

Jan Swasthya Abhiyan Statement on Missing Health System element of the Stimulus Package

The much-touted Stimulus package under yet another pompous *jumla* of Aatma Nirbhar Bharat Abhiyaan can be summarised in four words - Stimulus Package sans Stimulus. As has been pointed out by many mass organisations, civil society groups, mass movements and intellectuals, the economic relief package is full of empty promises, accounting juggleries and a series of concessions to big business, while rights of workers are being withdrawn. Most of the measures are oriented towards supply side measures and there is hardly any effort to provide a fiscal boost to kick-start the economy that has been thrown into turmoil with a hasty and unplanned lock-down. Despite prospects of massive job cuts in urban areas the relief package has remained completely silent on several demands to introduce an employment guarantee programme in the urban areas.

In comparison to the concessions announced for business community, the meagre cash transfers announced in late March 2020 as part of the Pradhan Mantri Garib Kalyan Yojana stand nowhere, since most of them are recycled versions of existing measures. They have offered little relief to the suffering masses, which is incomprehensible when the country is facing a large scale humanitarian crisis where millions of migrant daily wage workers have lost their livelihoods, have been forced to reverse migrate to villages on foot with no means to feed their families, and there have been hundreds of casualties as a result. In the wake of such widespread destitution and hardship faced by millions of working people, it was expected that some concrete budgetary commitments would be made to address these in the Aatma Nirbhar Bharat Abhiyaan. Among the many important elements missing in the package is any concrete commitment to strengthen the public health system.

Stimulus for Health?

In its first response in early April, the Centre [announced Rs. 15,000 crore](#) as Covid-19 emergency response and health system preparedness package, less than 0.1% of country's GDP and even less than the amount of money spent on health by some States currently. Out of this, the Centre planned to release Rs. 7,774 crore for immediate use and Rs 7226 crore for medium term support till 2024. Such paltry allocations can do little to materialise the lofty claims of mounting robust emergency response, strengthening National and State health systems, strengthening grassroots health institutions.

In May 2020, the second announcement was made of a Stimulus Package under Aatma Nirbhar Bharat Abhiyaan, with health featuring in the last tranche out of the total 5 tranches of the relief package. There were some pronouncements made which include augmenting public expenditure on health to strengthen grassroots health institutions in rural and urban areas, setting up of Infectious Diseases Hospital Blocks in all districts, strengthening of laboratory networks and surveillance systems and public health units and health research. However, in terms of concrete commitments there is very little that the relief package provides.

There has also been much hype about the USD 1 Billion loan in April for Covid-19 Emergency Response and Health System Preparedness from World Bank. The Rs. 15,000 crore package is probably out of this

loan grant and not a provision from own resources as is being projected by the Centre. A closer look at the WB agreement reveals the furthering of the agenda of vigorous privatisation of the health sector. The conditionalities of the loan include engaging private laboratories to expand capacity to test and manage Covid-19 as part of the Emergency Response. Further, as part of institutional arrangements, the Government is required to ensure that Indian Council of Medical Research (ICMR) will engage with both private and public research institutions to implement research on Covid-19 and also that both the participating states and central agencies would be involved in private sector engagement for expanding laboratory and intensive care services for Covid-19.

Pradhan Mantri Jan Arogya Yojana (PMJAY) exposed

Yet during the global crisis in the wake of Covid-19 pandemic the private sector has completely failed to respond to the crisis: the majority of private providers have been either incapable of or unwilling to help in overcoming the national crisis, despite much hype created by PMJAY. During the initial days of the pandemic, the private corporate sector was very vocal in demanding that Covid treatment be made part of the PMJAY package. The National Health Authority and the NITI Aayog promptly responded including Covid-19 reimbursements in their packages. But the Covid experience clearly suggests that neither the private sector is capable, nor is it interested in helping out in this public health crisis; a testimony to this is their demand for maintaining high pricing for tests (Rs. 4500), whereas the cost of testing in public facilities is much lower. There were number of cases of denial of care after which some state governments entered into agreement with private sector hospitals and also requisitioned their services. The PMJAY authorities, who were so far very vocal about handing over health care delivery to the private sector, have acknowledged that PMJAY as a scheme and private sector, in general, have failed miserably in providing desirable quality care to significant sections of the population during the pandemic. This points clearly to the importance of the long-standing demand that health care should largely be financed by tax money and provided by the public sector through principles of comprehensiveness and universality rather than as a commercial activity.

