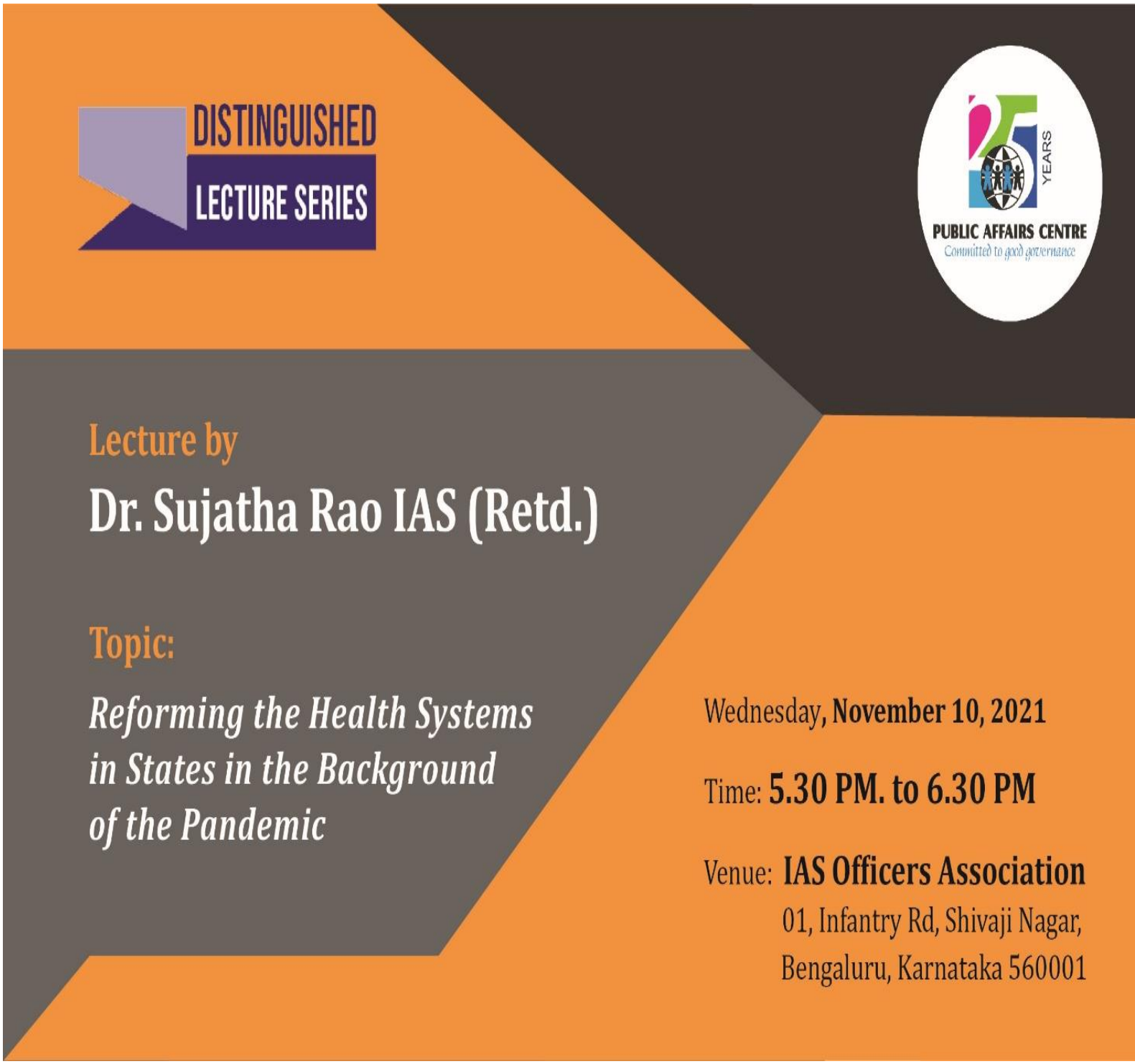

Public Affairs Centre

November 2021

Introduction

Public Affairs Centre launched the Distinguished Lecture Series (DLS) an annual event. The DLS will primarily engage with retired government officials by inviting them to speak on niche and relevant topics. The 1st event was launched on Wednesday, November 10, 2021 in Bengaluru, by inviting Dr. Sujatha Rao IAS (Retd) former Secretary of Health and Family Welfare, Government of India. The topic of discussion was **Reforming the Health Systems in States in the Background of the Pandemic.**

The event was kick started by Dr. Annapoorna Ravichander who welcomed all the dignitaries and introduced them.

