International Research Journal of Natural and Applied Sciences
ISSN: (2349-4077)
Impact Factor 5.46 Volume 8, Issue 02, February 2021
Website- www.aarf.asia, Email : editoraarf@gmail.com

COVID -19 PROVISIONS AND THE HEALTH POLICY POST PANDEMIC

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Abstract: The study indicates that the advent of a novel coronavirus disease pandemic in 2019 (COVID-19) presents unique challenges to the health system. Although, on the one hand, the government has to fight with COVID-19 management mechanisms, on the other hand, other routine health services still need to be controlled. The system needs to be improved to accommodate the imminent outbreak of cases. Economic security and household income must be guaranteed. All of these have complicated the routine ways in which governments have dealt with different trade-offs to evaluate public and health policies. In this paper, we outline main economic concepts for the government to consider in policy-making, during and after the pandemic of COVID-19. The pandemic rightly places long due focus on the part of policymakers to investing in the health sector. Policy makers and the public health community do not skip this once-in-a-lifetime policy window to increase the degree of support for sufficient investment in the health sector.

Keywords: *Coronavirus, Health, Technology, Priority, Economics*

Introduction

The novel Coronavirus Disease 2019 (COVID-19), which arose in Wuhan, China, was declared a global pandemic of worldwide importance by the World Health Organization on 11 March 2020. The pandemic of COVID-19 is distinguishable from other diseases in the degree to which its externalities have impacted society as a whole, in terms of health and economic effects. As a result, new problems have emerged for policy makers in seeking to balance their societal interests. In this paper, we use economic underpinnings to clarify some of these problems and to propose a way forward for health policy, during and after the COVID-19 pandemic in India. First of all, we identify the challenges of the COVID-19 pandemic in India. Some of these health sector issues include funding and delivering health care, designing policies that maximise the health of the population due to both COVID-19 and non-COVID-19 health conditions. Second, we describe the wider macro-economic effects of past influenza and SARS pandemics and discuss their consequences for the current COVID-19 pandemic. Third, we explain the parameters on which the goals were set and how COVID-19 influenced the priority setting process. Finally, we conclude by stating four main lessons for building a robust health system during and after the COVID-19 pandemic in India.

India has traditionally been one of the lowest public health spenders, with the government spending 1.5 per cent of gross domestic product (GDP) on health. As far as the expectations of universal health coverage (UHC) are concerned, it has been shown that an investment of 3.8% (2.1% – 6.8%) of GDP is required. Many developed countries with somewhat universal coverage of health services spend an average of 8% of their GDP on health care. The latest COVID-19 pandemic has revealed this historic perpetual underfunding of the health system in India, whether it concerns the availability of hospital beds, intensive care facilities, ventilators, personal protective equipment (PPE) or diagnostic facilities. The Government of India has announced the infusion of 15,000 Crore Rupees into the health care system to fulfil the requirements of the health care system. However, given the expectations of the UHC, there is a lot more need. Approximately 70 per cent of outpatient and 58 per cent of inpatient needs are met by the private sector. In such a scenario, wary of an increase in cases as seen in many other countries, several state governments in India have begun to look to the private sector for the provision of COVID-19 care. This has opened up questions on what the buying treatment process should be and how hospitals should pay for it. Three versions may be considered in terms of purchase. The entire private hospital is designated as a COVID hospital, hospital continues to offer regular care as well as segregation and treatment of COVID-19 patients on a case-by-case basis and the government uses this extraordinary national emergency situation as a pretext for the nationalisation of all private hospitals. Although the last choice tends to be a very challenging political proposition, most state governments take the first two options. Either way, it has consequences for the design of payment rates for the supplier. For hospitals that are taken over entirely as COVID hospitals, the provider's payment rate should be measured in two parts, the first part comprising a global monthly budget (per-bed rate for hospital size) to compensate for the opportunity cost of building and other capital assets, and the second part, preferably a packaged case-based payment per COVID-19-treated patient. The latter payment should be distinguished by the level of care rendered, i.e., isolation on its own, intensive care and artificial ventilation. However, consideration should also be taken to ensure that the packaged case-based payment does not contain capital expenses, which are included in the global budget. A bundled case-based payment containing the value of both capital and recurring resources should be set as the provider's payment rate for the second model of purchase of services in which private hospitals offer mixed care. Hospitals should be encouraged to provide treatment for COVID-19. One approach to incentivise is to measure the rate of payment on the basis of the expense that is measured at the lower level of bed occupancy. Second, the expense of improved infection prevention procedures, indicative of use during the COVID-19 pandemic, should be included. With respect to funding by public private health insurance, where the premium is actuarially calculated, one of the basic prerequisites is that the risk of contracting an individual's illness should be independent of the likelihood of anyone else being ill. The case of COVID-19, however, challenges this important condition. As a result, private insurance providers will either not include the treatment of COVID-19 in the compensation plan, or the premium would be much higher than the individual personal benefit. This has two apparent implications. Second, those who buy insurance are likely to be high-risk people for contracting illness, and thus the overall insurance outlook is likely to

follow what Akerlof calls the death spiral in economic literature. Second, it would lead to inequities in health financing and results, since the poor and vulnerable would be less able to buy insurance. This again points to the autonomous and powerful position of the state in the funding of COVID-19 treatment.

