

Health Policy Responses to COVID-19: India and UK

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Abstract

The global pandemic has forced governments across the world to rethink how public policy should be formulated. COVID-19 hit the world in a spectacular fashion, forcing governments to create public policy solutions quickly. As has been well documented in the global media, civil servants, policymakers and politicians had to make tough decisions that have had an impact on people's daily lives. Lockdown measures were common in 2020 and 2021; in some political quarters, lockdown measures were seen to be too stringent, raising questions as to whether people really live in a democratic society. The authors of this paper will provide a critical narrative on health policy responses to COVID-19 in the United Kingdom and India geographical context.

Keywords: COVID-19; India; Governance; Public Policy; Policy Making; Response; Stakeholders; United Kingdom.

INTRODUCTION

A hot topic that has developed as a consequence of the global pandemic is the relationship between scientists and government officials (*i.e.* civil servants, policymakers and politicians). Questions here concern who has the true power and why these decisions have been made from a public policy perspective. In a recent article in the UK newspaper *The Daily Telegraph* it was noted that scientific modelling was primarily used as a mechanism to relay public policy to the general

public (Knapton, 2022). Obviously, the decisions that have been made are primarily focused on health and social care provisions for the good of the population.

This paper applies two geographical case studies, namely India and the UK. The fundamental reason for the selection of these countries is that the authors have an extensive research knowledge base in their public/social policy contexts (see Halsall *et al.*, 2023; Oberoi *et al.*, 2021; Oberoi *et al.*, 2020; Oberoi *et al.*, 2019). To meet the aims of this important public policy research, the paper is divided into five sections. The first section will explain the shifting dimensions of public policy. Then, next section discusses the ever-increasing importance of stakeholder involvement in public policy, in reference to health and social care; to illustrate this, the authors provide a stakeholder explanation of the key characteristics. From this, sections three and four will discuss the health policy responses for COVID-19 in respect of India and the UK. The final section will conclude the paper by providing a summary of the main public policy ideas in the context of health and social care.

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The Moving Dimensions of Public Policy

“Unexpected” (Shariatmadari, 2020) and “unprecedented” (GOV.UK, 2020) are both terms famously used by the UK government throughout the first wave of the global COVID-19 outbreak. However, the UK was, theoretically, prepared for a pandemic (Jones and Hameri, 2020). According to the *Global Health Security Index* (2020), the United Kingdom was the most prepared to mitigate and prevent a pandemic (Mitha, 2020). The idea of preparedness was supported by the 2011 UK Influenza preparedness strategy, which was a built-in response to the 2007 Influenza pandemic (Gov. UK, 2011). As a result of this strategy, the UK had a vast stockpile of masks and respirators available for health workers (DH Pandemic Influenza Preparedness Team, 2011). Furthermore, the Influenza preparedness strategy highlights that the UK government should respond to pandemics based on evidence or existing practices and ethics based systems (DH Pandemic Influenza Preparedness Team, 2011). Such systems are to be rolled out and coordinated locally, nationally and internationally to protect population health (DH Pandemic Influenza Preparedness Team, 2011).

Aware of the virus, the UK government issued the first phase of their COVID-19 response, which saw a series of five Civil Contingencies Committee (COBRA) meetings. The meetings were chaired by the Secretary of State for the Department of Health and Social Care, Matt Hancock (Joyce, 2021). The government’s scientific experts told the government to work on a worst-case scenario basis, focusing on containing the virus, and thus taking a ‘spectator strategy approach’ (Joyce, 2021). This approach, outlined in the previous 2011 Influenza strategy, suggests no need to close borders, as this would only delay a peak in the pandemic and place too great a strain on public health resources (Joyce, 2021).

Following these meetings, the beginning of March 2020 saw the publication of a Coronavirus Action Plan (CVA) (Joyce, 2021). The CVA was passed through parliament quickly, granting powers to shut down social gatherings and ports, and allowing local authorities to reduce care support if the reduction of care did not impact individual rights as outlined in the European commission of human rights (Lock, Hidalgo and Londras, 2021). However, one of the many dimensions of policy is scrutiny, and due to being passed so quickly, the CVA received minimal parliamentary scrutiny (Lock, Hidalgo and Londras, 2021). Arguably, this lack of debate led to an ‘all or nothing’ dichotomy,

providing an excuse for an absence of meaningful scrutiny and inaccurate government reporting (Lock, Hidalgo and Londras, 2021).