Welcome Address and Introduction

Gurucharan. G, Director gave the Welcome Address and briefly introduces the Public Affairs Centre (PAC) and the Centre for Open Data Research, the analytical arm of PAC. He then continued by stating that there really is no more distinguished civil servant, certainly one who has served public health, as Ms. Sujatha Rao.

Dr Sujatha Rao is an exemplary leader in Public Health.

It is therefore an honour for us at PAC to have her deliver the inaugural lecture of the PAC Distinguished lecture series. So, a very warm welcome to you Ms. Sujatha Rao.

K. Sujatha Rao served as Union Secretary, Ministry of Health and Family Welfare of the government of India until 2010, and led the first ever national program for non-communicable diseases; the process for a national policy for use of antibiotics; and introducing vaccines in public health.

Prior to that, Dr Rao was the Director General of the National AIDS Control Organization (NACO) from 2006-2009, where she was instrumental in establishing systems and building up NACO with a capacity to implement programs with a five-fold budget increase.

Dr Rao has also served with great distinction as the Principal Secretary Health in two stints in the undivided Andhra Pradesh state. She spent 20 of her 36 years as a civil servant in the health sector. A unique distinction that gives her both expertise and the experience to make so distinguished.

She has represented India on the boards of the WHO, the Global Fund and UNAIDS. Dr Rao holds a Master's in Public Administration from the Harvard Kennedy School. She was a Takemi Fellow for International Health at Harvard School of Public Health (1993). She was also the first Gro Harlem Brundtland Senior Leadership Fellow at Harvard School of Public Health.

Dr. Sujatha Rao is the author of a widely acknowledged book '**Do we care? India's Health System'**

He concluded by stating that Dr. Rao spearheaded the first national programme on non-communicable diseases and introduced vaccines in public health. Despite the unpredictability and

fickleness of Administrative Services postings, Ms. Sujatha served in the same sector for more than 20 years, a remarkable achievement in itself.

Highlights

- In Karnataka, the pandemic overwhelmed the urban health systems more than rural health systems
- All states operate in resource-constrained environments and there is a need to optimise solutions
- Optimise solutions in resource constrained states
- What needs to be done to address the non-availability of data?

Distinguished Lecture

Dr. Sujatha Rao, started the Lecture by stating that the COVID-19-19 pandemic was one of the most impactful health disasters in a hundred years. In terms of spread, virulence and case fatality, it is second only to the 1918 Spanish Flu pandemic. While 18 million are estimated to have died in the flu pandemic, the official tally for COVID-19 is currently 5 million and still counting, as the pandemic has yet to end.

In India, we are currently reporting half a million deaths though experts have estimated it to be a serious undercount by at least 5- 6 times. Such undercounting could, however, be due to misclassification, misdiagnosis or deliberate misreporting. Many deaths could also have been of non COVID-19 patients who could not get timely treatment with all hospitals focusing on COVID-19 patients. Now it is apprehended that there could be an increase in numbers with the government announcing an incentive of Rs 50,000 per COVID-19 death.

Reliable data on real time basis is a critical aspect of pandemic management. Basic epidemiological and clinical information of where, when age, gender, nature or severity of pre and post COVID-19 morbidity and mortality, ought to have been routinely made available. But this has been near impossible to access as data is fragmented into various organizations with no single coordinating authority to provide the comprehensive picture. This is however more true for the central government. Such data is crucial for taking appropriate policy decisions It is necessary for assessing weaknesses and initiating steps to ensuring a more resilient health system for facing future outbreaks.

