NEWS / HEALTH

Modi's liberalised vaccination policy is a mistake that other countries avoided

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Individuals in the 18-45 age group wait at the pre-billing section of the vaccination centre at BLK-Max Super Speciality Hospital in Delhi, on 5 May 2021. India is the only one among the top ten countries worst-affected by COVID-19 not to ensure free vaccinations to all citizens. SONU MEHTA / HINDUSTAN TIMES

COVID-19

(/covid-19)

The government of India's refusal to bear the cost of universal, free COVID-19 vaccination has led to severe vaccine inequity in the country and has also posed a serious threat to recovery from one of the worst coronavirus outbreaks in the world. India is the only one among the top ten countries worst-affected by COVID-19 not to ensure free vaccinations to all citizens.

The United States and Brazil have both officially recorded more COVID-19 deaths than India as of 23 May. The US federal government has been

providing free vaccination to all people living in the country, regardless of their immigration or health insurance status. The Centers for Disease Control and Prevention—the national public-health agency of the country—has stated (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html) that a vaccination centre cannot charge a person any fee related to vaccination. Instead, such fees are deducted directly from the person's health insurance or charged to welfare programmes that support the uninsured. Jair Bolsonaro, the president of Brazil who downplayed the COVID-19 as "a little flu" in the early days of the pandemic, announced (https://www.hindustantimes.com/world-news/brazil-to-offer-covid-19-vaccine-for-all-at-no-cost-says-president/story-vfpemGjnYaY5wgpDna2D4H.html) in December that his government would offer the vaccine to all, free of charge.

The United Kingdom is providing (https://www.gov.uk/government/publications/covid-19-vaccination-why-you-are-being-asked-to-wait/why-you-have-to-wait-for-your-covid-19-vaccine) the COVID-19 vaccination free of cost and only through the National Health Service, its publicly funded healthcare system. The three countries in the European Union—Italy, France and Germany—that are among the ten countries with the highest recorded COVID-19 deaths have all offered vaccination for free, mostly by deducting costs from health-insurance schemes. Russia announced (https://www.aljazeera.com/news/2020/11/24/sputnik-vaccine) in November that it would give its Sputnik V vaccine free to citizens, Mexico announced (https://www.newindianexpress.com/world/2020/dec/09/universal-and-freemexico-to-launch-covid-19-vaccinations-by-december-end-2233604.html) a free universal COVID-19 vaccination programme in December and Colombia (https://www.reuters.com/business/healthcare-pharmaceuticals/colombia-allow-private-imports-covid-19-vaccine-shots-must-be-free-2021-04-05/) allowed private players to import vaccines but insisted that shots be given for free.

(https://caravanmagazine.in/health/modi-liberalised-vaccination-policy-mistake-that-other-countries-avoided/attachment-17120)

US	585,709	32,924,567	47.1	36.7	Free
Brazil	434,715	15,586,534	18.2	9	Free
India	**270,284**	**24,684,077**	**10.3**	**3**	**Up to Rs 2,000**
Mexico	220,384	2,380,690	11.8	7.9	Free
UK	127,937	4,464,663	54.4	29.5	Free
Italy	124,063	4,153,374	30.9	13.9	Free
Russia	113,927	4,883,734	8.2	5.2	Free
France	107,696	5,925,071	31	13.6	Free
Germany	86,104	3,602,103	36.6	10.9	Free
Colombia	80,780	3,103,333	8.9	5.5	Free

Data as of 16 May 2021. Source: Our World in Data, Bloomberg Covid Tracker

India's vaccination programme started out along the same lines with free vaccinations for all healthcare workers and frontline workers in January 2020. These vaccinations were given only at government-run health facilities. In a second phase, which began on 1 March, the government started vaccinating all people above the age of 60 and those above 45 with comorbidities. Vaccines continued to be given free of cost at government centres but the government allowed private health facilities to give vaccinations at the price of Rs 250—Rs 150 as cost of the vaccine and Rs 100 as a vaccination service fee. The moderate costs continued into a third phase that opened vaccinations for all people aged 45 and above. In the final, hurried phase, announced in the middle of the peak of the devastating second wave, the government opened vaccination to everyone 18 years old and above but also deregulated prices.