Later, on the 26th of March 2020, the UK saw a national lockdown. Lockdown was established under the powers of the Public Health (Control of Disease) Act (1984) and the 2008 Health and Social Care Act (Hogarth, 2020). However, it is unclear if the powers of the 1984 and 2008 acts allow such restrictions on individual liberty to the extent of the CVA (Hogarth, 2020). In essence, policy is open to interpretation; it would seem that the introduction of the UK national lockdown followed the guidance of scientific knowledge at the time, regardless of the reluctance of Boris Johnson to go into a lockdown (Pohle, 2020).

At this time, UK policy change was happening in a manner last seen in wartime Britain (Cairney, 2020). Epidemiological modelling constructed by the Imperial College COVID-19 Response Team (2020) informed UK policy strategies. Two possible strategies were outlined in the report: mitigation and suppression (Imperial College COVID-19 Response Team, 2020). Mitigation called for home isolation of all suspected COVID-19 cases, as well as the isolation of those with whom they had been in contact (Imperial College COVID-19 Response Team, 2020). Moreover, mitigation would mean that those most vulnerable to the symptoms of COVID-19 would be the first to receive a vaccine (Imperial College COVID-19 Response Team, 2020). Suppression, at the time, was considered the best option for UK outcomes (Imperial College COVID-19 Response Team, 2020). Suppression required the entire population to observe social distancing and enforced closures all educational establishments the need for suppression policies continued until a vaccine was made available (Imperial College COVID-19 Response Team, 2020). It seems that the CVA demonstrated a mitigation approach, much like the one reflected in the 2011 Influenza Act. Suppression, of course, is demonstrated in the move toward a national lockdown.

It is interesting here to consider this move from mitigation to suppression. The response to the COVID-19 pandemic saw a real battle between the UK’s economic well-being and physical well-being. Policy responses during this time had to consider the length and breadth of their implications.

Pre Brexit, the European Union was an influential dimension of UK policymaking. However, Colfer (2020) argues that post-Brexit Britain had its first real opportunity to take back control of its legislation

due to the outbreak of COVID-19. Since Brexit, the UK has asserted its sovereignty over several policies (Colfer, 2020, citing Bulmer & Quaglia, 2018). The UK eventually implemented measures similar to those in place in Europe; however, this was at least a week after the rest of Europe (Colfer, 2020). Rightly or wrongly, this late implementation of lockdown policy shows that there is more to policy than simply scientific understanding. Whitt and Collet-Fenson (2021) note the tensions in policy between the speed at which a problem is addressed and the rate at which scientific evidence is available. However, Colfer's (2020) point shows the breadth of policy dimensions and considerations.

There are multitudes of direct and indirect ways in which the UK economy could be and has been affected by COVID-19 (Keogh-Brown *et al.*, 2020). More obviously, the effects on the labour market and the strain placed on work time and productivity due to illness, but also the behaviour changes that are necessary for suppression policy (Keogh-Brown *et al.*, 2020). At face value, this could be understood as a purely economic consideration; however, as suggested by Dahlgren and Whitehead (1991), the economy can impact individual health outcomes. The economy drives the production of food, healthcare resources, building materials etc. (Keogh-Brown *et al.*, 2020). This means that it is arguably as important to sustain the economy as it is to administer public policy such as lockdown restrictions.

Stakeholder Involvement in Public Policy

Historical ideas on public policy have demonstrated that stakeholders play a fundamental role in shaping policy (see Pahl-Wostl, 2002; Brugha and Varvasovszky, 2000; Hasenfeld and Brock, 1991). Stakeholders are individuals or groups that come together to give a particular viewpoint on a policy idea or decision. Whether it is at local, national or global level, stakeholders in policymaking are seen as a collective group of individuals that are visionary (Okubo, 2009). Influential work by Freeman (1984) has pointed out that a stakeholder, in many ways, is the central point of a policy being successful because the stakeholder has a deep knowledge base on what has happened before and what can change. Süsser *et al.* have pointed out that "stakeholders can be involved in research to different degrees, encompassing information, consultation, cooperation, collaboration and empowerment" (2021, p. 3), and, as recent events have shown, stakeholders are fundamental to the

process of dealing with the global health crisis. Moreover, business and management studies literature (Richard *et al.*, 2009; Hillman and Keim, 2001; Agle *et al.*, 1999) has long been interested in defining stakeholders and their relationship with public policy. Hence, Clarkson defines stakeholders as:

"Persons or groups that have, or claim, ownership, rights, or interests in a corporation and its activities, past, present or future. Such claimed rights or interests are the result of transactions with, or actions taken by, the corporation, and may be legal or moral, individual or collective. Stakeholders with similar interests, claims, or rights can be classified as belonging to the same group: employees, shareholders, customers, and so on."