The fact that we had accounting and consulting companies like KPMG and BCG to do the data analysis and citizens and researchers had to depend on a voluntary group of individuals that designed and ran the website cowin.org providing the only credible data all through the months is telling. Non transparency, fudging, hiding and non-disclosure of vital data can lead to inaccurate estimations by experts, resulting in wrong policy responses and avoidable suffering as we saw happen regarding wave 2.

Besides, the improper understanding of the dynamics of viral pandemics was also partly responsible for the onset of the second wave. Modelling was done by government sponsored experts, who were mathematicians not public health experts. The underplaying of public health experts contributed to the chaotic management of the pandemic, at the central and state government levels – be it the hastiness in declaring a national lockdown on 24th March, the

confusion surrounding testing and treatment protocols, the handling of the social impacts of the pandemic or the vaccine roll out.

So the two points I am making are – 1. That reliable data and its regular communication to the people is of foundational importance in the control and management of a pandemic. And 2. That public health experts need to be central to crafting strategies and ignoring them has its own consequences as we saw in India.

And why is this so? Because a public health approach to contain and manage the pandemic is based on seven domains – as already said data on real time basis, testing and tracing, treatment, communication, vaccination, monitoring and intersectoral coordination ensuring the centrality of the community i.e. decentralised approaches – domains that have to be implemented by states.

It is in the above context that the importance of health systems at state levels arises. Most southern states – namely Kerala, Tamil Nadu, Karnataka that have strong health systems were exemplars in using evidence and public health expertise for setting their strategies, while broadly following the central government directives. For example, Kerala had issued detailed guidelines in February 2020 itself, before the Central government had even begun to take a handle on the pandemic. This was largely because of their recent experience of having managed the NIPAH virus outbreak. Kerala's handling of the pandemic during wave 1 turned out to be a model for the country – the detailed tracing of contacts, the vigorous testing of those with COVID-19 like symptoms, home isolation, hospitalization and most importantly the decentralization to the panchayat levels, that *interalia*, enabled community engagement, all classic public health approaches. Kerala was also the first state to take up a state-wide sero surveillance at the beginning of the second wave that gave them a better understanding of the prevalence levels across age and gender – the results showed that the younger age groups were as vulnerable to the infection with a prevalence level of 11% as was the case with those above 45 years. Such data then led to shape the discourse to have vaccines for all adults rolled out without too much of a time lag.

Karnataka was not far behind. Like Kerala, Karnataka also introduced several innovations in pandemic management. For example, Karnataka had at the state level several Expert Committees advising government on the various aspects of the pandemic. The architecture of decision making consisted of the State Task Force Team, chaired by the Chief Minister for coordination, a Technical Expert Committee comprising of public health experts, virologists, and clinicians to provide an evidence based response, and three other committees for clinical care and management, death audit committee, and telemedicine led by expert intensivists, pulmonologists and clinicians. And such mechanisms of coordination down to gram panchayat level.

What I did not find elsewhere was the preparation of District level crisis management plans and like in Mumbai, constitution of the Ward Decentralized Triage and Emergency Response (DETER) Committee for COVID-19 19 Management (WDC) in cities.

Similarly, Karnataka made intensive use of technology. Within a day, a 24/7 State-of-art Control room was set up in Bangalore with facilities for virtual training and video conferencing ; GIS mapping of cases and contacts; heat mapping technology for containment zone and clusters and large data management of contact tracing and quarantine; real-time tracking of ambulance services and dissemination of IEC with daily media bulletins; aTele ICU programme with support from intensivists working in private hospitals to train and guide the ICU staff working in different medical college and district hospitals and so on.

Finally, like in Kerala, Karnataka carried out sero surveillance in addition to fever surveys at household level and also enhanced lab testing capacity from one lab to 104. What was innovative was monitoring pharmacy stores for tracking drug sales to those patients suffering from severe respiratory infections and tracking them, capping prices of tests and coopting private sector infrastructure by reserving half of the available capacity.