India has vaccinated (https://www.covid19india.org/) only a little more than ten percent of its population with at least one dose of the vaccine. Instead of picking up pace, the rate of vaccination slowed (https://www.covid19india.org/) from a peak of more than four million doses per day in mid April to a little more than one million in mid May. This drop has occurred in the middle of vaccine shortages, amid a surge in cases that has people wary of going out to vaccination centres, and

during state lockdowns that make access to vaccination centres limited. But the more significant hurdles have been prices and digital requirements to register for vaccination.

Under a new liberalised policy that was effective from 1 May, vaccine manufacturers were required to give 50 percent of their supply to the central government and were allowed to sell the remaining to states and private players. The Serum Institute of India announced prices of Rs 150 for the central government, Rs 400 for state governments and Rs 600 for private players. Bharat Biotech announced it would sell Covaxin at Rs 150 to the centre, Rs 600 for states and Rs 1,200 for the private sector. After facing criticism for these high prices, SII reduced the price of Covishield to Rs 300 for states and Bharat Biotech agreed to sell Covaxin to states for Rs 400.

Since 1 May, vaccinations continued to be given for free in the public sector but prices went as high as Rs 2,000 per dose in the private sector, among the highest in the world. "There is no justification apart from trying to help vaccine companies and private sector hospitals make some profit out of this calamity," Indranil, a health economist and associate professor at the OP Jindal Global University, said. He said that the Rs 35,000 crore that the government had set aside for vaccinations alone in the budget was more than enough to cover the costs for a policy of free COVID-19 vaccinations for all, especially considering that the cost per dose to manufacturers had come down to Rs 150 per dose. The government, he said, could afford to cover even the vaccination fees that private hospitals were charging to ensure that vaccinations were completely free to people.

Moreover, vaccinations were largely available only at private hospitals in many cities for the first few days of the expanded drive. In Bangalore, for example, vaccinations for the age group of 18 to 44 between 1 and 7 May were available only at large corporate hospitals such as Manipal, Apollo, BGS Gleneagles. Apollo Hospitals was charging Rs 850 for one dose of

Covishield in five centres across the city. Manipal Hospitals was charging Rs 1,350 for a single dose of Covaxin at two of its hospitals and Rs 1,000 at a third. BGS Gleneagles Hospital was charging Rs 1,500 for a shot of Covaxin. The BP Poddar Hospital in Kolkata was charging Rs 2,000. On 7 May, only one urban primary health centre in Bangalore had started offering Covaxin for people 18 and above, according to the CoWin website.

"The biggest mistake was to privatise it," Hemant Shewade, a community physician who works with an international NGO, said. "This allowed consumption to increase at private hospitals as people who can afford it flock to private hospitals. In turn, the government is forced to restock these hospitals with vaccines."

The liberalised policy has worsened inequities that were already playing out in the first three phases of vaccination. The biggest problem has been the requirement to register digitally for vaccination. To get a vaccine slot, a person would have to register in an app or a website, which requires knowledge of English, access to a computer or a smartphone connected to the internet and documentation such as Aadhaar, PAN, passport or a driving licence.

“Nobody has access to such information,” Angela Chaudhuri, a partner with Swasti Health Catalyst, said. Swasti Health Catalyst is a non-profit working with marginalised communities. “Not every person has a smart phone, not every family is digitally literate or have access to technology. How are they to register themselves? Frontline workers are stretched. Far from registering, some people have no idea what is happening, what this vaccine is.”

