COMMENTARY / HEALTH

# The Rural Front Line

To control COVID-19, we must make better decisions in the face of uncertainty

NAMAN SHAH AND YOGESH JAIN

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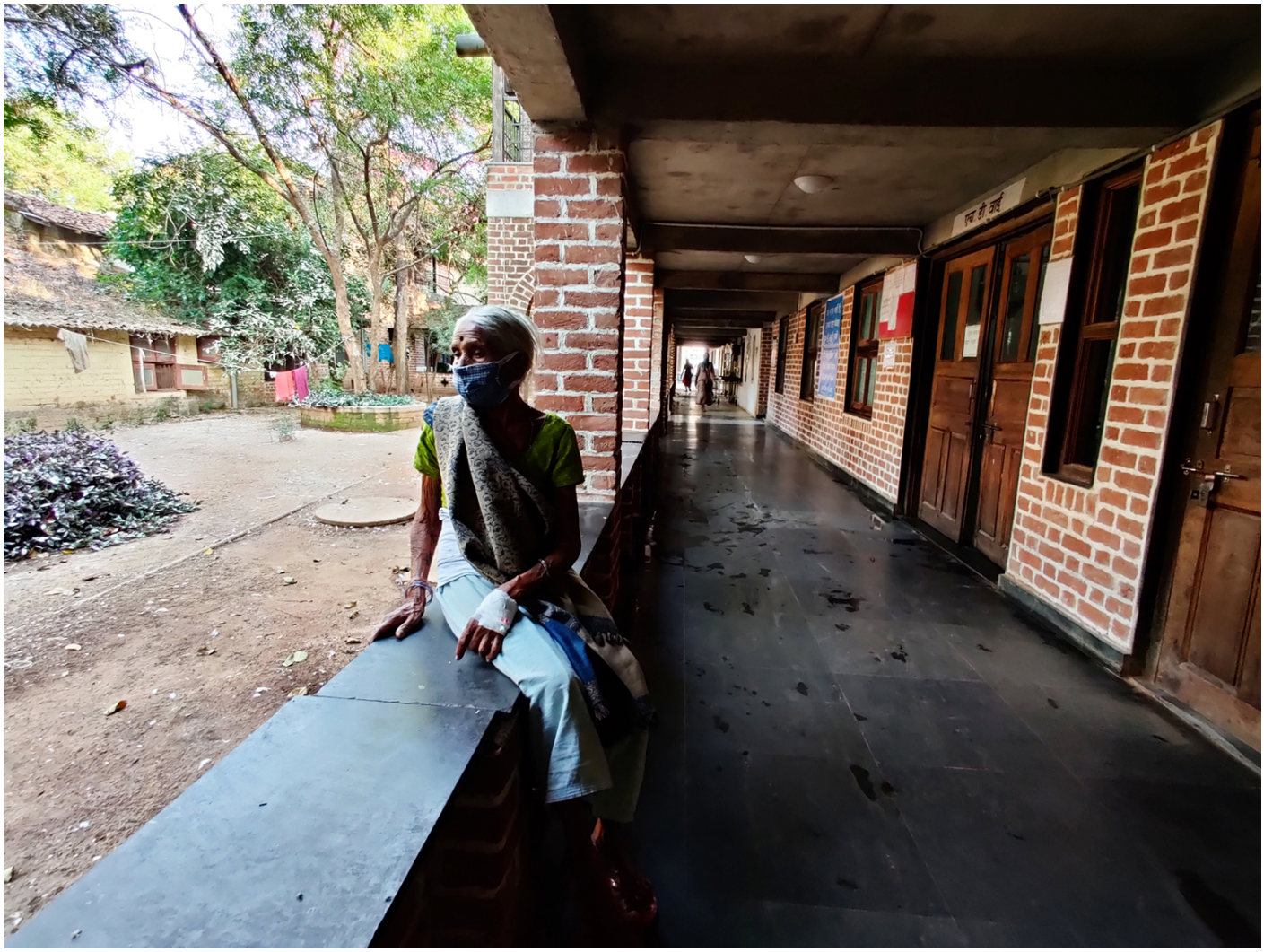

Even till the seventh day of the countrywide lockdown to contain COVID-19, chaos reigned at the Jan Swasthya Sahyog's hospital in Ganiyari village of Chhattisgarh's Bilaspur district. Due to the lockdown, the number of patients coming to the hospital everyday has fallen by ninety percent. DIPANKAN JANA

