India’s strategy to fight double jeopardy of CVD and Covid-19

# "As long as poverty, injustice and gross inequality persist in our world, none of us can truly rest." ~ Nelson Mandela at the Launch of the ‘Make Poverty History’ campaign , Trafalgar Square, London, England, 3 February 2005

Chalasani et al. write an editorial about the plight of non Covid-19 patients who are facing several challenges to visit the hospitals for their regular follow up (1). The authors correctly point out that as non communicable diseases have surpassed communicable diseases as principal causes of death, neglecting them will cost us dear in terms of poor overall health outcomes. They write under a heading of ‘Background’ that as most of the patients are poor, they are mostly bereft of personal savings or strong social security nets to fall back on in these difficult times. Then they provide its evidence in terms of a poverty line and also provide statistics about scores of people living below it. But I propose that while it’s true that our most of the population is poor, however counting its number and proportion in this way is fraught with several limitations. It’s reasons are many -including but not limited to- disclosure of incorrect facts in questionnaires, different ways of framing of questions and inflation (2).

To highlight deprivation of Indian population, the authors specify an average monthly income. However to capture this parameter we need to realise that there is another yardstick -called Human Development Index- which takes into account not only per capita income but two other markers of human well being also: namely life expectancy and literacy levels (3). Philosophy behind using this index is that earning money is not a goal in itself but only a means to fulfil a goal of having a decent, respectable and good quality of life. Therefore measuring quality of life on the basis of monthly income alone runs a risk to leave other dimensions of poverty behind. As authors use per- capita (mean) monthly income to underscore poor spending capacity of people, we need to realise that that marker hides wide inequality of masses. If number of billionaires rise (which is actually happening here), mean value of income will rise but that arithmetical calculation hardly has an impact on the life of an average citizen. Therefore now we developed tools to measure asymmetric distribution of wealth in population (4). India ranks poorly at 129 on this index (5).

At this crucial point in history of the mankind, we need to realise that both Cardiovascular disease and Covid-19 are mercilessly killing those having common risk factors of smoking, diabetes, hypertension, a history of heart disease and African American ethnicity (6). Hence not only we need to control these risk factors- as authors correctly point out- to avert a future healthcare catastrophe but also to reduce impact of the raging pandemic at present too. When those with these known risk factors for heart disease go for regular follow up and don’t avail services, we doubly destabilise our system- both in terms of increased risk of early mortality from coronavirus and also by accelerated pace of inflammation in body of them -leading to higher number of future events. And perhaps no existing graph or model systematically captures projections of both of these events -happening at different time scale. Therefore although we need to be careful from the virus, simultaneously we also need to be caring, considerate, compassionate, sympathetic- and above all humane- to reduce overall impact of the pandemic on our patients as much as we can. We’d make every possible attempt at our disposal to rescue those who are already standing at the cliffhanger from an impending vertical fall.

**References-**

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