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11.09.2020

New Delhi

To

Sri Bhupendra Bhaskar

Additional Director

Rajya Sabha Secretariat

Parliament House /Annexe

New Delhi 110001

Sub : Examination of the subject "Outbreak of Pandemic Covid-19 and related Contingent and Mitigation Plan" by the Department related Parliamentary Standing Committee on Health and Family Welfare

Dear sir

On behalf of the Indian Medical Association and the modern medical fraternity of India ,we thank the department related Parliamentary Standing Committee on Health and Family Welfare and the Rajyasabha Secretariat for giving an opportunity to IMA to present the views of the medical profession of the country "Outbreak of Pandemic Covid-19 and related Contingent and Mitigation Plan". Here with we are submitting our opinion and suggestions on the subject.

Thanking you,

Yours sincerely

Dr Rajan Sharma
National President, IMA

Dr R V Asokan
Hony Secretary General, IMA

Indian Medical Association

Outbreak of Pandemic COVID-19 and related contingent and mitigation plan: IMA's Views and Suggestion

Submitted to:
Department-related Parliamentary Standing Committee on Health and Family Welfare
Government of India

11 September 2020
New Delhi

Preamble

The performance of a country in management the pandemic, 2019 Novel Coronavirus (2019-nCoV) or COVID 19 should be measured on the following broad aspects:

1. Containing the spread of virus
2. Number of deaths
3. Balancing of Life and Livelihood

Indian Medical Association (IMA) is of the view that, the Government of India and all the state Governments and Union Territory have relatively managed the spread of virus well when compared with 32 nations which are currently having over 1,00,000 COVID cases.

India is ranked 129th in the UNDP Quality of Health Index wherein the key parameters taken for measurement are - Lost health expectancy and Number of Physicians and Hospital beds per 10,000 people. 29 out of 32 nations having over 100K COVID cases are ranked higher than India. The bottom two nations ranked below India are – Bangladesh and Pakistan.

India has 6.5 Physicians and 7 hospital beds per 10,000 people. Germany, which is ranked #4 in the UNDP Quality of Health Index, 42 Physicians and 83 Hospital beds per 10,000 people.

The ultimate measure for any nation's pandemic performance will be in relative terms of deaths to the total population. In this context, India's Death Per Million Population (DPM) is 52, whereas Germany's Death Per Million (DPM) population is 112. Further from COVID Case Fatality Rate CFR (%) point of view, India's CFR is 1.7% whereas Germany CFR is 3.7%.

India relatively contained the spread of virus well especially during the Lockdown period. However, somewhere during the staggered unlock period, states which were vulnerable for the spread of virus struggled to balance both, life and livelihood during the unlock period. This resulted in continued surge in COVID cases leading to increase in mortality.

Today, even though all the 523 Lok Sabha Constituencies are affected by COVID, there is a political leadership vacuum at the district level. There is an urgent need for strong political leadership at the District level. The Hon'ble Member of Parliament has been empowered by the constitution to lead and take appropriate decisions in the interest of their respective constituency. IMA is of the view that the active leadership and participation of Hon'ble Member of Parliament would help the said district to recover faster from COVID.

IMA is concerned with non-disclosure of testing data related to 40-50% of the districts by respective state Governments.

India: Hospital for the world

India has the potential to become Hospital for the world by providing world class healthcare to the global community. Therefore, the Government of India needs to develop a comprehensive healthcare policy which not only benefits large hospital chains, but also creates suitable opportunities for small clinics/nursing homes who are the backbone of India's primary and secondary healthcare.

COVID Performance Analysis of Nations having over 100K COVID Cases

India's UNDP Ranking for Quality of Health among the comparable nations in COVID Management is among the bottom 3, but managed to be among the 5 nations with least death/Mn population. This is the result of Government of India's relentless efforts and 573+ Doctors and other healthcare workers who laid down their lives in the service of the nation

COVID Performance Analysis of Nations having over 100K COVID Cases: As on 08 September						
Ranking	**Country**	**Test Positivity Rate (%)**	**Tests / Mn**	**Active Cases /Mn**	**Death / Mn**	**Case Fatality Rate (%)**
4	Germany	2.1	147707	178	112	3.7
13	Canada	2.3	155830	186	242	6.8
15	USA	7.3	267545	7615	586	3.0
15	UK	2.0	259291	NA	612	11.8
22	Israel	5.5	270569	3210	113	0.8
25	Spain	5.4	213595	NA	633	5.5
26	France	3.9	130166	3316	471	9.2
29	Italy	3.0	154922	559	588	12.7
36	Saudi Arabia	6.0	154838	569	118	1.3
41	Qatar	18.1	237885	1025	73	0.2
42	Chile	15.9	139423	842	610	2.7
48	Argentina	35.4	31191	2718	230	2.1

49	Russia	2.7	265564	1149	123	1.7
50	Kazakhstan	4.1	136648	260	87	1.5
59	Turkey	3.5	94593	275	80	2.4
65	Iran	11.4	40759	370	268	5.8
76	Mexico	44.4	11113	952	525	10.6
79	Brazil	28.9	67692	3009	599	3.1
79	Colombia	22.7	58780	2280	428	3.2
82	Peru	20.5	102953	4124	911	4.3
85	Ecuador	33.2	18876	502	601	9.6
88	Ukraine	8.1	39647	1694	67	2.1
89	Dominican Republic	25.0	36816	2249	174	1.9
106	Philippines	8.4	26158	481	36	1.6
111	Indonesia	8.1	9066	178	30	4.1
113	South Africa	16.8	64276	969	254	2.4
114	Bolivia	47.9	21674	3538	603	5.8
116	Egypt	74.2	1315	144	54	5.5
120	Iraq	15.7	42542	1377	190	2.8
129	India	8.6	36635	649	53	1.7
135	Bangladesh	19.8	10059	587	28	1.4
152	Pakistan	10.7	12641	30	29	2.1

India's Ranking on key COVID Management Performance Indicators:

1. Nations having LEAST Death Per Million Population: 5th
2. Nation having LEAST Case Fatality Rate (CFR) %: 7th
3. Nation having LEAST Test Positivity Rate (TPR) %: 16th
4. Nation conducted HIGHEST Test Per Million Population (TPM): 23rd

Responses on 'outbreak of Pandemic Covid-19 And Related Contingent And Mitigation Plan' To The Department Related Standing Committee on Health And Family Welfare For Rajya Sabha Secretariat

1. **Critical analysis of steps undertaken by Government during various lockdown and unlocking phases to contain and mitigate COVID-19.**
   a. India saw 4 'lockdown' and 4 'unlock' phases, running consecutively, after the 14-hour 'voluntary junta (public) curfew' on March 22, 2020.
      I.LockdownPhase 1 (25 March – 14 April)
      II. LockdownPhase 2 (15 April – 3 May)
      III. LockdownPhase 3 (4–17 May)
      IV. LockdownPhase 4 (18–31 May)
      V.Unlock Phase 1.0 (1–30 June)
      VI. Unlock Phase 2.0 (1–31 July)
      VII. Unlock Phase 3.0 (1–31 August)
      VIII. Unlock Phase 4.0 (1-30 September)

   Early recognition: Acted swiftly by announcing Lockdown 1.0 and initiated several measures in coordination with the State Governments.

   b. The first phase saw near complete shutdown of all services, manufacturing, travel and local movement of people, business, etc. Only threadbare essential supply was allowed. Each of the subsequent7 phases saw progressive levels of relaxations and resumption of services and life, along with demarcation of populations – red (further demarcated into containment and buffer zones), orange, and green – by level of COVID-19 cases in communities, and greater autonomy to states to take some decisions.
   c. The lockdowns slowed the spread of COVID-19 and provided some time for health care systems to be put in place to deal with the pandemic. Several lakh cases, and deaths due to COVID-19, were averted, especially during the first few phases of the lockdown.
   d. Public knowledge of prevention measures – use of masks, physical distancing, and handwashing – is probably nearly universal. This will benefit the country by reducing the spread of the common cold, other influenzas, pneumonias, tuberculosis, other viral and bacterial respiratory tract and other infections, including diarrheal diseases.

e. The key negative impact of the lockdown was on the economy that was already weak, resulting in huge losses in revenue to national and state governments. Nearly every citizen outside of government employment suffered from financial losses, especially in loss of incomes/livelihood. The impact on the poor, marginalized, and vulnerable (like migrant workers), will have been catastrophic and will take months to evaluate, and may never be fully quantified. The benefits of government financial reliefs announced are unclear.

f. Other important negative outcomes of the lockdown, or the implementation thereof, are psychosocial and medical.

   I. The lockdown resulted in undesired, sometimes brutal, administrative implementation, and media responses. This generated a lot of fear among people across the country. The fear is not just of COVID-19, the disease, but of social stigma if one were to have the disease, or show any symptoms suggestive of COVID-19. Fear of separation from family if affected by COVID-19, of forced quarantine in unfriendly environments, of insensitive or poor quality of health care, of catastrophic health care costs, etc. has had unmeasurable impact on society.

