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A BLUEPRINT FOR EMERGENCIES

Relevant for: Environment | Topic: Disaster and disaster management

The writer is a retired civil servant

The deaths of over 150 children in Bihar from Acute Encephalitis Syndrome over weeks are in the process of becoming a bad memory. Most critical analyses have found serious faults with the state's healthcare system. This provides a context to explore if the inadequacies in healthcare could have been offset, even compensated for, by rapid administrative action.

Investigations found that certain positive factors also existed, though notionally, in Bihar. For example, research finds that AES is treatable. Second, the government had already put in place robust and comprehensive healthcare programmes. The situation in Bihar apparently came more like a flash flood. This, along with the weak medical infrastructure, ignoring preventive measures and other healthcare programmes, worsened the AES outbreak.

There are examples where states in India have taken the primary healthcare seriously, and followed up on preventive healthcare programmes comprehensively. States like Bihar can learn from their example, and the past. What follows is a draft framework to deal with medical health emergencies.

The first step should be to declare a public health emergency within the affected region with immediate effect. This would mean that the state healthcare and other concerned agencies, including the district administration and disaster management authorities, will pool their wisdom and resources. A group (henceforth Group) comprising representatives from such organisations should be constituted and be headed by a dedicated administrative officer with the requisite expertise and experience. This Group will come into operation no later than 24 hours of the declaration of the emergency, and will take full control and responsibility for ensuring prompt life-saving medical services, including essential nutritional supplements.

The Group will be a largely autonomous body with defined administrative and financial powers. It will take necessary decisions and coordinate efforts, including putting in place research work, and additional infrastructural support from within the state and outside it. The Group's mandate will be all-inclusive, and will start with ensuring dissemination of information (by means of the media and field health workers) on the disease, general awareness on government nutrition and hygiene programmes, precautionary measures, obtaining and sharing of diagnosis-treatment protocol, taking feedback on the treated patients and finally, the disbursal of compensation to the unfortunate victim's entitled kith and kin speedily.

A blueprint of the suggested administrative mechanism can be kept ready by each state, with various functionaries nominated and notified. This can be done in districts with a poor public health record. The Group will conduct periodic mock drills in a professional manner, particularly in more vulnerable areas. This blueprint will be actually realised as and when a need arises. The Group's resources can be unscaled suiting situational demands. The Group must also organise frequent field visits to see all arrangements work flawlessly.

Yet another significant policy measure would be to reorganise working of the existing government hospitals, particularly at the primary and middle level. As health centres across

most states have adequate built up space and other infrastructure available, a part of the same can be leased to private hospital chains. In normal times, these privately-run units will provide regular, on payment, healthcare. Indeed, such private medical centres with their enhanced medical capacities in place can be recognised and co-opted under the Ayushman Bharat Yojana. In situations like the one under discussion here, these units can be commandeered to attend to the emergency.

Long-term plans to create and expand healthcare infrastructure demand more time and resources. The proposed reorganisation of health centres, besides substantially adding to the existing health services at literally no cost to the government, will also help to generate a healthier work culture.

Finally, it is of utmost importance that the functioning of such reorganised health centres be closely and professionally monitored. They should also be monitored by the local community and panchayati raj institutions.

It may also be useful to urgently fill the perennially existing vacancies at health centres. This can be accomplished in most healthcare institutions, particularly in remote rural areas, through the contractual appointment of doctors and para medical staff by from amongst retired personnel (both civil and military).

These ideas and models are practical and have been tried by this author in Ambala, Bareilly, Agra, and Delhi. India and its governance system cannot let people die, and must adopt fresh approaches. A crisis like the AES outbreak is not merely a medical battle, it must be seen as an administrative mission.

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