The vaccine shortage and the digital skew has also resulted in people from cities getting slots (https://www.google.com/search?client=safari&rls=en&q=indian+expres+people+goign+to+triabl+areas+for+vaccinati 8&oe=UTF-8) and vaccination in rural, even tribal, areas, and as a result depriving residents there of vaccination. The government has refused to accept that its requirement to register online is a hurdle for many people. It defended the online registration policy in the Supreme Court, stating (https://www.livelaw.in/top-stories/persons-without-digital-access-cowin-registration-centre-sc-173896) that “citizens who do not have access to digital resources can take help from family, friends, NGOs, and above referred Common Service Centres (CSC), etc.” The tone-deaf statement did not recognise the extra effort required to seek such help and the hesitancy it can engender.

The centre’s submission to the Supreme Court came in response to a detailed order (https://www.livelaw.in/pdf_upload/in-re-distribution-of-essential-supplies-and-services-during-pandemic-april-30-392778.pdf) passed by a three-judge bench comprising DY Chandrachud, Nageswara Rao and Ravindar Bhat, on 30 April, which raised significant questions about the centre’s vaccination policy. In the order, authored by Chandrachud, the bench noted, “Once the vaccination programme has been opened up for persons other than the 45 plus age group, it would not be logical to impose the obligation to source vaccinations for the 18-44 age group on the State Governments … The available stock of vaccines is not adequate to deal with the requirements of both the categories.”

On the question of pricing, too, the bench stated, "Prima facie, there are several aspects of the vaccine pricing policy adopted by the Central government which require that policy be revisited ... Prima facie, the rational method of proceeding in a manner consistent with the right to life (which includes the right to health) under Article 21 would be for the Central Government to procure all vaccines and to negotiate the price with vaccine manufacturers. Once quantities are allocated by it to each State Government, the latter would lift the allocated quantities and carry out the distribution."

The order raised several questions about the centre's vaccine policy, among other aspects of the COVID-19 response, including the accessibility of the CoWin platform. On 9 May, the centre filed an affidavit (https://www.livelaw.in/top-stories/supreme-court-covid-vaccination-policy-conforms-to-constitutional-mandate-173885) to address these questions, as directed by the court, in which the government submitted that the vaccine policy was constitutional and asked the Supreme Court not to interfere in it. "As the decisions are taken after detailed deliberations at the highest executive level, for germane reasons, no interference is called for in judicial proceedings, leaving it open for the executive to discharge its executive functions in larger interest ... Any overzealous, though well-meaning judicial intervention may lead to unforeseen and unintended consequences," the

affidavit stated (https://www.livelaw.in/pdf_upload/uoi-affidavit-9052021-final-with-annexures-1-91-393168.pdf).

Chaudhuri said that during the pandemic, her organisation had conducted pre-vaccination counselling in rural areas such as the Chikkaballapur district in Karnataka. They found that people knew very little about COVID-19 vaccines and did not know if they were eligible to get vaccinated. "They are hesitant to get the vaccine, they have heard they will get sick after the jab, they have heard rumours," she said. "The system assumes that you are already aware about the vaccine and are eager to get vaccinated."

The policy has, therefore, tilted access to vaccination towards urban middle-class Indians. "If you look at all the policy responses of the government, it has been essentially to pacify the upper-middle class in metropolitan cities who are generally very vocal," Indranil said. "The government has said, 'Look, we are opening vaccinations to you so you should not feel insecure more,' knowing very well that this would create supply-side bottlenecks."

Even before the announcement to open vaccination to people 18 years and above, Lalit Kant, the former head of epidemiology at the ICMR, told *The Caravan*, "We know that infections and death rate is higher in older populations. The centre released data saying that 88 percent of deaths occurred in those above the age of 45. We simply don't have enough vaccines for all so it makes sense to prioritise these age groups. The effects of the current vaccination drive will only be seen in four to six weeks, opening up the drive will not stop this wave. It will only create more supply demand issues." That is exactly what happened with vaccine shortages reported across the country.

Several public-health experts have argued that the government would have done better to follow the model for vaccination set out in India's successful Universal Immunisation Programme for childhood vaccinations. The UIP follows three modes—routine, campaign and

outreach—conducted largely by Accredited Social Health Activists, or ASHAs, and Auxiliary Nurse Midwives, or ANMs.