Though TN was known as the only state in India to have a strong public health cadre, it was surprising to see it falter in the initial months. We are all witness to the high caseloads and mortality in TN. In fact, there was a point when it was felt that they had lost total control of the

pandemic. But that situation was reversed within no time – government brought back to leadership positions all those with public health experience. Such a turnaround was possible only because the state health system was strong and had innate resilience. Thus, from a situation where TN had just one laboratory for PCR testing within a few months it had over 146.

A common thread in all the well performing states was that they followed the public health approaches of testing – tracing – containing and treating. They decentralized the implementation and controlled the trajectory by having control over data and close monitoring.

Thus what we learn from the above is that the pandemic created a crisis like never before forcing us to innovate. In the process, State Health systems have been strengthened by the extensive use of technology, reiterated the importance of decentralized approaches and more importantly working across sectors, and strengthened the laboratory network. But the pandemic also exposed the gaps that need to be prioritized and urgently addressed.

Resources are finite. Public spending in India has never been more than 1.15 percent of GDP on health. Over 60% of health spending continues to be by households. On account of such low spending, the public health infrastructure has been weak. We all witnessed the inadequacies in the health infrastructure that delayed the scaling up of testing and later during Wave 2, loss of lives for want of oxygen and a bed.

The pandemic revealed yet another weakness. Poorly equipped public hospitals at the district and regional levels resulted in the bunching of patients in cities and private hospitals adding to already stressed out household budgets. Failure to have a policy, underwriting such expenditures led to massive spending on treatment that one estimated to be in the region of over Rs. 65,000 crores. Some states like AP, however, did extend financial security providing all free treatment. But in states like Telengana, the private hospitals really exploited patients with package rates, extended ICU stays and unnecessary tests. Overall, the private sector and pharma companies are reported to have a CAGR of almost 22 % while the rest of the economy tanked.

Keeping the above in view, the Central Government has recently launched a health program for strengthening public health infrastructure at district levels for an out lay of Rs 65,000 crores to be spent over the next five years. The resources are being mobilized as a loan from the World Bank in addition to the loans for vaccination and other interventions from the ADB. With the world bank loan is being proposed to ramp up the primary health wellness clinics as well as strengthen the district hospitals with ICU and Oxygen supported beds and district level laboratories. Such expansion of access to emergency care and hospital beds is badly needed and long overdue.

So in terms of reforming the health system, the focus is going to be on strengthening the public health capacity to handle emergencies and basic health needs. It is however unclear regarding the criteria for allocating these resources. It is vital that evidence and not partisan political considerations be the basis, so as not to lose this opportunity to equalize state capacities since inequality in access was the one issue that came out starkly during the pandemic. The poor who could not afford private treatment and unable to access government lost their lives. I would, however, like to say that the pandemic was a leveller of sorts since many with financial capacity also could not access critical care.

Besides income, the infrastructure deficit is huge in the northern states. Though aware of the north south divide, yet the central government has never really had a strong differential policy towards bridging this divide to achieve a semblance of equalization over time. It is important that at least now, the Central government distribute resources differentially across states based on evidence, focussing on the poorly endowed states like Bihar and the NE. This is because these states neither have a public nor a private sector and had just one PCR lab in the whole state for several months into the pandemic. Their laboratory infrastructure is pitiable. Likewise, is the condition in NE. And we have to only think of how many children die due to JE in Gorakhpur largely on account of delays in seeking treatment since there are no hospitals – public or private - for over 200 miles till Gorakhpur!

A third concern with such programmatic approaches of governments is the temptation to get too absorbed with infrastructure gaps – that is easy to do, measurable and monitorable. Like the PSA oxygen plants that within a few months got set up to such an extent that we have a surplus of oxygen now. What, in such a process, that gets neglected is the equal attention to human resources. Money is not the sufficient condition to buy doctors and nurses. More important is time and the quality of training. So even while the PM laid foundation stones for 9 medical colleges in UP, it will take a decade before they can start producing doctors of competence and fit for practice. The existing colleges in UP itself are beset with problems of faculty and low teaching standards. The Private colleges almost folded up for want of faculty. So even as HR is the critical determinant, it is necessary that the issue is not simplified by merely relaxing standards and giving more incentives to further privatization and commercialisation of medical and nursing education. Moreover, the pandemic has also shown up the need to change curricula to improve competencies for handling emergencies – be it at times of natural disasters, epidemics or accidents.

