different – this being 0.48% for Kerala and 2.04% for Maharashtra, with the shocking implication that on average, a COVID-19 patient in Maharashtra has been over four times more likely to die when compared to one in Kerala.

A major reason for such critical divergence is likely to be the huge differences in the effectiveness of public health systems. Kerala has per capita two and a half times more government doctors, and an equally higher proportion of government hospital beds when compared to Maharashtra, while allocating per capita over one and half times higher funds on public health every year. Despite Maharashtra having a large private health-care sector, its weak public health system has proved to be a critical deficiency.

In contrast, robust government health-care services in Kerala have translated into: a more effective outreach, timely testing, early case detection and more rational treatment for COVID patients, which all together reduce fatality rates. Existing evidence from the COVID-19 pandemic provides a clear message: a neglect of public health systems can mean large-scale, avoidable losses of lives; hence, public health services must be upgraded rapidly and massively as a topmost priority.

Focus on public health

Talking of priorities, if the ₹20,000 crore or nearabout allocated for the Central Vista project were to be utilised instead to set up oxygen plants, two-thirds of the over 25,000 government hospitals across India could acquire their own oxygen source, thus helping to save the lives of lakhs of COVID-19 and non-COVID-19 patients. A larger programme which requires the immediate attention of the Health Minister is the National Health Mission (NHM); since 2017-18, Union government allocations for the NHM have declined in real terms, resulting in inadequate support to States for core activities such as immunisation, while systemic gaps affect the delivery of COVID-19 vaccination.

Although urban people across India have experienced major shortages of public health services during COVID-19, the condition of the National Urban Health Mission (NUHM) remains pathetic. This year's Central allocation for the

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NUHM is ₹1,000 crore, which amounts to less than ₹2 per month per urban Indian. This situation must change, and as recommended by the Parliamentary Standing Committee, for reaching National Health Policy targets, the Government must allocate ₹1.6-lakh crore for public health during the current year. This would amount to a doubling of the present central health Budget, which could enable major strengthening of health services in rural and urban areas across the country.

Private sector regulation

Another clear priority that has been highlighted during the COVID-19 pandemic is the need to regulate rates and standards of care in the private sector. Massive hospital bills have caused untold distress even among the middle class; COVID-19 care often costs ₹1 lakh to ₹3 lakh per week in large private hospitals. The 'Remdesivir panic' was significantly linked with major overuse of this medicine by unregulated private hospitals, despite the drug lacking efficacy to reduce COVID-19 mortality. Although various determinants have contributed to the Mucormycosis outbreak, irrational use of steroids in COVID-19 patients, especially diabetics, appears to be an important factor.

Yet, despite accumulating evidence on the need for comprehensive regulation of private hospitals, the central government is yet to take necessary steps to promote the implementation of the Clinical Establishments (Registration and Regulation) Act (CEA).

Passed in 2010 and presently applicable to 11 States across India, this Act is not effectively implemented due to a major delay in notification of central minimum standards, and failure to develop the central framework for regulation of rates. Responding to public distress, around 15 State governments invoked disaster-related provisions to regulate rates for COVID-19 treatment in private hospitals. However, initiatives from the central government to promote regulation of private hospitals during the COVID-19 situation are conspicuously inadequate. Learning from stark market failures during the COVID-19 pandemic, comprehensive regulation of private health care in public interest now must be a critical agenda for the new Health Minister.

NITI Aayog prescriptions

A logical corollary of the first two lessons is that health services should not be further privatised. However, flying in the face of health-care distress faced by ordinary Indians during the last 16 months, NITI Aayog has recently published the document, 'Investment Opportunities in India's Healthcare Sector' (https://bit.ly/3em8myP). This promotes further privatisation of health care in a country which already has one of the most privatised health systems in the world.

Published in the midst of widespread experiences of large-scale overcharging and irrational care by private providers during the COVID-19 epidemic, the report fails to acknowledge the negative aspects of unregulated private health care; neither is there any mention of the need for regulation of private hospitals. Instead, the document celebrates the COVID-19 epidemic as a prime business opportunity to be exploited, stating that 'in the hospital segment, the expansion of private players to Tier 2 and Tier 3 locations, beyond metropolitan cities, offers an attractive investment opportunity'. Proposals for handing over public hospitals to private operators, who would presumably now run these key public institutions on commercial lines under the 'Viability Gap Funding' scheme are deeply worrisome, especially since public health services which were hitherto free of cost, would begin to be charged for.

Assuming that the Union Health Ministry has a primary mandate to shape national health policy in India, the Health Minister must assert his authority to stop such moves for further privatisation, which might benefit health-care corporates but would be damaging for ordinary people.

To conclude, this is a time when it is critical to rebuild people's trust in public health systems. This would help in overcoming COVID-19 vaccination hesitancy while strengthening the promotion of healthy behaviours necessary to deal with the current wave of COVID-19 and prevent a third wave. This would be done best if the new Health Minister acts on three core health system lessons of the COVID-19 pandemic – a need for strengthening public health systems; regulating private health care, and preventing further privatisation of the health sector. It is not unjustified to expect our new Health Minister to present an example to the people of India, by acting decisively for public health systems.

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