   II. Routine medical services have been seriously hampered by COVID-19 and the resulting lockdown. People are refraining from accessing routine, non-COVID-19, medical services, including for check-ups, and they fear visiting hospitals and clinics, lest they get infected. Medical service delivery was restricted, especially in the early days of the lockdown, and are yet to regain their full spectrum. Many doctors practice sub-optimal consultations; physical examination of patients has been particularly compromised. Small and medium clinics and hospitals were shut. Some are still shut or are weakly functional, resulting in poor access to health care, loss of jobs/livelihood among health care staff, and resulting in increased cost of health service delivery. Diagnosis and treatment of acute and chronic infectious and non-communicable diseases have all taken a backseat. The impact of COVID-19 creating setbacks on efforts to eliminate TB, or manage NCDs like hypertension and diabetes, are estimated to be high, but are yet to be fully and accurately known.

g. Testing: Ramp-up of testing capabilities within a short span of time is commendable. Today, India has carried out 5+ crores tests, 3rd nation in terms of number of tests

carried out. (In terms of Tests Per Million population, India stands 120th primarily due to large population base value of 137+ crores).

h. Personal Protection Equipment (PPEs): India was dependent on PPEs when the pandemic broke. Government of India's swift action and facilitation, today India has become one of the major exporters of PPEs.

i. Development of Aarogya SETU app: India demonstrated its technological capabilities by indigenously developing and launching Aaarogya SETU app to manage COVID in India.

j. Management of guest workers: During the initial period of the pandemic, a large number of guest workers faced difficulty. The Central and State Government recognised the challenge and took necessary corrective steps to ensure guest workers reached home comfortably

k. Low and slow testing: Even though the Government has ramped-up testing, but due to fast and wide spread of COVID the number of tests conducted is falling short primarily due to the vast Indian population. As on 29th August, India had carried out approximately 4.2 Crores of COVID Testing, of which in August month alone nearly 2.27 Crores, 50% of the total tests conducted. This is one of the prime reasons for higher Test Positivity rate in India.

l. Lack of clarity for treating non-COVID patients during lockdown: The Government under estimated the criticality of the continuity medical services for Non-COVID patients. All private hospitals were advised to defer treatment and medical interventions required for other chronic ailments. Further, the Government instructed to keep 20% of the capacity for COVID without working out a feasible mechanism to support the sustenance of the operations. This led to total paralysis of regular healthcare service in India and severely impacted millions of people who were in dire need of medical services.

m. Treatment of COVID patients in Private Hospital: A meaningful dialogue between the Government and the private hospital management to arrive at a sustainable pricing model to treat COVID patients could have eased the anxiety for people, especially during the lockdown period.

2. SWOT analysis of the Government contingent and mitigation plans to COVID-19. Further strategies required to combat weaknesses and threats and capitalize on strengths and opportunities.

a. India tested more than 529 lakh samples, and has recorded 44.7 lakh cases of COVID-19 as on September 10, 2020. Of this number, 9.2 lakh are active cases. Deaths due to COVID-19 are documented to be about 75,000.

b. An analysis of India's response to COVID-19, and proposed future strategies to mitigate the impact of the pandemic, is to be done through multiple lenses – medical, public health, social and community, and economic. This response largelyfocuses on access to, and delivery of, health care services.

c. Key strengths, weaknesses, opportunities and threats of COVID-19 mitigation plans:

I. Strengths

a. Early enforcement of lockdown delayed spread of COVID-19 and givecentral and state health systems time to establish capacity. In terms of cases per million (10 lakh) population: with 3263 cases per 10 lakh population, India is 56th among all countries with a population of around 20 lakhs or more, and 5th among large countries(thosewith 10 crore population or more). The incidence of COVID-19 could have been higher.

b. Adequate national resources – financial and human/technical – to plan for and manage the pandemic. India has a robust public health system, with decentralized decision making possible at state, district, tehsil /block, and facility, levels.

c. Indigenous potential and capacity to develop, manufacture, and distribute COVID-19 specific products: testing kits, drugs, vaccines, PPE, hospital/medical equipment including ventilators, and other essentials to contain, treat or otherwise manage COVID-19.

d. India has a relatively small proportion of elderly.

e. Ability to quick turnaround: States such as Rajasthan, Gujarat and Mega cities which include – Ahmedabad, Bengaluru, Chennai, Delhi, Mumbai, and Kolkata have demonstrated that India has the required skill and competences to quickly turnaround the COVID and bring the growth of the virus under control.

f. Mature Political leadership: Political leadership is the main and critical pillar to manage a pandemic/epidemic. Handling of COVID epidemic by the Union Government and different State Governments reflected that India's political system has the maturity to work together in the interest of the general public inspite of different political ideologies.

II. Weaknesses

a. Poor spending on health care over several decades; COVID-19 has hit a facet of the country that is traditionally weak.

b. The trust of the public in government services, especially in its health care service delivery, is low, resulting in real or imagined belief that the quality of government health care is poor.

c. Lack of sensitivity to people's fears and concerns; government not taking steps to prevent, reduce, or address the stigma associated with COVID-19.These fears are further aggravated by police brutality towards ordinary people and by the media that tends towards sensationalized and fear-generating 'news'.

d. India's poverty levels are high, and the population may not be able to absorb the economic impact of the lockdown. This has a direct impact on the health of people.

e. Government machinery moves slowly; policy to implementation is slow.

f. Tendency for short-term gain by ignoring medium- and long-term implications: Various published reports indicate that Rapid Antigen Test even though is faster and cheaper, but it is unreliable because around 20-30% of its negative reports are false. In order to increase its testing numbers, the Government of India is using Rapid Antigen Test. On the other hand, according to ICMR, RT-PCR test is considered as Gold standard. Even there is an element of delay in getting RT-PCR test report, but it is much reliable than Rapid Antigen Test kits. As per media reports, Tamil Nadu has used only RT-PCR tests, one of the states which has carried out maximum number of COVID tests.

g. Overburdening of Health Department: Management of Pandemic depends on round the clock availability of manpower resources of different skills and competences. However, the State Health department and municipal corporation is currently going through tremendous stress due to continued workload without any break for frontline

workers. This has created fatigue and reduced their productivity and impacted their morale.

h. Insecurity amongst healthcare professionals: Due to lack of clarity and support of the Government for healthcare professionals under the circumstances of themselves becoming COVID positive has created insecurity in the minds of healthcare professionals especially frontline staff forcing them to withdraw from the services.

i. Information sharing: Due to lack of uniform sharing of information on critical aspects, the general public and medical professionals in particular are not getting clarity on the situation in the district / state.

III. Opportunities

a. A vast, highly competent, private health sector that has the trust of the community, and which has the capacity to provide access to all kinds of health care services, from primary to tertiary care.

b. Health professionals and workers are largely committed to their work. The country – Central and State Governments – should capitalize on this and ensure that the medical fraternity is coordinated, enabled, motivated, and adequately remunerated.

c. India has a thriving capacity for developing and using technology; this can be used for information exchange/reporting, effective social and behavior change communication through social media, and development of drugs, tests, equipment, etc.

d. Door-to-door screening and testing is possible in India, given (a) established community health care services being rendered in urban and rural India, and (b) a large community-level workforce that exists in the public and NGO/CBO sectors.

e. Potential to establish a COVID-19 task force with multi-sectoral collaboration and participation. Such a task force with additional representation from academia, professional associations, technical experts (microbiology, pulmonology, infectious diseases, etc.), public health and epidemiology, pharma and medical diagnostics companies, corporate sector, civil society, insurance companies, etc. can plan action to mitigate and manage the currentCOVID-19 pandemic, minimize costs and improve treatment outcomes. This task force can also look into prevention of future contingencies involving COVID-19, even and of other/new epidemics and health emergencies.

f. The Government can lead the development of standards for COVID-19 care in India, a set of guidelines for health care providers and services across sectors and along the continuum of COVID-19 care. This may be spearheaded by the task force mentioned above.

g. Local community and Private sector support and participation: Local community has actively participated and supported the Government in managing challenging situations due to natural calamities. The local administration needs to deepen its engagement with the local community to manage COVID, especially in matters related to surveillance and containment.