The pandemic also revealed the woeful status of public health – as a discipline and availability – of epidemiologists, bio statisticians, virologists, pathologists, entomologists, microbiologists etc. The quicker the policy makers acknowledge the importance and centrality of public health as a distinct discipline from clinical and medical knowledge the better. Public health expertise develops not only with the study of the science of public health disciplines but also years of researching and working in the field of public health. The problem in the way we handled the pandemic was the easy and seamless manner in which we merely – particularly TV channels- substituted a virologist or an epidemiologist in helping us understand and unravel the course of the pandemic and the nature of the virus with a bunch of clinicians – cardiologists in the main! Unintendedly, much harm did follow as in the absence of a sound communication strategy of the government providing credible and trustworthy information on the evolving situation, people relied on the TV anchors and their clinical experts to understand what and what not to do. The mad scramble for remdisivir or CT Scans as a diagnostic tool or this irrational fear of a third wave affecting children more disproportionately resulting in prolonging the closure of schools are examples of this stressful situation.

Finally, the pandemic has been so all encompassing that the panic like situation resulted in our inability to sustain and look after the needs of the non COVID-19 patients. There has been serious disruption in almost all programmes – maternal health, TB, HIV and so on and patients accessing hospitals for chemotherapy or dialysis. There is an urgent need to prepare plans for coping with such eventualities so the functioning of the whole health system is not stalled indefinitely.

So to recap. While state health systems got strengthened in dealing with the pandemic in terms of lab capacity, use of technology and forging intersectoral collaborations, there are gaps to be filled. Bridging inequitable access due to lack of incomes and facilities; wide variations in interstate and interdistrict infrastructure capacity for providing basic emergency care; inadequate availability of appropriately trained human resources; and the near absence of public health providing the leadership; and the neglect of non COVID-19 patients for undefined lengths of time were the main gaps that need to be addressed without delay. While infrastructure and some amount of health security cover can be done, bolstering human resources and restructuring the health systems towards a public health approach away from the doctor centered medical approach will require boldness and imagination. Never has the absence of a family centered primary health system been felt as much, that if available could have saved so many lives. This is the time to rework the primary health care models to ensure that they are not passive facilities waiting for patients to come or be brought to but active agents of change in making communities take responsibility for their own health and be there to alleviate pain and suffering.

The pandemic was devastating – not just in terms of the lives lost but the disruptions by way of loss of incomes and life balance. Children have suffered the most. There has also been a huge trust deficit that needs to be rebuilt. Once the pandemic becomes localized we need to start form the scratch and redesign, reconfigure and rebuild our health systems to build in greater resilience and connect with the people.

India will never get such an opportunity to focus on health reform. If it does not take advantage of the moment, the future generations will never forgive us and lives would have been lost in vain. We therefore own it to the dead, those suffering long COVID-19 morbidities and in pain, and those whose lives have been severely disrupted to see that there is never a repeat of what we have witnessed and lived through.