(1995, p. 106)

Rowley's research (2011) observes that the ideas around stakeholders have developed into 'stakeholder theory'. In essence, stakeholder theory acknowledges that there are interlinking relationships between different individual stakeholders. The idea is that all stakeholders are valued for their expert opinion. In the case of the pandemic, the interconnected relationships of stakeholders in shaping public governmental policy can be categorized into the following three key areas:

1. **The Scientific Element:** this is first point of contact for policymakers. Up-to-date scientific modelling is produced. The modelling provides a clear picture of the geographical impact of COVID-19 across the country. Here, scientific advice is given to politicians on the number of people who have been infected by the virus, along with predictions of the pressure on the state (*i.e.* healthcare system), potential further infections (increased mutation) and deaths. The idea is that the scientific data that is collected makes the case for the worst-case scenario (Stanley, 2020).
2. **The Political Element:** this is the second point for policymakers. Tough decisions need to be made by civil servants and elected politicians in government. Policies are created through analysis of the scientific data and listening to the scientists. Here, politicians may introduce new measures for society, *e.g.* wearing face masks, putting an area/region or a whole country into lockdown, protecting jobs, creating extra funding for the health and social care system,

and putting restrictions on people travelling around (Dixon *et al.*, 2020). Overall, the Managing Director of IMF and Director General of WHO appealed to policymakers “to recognize that protecting public health and putting people back go hand in hand” (Georgieva and Ghebreyesus, 2020, p. 23).

3. **Health and Social Care Element:** this is the final area and the most important for policymakers. The policies that are implemented by government will have a critical impact on the health and social care system. As previous evidence has suggested, putting tougher restrictions on society eases the pressure within the health and social care sectors (Local Government Association, 2021). Coupled with this are the extra resources that are placed into health and social care institutions by the government.

UK Health Policy Response to COVID

The COVID-19 pandemic that happened across the UK created an unprecedented challenge in the health and social care services. What was clear was the global pandemic it produced extreme stress and radical change in the health and social care system. From a UK health policy perspective, the response to COVID-19 started on the 30th January 2020 when National Health Service England working together with National Health Service Improvements stated a level 4 national incident, subsequently referred to as the first phase of the NHS’s response to global pandemic. Hence, this section of the paper explores how major events and milestones influenced the UK and devolved governments’ response to the emerging COVID-19 crisis and illustrates how national measures – in the form of wide ranging and dynamic policy development and change – help to tell the story of the government’s response in attempting to mitigate the impact of COVID-19.

Policy measures were broad, far reaching and, at times, short lived. Policy measures targeted three main areas related to:

1. Controlling the spread of the COVID-19 virus, such as social distancing, transport restrictions, testing, and contact tracing;
2. Managing care delivery within the NHS and social care, such as policies on funding, workforce, regulation, and infection prevention and control;
3. Limiting the social and economic impact of COVID-19, by, for example, providing support for the economy, individuals, and

wider public service.

Whilst the UK government hails the three-pronged strategy as a success, a recent report published by the UK’s House of Commons Health and Social Care, and Science and Technology Committees (House of Commons, 2021) suggests the response to the COVID-19 pandemic was a catastrophic public health failure. The report focused mainly on the England’s response to the pandemic. The committees did not examine at stages taken separately by Northern Ireland, Wales, and Scotland (BBC, 2021). Public health and social policy are devolved in the UK; consequently, there are national variations in some policies that are developed, and therefore some variance in terms of response and impact upon public health.

