

# WE MUST GIVE HIGHEST PRIORITY TO STRENGTHENING THE PUBLIC HEALTH SYSTEM

Relevant for: Developmental Issues | Topic: Health & Sanitation and related issues

A notable aspect of the [COVID-19 pandemic](#) unfolding in India, which has not been commented upon much so far, is the low profile maintained by the huge private healthcare sector. The first death from COVID-19 in India was of an elderly man from Karnataka — who was shifted between private hospitals in Kalaburagi and Hyderabad, before dying during his return to Kalaburagi — exposing poor coordination of private hospitals with public health authorities. Subsequently, there have been reports from Rajasthan and other states of certain private hospitals refusing to admit patients with COVID-19 symptoms. In a country where over 70 per cent of healthcare is provided by the private sector, we need to take a close look at the role of public health system as well as private providers, during such epidemics.

Public health systems are now under pressure to perform a range of complex and evolving functions, including public awareness, prevention, surveillance, epidemic control involving tracing, isolation and quarantine, laying down standard protocols, and treatment of patients without refusing anyone on financial grounds. They are doing a reasonable job, despite considerable constraints. Private health care provisioning cannot replace these public functions. Effective primary health care organised by public bodies is essential to detect cases at early stage, and then to both isolate and treat them. In this context, excessive focus on programmes for secondary and tertiary care involving private providers, such as Pradhan Mantri Jan Arogya Yojana (PMJAY) under Ayushman Bharat, might need rethinking. Note how this much-projected scheme has so far been of negligible relevance during the COVID-19 epidemic. Data for last two years shows that in the Union Health [budget](#), the share of National Health Mission (dealing mostly with public health services at primary and secondary levels) has dropped from 56 to 49 per cent, while the share of health insurance schemes has risen from 4 to 9 per cent. Is this the policy direction we want to continue?

Further, if the epidemic does spread significantly, there will be need for many more hospitalisations, with around 5 per cent of total cases needing advanced care with ventilators, ICUs etc. This could mean tens of thousands of serious cases concentrated in few areas. The existing capacities of public hospitals will be massively overstretched, since many district hospitals do not have the required facilities due to neglect of public health services in many states. If private hospitals are involved, will the dominant model of 'strategic purchasing' of services from private healthcare providers, paid on per case basis (as in PMJAY) be adequate to ensure seamless coordination of care, when there is a crunch? Seems unlikely, if we go by the experience of children affected by Acute Encephalitis Syndrome in [Muzaffarpur](#) last year (which claimed over 150 young lives). The vast majority of patients were ultimately treated by the main public hospital in the district, with PMJAY associated facilities playing only a peripheral role. An alternative approach has emerged in Kerala, where the Ernakulam District collector has asked private hospitals and non-governmental institutions to make available their medical and paramedical staff to public agencies involved in controlling COVID-19. Spain has moved one step forward, by bringing all private hospitals under public control during the epidemic; Ireland is considering similar steps.

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The current epidemic also reiterates the importance of unbroken coordination between primary, secondary and tertiary levels of healthcare. In this context, we might question the recent Niti

Aayog proposal to hand over large District hospitals to private operators in PPP mode, shifting these hospitals out of direct public control. Further these key public facilities would mostly start charging half of their patients at commercial rates. Such privatisation would weaken public health capacities, while fragmenting coordination across levels of care., and increasing the probability of denial of care to those unable to afford, in situations like the emerging scenario when services would be needed the most.

The US experience also demonstrates limitations of private agencies in dealing with public health emergencies. COVID-19 testing was left to commercial health insurance companies, leading to low levels of testing of the population, despite the growing epidemic. Only after serious questions were raised in US Congress, the official Centers for Disease Control assured that they will make free testing available to all, irrespective of health insurance coverage.

Taking all this into account, there is no alternative to infusing much higher level of resources into public health systems. This involves increasing public health budgets substantially, at least to achieve the National health policy goal of elevating public health spending to 2.5% of the GDP by 2025 (currently it hovers around just 1.2 per cent). This must be linked with employing a much larger pool of regular, skilled manpower which must be done urgently in most states; this will not only upgrade public health capacity, but will also increase employment, giving a boost to the economy. More immediately some priority areas would be – expanding testing to cover not just travellers and contacts, but any clinically suspected person; ensuring preparedness of larger public hospitals with ICUs, ventilators, oxygen supply etc.; strengthening the Integrated Disease Surveillance Programme; and involving voluntary health agencies in generating widespread scientific awareness about do's and don'ts related to COVID-19.

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In parallel, essential obligations of private healthcare providers — mandatorily contributing to disease notification and surveillance, adopting standard treatment protocols and quality standards, and working in coordination with public health services to treat cases in epidemic situations – must be emphasised. In line with the Ernakulam approach, public health authorities may need to insource beds from charitable and large private hospitals at standard rates, to deal with cases which cannot be managed by public hospitals alone. The private healthcare sector also needs to move beyond resisting regulation and focussing on profit maximisation, towards accepting public health goals and social accountability. The state must improve its capacity for providing technical direction and organising fair regulation of private providers, towards harnessing these resources in public interest. Both arms of action – public health system strengthening and private sector regulation – must be accompanied by strong provisions for social accountability, transparency, and patients' rights, to ensure that misuse of power is minimised, while public interests remain paramount.

Epidemics such as COVID-19 starkly remind us that public health systems are core social institutions in any society. No amount of strategic purchasing or outsourcing to private actors can replace their irreducible role. At the end of the day, it is public health services which will stand by our side in times of epidemics, and we must give highest priority to strengthening them. We dare to ignore this message only at our collective peril.

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