Routine immunisation is conducted at district hospitals, block hospitals, health sub-centres and anganwadis in villages on fixed days. In addition to this facility-based routine immunisation, the UIP has the outreach component, where health workers go to villages in rural areas or to particular neighbourhoods or building societies in urban areas, which is particularly helpful for elderly and ill people who might not be mobile. In the campaign mode, health workers vaccinate all eligible people in an area in concerted effort over three or four days.

The UIP has high rates of success for various childhood vaccinations largely because its outreach, communication and easy access overcame any potential vaccine hesitancy. "The point here is that there is always vaccine hesitancy but if you take the vaccine to people most people will take it, but you have to make access to vaccines easy," Shewade said. Illustrating the problem with the COVID-19 vaccination programme, he continued, "If I am a labourer staying in the outskirts of the city, I have to first look online to see what facility is giving the vaccine, so I will opt for the vaccine. On the day that I go, I will not know if they've already finished vaccinations for the day. How many days will I come back? In rural areas, if my PHC has run out of vaccine, should I go to the neighbouring PHC? How do I know which nearby PHC still has vaccines?"

Despite several appeals, the government has refused to allow door-to-door vaccinations for COVID-19. On 12 May, the Bombay High Court decried (https://www.ndtv.com/india-news/could-have-saved-many-lives-with-door-to-door-covid-19-vaccination-high-court-2440537) the centre's stand, stating that many lives could have been saved if door-to-door vaccinations were allowed for senior citizens.

Yet another problem with the expanded liberalised vaccination policy is that it is depriving more vulnerable people of early vaccination. "In this way, you are essentially depriving the 45 plus group," Indranil said. "You could have, instead, increased procurement for the 45 plus group." States now have been forced to make that choice on their own. For example, on 7 May, the Karnataka government decided (https://www.deccanherald.com/state/karnataka-govt-suspends-vaccination-for-18-44-age-group-from-may-14-985210.html) to suspend vaccinations for the 18 to 44 age group and use vaccines that it directly procured to complete vaccinating older people.

Two weeks after the vaccine drive was opened to all adults, NK Arora, the head of operations research of the centre's national task force on COVID-19 , said (https://www.cnbctv18.com/healthcare/vaccine-shortage-will-last-for-over-2-months-says-national-covid-19-task-forces-dr-nk-arora-9301841.htm) in an interview that he and many members of the committee did not want the vaccinations for the 18 to 45 age group to start till everyone 45 and above got both doses. He said that data showed that more than 75 percent of those who had died were older than 45. "The disease severity requiring hospitalisation is in the same group," he added. "The initial purpose of the vaccination drive was to reduce the burden of the health system." Arora said that one dose had been given to about 35 percent of all people 45 and older.

Shewade said that the government should ideally have deployed COVID-19 vaccines through the public health system, ensuring that all elderly and vulnerable were first vaccinated before it was open to younger and healthy individuals. He compared the situation of an elderly person from a financially comfortable family, like his own, to that of an elderly person who is financially insecure. "Should my father get the vaccine or an elderly man in an urban slum?" he asked. "I would say both. But the vaccine delivery mechanism should be such that an elderly from the slums should not have lower chances of getting vaccinated when compared to my father. The elderly in a slum has a high chance of

getting infected because he probably works outside or his son or daughter has to go out to earn a living. If he catches COVID-19, he will have less chances of identifying early warning signs while I will be monitoring my father's oxygen using a pulse oximeter. The chances of becoming sick are equal for both of them but the chances of getting a bed are lower for him/her. He is not covered by private insurance. That elderly from slums probably has a very low chance of even getting tested."

Narendra Gupta, a public-health expert with the Jan Swasthya Abhiyan or People's Health Movement in India, argued that the vaccine rollout should have focused on the hardest hit regions. "The best way to conduct this vaccine rollout would have been to focus on particular areas which have the largest burden of disease currently," he said. "In this way, we could have control at least in those pockets which are suffering the most, where the most number of hospitalisations and deaths are occuring."

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