India's Vaccine Policy Needs Clarity

(Former Union Health Secretary K. Sujatha Rao's Comment, The Hindu, June 22, 2021)

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Contrary to popular perception, public policies are made without full knowledge or facts. More often than not, they embody assumptions arising from experience, an understanding of history, and present conditions. Considering the vast sea of unknowns surrounding COVID-19, it would be understandable to place a greater reliance on historical experience. Instead, **India's vaccine policy** appears to be one of experimentation. Despite several modifications, the final policy as articulated by the Prime Minister on June 7 continues to lack clarity in its intent, design, funding and outcomes. In seeking to pursue conflicting objectives, the policy architecture is complex, difficult to implement, and could be a nightmare for accountants.

The Vaccine Policy

After much loss of time, the final policy has the following elements: the stated objective is universal access to free vaccinations in all government and accredited facilities; the design for achieving the objective is creating a dual market under which the Central government will procure 75% of the total quantity manufactured, leaving the residue for commercial sale. The funding will be a mix of public finance and out-of-pocket expenditure. The outcome is to ensure that all 95 crore adults are fully vaccinated by the end of this year.

The policy has two caveats related to pricing and volume of sales. While **Covishield and Covaxin** are supplied to the Central government at Rs. 150 per dose, the price for a consumer in the private market is capped at Rs. 780 for Covishield, Rs. 1,145 for Sputnik V and Rs. 1,410 for Covaxin. To avoid cornering of vaccines by corporates and enable medium and small hospitals to participate in vaccination, the Central government will specify hospital-wise and State-wise quotas for private sales. Based on the quota allocated, the said hospitals will procure the vaccine directly from the

manufacturer or use the option of the National Health Authority portal, if accredited.

Compare this maze with the policy followed under the Universal Immunisation Programme – the Central government indicates the quantity required, the delivery schedules and the rates as per global tender, and supplies quality, ready-to-use vaccines to the States to be provided free. The manufacturer is left to dispose of excess quantity, if any, in accordance with market forces and without interference from the government. Under this system, the government has negotiated incredibly low prices due to the volume of its orders. In view of its wide reach, the private sector's participation, catering to the better-off sections which have the ability to pay, has averaged 5%-15% depending on the vaccine.

Current Status of Procurement

It is estimated that the Central government has procured and placed advance purchases for 79 crore doses for Rs. 12,405 crore (including Rs. 1,485 crore from PM CARES). The State governments in May procured 2.6 crore doses incurring Rs. 810 crore, while the private sector (nine corporate chains and 300 hospitals) procured 1.2 crore doses. Selling at Rs. 1,000 per dose of Covishield and an average of Rs. 1,400 for Covaxin, the household expenditure on vaccines comes to about Rs. 1,332 crore. The private sector's share in the total 82.8 crore doses procured and amount incurred is 1.45% and 9.1%, respectively.

The total number of people who got vaccinated by June 21 with a single dose was 23.2 crore and with two doses was 5.05 crore. Of the total 190 crore vaccines required for covering the eligible population with two doses and 83 crore already secured for supply till year-end, the gap is 107 crore. This brings us to the first level of policy confusion. In the absence of spelling out the population segments that the government proposes to cover, it is unclear whether the 75% procurement cap refers to the stocks manufactured or by implication the eligible population. Clarity on this is important. If it refers to stocks, then the position can vary due to uncertainties and externalities associated with production. Besides, in the absence of credible information regarding real-world manufacturing capacity and wide price differentials,

arriving at what that 75% of manu- factured stocks would entail is difficult, creating an unstable environment for operation and planning.

If it is 75% of the population to be covered, the policy assumes that 24 crore people have the ability to pay such high prices for a vaccine. How far is that a realistic assumption, given that as per data of the Pew Research Centre, the number of people earning less than $2 a day has doubled from 5.9 crore to 13.4 crore as a result of the pandemic? Due to the pandemic, under every income segment, the numbers have reduced — the number of people in the high and upper-middle class is estimated to have fallen to 1.8 crore from 2.5 crore, the middle class to 6.6 crore from the 9.9 crore prior to the pandemic, and the lower middle class to 116.2 crore from 119.7 crore.

The second policy confusion is determining from where the 24 crore-paying population is to come from for buying the vaccine at the rates laid down by the government. The inequity this policy will generate between the rich and poor, urban and rural is embedded and will be hard to justify, besides clouding the actual requirement of vaccines for the government to administer. In other words, the demand may be more for free vaccines while the self-imposed ceiling of 75% of stocks may create artificial scarcities.

Or is there an assumption that 75% coverage would ensure herd immunity and, with some luck, the pandemic may just blow over?

Concerns

Apart from concerns of ethics and morality, the 'two steps forward, one step backward' policy fix has given rise to another set of issues necessitating simplification of the policy design. One, the idea of manipulating markets is not as smart as it sounds. Piecemeal orders increase investment risk for a company. Besides, delivering and processing small orders by multiple small entities (private hospitals) located in remote areas would further add to costs impacting the price at the point of delivery. Since price must ensure a minimum return on investment, it is critical that such complexities be addressed.

Two, the small and medium private hospitals that have the reach in Tier 2 towns and rural areas do not have deep pockets to buy such costly vaccines. Given vaccine hesitancy, heightened by a constrained ability to pay, the mutating virus and constant shifts in vaccine dosage and periodicity due to emerging evidence, the additional burden of organising quality assurance all add to the risk.

Three, differential pricing and dual markets provide wrong incentives and result in unhealthy competition, illegal charging for vaccines in government facilities, siphoning, diversion and leakage of the free vaccines to the private markets where in large swathes of the country it is the government doctors that double up as owners of private enterprises.

Clearly, there is a need to simplify the policy with the government as the sole procurer. Implementation must be in accordance with district-level micro plans incorporating the public and private sector, to cover target groups as specified in accordance with epidemiological data. The objective has to be to restore normalcy, kick-start the economy, start schools and ensure people's well-being. It is not the time to ask people to share costs when the economy is tanking. Vaccines are our only lifeline. They should be freely available and accessible to all, not only to the privileged few.