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Health policy for the coming year

The priority for health policy is now a decentralised process for testing and engaging with private health care

SNAKES & LADDERS

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While the lockdowns are easing, the pandemic is not. How should health policy play for the coming year? In public health, the key gap is the population-scale measurement, which will generate better private decisions, and also help the decentralised process of evolving social distancing rules. A large expansion of health care capacity is prudent. This requires a wise engagement with private health care firms, which are under great stress today.

India started out in late March with what has been described as the world's most comprehensive lockdown. From mid-April, a pragmatic process of easing restrictions has begun. The employment rate, which was at 40 per cent in February-end, and had dropped to 26 per cent in mid-April, is back to 29 per cent. It is expected that this will recover further in the coming weeks. There is an unmistakable sense of moving towards normalcy in everyday life.

At the same time, the pandemic is still with us. The data on infections and deaths has many problems, and we should be cautious about using this. The data does, however, suggest that a large number of persons in India are infected and that the pandemic is spreading. Simplistic multiplication of age-specific infection fatality rates, applied to the Indian population, yields large values.

Looking forward, a risk management approach is useful. We don't know that there will be a bad outcome, but there is a possibility of a bad outcome, and that bad scenario is sufficiently bad to justify effort today in forestalling it. Hence, we should be willing to undertake large-scale efforts on health policy starting today, in order to fare better if the bulk of the pandemic lies in the next one year.

Health policy consists of two prongs, prevention (i.e. public health) and cure (i.e. health care). On prevention, the standard methods of isolation and social distancing have not worked too well, with the possible exceptions of Kerala and Tamil Nadu.

How can public health do better? We should undertake decentralised work, at cities and districts, to measure the state of the population using polymerase chain reaction (PCR) and antibody testing. Where has the disease reached so far? What kind of people have developed immunity? How far are we from herd immunity? This measurement needs to take place, one suburb and one village at a time.

Why are these facts useful? First, when each individual is presented with salient information (the share of antibody-positive people, and infected people, in my neighbourhood) and the characteristics of people who have got the disease, each person will make better decisions on how to modify everyday life. Second, each community will use this data to make better local decisions about the activities that can be safely restarted. Better decisions at the level of each individual and each community will slow down the epidemic.

Despite the best decisions by individuals and neighbourhoods, the disease will spread, and there is a possibility that much more capacity will be required in health care. Much more needs to be done to gear up in terms of establishing greater health care capacity.

The bulk of health care in India is private. Hence, we require the Indian private health care sector to be working at full swing, looking for ways to achieve much larger capacity, fighting a health care problem of epic proportions.

Unfortunately, the Indian private health care sector is facing severe difficulties. Some health care workers have retreated from their work. Patients are postponing their health care requirements owing to a fear of infection. The decline in revenues has created financial stress in many health care firms. While the ambition of health care policy should be to increase capacity for the simple supportive care that is required for Covid-19, what we have is degraded capacity through the combination of finance and human resource (HR) crises.

State organisations have occasionally wielded coercive power and commandeered private health care facilities. This approach will disappoint for three reasons. First, there is much more to an airline than the hardware, the aircraft. There is much more to a hospital than physical infrastructure and medical equipment: A hospital is a complex web of information and incentives. If a state agency seizes control of the physical facility, the organisational capability could melt away, particularly given the finance and HR crises that these organisations face. Second, the health care capacity required in India for a gloomy scenario does not exist today, and the only people who have the management capacity to rapidly build and operate large new facilities are in the private sector. But state coercion will not elicit their energy and passion. Third, each act of expropriation sends a wrong message to the private sector; it diminishes the commitment of private persons to build organisations in India for the coming decades.

How can we do better? Health care policy needs to recognise that 70 per cent of health care in India is done by private firms. This vital sector is facing a crisis right now and needs help in overcoming this crisis. Policymakers need to understand and respect the pursuit for profit, by private health care firms, and give them the appropriate incentives to play the dominant role in a scenario where a surge in health care capacity is required.

Local and state governments should invite voluntary participation by private health care firms to build new capacity for Covid-19 care. This requires sophistication on the part of the government in public financial management (PFM). The government should pay a fixed cost at the commissioning date so that the private firm does not take traffic risk. These additional facilities would then be there for us, for the scenario of a large increase in hospitalisation for the coming year.

This will call for financing. Back of the envelope calculations show that large resource flows will need to be organised, to pay private firms for testing and for health care. Fiscal planning is required, through which these resources reach the cities and the districts.

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