Non-covid Health conditions

The advent of COVID-19 in India and other countries has led to the implementation of physical distance steps in the form of full state-forced lockdowns. The latter placed regional barriers on access to curative care facilities and on supply-side constraints on the provision of health services. Owing to the communicable existence of the disease, health care providers have both indirectly and specifically limited the provision of care for non-COVID conditions, citing concerns about the safety of health care providers and decreasing community transmission in hospitals. The bulk of this negative externality has been observed in maternal and child health programmes, which have had a high degree of national coverage in recent years, and in the care of diseases requiring continuity of services such as tuberculosis, dialysis for chronic kidney disease, or radiation therapy for cancer. This is expected to have substantial health and economic implications at the population level. Immediate re-examination of how access to routine treatment is not interrupted requires attention.

Economic Influence welfare and Income security

A further significant influence of the COVID-19 pandemic has been at the micro and macro level. It has had an effect on household income and its resulting consumption. In a country like India, where more than 90% of its working population is in the informal sector, the impact of the lockdown on household income is likely to be even higher. It is shown that the implementation of serological tests to ensure that individuals with antibodies return to work after a period of physical distance will result in a 2% increase in GDP in the Philippines. Walmsley et al. found that a 4-month business closure during SARS would lead to a 21.6 per cent decrease in GDP and a 23,0 per cent fall in jobs. Similarly, it is estimated that the "Hong Kong Flu" and "Spanish Flu" pandemic would contribute to a 2% – 8% fall in global GDP. However, there is no such evidence for setting low and middle-income countries.

Precedence Scenery and Trade-Offs Strategy

The COVID-19 pandemic also faces major challenges in setting health and public policy goals. A recent analysis cited the inclusion of cost-effectiveness, equity, viability and policy factors in the LMIC priority setting criteria. India recently set up the Health Technology Evaluation Board (HTAB) to promote evidence-based policy making. The HTAB correctly identified three requirements for making recommendations on resource allocation decisions: health maximisation, health use equity, and reduction of out-of-pocket spending. Even so, the advent of COVID-19 has led to a profound change in trade-offs for evidence-based policy making. Second, in the pre-COVID-19 period, decisions on priority setting were made at the margin, i.e., the additional health benefits of the additional expenditure of the intervention relative to

the cost-effectiveness threshold. Not much focus has been placed on the externalities of the intervention, other health issues and services. However, COVID-19 approaches have a major externality to non-COVID health programmes. This means that the evaluation has to be more detailed and more thorough. Second, although most of the costs considered in the evaluation of health technology were direct and indirect medical expenditure, COVID-19 initiatives had substantial non-health costs. As a result, the concept of the social perspective to be used in the study is multiplying. There are a variety of important questions regarding priority setting that may contradict the concepts of productivity and equity. COVID-19 puts health care providers at a substantially higher risk of exposure. Health care professionals, though still at the helm of prevention measures, will still need to be shielded from infection. As a result, there may be trade-offs in their defence, with regard to the use of PPE, infection management methods, chemoprophylaxis, care, etc., which may not be justified on the basis of clear efficacy arguments. Disproportionally greater resources ought to be allocated to healthcare facilities, which can contradict conventional concepts of equity.

Conclusion

The study shows that the COVID-19 pandemic has valuable lessons to draw from health and public policy. It rightly places long due focus on the part of politicians to making the right investments in the health sector. Policy makers and the public health community at large should not skip this critical once-in-a-lifetime policy window to increase the level of advocacy for sufficient investment in the health sector. Core economic principles for buying treatment and paying providers should be pursued in order to optimise population health, social security and the provision of UHC. The COVID-19 pandemic offers an important lesson in developing public healthcare provisioning programmes and reducing dependency on the purchase of healthcare from the private sector. This is much more important to consider, considering the important public health role performed by the public sector. Finally, the management of the COVID-19 pandemic, which affected all sectors of government, offers an opportunity to further advance the cause of health-in-all policies. Only time will say how much the governments and the public health community learn and take advantage of COVID-19 to create a resilient public sector for the provision of health services.

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