Editorial

The Covid-19 Pandemic: Impact on primary and secondary healthcare in India

The National Disaster Management Authority (NDMA) on 24 March 2020 issued directions to the Government of India (GoI) to implement various measures, including countrywide lockdown, for the containment of Covid-19 pandemic.[1] Consequently, the Ministry of Home Affairs, GoI, initially imposed a countrywide lockdown for a period of 21 days with effect from 25 March 2020.[2] The NDMA, it seems, was apprehensive of the likely adverse consequences of the lockdown on the health sector. Therefore, it specifically recommended to ensure, '…maintenance of essential services and supplies, including health infrastructure' during the lockdown period. The ongoing lockdown (started on 18 May 2020) is the fourth extension, albeit with some area-specific relaxations. By 25 May 2020, the 62nd day of the lockdown, India reported cumulatively 138 845 cases and 4021 deaths.[3]

Apart from the lockdown, the GoI took many other policy decisions in response to the Covid pandemic. The typical response to the pandemic can be described as the so-called 'Operation SHIELD'.[4] The acronym SHIELD stood for **S**ealing of the immediate area from where the cases were reported, **H**ome quarantine of all in the area, **I**solation and tracing of contacts, **E**ssential supplies delivered at the doorstep, **L**ocal sanitization and disinfection, and **D**oor-to-door checking for symptomatic persons who could then be isolated and tested for Covid. There were varying degrees of emphasis on individual components of this strategy in different parts of the country. This strategy impacted the 'maintenance of health infrastructure'.

Sealing of an area meant that no movement, in either direction of the sealed area, was permitted except in case of a medical emergency.[5] All vehicular movement, movement of public transport and personnel were also stopped. Criteria for home isolation were stringent, including availability of separate washroom for the patient, absence of any comorbid conditions, age group eligibility, etc. Isolation and tracing of contacts was intense, and was mostly done by the accredited social health activists (ASHA), auxiliary nurse midwives (ANM), and other healthcare workers (HCW). They spent substantial time in updating the information on the web portal of the Indian Council of Medical Research. Door-to-door checking of patients with fever around the Covid-positive person's house was mostly done by the ASHA. The strategy to combat the Covid-19 pandemic affected the primary and secondary healthcare services, both by demand, as well as, supply side implications.

Supply side issues

New activities related to the Covid pandemic were added without formally removing any of the past routine work of HCW. Some of the new activities included quarantine/home isolation of patients and their daily monitoring for the next 14 days, contact tracing, scaling up of corona virus testing services, and daily reporting to various authorities. Existing HCW were diverted to do duties at corona care and corona health centres. In addition, the HCW themselves disproportionately suffered from Covid-19. All this resulted in reduced availability of HCW to perform their tasks related to primary and secondary healthcare services.

The Alma-Ata Declaration, to which GoI is a signatory, recognized health as a fundamental right, and pledged to provide acceptable level of Health for All. The strategy recommended was primary healthcare with eight essential components.[6] Components that were particularly relevant in the Indian context have been included in our national public health programmes. These programmes are implemented through

government-operated primary and secondary healthcare facilities. Since the health system was overwhelmed by the Covid-19 pandemic, the national health programmes got deprioritized. To get a sense of the impact of the Covid-19 pandemic measures on the national health programmes we can, as illustrative examples, examine just three of them, viz. tuberculosis (TB), HIV, and maternal and child health.

GeneXpert and CB-NAAT platforms were originally procured to enhance the diagnostic capacity of TB. However, to augment Covid-19 diagnostic capacity they were repurposed for Covid-19 testing.[7] Similarly, doctors and staff nurses at primary and secondary healthcare facilities were diverted to Covid-related work. There are early indications that the detection of new patients of TB has declined substantially. Absence or irregularity in supply of anti-TB drugs witnessed so far is likely to raise the incidence of drug-resistant TB.

Testing for HIV is considered a gateway to the treatment cascade. During the lockdown, the HIV testing services and antiretroviral treatment clinics were disrupted. The most vulnerable among the HIV-infected persons, i.e. injecting drug users could not get fresh supplies of sterile needles and syringes, and opioid substitution therapy. One could, therefore, expect a serious setback to the National AIDS Control Programme.

Provision of antenatal care and immunization of children against vaccine-preventable diseases has brought great health dividend in the past. These services became unavailable during the lockdown period. Some of these services can be considered as denied (e.g. non-institutional delivery) while others (e.g. immunization) can be termed as deferred.

Demand side issues

The lockdown resulted in loss of earnings, particularly for those employed in the unorganized sector. Most of these individuals did not have any insurance coverage either. Almost 70% of healthcare in India is provided by the private sector.[8] Lack of financial resources dampened the demand for private sector services, even if it were to be available in the first instance. In addition, the beneficiaries faced restricted or no access to these health facilities due to quarantine/home isolation, living in containment zone, non-availability of public transport, etc.

Approximately 22% of India's population is below the poverty line, with 86 million living in extreme poverty.[9] These marginalized and vulnerable populations were mostly dependent on publicly funded primary and secondary healthcare services. However, this is precisely the group that disproportionately bore the brunt of inaccessibility of healthcare due to the Covid-19 pandemic. Published data are currently not available. Nonetheless, it is reasonable to assume that primary and secondary healthcare in India was adversely affected by the Covid-19 pandemic. The short- as well long-term consequences would become apparent at a later date.

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