Lowest public spending

Public investment on health in India is among the lowest: in terms of government resources invested in health care, India's spending is among the least (0.9% of the GDP) across countries, while emerging economies such as China, Brazil and South Africa spend more than 3% on health. Our Asian neighbours who have done reasonably well in providing universal access to health for its citizens, such as Thailand (2.8%), Malaysia (2%), Sri Lanka (1.6%), invest much more on health. The Out of Pocket (OOP) expenditure on health as percent of current health expenditure is among the highest in India (62%), pushing around 5 crore people every year below the poverty line. Despite this, last year the NITI Aayog had already come up with an unwarranted plan of privatisation of district hospitals via PPP.

In the last budget presented in February, about a month-and-a-half before the lockdown due to pandemic, there was a 4.3% decline in real terms in allocations for the health sector. Union government allocation on health came down to 0.24% of GDP in the year 2015-16 and recovered only marginally since then. The Health and Wellness Centres (HWCs), a key component under Ayushman Bharat, meant to make primary care more comprehensive, also did not receive any significant allocations. These systemic challenges have shown up the grossly inadequate response of the government health system to the COVID 19 challenge, demonstrating their total the lack of preparedness. The response of the Union and State governments in trying to manage the procurement of equipment, kits and setting aside facilities for Covid

management has come at the cost of compromising routine health services – affecting people’s access to routine maternal and child health, family planning services, TB, dialysis, cancer care etc. which have severe long term consequences.

A Strong public system could prevent many Covid deaths

There are wide variations in public expenditure on health across States, which has clearly manifested in the response of the health system to the current Covid crisis, whereby some States such as Kerala have been more effective in dealing with the crisis than other States. As per 2016-17 NHA report, Government Expenditure on health (GHE) in Kerala stood at Rs.2149 per capita, more than four times higher compared to what is spent in Bihar (Rs.504 per capita), and thrice as much as UP spends (Rs.772 per capita). This disparity in spending also gets reflected in the varying density of government infrastructure for health care and shortage of human resources in States. States such as Kerala and Tamil Nadu have not only created more health care institutions, but have also invested substantially in strengthening primary care, preventive and public health services over a long period of time. Failure of resource rich states such as Maharashtra and Gujarat in dealing with the pandemic has exposed weaknesses of public health and primary care in urban areas in these States (these States also have low per capita expenditure as % GHE – Rs.1216 and Rs.1429 respectively).

Human Resources under severe stress

There have been significant efforts from frontline health workers across the country working overtime and putting aside threats to personal safety, family interests, and stigma to provide the best possible care despite limited resources, lack of protective equipment, testing kits and other necessary resources. Many personnel have also been threatened with suspension for raising voices against such issues. Several frontline health workers such as nurses, doctors, ASHA workers became victims of the virus while fighting against it. There are also reports of ASHA workers being attacked or harassed while performing their surveillance and tracking duties during the pandemic. The health insurance that has been announced for the health workers affected by Covid is a mockery of all the dedication and hard work that health workers are putting in. The scheme covers health workers only in the instance of death due to Covid and does not protect them from hospital and treatment charges in case of admission. The coverage of 22.12 lakh public health workers appears to be a grossly underestimated number as it does not include health workers such as cleaning staff, ward attendants, ambulance drivers, ASHAs and ANMs; this figure is estimated to be close to 40 lakhs.

During the last two decades, expansion of medical and nursing education has mainly taken place in the private sector, resulting in greater inter-state and rural-urban inequalities. Considerable shortage of skilled human resources in rural areas and high density of medical professionals in metropolitan cities not only leads to lack of access to health care in rural areas and significant loss of lives, it also creates huge distortions in the quality and rational care provided in bigger cities.