COVID-19

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*This is the second piece in a series titled "The Rural Front Line (https://caravanmagazine.in/tag/the-rural-front-line)," by Yogesh Jain and Naman Shah, about the COVID-19 pandemic. Jain and Shah are both doctors working with Jan Swasthya Sahyog, a public-health initiative based in rural Chhattisgarh. Over the course of the series, they will address the issues they witness on the ground while dealing with the virus and discuss how policy decisions affect the lives of India's rural residents.*

Even until the seventh day of the countrywide lockdown to contain COVID-19, chaos reigned at the Jan Swasthya Sahyog's hospital in Ganiyari village of Chhattisgarh's Bilaspur district. Due to the lockdown, the number of patients coming to the hospital every day has fallen by ninety percent. We discharged 28 patients on 25 March, from neighbouring Madhya Pradesh, but they remain trapped in the hospital as they could not travel back. One tuberculosis patient, from rural Bilaspur district, unexpectedly died on 27 March. The police had prevented him from travelling to the hospital a day earlier, according to his family. A woman, pregnant with twins, laboured in the forest throughout the day on 28 March as she was unable to find transportation. She arrived at night, bleeding profusely, and thankfully, delivered two preterm but vigorous girls weighing 1.3 kilogrammes each.

The overall vision to combat the pandemic remains a mystery—the government seems to be making it up as they go. We were and still are, entirely unprepared. While poorly planned, the lockdown allowed a semblance of action. Follow-up steps are now trickling in to correct the mistakes made while enacting it. Our state of Chhattisgarh, among others, expanded the eligibility criteria of the public-distribution system and has given additional rations. States seemed to wake up to the horrific plight of migrants only after being prodded by public outcries and civil society. It was only on the third day of the lockdown that the government exempted categories required for agricultural work—essential for survival in rural India—from the lockdown guidelines.

Epidemics bring a need to move fast, compounding the usual difficulties associated with policy making. At times, public policy requires making decisions even if there is a dearth of information. Examples abound to show that such decisions were taken with respect to COVID-19 as well. What was the decision-making process for the

restrictive testing policy for the coronavirus? Why did we start using the anti-malarial drugs chloroquine and hydroxychloroquine for preventing COVID-19 infections in health workers?

Sometimes a lack of information leads to paralysis in policy formation, due to a fear of mistakes. Other times, this results in knee-jerk reactions—often, too little too late. Principles offered by three economists provide insight for navigating the challenge posed by uncertainties.

The first is to remember "the fact that research is a scientific act, and policy advice a political act," as Jean Drèze, India's leading development economist, wrote (https://www.sciencedirect.com/science/article/abs/pii/S0277953618301928?via%3Dihub) in 2018. Drèze explained that economists should be cautious in offering evidence-based policy advice. According to him, the road from evidence to policy is long and fraught with danger. It entails making value judgments and dealing with stakeholders who have different priorities. Plus, there are operational, ethical and legal considerations, which economists may not be familiar with.

A parallel caution exists for doctors and epidemiologists. Understanding the clinical characteristics of coronavirus along with its determinants and distribution forms the foundation of any response. But we suffer from the same dangers listed above. Pandemics require communication, coordination, logistics and social planning in equal measures, besides health recommendations. One mistake was to treat COVID-19 solely as a health problem under the leadership of an individually talented, but collectively narrow, Delhi-centric task force (https://icmr.nic.in/sites/default/files/upload_documents/Letter_Shri_Lav_Aggarwal_JSI It was only on the fifth day of the lockdown that the government set up (https://indianexpress.com/article/coronavirus/coronavirus-cases-india-govt-groups-fight-spread-covid-19-6337907/) eleven empowered groups, with individuals from a wide range of sectors, to tackle a comprehensive set of issues.

The second principle is to publicly explain the rationale behind decisions, including areas of uncertainty. The economist and philosopher Amartya Sen elaborated in his 2009 book, *The Idea of Justice*, how reasoning in public helps negotiate the varying

demands placed by different groups in society while making decisions, and thus, makes democracy more effective. This relationship allows us to understand democracy not just as counting votes, but in its full potential as a "government by discussion."

Alongside timely, considered decisions, the act of explanation has been absent in India's pandemic response. Without knowledge, many of those at the least risk from the virus, or its containment measures such as the lockdown, are enamoured with how swift or bold some of the government's actions appear. The paradox of the coronavirus epidemic is that from entrepreneur godmen to surgeon entrepreneurs—men of a similar breed, despite their outward differences—everyone is now an expert, while those entrusted with responsibility remain shockingly silent. Policymakers need to cultivate a culture and skill of justifying their actions to the public.