IV. Threats

a. COVID-19 is currently spreading fastest in India; daily new cases range around 85,000 to 90,000 in the 2nd week of September, 2020. This is likely to be well below the expected peak.

b. Large numbers of migrant workers moved out of cities and towns, moving back to their hometowns and villages. This has repercussions on the country's and individual's economy. Migrants who suffered excruciating experiences while journeying to hometowns and villages are unlikely to easily regain faith in Government schemes and promises.

c. With migration, loss of income/livelihoods, and out of stigma and fear, there will be delay in seeking care for any health problem, resulting in increased non-COVID-19 morbidity and deaths in the medium and long term.

d. Health care services are also affected by loss of demand, out-migration of health care staff, and out of fear of infection and increased costs. This reduces already weakened access to health care services, and further increases cost of health care. The elderly and sick, and those developing serious disabling illness or cancers, are particularly vulnerable.

e. Most government and many private hospitals have allocated resources and infrastructure disproportionately for COVID-19. Even this may not be adequate for a worst-case scenario. It additionally makes it very difficult for people to access non-COVID-19 care. This adverse supply-demand cycle can spiral out of

control, potentially making standardized health care services unviable for the average Indian.

f. Data: Limited Sharing and Poor Accuracy: India's success in its fight against COVID depends on actions taken at district level. Today, many state Governments are not sharing districtwise critical data related to testing, positivity rate, mortality etc.,

g. Undemocratic enforcement: Some State Governments are trying to undemocratically enforce guidelines on Private Hospitals to accept some of the illogical guidelines for COVID.

Strategies required to combat weaknesses and threats and capitalise on the strength and opportunities

WHO often refers COVID 19 to Spanish flu which occurred in 1918 resulting in the death of over 100 Million people, around 4% of the then world population of 1.8+ billion. India was also severely affected during the referred pandemic.

According to independent reports received by IMA, with an assumption of Test Positivity Rate being atleast maintained at current levels, preferably reduced, the number of COVID positive cases is likely to cross 10 - 11 Mn and deaths to 1.25 – 1.5 lacs by end of October 2020. In case TPR increases more than the current level of 8.4% then, with higher testing, positive cases will further increase which will also lead to an increase in mortality.

Proposed India's strategy in its future fight against COVID

Hon'ble Member of Parliament (MP) Led and strategized, and supervised COVID battle: As on date, India has nearly 0.9 Mn active COVID cases spread across 543 Lok Sabha constituencies in India. Each of these constituencies are in different quadrants on Virus Spread Matrix, which requires appropriate strategy and execution. In this circumstance, a standardised operating system for all the constituencies will yield limited results. Therefore, Hon'ble Member of Parliament need to lead and help the local administration to devise appropriate strategies suitable to the need of their respective constituency and guide the local administration.

The constitution of India has given the required rights and authority for the Member of Parliament to initiate actions required to help the people of their constituency to manage both life and livelihood. They also possess required influence on both, state and central government agencies to act and hasten the process.

Testing - Emphasis on vulnerable groups: India needs to intensify its current testing strategy – Tracing, Testing, and Isolation. Along with this it should also aggressively test the most COVID vulnerable segment of the society - Male, aged between 55–70 years with comorbidities - Diabetes Mellitus (DM) and Hypertension (HTN).

Change in Home Isolation Strategy: Today, most of the asymptomatic COVID positive patients with comorbidities, preferably to be hospitaliseed, are isolating themselves at home exposing themselves for higher risk of fast deterioration leading to limited scope for medical intervention. For instance, this is one of the reasons for Delhi's continued increase in the number of deaths, leading to increase in Death Per Million population.

On the other hand, young asymptomatic COVID positive patients without comorbidities are in institutional isolation, which should be avoided.

Robust Resource Planning: India currently has 4.2 Mn COVID cases and around 9 lacs active COVID cases. According to the published reports, the current capacity utilisation of ventilator and ICU beds would be as per the following table. Therefore in order to effectively manage the expected continued surge in COVID cases, India should keep ready its blueprint to manage COVID in case if the number of positive cases move upto 25 Million, which is a possibility in case if COVID current growth rate, which is currently moving downwards, start moving upwards.

Assessment of ICU Beds and Ventilator Capacity Utilisation			
	Estimated Usage	Current Capacity *	Available for use
Number of Patients requiring ventilator support (1%)	43750	47500	3750
Number of Patients in the ICU (2%)	87500	95000	7500
Current Capacity Data as on April 2020	www.cddep.org: Princeton University *		

3. **Challenges posed due to changing character/strains/mutation by corona virus and its symptoms, and need for further R&D to find drugs/vaccine solution.**

The Ministry of Science and Technology, Government of India, ICMR, and other central and state Government competent Institutions need to carry out a detailed need assessment study and take up timebound appropriate actions. Indian Medical Association (IMA) would be pleased to actively participate in the deliberation

4. **Action plan for comprehensive research projects for having protective umbrella/biological weapons/defence mechanism against possible spread of virus and projected funds requirements for the next 5 years along with detailed justification .**

Research projects on COVID-19may benefit the country either in the short term or in the long term.

a. For short term benefits, research should focus on learning that will enhance prevention of spread of COVID-19, including through the development, testing, and use of, vaccines; or they should accelerate COVID-19 testing, and/or improve treatment outcomes.

b. For long term benefits, research should look at how future outbreaks of serious infectious diseases, new or existing, can be contained within a minimized local zone, and prevented from uncontrolled spread in the general community and across the country/globe. Learning will include understanding of measures that will have political, administrative, technical, and technological ramifications.

5. **Impact of COVID-19 on certain sections of the population, like women, children, laborers, etc.**
    a. Like many other health care problems, COVID-19 too disproportionately affects vulnerable and marginalized populations. A quick way to organize populations/sub-populations specially affected by COVID-19 is to see this under 3 dimensions:
        i. Dimension 1: vulnerable groups with finite numbers, located in, or outside of, defined geographies, e.g. urban poor communities with people living or working in overcrowded communities (e.g. urban slums), institutions (prisons, old-age homes, schools and other educational institutes when they are opened, etc.), high-risk occupations (e.g. health care services, e-commerce delivery, etc.), etc.;
        ii. Dimension 2: people with defined cross-cutting high-risk profiles, e.g. those with socio-demographic vulnerabilities such as the elderly, etc., migrants, those with co-morbidities such as CVD, hypertension, obesity, etc.
        iii. Dimension 3: equity issues affecting individuals, families, or communities defined by dimensions 1 and 2, including issues impacting access to quality and affordable health care.
    b. To be effective, the Government's COVID-19 response needs to address the most vulnerable of the country's citizens. Guidelines for doing soshould utilize the positive social, cultural, and community,strengthsof the country, and should definitely ensure that individual rights are maintained, and that sensibilities are addressed.
6. **Problems being faced due to huge Indian population in fight against COVID-19 and requisite course of action to overcome the problem.**
    a. India's population is huge and diverse. It is divided on the basis of geography, socio-economic status, language, culture, religion, caste, age groups, sex and gender, race, dietary habits, climate, health risks, occupation, size of family, vulnerabilities, and more.

b. While problems, and their solutions, can be listed and addressed based on each of these categories, the broad differences from the point of view of prevention and management of COVID-19 are economic and locational.
    i. The economic problems may be defrayed by ensuring that:
        1. Health services – whether public or private; from basic outpatient care to hospital care and intensive care – are standardized, of the highest possible quality, and updated as and when information and evidence on the prevention and management of COVID-19 emerges.
        2. Health costs necessary for COVID-19 are defrayed by insurance schemes or Government reimbursements.
        3. The Government and the medical profession take measures to ensure that out-of-pocket charges for health services and products in the private sector are rational and transparent.
    ii. Location-based problems are those dependent on where a person lives and/or works. Spread of COVID-19 is largely based on the number of contacts a person has with others, preventive measures taken, and on the exposure to, and virility of, the virus. People living/working in over-crowded areas, such as in urban slums, are much more exposed to COVID-19 than those living in large, spacious, well ventilated, houses. Health care workers in hospitals, especially those taking care of COVID-19 patients, are much more vulnerable that others. Prevention is largely dependent on the people taking the proper steps, especially:
        1. The use of the right type of masks in the manner that they are meant to be donned, doffed, and used.
        2. Physical distancing, with efforts to maintain a minimum of 6 feet distance from others.
        3. Washing or sanitizing of hands, and of clothes and surfaces that are exposed to SARS-CoV-2 virus.

7. **Social and psychological impact of COVID-19 and steps required for rehabilitation and resilience.**

   a. The social and psychological impact of COVID-19 arises from several factors, both experienced and/or anticipated:

      i. Fear of unprecedented change, and of the unknown, and not knowing when life will revert to the familiar 'normal'.

      ii. Fear of infection and disease, especially fear of serious complications and death.

      iii. Fear of losing loved ones/family members.

      iv. Fear of possible medical costs, especially if these are beyond what is affordable.

      v. Fear of separation from family if affected by COVID-19, of forced quarantine in unfriendly environment.

      vi. Fear of insensitive or poor quality of health care services.

      vii. Fear of how others – friends, family members, neighbours, colleagues, etc. – will behave if they come to know of a person suffering from COVID-19, or its symptoms. Fear of stigma and discrimination that layers itself on all the other aspects of the disease.

      viii. Fear of financial losses accrued, or anticipated; loss of jobs/employment/daily wages/business, reduced income from employments/rent/business/other, increased medical expenses, etc.

   b. The Government needs to take 3 broad measures to prevent social and psychological impact of COVID-19, and ensure that people are more accepting of the pandemic and its impact on life.

      i. Be as transparent as possible in all COVID-19 related policies and measures taken, and ensure that implementation of these measures provoke community support, rather than resentment. In the same fashion, Government should prevent fear-mongering by the media, and counter stigma and discrimination through effective awareness building and through social and behavior change communication.

ii. Build public trust in Government policies and services by showing evidence of providing quality services to those who need COVID-19 services (testing, treatment, and rehabilitation).

iii. Find ways to defray costs of getting COVID-19, through direct provision of quality care, and/or universal health care options.