Public investment in education and training of health personnel needs to be stepped up keeping in mind the rural-urban disparities. A well governed and adequate public health workforce should be ensured by creating adequate numbers of permanent posts. All levels of public health system staff shall be provided with adequate and continued skill training, fair wages, social security and decent working conditions. It

is important that all contractual health workers, an overwhelming majority of whom are women, should be regularised and receive protection under the entire range of labour laws.

Public sector manufacturing of drugs and equipment

The crisis of Personal Protective Equipment (PPE), ventilators, testing kits and over dependence on imports delayed India's response to tackle the pandemic. The crisis has clearly hinted that we need a strong presence of Public Sector Undertakings (PSUs) in medicines and equipment manufacturing to be able to respond effectively and timely. However, last year the government shut down Indian Drugs and Pharmaceuticals Limited (IDPL) and its subsidiary Rajasthan Drugs and Pharmaceuticals Limited and put Hindustan Antibiotics Limited (HAL) and Bengal Chemicals and Pharmaceuticals Ltd (BPCL) on strategic sale. It was expected that the government would provide considerable support to pharma PSUs through the relief package. But no such step has been initiated.

Despite being pharmacy of the global south over the years, India's medical equipment manufacturing sector is rather weak. It either imports second hand instruments and refurbishes to sell in domestic or exports to other developing country markets. It is of utmost importance that self-reliance in equipment manufacturing is achieved through robust investment in pharma and medical equipment manufacturing industries. These actions need to be complemented with a centralised and transparent procurement, and decentralised distribution to ensure regular availability of good quality generic medicines in public facilities both for national programmes and State systems, as we have in Tamil Nadu, Rajasthan and Kerala.

Expansion of local manufacturing capacity can be enhanced by the use of TRIPS flexibilities of compulsory licensing available under international trade law. During a health emergency a government can invoke provisions and order the manufacture of patented drugs and equipment. In the present scenario where protective equipment such as N95 are under patents, Indian government should be bold enough to use compulsory licensing and ensure adequate availability of drugs and equipment.

Health research and disease surveillance systems

The Covid crisis also raises concerns regarding investment in research in the health sector. For the past several years, the allocation for the Department of health research has been a meagre 3% of the total budget of MoHFW. For some of the sub heads aimed at strengthening the surveillance for Zoonotic Diseases and other neglected tropical diseases the utilisation of the already meagre budgets has been as low as 15% (in 2018-19). Public investment on health research needs to increase manifold to be able to meet the upcoming public health challenges.

Reporting of cases, mortality and test data has been a source of controversy in many States. Data is a crucial ingredient of a pandemic response, and in such a rapidly evolving situation as under COVID-19, it is especially vital for day-to-day decision-making. The weekly data published by the age-old Integrated Disease Surveillance Project (IDSP), which has the larger data set, comprising information gathered from contact-tracing operations, quarantine centres, and airports, was suddenly stopped in February by the Union government for reasons unknown, resulting in complete information blackout. Without IDSP data, responses from the State and district level authorities have been inadequate. Instead of strengthening the IDSP and routine MIS systems, the Union Government is hell bent on replacing all

these systems with an app, which has its own privacy issues and has been extremely limited in reporting accuracy.

Access to nutrition, safe drinking water and proper sanitation

During the continuing Covid-19 crisis, the healthcare and nutrition services for women and children have taken a severe hit. The umbrella scheme ICDS which a key intervention for children below 6 years of age and pregnant women, has over the past few years seen only marginal increase in nominal budget allocations and, in fact, a decline in real terms. The services under the ICDS programme which are essentially provided by the ASHAs and Aanganwadi workers have been severely affected due to excessive burden on these frontline workers owing to deployment in Covid19 surveillance activities.