The initial government approach in terms of policy formation was to manage the situation by achieving herd immunity, highlighted within the report (House of Commons, 2021) as a fundamental error, which resulted in a delay to implementing measures designed to control the spread and subsequently causing thousands of deaths (Oberoi, Halsall and Snowden, 2021). In the first few months of the COVID-19 pandemic, Scally, Jacobson and Abbasi (2020) asserted that whilst the government was confident that they were well prepared and planning was supported by all UK countries, it was evident that the UK’s response was neither organised nor adequate. As of March 2022, it is estimated that the total number of deaths associated with COVID-19 in the UK was more than 163,000, with almost 20 million reported cases (European Centre for Disease Prevention and Control, 2022). Europe had recorded 1,883,711 deaths as of March 2022. Across Europe the five countries that reported the most deaths was Russia with a staggering 361,344, followed by the UK (163,079) then Italy (156,868), 153,824 in France and finally a total of 125,856 deaths in Germany. In total Europe saw 183,944,230 COVID-19 cases. France saw the most cases of COVID-19 at 23,495,797, followed by the UK with 19,767,359 cases, then Russia (17,376,241), Germany (17,298,064) and finally Turkey (14,530,309). As illustrated in this data, the UK has not suffered alone in the tragedy brought about by COVID-19. That said, any direct comparison made between countries should be considered somewhat unreliable due to the variations in how deaths are reported country to country.

Nonetheless, in the early stages of the pandemic the UK infection and death rates were considerably higher than many countries as a result of an erroneous initial policy response.

The World Health Organization (WHO) declared an international emergency at the end of January 2020. This urged governments to prepare for the spread of COVID-19 globally. Cases and treatment reviews from Eastern Asia as a result of the highly transmissible virus illustrated the high death rates and the profound need for mechanically assisted ventilation. However, the UK failed to respond to these concerns. Across Europe, COVID-19 infection rates began to soar in late February-early March followed by an increasing wave of deaths. In response, Italy enacted a decisive COVID-19 mitigation policy and, on the 11th of March 2020, in an attempt to contain the virus, entered a full national lockdown. France and Spain soon followed suit, along with other European countries. Whilst European countries such as France, Germany and Italy had limited mass gatherings prior to entering lockdown, the UK failed to do this, despite the emerging COVID-19 pandemic. Major sporting events, for example, the Champions League match Liverpool v Atletico Madrid – attended by 52,000 people including 3,000 Atletico Madrid supporters – was held on 11th March (the same day Italy entered lockdown), and, also in line with government advice, The Cheltenham Festival went ahead from 10th to 13th March 2020, attended by 251,684 people. The UK's Prime Minister advised the population to limit non-essential contact and travel on the 16th of March, also stating on the 19th March that the UK could turn the tide of coronavirus in 12 weeks.

The UK government had refused any form of statutory lockdown as it was felt it would be rejected by the population and, consequently, would have limited effect due to lack of compliance. The UK's strategic approach at this point in time (the second week in March 2020) diverted from the original containment approach adopted by other countries and supported by WHO, which was based on the principles of find, test, treat, and isolate. However, it was not replaced by a coherent policy. At the time global travel stayed unrestricted and there were no plans put in place for community base identification, testing or contact tracing. Fundamentally, there was no effective plan for procurement and delivery of testing resources. These policy mistakes were heightened by the choice on 19th March 2020 to reduce the threat of COVID-19 from level four (highest level of threat) to level three. A second wave of the pandemic was permitted due to reckless policy of discharging patients back into the community, without testing, and lower levels of required personal protective equipment (PPE) required for health and social care staff. This led to

the second wave of the infection.

During these pivotal weeks in March 2020, strategic policy assumed that the COVID-19 impact of COVID-19 on the UK would be similar to that of influenza, in that it would have mild implications. Hence, the approach adopted would be to build up a herd immunity that would limit the spread and impact of the virus. However, epidemiological modeling presented to the government by Imperial College London illustrated that, without a change of direction, 250,000 might die from COVID-19. The study drew upon two key pieces of information: an updated assessment of what the NHS could manage and data from medical staff in Italy indicating that the intensive care requirement was at least double what had been anticipated. It was not until 23rd March 2020 that the then UK's Prime Minister Boris Johnson announced the first lockdown to start on the 26th of March 2020 and whereby ordering citizens to stay at home. This was followed by policy that would provide immense social, health and economic support measures. However, as reported by the House of Commons (2021) report, more than two months of preparation and prevention time had been lost. The UK has been widely criticized for its handling of the early stages of the pandemic (Oberoi, Halsall and Snowden, 2021); the impact of the delay, despite the evidence from Italian lockdown and guidance from the WHO, is likely to have cost countless lives unnecessarily.