8. **Health insurance and medical facilities coverage and need for revisiting the same for reformulation.**

   a. All health insurers and insurance schemes should cover COVID-19 with immediate effect, if not already doing so.

   b. In the event of an insured person being affected by COVID-19, insurance schemes should (at least) double the coverage amount, allow reimbursement of outpatient costs, and the Government should defray any losses to insurance companies through payment of the difference arising in premium amounts.

   c. All medical services provided by qualified professionals should be covered by insurance for COVID-19.

   d. However, most Indians are not covered by health insurance. Government schemes should therefore extend to people suffering from COVID-19, and accessing qualified and registered private health care services, even when such persons are not BPL card carriers. Cost of health care services should be capped at reasonable levels.

According to the November 2019 report - Key Indicators of social consumption in India: Health released by the Ministry of Statistics and Programme Implementation, Government of India, 19% of the urban population and 14% of the rural population in India have health insurance cover for their health expenditure. Further, almost 2/3 of the insurance covered are through Government sponsored Insurance schemes.

The above clearly indicates that the majority of the Indian population are not covered in any of the health insurance schemes.

84% and 80% of the urban and rural population are meeting their medical expenditure through their savings and balance through personal borrowings along with marginal contribution from friends and relatives.

Average Medical Expenditure per treated ailment by healthcare service providers						
Sector	Government / Public Hospital	Private Hospital	Trust / NGO Run Hospital	Private Doctors / Clinic	Informal Healthcare Providers	All
Rural	325	1081	624	566	487	592
Urban	344	1038	863	714	1035	710
All	331	1062	732	624	552	636
				source:www.mospi.gov.in		

Further, as per the above-mentioned report, more than 44% of the Indian population prefer Private Doctors / Clinic / Nursing homes for their medical treatment. The average medical expenditure per treated ailment is lower at Private Doctors / Clinic than the private hospital / Trust run hospital.

Primary and secondary healthcare systems are the backbone of a healthcare delivery system. In India, there are more than 1,50,000 Primary and Secondary healthcare centres in India. These centres need suitable policy intervention and support by the Government to ensure appropriate and right levels of healthcare support is given to the people at affordable prices.

Components of Medical Expenditure	% Share of Medical Expenditure				
	Healthcare service provider				
	Govt / Public Hospital	Private Hospital	Charitable / NGO-Trust Run Hospitals	Private Doctors / Clinics	All (inclusive informal healthcare providers)
Medicines	82.2	64.3	54.1	70.1	70.3
Diagnostics Tests	10.9	15.7	28.8	10.9	12.6
Doctor's fees	2.4	14.2	14.3	17.1	13.3
Other	4.5	5.8	2.8	1.9	3.8

According to the above report, more than 70-80% share of expenditure is towards medicines. In order to reduce the cost of medical care for the people, the Government of India needs to bring in appropriate policy interventions which would reduce the cost of medicines. This will help both, the Government to reduce the Government sponsored healthcare expenses and also the general public who directly avail the medical service. The report clearly indicates that the Doctor's fees is in the range of 14 – 17% of the total medical expenditure which is the only source of income for its livelihood. This is substantially lower when compared to other developed and developing countries.

9. Status of health infrastructure in the country, and its adequacy/inadequacy to deal with pandemic like situations.

a. Health infrastructure in India is robust on paper, extending to the smallest populations and communities in the country. However, in reality, this is varied and patchy, with several geographies and areas, especially rural parts of several states, being devoid of any decent public health services.

b. Private health care fills several gaps in public health care delivery. However, this too varies in quality.

c. With about 1.1% of the GDP spent on health, India's health infrastructure and services are terribly weak. Most expenditure on health care, about 70%, is out-of-pocket. This must be defrayed, especially for those affected by COVID-19.

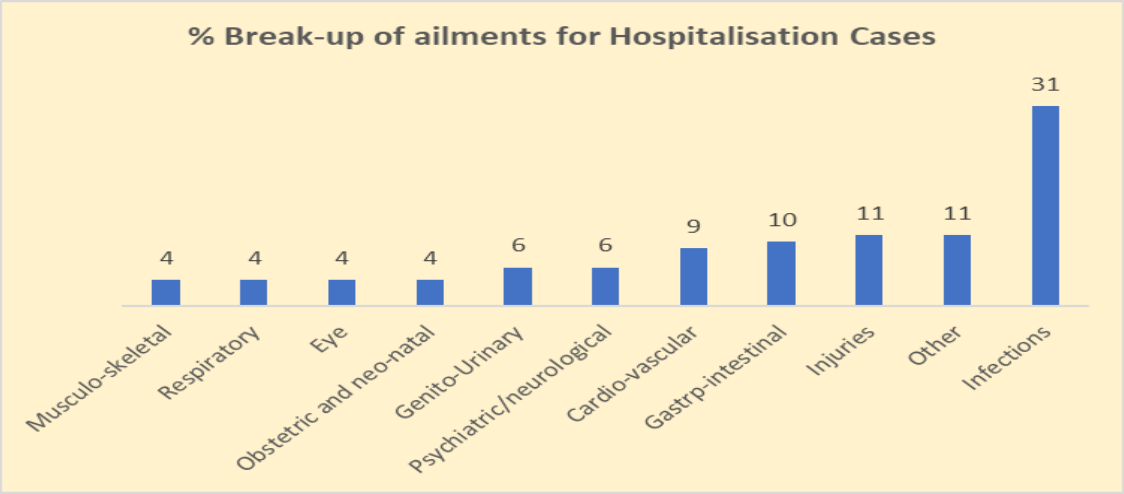
d. It is possible that early deployment of an effective vaccine against COVID-19, and some other currently inconclusive genetic/environmental factors may temper the pandemic in the country over the coming months. However, in the absence of such eventualities, the country may need to see 60%-80% if its population become infected, before herd immunity prevents further spread at a massive rate. In such a 'worst-case' scenario, it can be estimated that 96 crore Indians (70%) will get infected:

    i. Assuming that the actual numbers infected are currently 4 times higher than those reported positive, but that deaths and critical COVID-19 patient numbers are as (or close to) reported, projected total numbers for India to

manage over the next 2-3 years are 40 lakh deaths and 120 lakh critically ill persons.

ii. Till otherwise indicated, the country needs to prepare for and manage these numbers over a relatively short period of time.

e. While dealing with the huge task of preventing and managing COVID-19, health infrastructure and capacity (technical, human, resources, other) will need to be strengthened to also deal with routine health care needs of the population.



The above table clearly indicates that, more than 1/3 of the hospitalisation cases are related to infections (which include -fevers, jaundice, diarrhoea/dysentery) which require basic healthcare infrastructure. This is efficiently met by the existing primary healthcare centres. Further, other ailments are met by either primary or secondary healthcare centres. The Government needs to provide financial grants for small and medium nursing homes to upgrade their regular bed infrastructure with additional ICU and related facilities which could cater to the needs of pandemic/epidemic.

In a capital starved nation like India, medical infrastructure exclusively for pandemic/epidemic will be of limited use. Therefore, a strong process and system should be put in place wherein public infrastructure such as sports complexes, trade centres are converted to emergency institutional isolation centres.

10. **Strengthening R&D and promotion to innovation for containing and mitigating the threat of spread of COVID-19 like viruses.**

IMA requires more time to respond

11. **Expectation from various scientific and tech/health research institutes and issue of adequate budgetary allocation to these institutes.**

IMA requires more time to respond

12. **Need for enhanced lab facility to conduct tests like Serum Virus Neutralization assay test (SVN) and Bio Safety Level-IV (BSL-IV).**

IMA requires more time to respond

13. **Issue of availability of quality medical devices like ventilators, PPE kits, Masks, etc. Menace of black-marketing of essential drugs being prescribed for COVID-19 infected persons; suggestions for improvement.**

a. India has robust manufacturing and distribution capabilities to develop, make and supply medical equipment needed to prevent and manage COVID-19.

b. Manufacturers and distributors involved in ensuring availability of essential medical equipment related to COVID-19 should be guided by standards, regulated by administrative guidelines and quality assurance checks, and rewarded for meeting standards and deliverables with performance-based incentives (e.g. tax cuts).

c. Government may reach out and seek the aid of professional associations (e.g. hospital associations) and civil society organizations to ensure that black-marketing of essentials, or manufacture/distribution/use of sub-standard material/equipment does not take place. The Government may also look into enforcing exemplary punishments to those involved in illicitly gaining from the pandemic.