In many States, during the lockdown, the mid-day meals to children were arbitrarily stopped and eventually the courts had to intervene, though states like Kerala ensured that food and ration reaches to children at their door steps. It emerges that during lockdown, there was complete absence of Anganwadis and creches in urban slums. The extra 5 kg of wheat and 1kg of rice under PDS announced by the Centre are not reaching the most vulnerable, as most of the marginalised section does not have ration cards and the supplies of the ration are not on schedule. While the government machinery has failed in ensuring food to the hungry, much of the help has come from mass organisations, NGOs and citizen groups who helped avert many hunger deaths. UNICEF estimates that because of disruption of food services, nearly 3 lakh children in India may die due to malnutrition over the next 6 months.

The class character of the current Covid advisories such as physical distancing or frequent washing of hands fail to recognize the realities in urban slums where the majority of informal workers live: for example, in Dharavi in Mumbai the population density goes up to 270,000 per square kilometre, and one toilet would be shared by about 500 people. Regular piped water is a luxury available only for a small percentage of our population, and this needs to be a policy priority if hand hygiene is to be enhanced.

Resource mobilisation in hard times:

The Situation Analysis for the National Health Policy 2017 acknowledged that “unless a country spends at least 5-6% of its GDP on health with Government expenditure being a major part, basic health care needs are seldom met”. The government must honour its commitment of allocation for the health sector. The revival of the public sector would require a commitment of an allocation of 3% of GDP in the short term (by 2025) and targeting 5% thereafter. The perennially under-resourced public health system lacks the resilience to face shocks such as the current pandemic.

But instead of trying to garner more resources to safeguard lives of the hungry millions the government has chosen to provide numerous concessions to big corporates to make their business more profitable. In order to ensure sufficient resources for the critical social sectors as health it is important that overall resource space increases. With a low tax-GDP ratio (10.9% in 2018-19), increase in investment cannot be realised unless the rich are taxed more and tax base is widened. Imposition of wealth and other taxes on the super-rich, use of short and long term capital gains tax and reducing unproductive tax concessions could increase tax revenue significantly.

A major part of the increased investment has to come from States, but unless Centre-State fiscal relationships change and States receive a larger share of the GST and other direct taxes, garnering more resources would be difficult for States. The 15th Finance Commission in its Report for 2020-21, though has proposed special transfer of funds to improve nutrition, should include recommendations for special allocation to States to meet HR and infrastructural gaps in the backward regions of States. Much has been said about limited fund absorption capacity of States. It has been argued that since States do not have the capacity to spend, additional money allocated remains unutilised and hence an increase in budgets is unwarranted. During the last decade or so, while Union Government allocation has either grown very slowly or declined under the Modi regime, State governments have increased allocation at more than 9% per annum. Utilisation of National Health Mission funding has also increased over the years indicating greater absorptive capacity.

One key way to improve fund absorption by States is to introduce multi-year budgeting, where budgetary allocations would be made for a programme cycle for 3 or 5 years. As per the changed concept, once the major components of a 5 year cycle are approved with clear objectives and annual milestones of outputs and achievements agreed upon, the fund flow should be staggered and periodical release should not have an expiry date of annual closure of 31st March. The utilisation certificates should be limited to funds released for a particular component rather than the entire project or State allocation. This will remove a lot of bureaucratic hurdles of perfection of entire budget proposals, formal approvals every year and liquidation of earlier advances of an ongoing project. This has been a major limiting factor in fund absorption capacity of many States.

Reimagining the public system

It is of utmost importance that our long-lasting demand of acknowledging Right to Health as a constitutional right is met. During the times of pandemic, several instances of denial of care to people belonging to vulnerable sections of the society have come up under the public system. It is not new that the public system works with prejudices and class biases; it sees the poor, the women, dalits, minorities and other vulnerable sections of the society with very little empathy, and fails to ensure dignity to patients. One major reason is lack of accountability of the system towards people. However, the example of Kerala has shown the importance of community involvement and strong decentralised and participatory planning through effective Panchayati Raj institutions in delivering care for the elderly and other vulnerable sections during the time of pandemic. The strengthening of the public system needs a shift towards pro-people orientation. There is, therefore, a need to ensure a genuine bottom up, need-based decentralised planning, implementation and monitoring, with strong involvement of communities.