Nonetheless, subsequent measures adopted provided some degree of mitigation, although the cry of "too little, too late" was heard from many at this time (Scally, Jacobson and Abbasi, 2020).

Despite the weeks of a lack of clear direction in health policy, the UK's Prime Minister Boris Johnson offered a clear message which led to a major overhaul in how the pandemic was handled: "everyone who can work from home must do so... if you cannot work from home, plan your journey to avoid crowds" (Gov.UK, 2021). However, there are a number of occupations that are essential to maintain the economy and public services. These included all essential NHS and social care staff as well as security staff, frontline public service staff and animal welfare staff. Those involved in the manufacture and supply of food and crucial goods were also considered to be 'key workers', all of which are required to work in the newly formed COVID health and safety regulations that are applied to the workplace. The only exception to this was the clinically vulnerable who, regardless of being classed as a key worker, were expected to stay home and self-isolate. The role of key workers

was vital with the UK Prime Minister and the Leader of the Opposition both voicing their sincere appreciation. In addition, the George Cross was awarded by Her Majesty the Queen to recognize the brave efforts of health care workers across the UK (Oberoi *et al.*, 2021).

Financial stability, priority access to testing and vaccination were all largely positive outcomes for those with Key Worker status during the pandemic. That said, these were severally counted by the economic and health risks that were prevalent working during the pandemic. This was a contrast to the financial uncertainty of those who did not have key worker status. However, the government introduced a historic package of measures designed to support those individuals, families and businesses that faced financial uncertainty - the March 2020 Coronavirus Job Retention Scheme.

The Coronavirus Job Retention Scheme provided a financial safety net for all those deemed non-key workers. The scheme provided non-repayable grants to employers which allowed them to pay and retain staff during the lockdowns. This saw the furloughing of employees, providing them with 80% of their wages while they were joining the efforts and staying at home. With an estimated cost of £70 billion, 11.7 million people were furloughed (House of Commons, 2022). The scheme ended on the 30th of September 2021 with 4% of eligible jobs being furloughed and 21% of employers having at least one member of staff on furlough (Francis-Devine *et al.*, 2021).

Those individuals who were self-employed and not entitled to the job retention scheme payments were offered the opportunity to enroll for the Government's Self-Employment Income Support Scheme. The scheme had an estimated cost of £ 28 billion, but successfully granted 1.7 million claims, with the final grant being offered in May 2021 (House of Commons, 2022). The track and trace system, implemented by the UK's Department of Health and Social care (DHSC) became a key element of the UK's COVID-19 response. The contact tracing system was implemented in May 2020 with the purpose of limiting the spread of COVID-19. This was primarily a smart phone application, which informed the user if they had been in proximity with someone who had tested positive for COVID-19. Following a notification of close contact, the user would be advised to perform a test and quarantine themselves if they subsequently tested positive. The DHSC justified the scale of investment, £ 37 billion over the two years, by arguing that an effective test and trace

system would help avoid future lockdowns. However, two further lockdowns have occurred since its inception.

Whilst the House of Commons (2021) report acknowledges that the test and trace system was required to be implemented swiftly, it remains unclear regarding the effectiveness of the programme in reducing infection levels compared to other measures. However, at the pandemic's peak, in excess of 700,000 tests were being performed on a daily basis.

In the early months of the COVID-19 pandemic, the UK's policy was clearly far from the exacting standards expected from a country with an international reputation for public health. The House of Commons report (2021) illustrates how, at the outset of the pandemic and at further points in the COVID journey thus far, the economy had priority over health. Initially, the government reacted slowly, characterised by erroneous decisions, and sought support from parts of the private sector that had limited experience. Disturbingly, the report pointed towards successive public health funding failures in previous years, marked by the lack of pandemic preparedness. This lack in preparedness was characterized by a failure to initiate a national lock down early enough and the choice to discharge elderly patients from hospitals and send them back to their social care homes without adequate testing for the virus. It was estimated that 25% of deaths caused by COVID-19 were care home residents (Dyer, 2021). Furthermore, the report highlights the abject failure to provide personal protective equipment of an appropriate standard for frontline workers. The report further highlights the government's COVID-19 contract handling failures, which resulted, for example, in PPE contracts being awarded to organisations with no relevant experience and without tender. Somewhat damningly, the report illustrates that, despite the money invested, the test and trace system has not made a measurable difference to the pandemic.