14. **Action plan for capacity building of health workers/human resource management to tackle the situation arising out of spread of viruses.**

a. Human resources to tackle health related aspects of COVID-19 falls largely into the following categories:

    i. Hospital staff – doctors, nurses, technicians, house-keeping, etc. – to manage patients on critical care, including those on invasive ventilators.

ii. Hospital staff – doctors, nurses, technicians, house-keeping, etc. – to manage wards/beds with patients with moderate to severe COVID-19, needing hospital care, but not requiring critical/ICU care.
iii. Hospital/clinic staff – doctors, nurses, technicians, house-keeping, etc. – to segregate, triage, and manage patients in out-patient departments.
iv. Staff for managing allied functions, such as lab testing and radiological tests for diagnosing and managing COVID-19.
v. Ambulance drivers and paramedical personnel, security staff, and others ensuring smooth transitions of patients into, within, and out of, hospitals.
vi. Community health care workers who screen for COVID-19, take samples at homes of people, provide health information, monitor people on home quarantine, conduct surveillance, etc.
vii. Public health experts, epidemiologists, researchers, etc., to ensure that the COVID-19 containment measures are being implemented, improved and managed effectively.
viii. Health care staff – doctors, nurses, technicians, house-keeping, etc. – not directly or knowingly engaged in COVID-19 care.

b. All health HR working on COVID-19 need to have the capacity to carry out their work effectively and ethically. In addition to needing/having in-depth knowledge pertaining to their respective areas of work, common capacity building needs include:
    i. Basics about COVID-19, especially on its symptoms, how it spreads, and how it's to be prevented and managed.
    ii. Knowledge on correct use of PPEs – type of PPE to be used in different areas and situations, donning and doffing of PPEs, looking for and preventing damages to the integrity of PPE equipment, etc.
    iii. Soft skills for managing patients and family members who are psychologically affected, financially compromised, and/or otherwise unable to cope with the disease, in any stage or form of its affliction.
    iv. Skills in patient education, and in preventing and removing stigma and discrimination due to COVID-19.

v. Some medical/health staff may need to be trained on provision of palliative and end-of-life care.

c. Non-government organizations can play a major role in coordinating and ensuring adequate capacity building among health workers of all levels and type. Established NGOs are generally trusted by public and private sectors, and working as interface agencies, can source trainers/experts from various establishments, including academic and teaching institutions.

d. To reach the maximum number of people as quickly as possible, HR capacity building efforts will need to rely largely on technology, including webinars and telephone helpdesks, and on-the-job training by trained master trainers.

e. The skills and competences required to manage COVID when India had only 1 lac COVID cases is different when it is having over 4.5 Mn COVID cases.

   i. Task force for Surveillance and Containment: The COVID surge is happening in the hinterland (rural areas). Therefore, the Department of Rural Development and Panchayat Raj of the respective state should manage the entire surveillance and containment. The law and order part of containment management could be independently managed by the respective police department.

   ii. Task force for Medical Intervention: The Health Department of the state should focus on managing Isolation (home and Institutional), COVID Health Centres, and COVID Hospitals. The primary focus should be to ensure minimum number of COVID patients slip into critical condition. Also, focus on increasing the success rate of reviving patients in Critical condition.

   iii. Task force to protect Women and Child: In every 1 COVID containment zone there will be 0.75 pregnant / lactating women. This means, currently in India there will be around 75K – 100K pregnant / lactating women in the containment zone. They need to be protected carefully. The Women and Child Department needs to be proactive and take measures to protect them. The Department of Women and Child in the respective state should

iv. Task Force for Livelihood: The Department of Industries and Commerce should lead the facilitation of livelihood. They need to be single point of contact

f. IMA Demands an All India service: Indian Medical Service

All India Services are carved out in terms of the governing provisions incorporated in the Parliamentary enactment titled 'All India Services Act, 1951' vide which the various All India Union Services have been carved out in terms of Indian Foreign Services, Indian Administrative Services, Indian Police Services, Indian Revenue Services, Indian Allied Services etc. Indian Medical Services, therefore, would be created in terms of a carving for itself out of the All India Service Act, 1951 prescribed and stipulated by the Parliament as a parliamentary enactment.

On this count it is necessary to take note of the material fact that the need for All India Services was brought out by the State Reorganization Commission in their report (1953-55). In continuation the Health Survey and Planning Committee (also known as Mudaliar Committee) had recommended the formation of a 'CENTRAL HEALTH CADRE ' in its report in 1961 and the said recommendation therein came to be endorsed at the Chief Ministers Conference held in August, 1961. In the month of December, of the year 1961 a required resolution under Article 312(1) of the Constitution of India was adopted by the Rajyasabha and the broad outlines of the proposed Indian Medical and Health Services were discussed at a conference of Chief Secretaries of the States in the year 1963.

A draft Memorandum and Draft of the Rules of regulating and cadre management were drawn up and discussed by a Sub-Committee of the Central Council for Health in June, 1966 and same came to be forwarded to the State Government for their comments in December, 1966.

In terms of the response from the same in May, 1968 the Government of India decided to constitute All India Medical and Health Services excluding the State of Tamilnadu, Karnataka and Nagaland (May, 1968). The recruitment rules came to be finalized and the Notification for formally constitution of Indian Medical and Health Services w.e.f. 1st February, 1969 was processed.

The said matter was placed for discussion before the consultative committee of Parliament of Ministry of Health in 1970 and the Executive Committee of the Central Council of Health Govt. of India considered the same in July, 1970. In August, 1972 the Hon'ble Union Ministry of Health and Family Welfare informed the consultative committee of the Parliament of the Health Ministry that the Government intends to proceed with the Constitution of Indian Medical and Health Services.

Kartar Singh Committee (1973) flagged all over again the said issue observing that "Doctors with no formal training to infectious disease control, surveillance system, data management, community health related problems and lacking in leadership and communication skills with no exposure to rural environments and their social dynamics, nor having been trained to manage a facility or draw up a budget estimates, were ill-equipped and misfits to work in public facilities. The inadequate knowledge of public health and management capabilities, calling for an All India Health Cadre to be established".

It is a matter of record that the 89th Report of the Estimates Committee of the Loksabha advised the Govt. of India to expedite and finalize the formation of All India Medical and Health Services. The matter once again came up for discussion in the conference of Chief Secretaries in May, 1976 resulting in a consensus in regard to formation of the Indian Medical and Health Services. The confirmation of the State Governments was sought for their agreement to participate in Indian Medical and Health Services in July, 1976. It is also a matter of record that the Department of Personnel and Administrative Reforms notified the formation of Indian Medical and Health Services on 25th January, 1977 but cancelled the same and it was withdrawn.

In March, 1978 the Union Cabinet decided to constitute Indian Medical and Health Services and the State Govts. were informed accordingly in April, 1978 , but the things remained in limbo.

The concerned issue was re-examined and relooked by the Department of Personnel and Training Govt. of India in the year 1986 and once again the Govt. of India decided to consult the State Govt. on the said issue to ascertain their views.

The High Power Committee known as 'Tikoo Committee' in their report submitted to the Govt. of India recommended the constitution of 'Indian Medical Service'. The matter was discussed in the Rajyasabha on 23rd December, 1993 Smt. Margret Alwa the then Hon'ble Minister of State, Department of Personnel and Training assured the House to persuade the State Governments to accept the formation of Indian Medical and Health Services.

It is pertinent to note that Prof. J. S. Bajaj Committee constituted by the Ministry of Health and family Welfare Govt. of India in their report (1996) vide para E 10.1 recommended constitution of 'Indian Medical and Health Services' stating that "the committee reinforces in the strongest terms the need to constitute Indian Medical and Health Services without any further delay. In continuation thereto the 5th Central Pay Commission vide its recommendation Para 52-10 expressed for constitution of 'Indian Medical and Health Services' with immediate effect. Since then the matter is pending in the very same stage till date of seeking opinion from the States and a consensus thereon eluding for various reasons primarily on the core context of the cardinal principle of 'Federalism'.

Scope

The scope of the Indian Medical Services which would be a cadre under the umbrella rubric of Union Public Services in terms of their origin from All India Services Act, 1951 needs to be viewed in the context of material realities catalogued herein below:

1. Public health management means not only addressing Preventive and Promotive measures of health, but also organising of Primary, Secondary and Tertiary healthcare services as an integral part of crystallized healthcare delivery system. This, in turn, needs expertise in all key health systems components including human resources for health, community participation, health informatics, management approaches, suited technology for the health governance and management, financing of healthcare in the domain of health economics, demographics and above all it also needs a sound ingraining in epidemiology, as well as surveillance.

2. There is a myth that doctors as professionals are poor managers. However, the runaway success of doctors as leaders in private healthcare industry belies such a generalized and simplistic conclusion.

3. Doctors in Health Services are recruited and trained to play entirely different roles than what is required for health administrators and policy makers.

