Source : www.indianexpress.com Date : 2020-05-05

DEALING WITH COVID-19 PANDEMIC: WHY THE ‘KERALA MODEL’ IS WORKING

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

Written by Saikat Sinha Roy and M Suresh Babu

The first case of COVID 19 in India surfaced in Kerala on January 31, 2020, imported from Wuhan. This provoked discussions on the negative spillover effects of international migration, which has been a feature of Kerala’s development trajectory in recent years. In early March, Kerala and Maharashtra were the leading states in terms of the positive COVID19 cases. The number of infected patients started to increase in Kerala until the end of March, as a section of international migrants started to return to the state.

The swift action of the state government in identifying the possible social contacts and subsequently tracing them started to show results by early April. This onerous task continued for a longer duration as more and more imported cases began to surface in an economy, which is driven to a large extent by the opportunities in global labour markets and international tourism. The sustained efforts started to yield results and by mid-April the state, which was second in total number of infected cases in mid-March, slipped to the 10th position and was well on its way to have a carefully drafted exit policy from the lockdown. This remarkable achievement of Kerala has now attracted international attention much like the famous ‘Kerala Model’ of development.

Kerala has a long history of social sector development, which predates the coinage of the ‘Kerala Model of Development’ in the 1970s. Kerala’s model has essentially emphasised on the development of health and education and thus laying a strong foundation for sustained long-run development. Not only did the state consciously develop government-funded primary health care and education but also allowed private participation in tertiary health care and education without losing the focus on the primary priorities. Successive governments in Kerala emphasised on universal literacy much ahead of the rest of the country, in tandem with making smart moves on seizing the opportunities provided by globalization. The underlying strategy was to realise the benefits that would accrue from globalisation, which will be possible if and only if there is a strong human resource base. Hence, health and education sector indicators continued to improve even after the state embraced policies towards globalisation. What becomes important in the context of ‘flattening the curve’ of spread of COVID 19, is this priority accorded to public health. Public health and hygiene issues have never taken a back seat even when the focus started drifting towards privatisation and efficiency in the health sector.

Apart from a well-laid health system throughout the state, the general level of awareness is high, especially among women due to high female literacy. On account of awareness, the reported morbidity in Kerala is always significantly higher than in the rest of the country and it is often argued out that morbidity among infants is high not necessarily as an indicator of ill health, but it is indicative of mother’s awareness. In case of COVID 19, with this combination of high level of awareness and a well functioning health sector, Kerala has been able to contain the possible rapid spread swiftly. This assumes significance as the state has a larger share of aging and migrant population. Eventually, both morbidity and mortality on account of COVID 19 has been much lower than in many developed countries. It is here that the human development achievements contributed, as the state is endowed with an army of skillful population and a large pool of medics and paramedics, who are integral to a well-functioning health sector. Kerala has thus created its own comparative advantage and is thus uniquely placed to deal with calamities much more adroitly.

What can the rest of the world learn from Kerala's experience? Unarguably it is difficult to replicate the 'Kerala Model', as the rest have poorly invested in health and education, more so than the other states in India. However, the 'Kerala Model' offers some important insights. First, efficiently dealing with such a pandemic would require larger investments in social sector to create capacity and make the population aware of the gravity of the situation so that they are equipped to tackle it at their individual level. This is perhaps what is meant by Kerala's "preparedness" to deal with the pandemic. Perhaps other states in India should swiftly increase their COVID-19 related expenditure manifold in order to flatten the rising curve. This higher expenditure is imperative due to their low base in social development, which demands much more effort now to reach the level that exists in Kerala. Perhaps the lockdown has given an opportunity to create capacity by instituting prudent policies for the health sector.

Second, there exists a dire necessity for having more public goods. The approach of WHO, 'test, trace, isolate, treat', which Kerala followed diligently, banks on the availability of public goods in the system. Markets fail in dealing with this sequential approach as each component is intertwined with the other. Global experience shows that shortage of public goods and the inability of markets to respond have been the two major reasons for loss of lives even in the advanced economies. Kerala could ramp up testing to 450 per million due to the capacity created in the public health system. A public good perspective in dealing with basic needs of the citizens is an important lesson that Kerala provides. A well-functioning public distribution system, which provides the much needed 'safety net' to vulnerable sections of the population, bears testimony to this.

Third, the success of dealing with a crisis of this dimension lies in social mobilisation. Kerala could successfully quarantine the infected and deal with the issues of in-migrant workers simultaneously due to community participation. Much like the previous episodes of crisis, Kerala launched a campaign mode to mobilise people for a variety of activities ranging from 'break the chain' campaign to setting up community kitchens. The leadership was swift to realise the secondary effects of the lock down such as increased poverty and deprivation and counter it upfront due to the unstinted support of the community. Social mobilisation of this scale can only be possible with high levels of social development. Kerala's experience underscores the need for sustained development policies and not short-term one-off interventions.

(M Suresh Babu is Professor, Department of Humanities and Social Sciences, Indian Institute of Technology Madras; Saikat Sinharoy is professor of economics at Jadavpur University.)

END