COVID-19 has illustrated fundamental pre-existing social, economic and health inequalities - the "unacceptably high" (House of Commons, 2021) death rates among ethnic minority groups and people with learning disabilities and autism. Nonetheless, the vaccination system is lauded globally as a great success, reporting that "the forward-planning, agility and decisive organization of the vaccine development and deployment effort will save millions of lives globally and should be a guide to future Government practice" (House of Commons, 2021). UK policy in managing

the COVID-19 pandemic with reports stating is marked by contrasts, as summarised by the House of Commons (2021), which called the COVID vaccine programmed “one of the most effective initiatives in UK history” but the delay to the first national lockdown is considered a “serious error” that should have been challenged.

The impact that COVID-19 has had on society, community, family and individuals has been unprecedented, this has led to creative and innovative responses from social enterprises. Government funding has been granted to the private sector, but there has been a major lack of awareness in the tactical support of the public and statutory services. The endemic inequalities displayed here have been exaggerated as a product of the COVID-19 pandemic (Snowden, Oberoi and Halsall, 2021)

India Health Policy Response to COVID

Since the start of the pandemic, literature in all subjects has pursued the progress and implications of COVID-19, the disease and its complications, along with its social and economic consequences. The policy response of any country to a pandemic is a multifaceted procedure that is directed by its prevailing health infrastructure, the scalability of skills among medical professionals and apparatus to counter the contagion, the swiftness in creating vaccine protection, and the financial practicability of large and prolonged lockdowns to slow the pace of infection spread in communities. India, with its ups and downs, stood resolutely to manage the unparalleled challenge of COVID-19. Community organisations, alongside state administrations managed to supplement support by providing health and research facilities, as well as tracking services. (Singh, 2019; 2020). The COVID-19 pandemic laid bare the obstinate and deep-rooted challenges of ensuring equitable health outcomes for all.

India was brutally impacted comparatively, in terms of world cases and deaths of COVID-19. This caused huge economic distress. More than 4.01,00,000 total cases and 4.91 lakhs deaths as of January 2022. As an economy, India is unorganised and informal meaning millions of people lost their jobs and saw increased poverty as a product of lockdown mandates. Moreover, the lockdown mandates meant that there was large scale displacement of labourers and their migration back to rural villages and their hometowns. “What happens in India has a big impact, both in the region and in the world,” Luis Breuer mentioned in an IMF

podcast; he went on to say, “You’re talking about a large slice of humanity and the global economy”. India had a detailed and quick response to the pandemic, which included economic alterations and fiscal position. This response was founded in economic growth. India is now one of the fastest major economies in the developing world (Halsall *et al.*, 2023; Reed and Lin, 2024).

As the COVID-19 pandemic spread in the world in 2019 and with no specific treatment or vaccine for the virus, stringent policy interventions had to be timely and resource-intensive. Immediately, policies like mandatory masks, social distancing, individual protection, regular contact tracing and self-isolation, and curfew like restriction had to be implemented. However, given the social and economic challenges, poverty, lack of jobs etc., COVID-19 policies resulted in multiple concerns. Healthcare infrastructure and other vulnerabilities like the prevalence of informal jobs, lack of job security and health protection, insufficient health alertness and care access remained huge and under assessed.

However, India also has some strength. It has good communication channels with large number of healthcare workers, which helped during the pandemic. But India doesn’t have remarkable track records in the cases of disease prevention, emergency readiness and response mechanism, extent of health amenities, and medical countermeasures and staff’s preparation (Ipchita Bharali, July 2, 2020). India reported its first cases in January 2020, and, by early March, cases started increasing. Increasing readiness for the extraordinary danger from COVID-19, Indian government established an inter-ministerial committee for coordinated action by the Ministry of Health and Family Welfare, External Affairs, Home, and Civil Aviation, along with the National Disaster Management Authority to coordinate the policies and responses to this big risk (Press Information Bureau, 2020). Starting mid-March, India started taking rapid steps to curtail the spread of the pandemic, issuing advisories against nonessential international travel, barring mass congregations, and imposing restrictions in certain areas. The public advisory was given to maintain social distancing, hand hygiene and work from home. The country went into a 21-day strict lockdown that was subsequently extended.