4. As of now it is vividly seen that there is a palpable technical gap between planning, and execution in as much as that the personnel in the administrative cadre may be a good administrator but necessarily may not understand the intricacies of the healthcare sector. Similarly, a doctor may be excellent in his clinical practice, but may not be as good as an administrator. This gap is bridgeable in terms of creation of a specialized breed of administrators that would cater to better management and administration of healthcare systems including the Public Health in the country as a whole.

5. The core scope of the Indian Medical Services therefore, would invariably be to create a specialized breed of administrators who would undertake better management of healthcare system including public health with ease, elegance and desired innovation in larger public interest as a part of cadre under All India Civil Services christened as 'Indian Medical Services'.

Relevance

The relevance of All India Services have been viewed and are continue to be viewed in the context of material fact that :

1. The All India Services continue to be one of the premier institution to uphold the unity of the country as a whole.

2. The members of the All India Services have lived up to the vision as envisaged by the framers of the Constitution of India.

3. The All India Services ensure integrity, cohesion, efficiency and coordination with administration of the country. The common recruitment and training ensures uniform standard of administration in the States and Union Territories as well.

4. The availability of experience gained in different parts of the country turns out to be an asset in itself.

5. An 'Espirit De Corps' inter-alia professional fellow feeling develops amongst fellow professional members.

6. The required and sought after staff support comes through permissible 'Lateral entry'

7. The effective leadership stands acquire through placements Right from Sub-Divisional/District, provincial, up to central level that would smoothen the core dispensation of healthcare delivery system.

8. The varied administrative experience blended with professional medical skills including in the domain of public health, would augur well for the incumbents to discharge their duties and responsibilities with precision and optimal perfection.

9. It would add to the qualitative improvement in medical and health services including public health in the country.

10. The National Health Programme Scheme and projects thereto would get better implemented yielding optimal public benefits.

11. The union Government and also the State Governments including those of Union Territories would get wide scope for selecting suitable Officers for manning the administrative posts.

12. The Union as well as the State Governments and those of Union Territories would stand to mutual benefit due to rich experiences gained by the personnel under the Indian Medical Services postings.

13. It would cater to National integration and provide a bull work against the forces of disruption parochialism and regionalism.

14. It would serve as a strong catalytic agent for realization of core guarantee of Right to Health to all the citizens guaranteed under Article 21 of the Constitution of India and also the universal goal health equitably and affordably.

Structure

The structure of the Indian Medical Services would be in the form of a cadre specialized in character for the dispensation of healthcare services including those in the domain of public health excluding the domain of medical education in its entirety as All India Civil Services emanating out of All India Services Act, 1951 read with Article 312 (1) of the Constitution of India with service conditions thereto being such as would be prescribed by the Ministry of Personnel and Training in the Govt. of India from time to time in tune with those applicable to other cadres created under the very statutory provisions without prejudicing the right to create State services on the very count by the concerned State Govt. in tune with the spirit of Federalism embedded in the Constitution of India and also provision for the lateral entry thereto as applicable to other administrative cadres under the very rubric.

Operation

The operation of the Indian Medical Services would be akin to and on par with those as applicable to Indian Administrative Services with reference to terms, service conditions, postings, modality of recruitment, allotment of cadre and other cogent correlates.

Eligibility for Entry

The entry to the Indian Medical Services would be exclusively allocable to those who possesses minimum Graduate qualification in modern medicine (MBBS) from a recognized medical college and examining University thereto included in the governing schedule appended to the Indian Medical Council Act, 1956 now

repealed by National Medical Commission Act, 2019, in view of the specialized nature of the services entrustable to the personnel under Indian Medical Services. All other cogent matters that pertain to and are applicable to governance of Indian Medical Services as a specialized cadre under the ambit of All India Services Act, 1951 would be such as would be worked out and notified by the competent authorities from time to time in terms of the required and cogent statutory rules and regulations as 'subordinate legislation'.

S.No.	Year	Event
1	1954	ASHOK CHANDRA REPORT IN 1954 recommended the constitution of new All India Services in technical fields
2.	1953-55	Need for more All India Services was felt by the State Reorganization Commission : reflected in their report – 1953-55
3.	Aug-1961	Subsequent endorsement by the Chief Ministers Conference – August 1961
4.	Dec-1961	Requsite resolution under Article 312 (1) of the Constitution of India Passed by Rajya Sabha- December, 1961
5.	1963	Chief Secretaries 'Conference broad outlines of the proposed Indian Medical and Health service were discussed-1963
6.	June 1966	A draft memorandum and drafts of the rules of regulating and cadre management were drawn up and discussed by the sub-committee of Central Council of Health June – 1996
7.	Dec 1966	Draft Memorandum forwarded to the State Governments for comments – December 1966
8.	May 1968	The Government of India Decided to constitute the All India Medical and Health Service excluding the States of

		Tamil Nadu, Karnatka and Nagaland – May 1968
9.	Jan-1969	The recruitment rules – finalized – notification for format constitution of IM & HS w.e.f. February 1,1969 – January 1969
10.	April-1970	Discussion of the issue (IM & HS) in the Consultative Committee of Parliament of Ministry of Health
11.	July-1970	Consideration of the issue by the Executive Committee of the Central Council of Health
12.	Aug-1972	The Consultative Committee of Parliament discussed the issue in question. Hon'ble Minister of Health and Family Welfare informed the Hon'ble Committee of Govt. would proceed with the constitution of IM & HS
13.	5th Feb – 1976	The Eighty ninth report of the Estimates Committee of the Lok Sabha advised the Government of India to expedite and finalize the formation of All India Medical and Health Service
14.	May-1976	The matter came up again for discussion in the conference of Chief Secretaries; Consensus of the conference: to form the Indian Medical and Health Service.
15.	July,1976	The state governments were addressed to confirm their agreement to participate in the IM & HS
16.	25th Jan-1977	The Department of Personnel and Administrative reforms notified for formation of IM & HS and later cancelled it.
17.	March-1978	The Hon'ble Cabinet, Union of India, decided to constitute IM & HS
18.	Apr-1978	The State Governments were informed accordingly
19.	1986	The issue was re-examined in the Department of Personnel and Training
20.	1987	The Hon'ble Cabinet, Union of India, reconsidered the question of the IM & HS and decided to consult the State

		Governments and ascertain their views
21.	Sep-1990	High Power Committee "Tikku Committee" recommended the formation of 'Indian Medical Service'
22.	23rd Dec-1993	The Hon'ble Rajya Sabha discussed the issue and Smt. Margaret Alva, the Hon'ble Minister of State, Dept. of Personnel and Training assured the house to persuade the State Governments to accept the formation of IM & HS
23.	1996	Prof. Bajaj Committee by MOH & FW, GOI, recommended vide para E.10.1 CONSITUTION OF INDIAN MEDICAL AND HEALTH SERVICES: "The committee reinforces in the strongest terms the need to constitute Indian Medical and Health Services without any further delay"
24.	1997	The 5th Central Pay Commission vide its recommendation para 52-10 asks for constitution of Indian Medical AND HEALTH SERVICES: "ULTIMATE AIM"
25.	2014	Ministry of Health DGHS in looking into it again and as usual Ministry of Health from lowest desk level onwards trying again to scuttle the move of creation of "Indian Medical Service"
26.	2017	Ministry of Health once again wrote to all the State Health Services / Chief Secretaries for their opinion for IMS.

15. Incentives for health workers dealing directly with Corona, like doctors, nurses, and health workers like ASHA, etc.

a. Health care workers need to be adequately remunerated, financially. This is not as incentive or reward, but out of respect for what they are worth.

b. Health care workers working on COVID-19 should be incentivized through non-financial means, including through respect and recognition from authorities and the public.

c. Importantly, health workers, as they are at high risk of being infected with SARS-CoV-2 virus, need to be well protected from getting COVID-19, with the assurance that if they or their families are infected, they will receive the best possible medical care, at no cost.

d. Health workers should also be protected from physical harm/threats, and should have acceptable work environments that are conducive to optimal service delivery.

e. Finally, health workers involved in COVID-19 care should have substantial life insurance that protects their dependents/families from additional financial catastrophe in the event of death.

f. 573 healthcare workers which include 364 Doctors have laid down their lives in fighting against COVID. Over 87000 healthcare workers are infected with the virus. IMA strongly appeals that all doctors who have laid down their lives in fighting this epidemic should be treated at par with the martyrs of Indian armed forces and acknowledged appropriately. The surviving spouse or dependent should be provided a Government job as per their qualification. Substantial differences are noticed from district to district in how doctors and health care workers are deployed. District administration are not sensitive to the safety angle and the concerns of stress and fatigue of the medical manpower. Deploying doctors 24X7 without intermittent quarantine periods or long working hours in PPE for COVID care is not the same as 24X7 COVID control from safe offices. Uniform practices have to be put in place throughout the country. The current system of administration has led to considerable difficulties for the medical profession in all sectors.

