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INDIA'S DISEASE SURVEILLANCE SYSTEM NEEDS A REBOOT

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

In a recent press briefing, the Ministry of Health and Family Welfare reported noticeable trends with respect to COVID-19 cases in India. Its data shows that 75.3% of deaths have been concentrated in the age group of 60 years and above, and in 83% of deaths, the deceased were battling pre-existing identified health conditions. Evidently, we have reason to fear the novel coronavirus for which we have no established cure. However, there is even more reason to fear a combination of COVID-19 with existing illnesses and medical complications. The disease is lethal for those with compromised immunity brought on by age, existing respiratory infections, or essentially, malnutrition. In technical medical terms, this is a situation of comorbidity, which in ways makes it difficult to differentiate between dying of COVID-19, or, dying with COVID-19.

In comparison to many western countries combating the disease, India appears to have the advantage of a relatively young population. This is, of course, negated by the poor health conditions of the vast majority of Indians. It is then imperative that we do not ignore already prevalent diseases and illnesses. Unfortunately, the recent experiences of the public health-care system in India indicate the side-stepping of precisely this issue.

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There are many among the poor who are battling various diseases but now have little access to major public hospitals in the wake of the lockdown. Routine functioning, particularly of out-patient department services in public hospitals, has been severely affected, and largely, emergency cases are being entertained. Patients now complain of even greater high-handedness of hospital staff in the still functioning emergency intensive care unit, labour rooms, tuberculosis (TB) wards, etc. Ironically, cardiology and neurology departments that cater to elderly sick patients are turning away many in the bid to streamline "critical" cases. In such circumstances we can expect an aggravation in the poor health conditions already affecting large sections of people who have limited access to health-care services.

Let us scrutinise this issue more closely. Many of the adverse medical conditions prevalent among the vast majority of our country are not even identified due to the lax disease surveillance system. The failure of disease surveillance requires explanation. For one, a significant number of the infected (poor and marginalised people) do not have access to health-care facilities and so fail to report their condition to certified medical practitioners. Even when an infected person has access to such facilities, their clinical case does not always culminate in the required testing (blood/serum, throat swab, sputum, stool, urine). Third, there is a widespread practice among pathological laboratories to categorise diseases on the basis of the pre-existing classificatory system, which results in failure to identify the definitive cause (aetiology) for an illness by differentiating and separating pathogens (disease-causing microorganisms) on the basis of variations in groups, subgroups, strains, etc.

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There is, consequently, pervasive non-identification of a definitive cause behind a number of illnesses. Many ailments are simply clubbed together and referred to by generic names such as 'Respiratory Tract Infection' (RTI), 'Urinary Tract Infection', 'Acute Febrile Illness (AFI)', 'Acute

Undifferentiated Fever', 'Fever of Unknown Origin' (FUO). Certain of these undifferentiated illnesses are known to affect lakhs of people every year worldwide. They claim many lives, especially of the poor who are victims of low immunity and have limited access to health care. Sources claim that RTI kills over 900 people in India every day. Likewise, Acute Lower Respiratory Tract Infection (ALRTI), which affects mostly children below the age of five years, has been known to infect approximately 3.40 crore people every year worldwide. In recent years it has led to roughly 66,000 to 199,000 deaths. Shockingly, 99% of these deaths are reported from developing countries, and India has a larger share in it. The large number of hospitalisations, enormous deaths and suffering caused by contagious undifferentiated diseases indicate the prevalence of persistent but undeclared silent epidemics.

Even if the definitive cause of an illness is identified, it does not necessarily gain the focused attention of scientific research. As the disease evolves but "interest" in it remains fleeting, the differences developing in the sub-groups, strains in genotype of the pathogen concerned fail to be consistently tracked. Knowledge of the pathogen, and, consequently, the required disease control soon lag behind. This overall process is due to the selective, biased approach of mainstream scientific research that is driven by the profits of private pharmaceutical companies, and is the fallout of the lack of priority that governments assign to general health care and diseases of the poor.

Even when the identity of a contagious disease and its treatment are well known it does not mean that the disease's prevalence will generate the necessary reaction. TB is a suitable example. According to public health experts, one person in every 10 seconds contracts TB, and up to 1,400 people in India die every day of the disease. This indicates that TB has a R0 value (basic reproduction number) and fatality rate that is way higher than those attributed to COVID-19 so far. However, it is important to note that TB and many other contagious diseases are ignored as "ordinary", and elicit very low attention. In contrast, some diseases are quickly identified as epidemics of greater public concern.

Diseases are being selectively discovered and have the propensity to be identified as an epidemic when they have a signalling effect for the scientific community. In a majority of instances, it is only when there is a threat of transmission to the well-to-do sections of society or wealthier regions that the disease actually has such a signalling effect. It is not a coincidence that a relatively downplayed disease such as TB is largely a poor man's disease.

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Clearly, we are confronted by a skewed relationship between our ways of knowing (social epistemology) and epidemiology. It is precisely in this context that COVID-19 has gained singular prominence over several other lethal diseases. Importantly, pre-existing diseases have the potential to combine with COVID-19, and with devastating consequences. It becomes imperative to identify the comparative fatality rates of many of the silent epidemics, which in their own right require urgent attention.

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To reassure Indian Muslims, the PM needs to state that the govt. will not conduct an exercise like NRC