To mitigate and manage the disproportionate and severe consequences of the lockdowns on private health services, the public healthcare system increased both preventive and curative services for COVID-19. “Community-based surveillance

activities were scaled up across India by end of March. The number of testing and collection centres was increased, testing criteria were extended, and private laboratories were engaged. On 4 April, free-of-cost testing and treatment for COVID-19 was mandated under the national universal health insurance scheme (Pradhan Mantri Jan Arogya Yojana), further expanding testing outreach" (National Health Authority, 2020). The Pradhan Mantri Jan Arogya Yojana relief package allocated \$23 billion for poor and vulnerable people (Ipchita Bharali, 2020).

India setup a three-tiered policy of quarantine, isolate, and treat COVID-19 cases, through devoted care centres, health centres and care hospitals for handling COVID-19 patients all over the country. The Indian government immediately increased the requirements for institutional quarantine and isolation centres and COVID-19 hospitals. "Ventilators and personal protection equipment were consigned from vendors in the country and abroad. Training of personnel in the care of COVID-19 suspects and patients was undertaken aggressively. A series of guidelines and standard operating procedures were disseminated as webinars and video modules by the Ministry of Health and Family Welfare, Government of India and the country's top medical establishments like All India Institute of Medical Sciences" (MoHFW website).

Private vendors and services were recognised and prepared for institutional surge readiness. Volunteers and health workers from various community and non-government organisations were solicited to help state and public healthcare professionals. "The government also launched e-health platform Aarogya Setu (Health Bridge) in April 2020 and made obligatory in workplaces and public places to allow online broadcasting of regular updates, advisories, best practices and tracking, besides medical, non-pharmaceutical interventions were pushed into action at the individual and the community" (MoHFW, 2022).

India's federal structure means that coordinating policies and actions is vital to coordinate policies and actions. The central and state governments announced numerous interventions to ease hardship among the vulnerable and underprivileged.

Besides the very comprehensive National Health Policy of 2017 incorporates the principles of guaranteeing access, affordability, fairness, diversity, comprehensive partnership, patient-centred quality care, dynamism and devolution based on the WHO's Health in All policies (National

Health Authority, 2018). The policy aims to strengthen people's faith in health care systems and use this to support private healthcare infrastructure development. Swasth Nagrik Abhiyan is an important aspect of this policy, this is the "Health in All" approach to providing "assured healthcare for all at an affordable cost". In essence, this approach intends to offer health insurance to lower and more deprived sections of the population. This scheme aims to cover over 50 crores (500 million) citizens, linking to the UN Sustainable Development Goal (SDG) of guaranteeing and encouraging healthy lives and wellbeing (Jakovljevic, 2020). The policy recommends 2.5% GDP rise in public health spending. However, the outbreak of COVID-19 meant that any resources had to be diverted and used to aid the combat of the virus. This sudden disruption created the perfect testing ground for the execution of the National Health Policy 2017 (Bhatia, 2020).

Following the first wave of the virus, COVID-19 cases fell by early 2021. At this stage it seemed as though India had beaten the virus. The government allowed the country to return to business as usual. However, this resulted in mass gatherings, crowded election gatherings and a false sense of security. This overconfidence saw mask-wearing and social distancing decrease (Seervai and Shah, 2021). Another area of criticism was that fact that despite India being the leading vaccine manufacturer, the supply of COVID-19 vaccines in India was not sufficient to meet population demands. On the 3rd of January 2021, the Central Drugs Standard Control Organisation of India (CDSCO) allowed for the emergency use of the Astra Zeneca and the COVAX vaccine. Eight days later on the 11th of Jan 2021, the prime minister announced the commencement of the world's largest vaccination crusade that was to start 16th of January 2021.