16. Need for collaborative health R&D activities amongst CSIR, ICMR, National Institute of Virology, National Biomedical Research Indigenization Consortium, and other research institutes of containment and mitigation of viruses in case of possible outbreak of future and need for unified and indicated research activities.

a. The need for collaboration among related and concerned institutions cannot be overstated. However, in addition to the institutes mentioned here, collaboration

should include private and other non-government institutions and think tanks (including individual experts).

b. Establish an effective task force with multi-sectoral collaboration and participation, with additional representation from academia, professional associations, technical experts (microbiology, pulmonology, infectious diseases, etc.), public health and epidemiology, pharma and medical diagnostics companies, corporate sector, civil society, insurance companies, etc. can plan action to mitigate/manage the current COVID-19 pandemic, minimize costs and improve treatment outcomes. This task force can also look into prevention of future contingencies involving COVID-19, even and of other/new epidemics and health emergencies.

17. R&D activities required to ensure development of cost-effective vaccine/drugs.

IMA requires more time to respond

18. R&D activities required for enhancing the efficiency and quality of different types of diagnostic tests, including rapid antigen tests.

IMA requires more time to respond

19. Suggestions for preparedness for such pandemic like situations in the future.

a. Establish an effective task force with multi-sectoral collaboration and participation, with additional representation from academia, professional associations, technical experts (microbiology, pulmonology, infectious diseases, etc.), public health and epidemiology, pharma and medical diagnostics companies, corporate sector, civil society, insurance companies, etc. can plan action to mitigate/manage the current COVID-19 pandemic, minimize costs and improve treatment outcomes. This task force can also look into prevention of future contingencies involving COVID-19, even and of other/new epidemics and health emergencies.

b. The Government can lead the development of standards for COVID-19 care in India, a set of guidelines for health care providers and services across sectors and along the continuum of COVID-19 care. This may be spearheaded by the task force

mentioned above. This can act as a template for development of standards for future epidemics or pandemics.

20. Any other incidental and related matters pertaining to the subject.

a)IMA COVID DATA - 10.09.2020 (All India)

Total Infected : 2174

Practicing Doctors 1023

Residents 827

House Surgeons 324

Deaths 364

IMA COVID DATA		
State wise death of doctors		
S. No	**States**	**Number of Death**
1	Andhra Pradesh	41
2	Assan	10
3	Bihar	23
4	Chandigarh	3
5	Chhattisgarh	3
6	Delhi	13
7	Gujarat	38
8	Haryana	6
9	Himachal Pradesh	2
10	Jammu and Kashmir	1
11	Jharkhand	4
12	Karnataka	35
13	Madhya Pradesh	11
14	Maharashtra	36
15	Meghalaya	1
16	Odisha	8
17	Pondicherry	2
18	Punjab	4
19	Rajasthan	4
20	Tamil Nadu	61

21	Telangana	10
22	Uttar Pradesh	21
23	West Bengal	27
	Total Deaths	**364**

b)IMA writes to the Hon'ble Prime Minister

30.08.2020
New Delhi

To
Shri Narendra Modi Ji
Honourable Prime Minister of India
Government of India ,New Delhi.

Respected sir,

Government of India has released the statistics that 87000 health care workers have been infected and 573 of them have lost their lives due to Covid. The data has raised concerns all across the country. IMA's data for doctors alone has registered 307deaths as of today and a total 2006 infected. 188 of those died are General Practitioners who are the first point of contact for people. Doctors suffer a higher viral load and a higher CFR (Case Fatality Rate) as a community. IMA is constrained to point out that they could have stayed back at home during the epidemic safely. They chose to serve the nation in the best traditions of the medical profession. The solatium approved by the National Government for their colleagues in Government Services in all fairness is deserved by the children of these martyrs as well.All doctors who have laid down their lives in fighting this epidemic should be treated at par with the martyrs of Indian Armed Forces and acknowledged appropriately. The surviving spouse or dependent should be provided a Government job as per their qualifications.

There is also the issue of whatever solatium that is in place has failed to reach the unfortunate beneficiaries due to the inadequacy of the chosen instrument and the indifference.The scheme is reported to have been lapsed as well. There is a pressing need to reconsider the same on merit and create dedicated system to administer. A National scheme to support the soldiers fighting a pandemic cannot be allowed to degenerate into just another pecuniary benefit for Government

servants. It will remain an indelible injustice on the concept of nationhood itself. We once again appeal to your goodself that such a sacrifice by doctors needs to be acknowledged by the highest office of the nation irrespective of the sectors. An inclusive National solatium for all doctors who have laid down their lives in the calling of the nation only would render justice to the sacrifice of their families.

We are also writing to you at this juncture since it has been predicted that India will top the world in number of cases in a few weeks. Health Care manpower is precious. Uniform practices have to be put in place throughout the country. Substantial differences are noticed from district to district in how doctors and health care workers are deployed. Their service situations differ and mostly reflect the logistics of the district. Districts are not sensitive to the safety angle and the concerns of stress and fatigue of the medical manpower. Deploying doctors 24 X 7 without intermittent quarantine periods or long working hours in PPE for Covid care is not the same as 24X 7 Covid control from safe offices. How India will emerge out of this challenge will depend on the wise deployment of Human resources cutting across the sectors. Case Fatality Rate and not the total number of cases would define success. Only doctors are capable of making a difference in this rarefied area of CFR. The current CFR of 1.82 is an achievement of Covid Care by the selfless doctors and their team. Empowering the medical profession in real time in Government Services and honourable engagement of private doctors and hospitals in a three tier referral system on war footing will meet the challenge squarely. The current system of administration has led to considerable difficulties for the medical profession in all sectors. The nation deserves a radical approach to the situation. We fervently appeal to you and your Government to bring in appropriate reforms which are long overdue. Indian Medical Association and the doctors of this great nation rededicate ourselves and will stand shoulder to shoulder with our National Government.

Jai Hind.

Thanking you

Yours sincerely

Dr Rajan Sharma
National President, IMA

Dr R V Asokan
Hony Secretary General, IMA

c) Administration and the profession in Covid times

I. Travails of the Government Sector:

Doctors in Government Sector are silent sufferers of targets and deadlines. In many districts the Covid control is under officers who are not Medical Officers. District Medical Officer has to be the leader of the team to evoke confidence in the team members. In some Government medical colleges and hospitals officials other than the Dean or Medical Superintendents are in charge of the situation. Such non medical leadership in Covid care and control fails to establish a rapport with the team and hardly evokes any enthusiasm. In some states the whole Covid control had been handed over to police only to return the responsibility back to the Health Services in three weeks. A general administrator supervising district health matters, does not have the domain knowledge in this knowledge-intensive sector. It also needs a sound grounding in epidemiology and an understanding of clinical care.

1. The doctors in Government sector are stressed out due to work load and harassment .They suffer from mental fatigue, inadequate resting and quarantine for ICU duties. Given the present weather conditions, wearing PPE for more than five to six hours is unendurable.
2. A Government Medical Officer in Mysore district committed suicide allegedly due to harassment from superior officers. The doctor had worked for more than 3 months continuously without leave and had not seen his family. The CEO was pushing for higher target for testing while there were large vacancies in teh Health team.
3. Salaries of doctors have been deducted for the period of quarantine/isolation when doctors get infected while on duty. Shabby treatment is meted out when they are admitted for their own treatment.
4. Quarantine period is not uniform everywhere.
5. The Supreme Court had to intervene to revoke the suspension of a doctor for exposing the situation inside a Government hospital in a state.

6. Adhocism has become the curse of Indian Public Health services. Good care to the citizens cannot be assured when doctors are on temporary basis. Not only Residents even specialist posts are still on contractual basis in the country. Doctors on contractual period of three months to six months remain a big loophole. This adhocism must be abolished for the betterment of the sector.

Recommendations:-

1. Covid care and control in all the districts of India should be led by the District Medical Officers in letter and spirit. The office of Civil surgeon, Director of Health Services and DGHS should be restored to its prestige and decision making authority. This will increase the comfort level, understanding and working equations of doctors and the Health team.
2. Adhoc appointments in public sector should be discontinued as a policy.
3. Whoever has served the Government in these difficult times should be given an option to join regular Government service directly as an one time concession.
4. Creation of an All India Services- Indian Medical Services is a well deserved reform for the present and future.
5. a)Quarantine should be defined centrally and implemented equally for Resident Doctors, Faculty, Paramedical staff and servants.
   b) Mental health and Conselling for doctors working in COVID hospitals is an important dimension.
   c)Nutrition Supplementation on duty could be a value addition.
   d)Certification for providing Covid care for young doctors with credit points.
6. The major challenges across the board are :
   a) Discontinuous care.
   b) Learning curve of the teams.
   c) Lack of team work.
   d) Suboptimal clinical management.
   e) Lack of adequate laboratory and radiology (CT scan) support.
7. A formal state task force on clinical management should be made having members from Department of Health, Medical Education and research , Corporate

hospitals having experience in diagnosis and management of Covid under the chairperson ship of state Nodal officer for Covid with a mandate to make or suggest treatment guidelines for the state and reporting to ACS Health/DGHS.