- The Health Department has always been at the bottom of the heap in the Financial Department's considerations; with COVID-19-19, Health has become a part of the national discourse
- There has been a large undercounting of deaths in the country
- In a Pandemic, the most fundamental principle is communication with the people
- Reliable data is the first principle of pandemic management
- Today we have huge intellectual capacity outside the government; Boston Consulting Group (BCG) and KPMG –consulting firms, essentially- are tasked with analysing the Pandemic instead of epidemiologists
- Data is so crucial yet we could not get our act together and procure this data
- Wrong data was partly responsible for the suffering from the Pandemic
- We need a proper understanding of working with the right people. Public Health experts were not called on for modelling/projecting the impact of the Pandemic, only mathematicians were called
- There are 2 prongs of pandemic management- reliable data and their regular communication to the people
- In Karnataka, policies relating to Pandemic management arose from technical expediency and political experience
- Karnataka's experience was characterised by nimbleness of policy-making and innovations like telemedicine, monitoring pharmacy sales to use as a data point to track serious respiratory problems
- The Pandemic exposed gaps which need to be prioritised
- On account of low public spending on health, households bore the medical expenses
- The Pandemic was a leveller; everyone lost but the poor lost more
- The Central Government should allocate resources differentially on the basis of evidence, accounting for states like Bihar where there is neither private nor public healthcare
- Governments are tempted to address infrastructural gaps as they are most observable, not giving equal attention to human resources like doctors and nurses
- The pandemic has been so all-encompassing/all-consuming that there has been a neglect of non-COVID-19 concerns
- Health is such a market failure that state intervention is absolutely crucial
- India needs to reconfigure and rebuild health systems once the pandemic subsides.

Presidential Remarks

Dr. A. Ravindra, Chairman PAC delivered the Presidential Remarks. He began by stating that PAC could not have invited a better person than Dr. Sujatha Rao to be invited as a speaker in this new initiative of Distinguished Lecture Series.

He added" *I think it's just really justified to let me say, it is a distinguished lecture honoured by the presence of a distinguished person"*.

He continued stating that although it's not very appropriate, on a distinguished subject of the day, as it is the topic of the day, and I'm sure we all feel more enlightened about not only the pandemic COVID-19. This lecture has not dealt on health systems in general, and how is the functioning in the country I think the most important part is the lessons to be learnt, what reforms can be brought in. I was the Secretary of Karnataka, that is decades ago and I don't know as she said it's such a fascinating subject, and also felt that what has strayed into the urban development sectors and more time there. But I think overall, what the relevant issues have come up I think a couple of critical issues that was number one, the importance of data how unreliable the data is right now. Under reporting of deaths as she mentions from what I've been reading also that now the correct figures have been taken into consideration. But how are we going to tackle this question of data it's not only in the health sectors in general, the problem is everywhere.

As I have worked in the Municipal Corporation in Bengaluru I know that there is public health department which is so weak which does not even provide all the basic inoculations vaccinations, the preventive side of healthcare which is the most important thing. Some of them include providing clean water supply, sanitation and all this including registration of birth and death which has been mentioned.

The political economy is a part of any sector, health, education urban development that exists and t causes a lot of distortion in India. With reference to man power, I myself have experienced a shortage of public health specialists, professionals and lack of attempt to change the entire system. We are not thinking of changing the system, it is again a political economy. We need leaders, champions whether at a democratic level or the political level.

So how do we sustain interest in the question of continuity on how to bring in it is not merely the knowledge on the subject, not merely the experience as what we have seen it is the passion that also counts. We need more people who are passionate in all sectors in India but particularly in the health sector. We have a wonderful opportunity to bring in health reforms. Maybe the government will be in the mood to listen now as this is the time. As it's not over, people are still talking about the possibilities of it. We all wear a mask, so this is the time to push in some reforms and to deal with the market failure so this is where the government should support the private sectors, we do need the private sector without it it's not possible to deal with the health issues in such a large country but regulating the private sector. It's the voice of the people that will count, I think we have to raise our voices, we should spread this, and get together and come out more on the needs of the government.

Highlights

- Dr. Sujatha's lecture highlighted the importance of data
- In times of emergency, tried and tested systems respond better
- We have an opportunity to bring health reforms; maybe the Government will listen now.

Vote of Thanks

Dr. Annapoorna Ravichander, Executive Director, Public Affairs Foundation delivered the Vote of Thanks by thanking all the dignitaries, Board Members of PAC and PAF, senior government official, Retired IAS Officers, media and all the staff of PAC and PAF.

Glimpses of the Event


Board Members

Public Affairs Centre
#15, KIADB Industrial Area,
Jigani-Bommasandra Link Road
Jigani Post, Anekal Taluk
Bengaluru - 560105
Karnataka, India