By mid-February, the Indian administration had only ordered enough vaccine doses to protect 3 percent of the population. The Delta Variant of COVID-19 hit the country in April 2021, meaning that the government undertook quick policy checks and curtailed the exports of vaccines. On the 1st of May 2021 vaccinations were made available for all citizens over the age of 18, however supply remained insufficient to meet demand. However, subsequently the situation improved and India saw a successful vaccination drive, along with revisions of its COVID-19 strategy which proved useful in the third wave. The domestic production of COVID-19 vaccinations was fast-tracked and there was then a sufficient supply of vaccines. The projection is that by mid-2022, a large section of the population will

be covered by the vaccination drive. According to the Union Health Ministry, as of January 22nd, 2022, “India has administered over 1.62 billion doses overall, including first, second and precautionary (booster) doses of the currently approved vaccines” (MoHFW, 2022). In the current Omicron wave, approximately 80 percent to 90 percent of cases are asymptomatic or with only slight symptoms. Hospitalisation has remained low (Lahariya, 2022). In contrast to the second wave, the response of the government in the current wave has been practical and evidence-informed and determined by the guidelines of public health.

Indian health systems were severely tested by the COVID-19 pandemic and crumbled during the second wave of March 2021. It is therefore time that every Indian state plans to strengthen government health facilities and engage with the private sector more actively to evolve a comprehensive health policy for its citizens. It is vital that state governments increase the allocation of funds to strengthen health services and resources. Moreover, India’s National Health Policy states that 8 percent of the budget should be spent on health services, but this is only 5 percent. It is important that more science-based approaches to public health become priority.

The outbreak of COVID-19 has been an eye-opener for healthcare infrastructures and healthcare policies and services. Some common highlighted concerns that besieged India during the pandemic were the insufficient accessibility of medical specialists, including medics, nurses, and paramedics. The GDP outlay on the public health sector is still low and needs to be improved as per recommendations. What also came to light was the passivity and profiteering of private health sectors during the pandemic, which is a significant concern. Only a robust public health system is appropriate for India, as large numbers of Indian citizens are rural and poor (Gautta, 2021, p.14).

The country presents a combination of essential strengths and weaknesses in fighting the pandemic. Nonetheless, despite the numerous combatting policies implemented on a war-footing level, COVID-19 continues to place an extra burden on the already overstretched healthcare infrastructure. The private healthcare arrangement has proved to be largely unreliable during the national health emergency. Common people relied on and trusted public health schemes and arrangements, particularly the poor sections of the population. Thus, the COVID-19 pandemic policies reveal some understandable prospects and threats: “Given the

dynamicity of India’s response, our current account may be non-exhaustive, but captures information from across the country. Some of the approaches undertaken by India seemed to have worked out in favour, while some needed better planning” (GRID COVID-19 Study Group, 2020, p. 10). These facets need to be considered and appreciated to allow us to fully understand the context and its influence on India’s policy response during these unprecedented times.

CONCLUSION

The 2019 COVID-19 pandemic is an appropriate reminder of the nature and impact of Public Health. While the consequence of the pandemic takes variable shapes and forms, the implications of COVID-19 have been devastating worldwide. It is no exaggeration to assume that the impact of COVID-19 will be felt for generations. However, COVID-19 provides an opportunity for the global community to learn, enhance preparedness and mitigate endemic inequalities. The pandemic has taught the global community several lessons: the notion of herd immunity cannot be relied upon; vaccination needs global collaboration and education, and inequity perpetuates inequalities. Good, effective, health policy requires collaboration and openness. There is a need to learn from mistakes made and lives lost as a product of poor preparedness. Across both the UK and India, COVID-19 exacerbated pre-existing socioeconomic disparities. Whilst some of the global policies implemented suggest little social consideration and rather a peruse of economic gain, it is important to be mindful of the ties that health has with the global economy. The economy is responsible for providing social security for all in terms of resources, food, healthcare and building materials (Keogh-Brown *et al.*, 2020).

In the case of the UK there is clearly a need for a pandemic preparedness plan led by public health specialists and free from political influence. Should another disastrous pandemic strike, this plan needs to be implemented with speed and clarity, taking a dynamic and adaptable approach. India demonstrated some strengths in its response to the pandemic with announcements of interventions to ease hardship and inequalities. However, the government health facilities were simply not ready to support with such widespread health issues. Therefore, suggestion is made that public health should be prioritized within budget planning across India; this is something that could also be beneficial in the UK.

The key, we suggest here, is that good effective health policy requires collaboration, openness, the opportunity to learn from others. Clearly, a pandemic preparedness plan needs to be revisited and made available globally to be adapted to the needs of countries. This plan should be dynamic and incorporate the honesty to accept mistakes, adjust, and, in a global community, be committed to international cooperation.

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