8. A district task force for clinical management of Covid under the chairpersonship of DMO. Its member should include internist, respiratory physician, intensivist/ anesthetist trained in oxygen therapy and ventilation, radiologist and laboratory professional.
9. Patients admitted in critical care units must be evaluated by a multidisciplinary team in the hospital either physically or through e- ICU. If must be made mandatory for the hospital to provide the name of multidisciplinary team members to the District task force as directed by the Honorary Supreme Court of India.
10. District hospital laboratories do not have the infrastructure for specialised tests (S Ferritin, LDH, quantitative CRP, IL-6, D –Dimer etc.) required for Covid. Therefore, in short term preferably at the level of state or alternatively at the level of district one should have MOU with NABL/NABH accredited laboratories or competant labs to provide ready availability of these tests.
11. One consultant (Medicine, Respiratory Medicine, Anaesthesia eta) from Medical colleges, experienced in handling COVID cases, be given a charge of a district showing upswing to help district task force in training of manpower and management of these cases and as first on call.The consultant should act as a bridge between treating team and state task force/state nodal officer for any guidance on management.
12. The health department is working relentlessly since the beginning . Manpower is tired and exhausted. Due to upswing of cases in general population, more and more HCWs are getting affected. This number is going to increase in near future and can put nearly one third of manpower off duty. Therefore strategy must be made to overcome the shortage of HCW across the spectrum.
13. A grievance and counselling cell must be set up in Directorate to listen to HCWs and counsel them from time to time .

II. High handedness in private sector

After 70 years of independence Governments still perceive the private sector as being run for profit. Private Sector is a victim of this perception. Private Sector brings 3.3% of GDP to Health Care while all Governments put together bring in 1.1 %of GDP.

The harassment the private hospitals endure every day include inadequate workers to deploy, strict protocols imposed on unwilling patients, availability of life saving drugs etc. Their health care workers have to overcome challenges both at work and in places of residence. The picture portrayed by the media is also negative.

1. Governments have fixed the charges for COVID management unilaterally. Mostly rates are enforced without any discussion. IMA has raised the issues concerning these charges. But the realities remain. COVID demands a different set of hospital management protocols. It involves additional expenses on human resources, infection control, safety of doctors-HCWs, high Oxygen requirements, high administrative costs etc. Markets of PPEs, safety gears remain unregulated. This has resulted in high treatment costs. Closure of small and medium hospitals during and after COVID is a distinct possibility.

2. Private practitioners were initially asked to keep their clinics and hospitals open so that non-Covid patients would not suffer. Now in various Tier II & III towns they are forced to give their services for dedicated Covid hospitals for 8 to 10 hours a day leading to neglect of their own institutions and patients.
3. They are not being adequately compensated as well. In many places they are being forced to work for free or face action under the Epidemic Act and Disaster Management Act.
4. Every notice, by local officials or district Collectors always ends with the threat of FIR under the Epidemic Act and Disaster Management Act .
5. Many hospital licenses have been suspended for reasons including complaints of overcharging. The High Courts have ruled that the commissioners do not have the powers of suspension of Hospital License.

6. Doctors have been threatened with cancellation of license to practice even for asking RTPCR tests for their patients.
7. Governments are controlling upto 80% of all the beds in Non-Covid private hospitals and forcing the institutions to charge as per Govt Notification (Capping of charges).
8. Small Private Hospitals in Tier II and III towns are being converted to Covid Hospitals compulsorily inspite of not having the infrastructure nor the personnel to treat Covid patients.
9. There is no regulation of prices of PPE kits and N95 masks, which are being sold in the black market to Medical Institutions at 3 to 4 times their cost.
10. FIRs are being filled against doctors due to frivolous complaints by patients.
11. Senior Doctors with co-morbid conditions are being forced to work in Covid hospitals and also made to forcibly open their clinics .
12. Private hospitals are forced to admit only patients from Municipal Corporations in some states.
13. All bills of Covid and Non-Covid patients are being presented for approval of government appointed auditors.
14. Non Covid work does not come under the Epidemic Act or the Disaster Management Act. The Government is not justified in reserving and administrating Non Covid beds in Private Hospitals.
15. Municipal Corporations are issuing show cause notices to all hospitals assuming they have closed without confirming the facts.
16. Inspite of the shabby treatment meted out doctors are bound to see patients, perform life-saving procedures or surgeries. They get infected. FIRs have been lodged against doctors under the provisions of IPC for spreading an infectious disease either knowingly (Section 270) or unknowingly or negligently (Section 269). The former attracts imprisonment for 2 years. As if that was not enough, some Governments have issued notices asking the doctors to explain how they got infected despite the PPEs provided to them.

17. There are protocols for investigations and management of COVID-19. However doctors had to fight the administration that testing is a professional right and has to be by the clinical decision of doctors.
18. Blaming small hospitals for high death rates have been reported at some places. The ground realities are that, patients reach hospitals late. The Happy Hypoxia is pushing the patients to a mode of denial.
19. Hyperactivity of Government departments in areas of non Covid regulations including CEA, STPs and ETPs are perceived as harassment during a difficult period.

Recommendations:

1. The private sector needs to be delineated atleast into
   a. Primary care, secondary care and speciality care clinics , nursing homes and hospitals run by doctors as part of their professional practice as well as HCE run by not for profit institutions .
   b. Tertiary care Hospitals run by Corporate managements.
2. Certain states have exempted hospitals run by doctors as part of their professional practice and hospitals less than 50 beds from the Clinical Establishments Act. Similar exemption may be granted in the Central Act as well.
3. Time has come to delineate paid and fee services. The profession deserves and demands financial, administrative and clinical authority.
4. Streamlining the administration under the District Medical Officer should remove much of the friction and ease out the relationship with private sector.
5. Developing a proper concept and structure to engage private sector with honour, dignity and fair pricing based on scientific costing.

III. Resident doctors

1. Resident doctors are working under extreme conditions and have multiple issues. Resident Doctors are posted to COVID ICUs irrespective of their specialty.

2. Resident doctors are being asked to join duty without mandatory 14 days quarantine when they test positive for COVID.
3. Resident doctors pay is cut when they are quarantined after being tested positive while on duty.
4. Duty hours - Resident Doctors work from 15-20 hours a day or 110-140 hours/week which is absolute violation of central residency scheme 1992 which recommends 48/week. Extended duty hours without break and extreme patient load affect residents mental status inversely.
5. Resident doctors man the casualties and critical care units. Hence they are susceptible for violence.
6. Duty rooms - most of the hospitals do not provide Duty rooms to resident doctors, doctors are forced to sleep in treatment rooms, nursing stations or other temporary arrangements.
7. Resident doctors and other young doctors are major working force still they are facing exploitation irrespective of sectors. 800 young doctors forcibly appointed as temporary medical officers resigned en masse in a state.

Recommendations:

1. Strict implementation of central residency scheme in all hospitals of India. Formulate central residency scheme with a core theme to nurture medical graduate with job prospects, academic growth to achieve excellence and financial stability to sustain .
2. Adequate security at work place.
3. Duty rooms should be well maintained and taken care by Administration including food and water.
4. Resident doctors who have worked in Covid for additional months above their residency period should be relieved of the bond wherever it exists.

IV. Violence

1. No concrete action is being taken against the culprits who are responsible for the violence inspite of provisions in the Epidemic Act. There are many incidences of social media defamation of the medical fraternity and hospitals.

2. A doctor in Latur was stabbed in gruesome way. The injuries were so bad that the stabs missed important vessels by few millimeters. The attacks on hospitals and doctors are really National Embarrassment".

3. Violence has been reported from several states including the one that provoked the strike by young doctors in Gandhi Hospital, Hyderabad.

Recommendations:

1. Incorporation of the amendments to Epidemic Diseases Act 1897 into all state Hospital Protection Acts.

2. Enactment of Central Hospital Protection Act.

3. Declaring hospitals as 'safe zones' and providing structured security.

V. Non acknowledgement of the sacrifice of private doctors

The Government's non acknowledgement of the sacrifice of private doctors is a matter of great concern. A good percentage of the private doctors who have lost their lives are General Practitioners. As a class they are the first point of contact for everyone and spend quality time with patients before the patient is diagnosed as Covid. Non ownership of their services amounts to indifference. The goodwill and morale of the medical fraternity is an important component to fight this epidemic. They should be accorded martyr status.

Recommendations :

The sacrifice of the family and children of such family doctors is unsung and uncared for. They deserve recognition and a decent solatium. Access to care if infected in line of duty and a compensation with dignity to the bereaved family is legitimate right of doctors during this epidemic.

VI. Barriers to solatium to Covid death of Government Doctors

The instrument chosen for compensating the doctors and other healthcare workers of Government services is inappropriate and unfriendly to the families of these martyrs.

Recommendations :

It is preferable the Governments compensate these families directly and also provide a Government job for one of the family members. The doctors who lose their lives to COVID should be accorded martyr status.

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