Third, we must learn to walk before we run. The story of Indian policy is that grand ideas fail during implementation. While these failures involve many factors, not considering the capacity of the state is common. Ajay Shah, at the National Institute of Public Policy and Finance, has elaborated on the concept of "premature load bearing," which permeates many of our institutions. Systems without the ability to meet the aim collapse when we overload them. Overloads result from a combination of lacking the ability to process many transactions; when ill-equipped front-line officials need to exercise a high amount of discretion; and when the stakes involved in the service are high. The result is a gap between policy objectives and ground behaviour that settles into persistent dysfunction. To prevent this, we should strategically not take on certain things, design policies according to load-bearing capacity, and master smaller problems first and then only take on more complex tasks.

In our public health system, multi-purpose front-line staff, including nurses and community-health workers, are overburdened with an impossible list of duties. They are set up to fail. So, when they expectedly underperform, it is difficult to hold them responsible for specific tasks, thus, creating a vicious cycle of unaccountability. The Pradhan Mantri Jan Arogya Yojana seeks to expand hospital-based care—a wonderful

aim—but through insurance, a mechanism difficult to administer even for advanced countries. The programme diverts funds—and even attention, an often overlooked element—away from fixing primary care and public health. The low-quality system we have in place for dealing with the outbreak is what makes India's spread so frightening. Those who call on India to emulate the strategies of South Korea and Taiwan, glossing over vast differences in capacity, endanger their credibility.

This is set of principles from our colleagues who have been trained in economics. To this, we would add two more from our experience of working in public health in rural India.



Crises such as COVID-19 are moments to reinvent health systems for the long term. Due to the limited opportunities in which healthcare receives interest and investment, we should prioritise interventions that cut across a range of illnesses. This becomes important with respect to COVID-19 as there are many unanswered questions which can result in hasty decisions. How will weather affect transmission? Will our investigational therapies work? Will mutations in the virus change its fatality?

We saw similar pitfalls in 2009, when the world braced itself for the spread of H1N1, a novel, more virulent strain of influenza. Countries stockpiled huge amounts of vaccine for the H1N1 flu. The United States alone spent around two billion dollars on vaccine and related expenses. But the vaccine turned out to be of limited efficacy and never achieved high acceptance among the population.

Just bringing more testing kits and ventilators, beyond a point, may or may not ease the current outbreak. They will certainly not improve our long-term health. On the other hand, building up public-health systems through increased staffing, supplies and better training helps tackle not only coronavirus, but also our chronic epidemics and the future ones to come.

Secondly, in a grossly unequal, unjust country, planning for emergencies such as COVID-19, while also keeping the aim of equity in mind, will improve decision making. To do this, the World Health Organization has delineated some approaches.

Using a targeted approach—geographic, income, or social criteria—is important to reach marginalised populations who otherwise often miss out on the benefits of public effort. We should note that sometimes the best form of targeting is the use of universal policies which avoid errors of exclusion and generate a wider buy-in. In the COVID context, targeted lockdowns of districts—perhaps based on surveillance data—or protecting high-risk groups such as the elderly, could be considered after the 21-day lockdown.

Increasing social participation in designing, implementing and monitoring programmes improves equity. The state alone cannot isolate 0.1-percent of the population, much less when the epidemic crosses that. Community-based isolation and home isolation will be needed and cannot work without participation.

Ensuring financial protection for those who become ill will prevent an increase in poverty from healthcare costs. Universal-health coverage is the way forward. Till we can ensure that, price gouging from coronavirus testing or treatment by the private sector is occurring and needs to be prevented.

Finally, it is essential to maintain a focus on equity by developing appropriate indicators. An equity lens helps us see who benefits and who pays the costs. For instance, measuring mortality from all causes during the epidemic will let us account for COVID-19 deaths and other preventable causes of death. This figure would include the deaths of 22 migrant workers, that occurred as a consequence of suddenly blocking people's livelihood.

In the end, the poor always bear the brunt of any disaster—be it natural, or man-made. But when a disaster has been ongoing for decades, such as the slow bleeding of our healthcare system, we wonder if it even registers as one? Applying these principles, even in the face of the unknown, can help prevent added tragedy.

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KEYWORDS: The Rural Front Line(/tag/the-rural-front-line) COVID-19(/tag/covid-19) Chhattisgarh(/tag/chhattisgarh)

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03 Apr, 2020

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