LETTERS

Pandemic profiteering during the second wave of Covid-19

It's time for indignant citizens today to confront a new breed of shameful greed merchants

— *Jim Hightower*

The first wave of the Covid-19 pandemic saw us facing acute shortages of masks, personal protective equipment, and sanitisers, with even toilet paper disappearing from store shelves. But the Indian small manufacturers seized the opportunity and by the end of last year, we had enough PPE and masks to even export the surplus to other countries. Though we rationed even the lowly surgical masks, people did not hoard or black market any of these. But it gave people the knowledge of what would be required and would be in short supply if the second wave struck. And so started the pandemic profiteering business.

Medical professionals in India have never witnessed the amount of pandemic profiteering that occurred when the second wave of Covid-19 hit the country. With more than three lakh people getting infected every day, India saw a spike in profiteering in medical essentials trading on patient distress and touching a new low in the breach of medical ethics.

Why did pandemic profiteering occur?

In contrast to the first wave, no clear protocols were laid down for lockdown, quarantine or treatment to be followed, by either the Indian Council of Medical Research or the Union Health Ministry. The policy paralysis resulted in a free-for-all. The union and state governments' price cap on scarce life-saving medicines and oxygen cylinders, with inadequate regulation, led to black marketing (1). With an increasing patient load and scarcity of hospital beds, there was panic buying of medicines and hoarding of essentials during this wave.

What were the effects of pandemic profiteering?

To list only a few examples of pandemic profiteering during the peak of the second wave: pulse oximeters, high-flow oxygen masks, oxygen cylinders and concentrators were being sold at more than ten times the normal price; private ambulances and mortuary vans were overcharging, both to ferry patients to, or bring dead bodies home from hospital. Several hospitals demanded exorbitant advance deposits for admission into intensive care units. RT PCR Covid tests that usually cost Rs 800, cost Rs 3000 at many centres. A few re-purposed medicines like Remdesivir and Tocilizumab, which normally cost less than Rs 2000, were sold at Rs 40,000/vial (2).

Some state governments even hiked intensive care bed charges in private hospitals (3). Panic stricken people were ready to hoard these essentials for an emergency, with no knowledge of how to use or replenish them.

Stranded by the sudden government lockdown, the poor migrant population, who were obliged to go home to their villages, had to spend exorbitant amounts to hire vehicles, or had to walk.

Funeral homes were literally the last straw to break the Covid victim's back, not only with long waiting lists but exorbitant charges for scarce wood and cremation procedures (4).

Fake medicines, scams and scandals

As if the curse of pandemic profiteering were not enough, scamsters produced spurious versions of drugs like Remdesivir, jeopardising the lives of innumerable hapless patients and depriving their desperate families of their hard-earned money by online scams via WhatsApp, selling oxygen cylinders, oxygen concentrators, etc. Elsewhere, hospital authorities deliberately switched off oxygen supply in the intensive care unit to force patients to buy oxygen cylinders (5).

The crime branch of Karnataka police did arrest a few people involved in the "Covid bed allocation scam", even though on paper the beds were allotted officially through the Central Hospital Bed Management System of the Bruhat Bengaluru Mahanagara Palike.

How can the system be cleaned?

The Disaster Management Act of 2005 (6) clearly states that when it is enforced:

· there should be a National Plan;

· all help should be given to the states to carry out the plan;

· the government should make available the resources for emergency response, rescue and relief (7);

· sweeping powers are given to designated disaster management officers to enforce the plan and punish people acting in breach of the Act.

Unfortunately, none of these were implemented in the second wave. It was a case of complete policy paralysis with no clear direction or plan, resulting in every common man, hospital, or business, including crematoria, shamelessly making a quick buck from desperate patients. Swift and visible action with exemplary punishments should be meted out to black marketers, hoarders and extortionists, so that people fear doing such acts.

We have also seen extraordinary acts of sacrifice and

empathy in many doctors, nurses, other healthcare workers, police and other essential services staff. So, one can see that there is still humanity and goodness left in our people. We need capable leaders to direct constructive action, reassure citizens by rapidly increasing and upgrading infrastructure, and take swift action against those spreading misinformation and panic. If this had been done in time, maybe we would not have to use the term "pandemic profiteering" today.

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Addressing stigma and discrimination in the Covid-19 pandemic: a public health ethics issue

The Covid-19 pandemic continues to stalk the globe, ever since the first outbreak in December 2019. Variants of concern and fear of subsequent pandemic waves continue to challenge every nation. The virus has caught communities off-guard many times with grave consequences.

The scale of the pandemic initially led to unprecedented measures, including widespread lockdowns and travel restrictions, social distancing measures and isolation of infected individuals. The disruption of normal life with the emphasis on exclusionary measures resulted in misinformation, fear, mistrust and stigma in the community (1). The consequent discrimination against the susceptible was against all norms of public health ethics which seek to secure adequate health for all and to minimise inequalities. Stigmatisation, leading to delay in treatment-seeking and aggravating disease transmission, yields poor health outcomes (2).

Furthermore, health-related stigma exacerbates pre-existing divisions in communities such as race, gender, religion, and class (3, 4). In the Covid-19 pandemic, people of Asian descent around the world have been subjected to racist attacks, significantly affecting their health and livelihoods (5). Public health measures that do not take into account these effects, add to the problem, by disproportionally affecting disadvantaged groups eg transport and visa restrictions, or denial of employment or housing. All these are causes of severe distress.

The current pandemic differs from its predecessors in the sheer flow of unregulated information, marked by conspiracy theories and inaccurate medical information (6). However, the accessibility and penetration of technology can be used for targeted messaging to avoid stigmatising patients or groups of patients.

Heijinder and Van Der Meij have described multiple levels of interventions against stigma: at the intrapersonal, interpersonal, organisational and community levels (7). All of these can be utilised to plan interventions to address stigma and discrimination in the current pandemic.

- *Intrapersonal/individual level*

These interventions aim to improve knowledge and empower individuals to make the right decisions about how to seek care, protect themselves, avoid panic, and to encourage them to share their experiences and lend support to other patients. Social media platforms can be harnessed to create a positive narrative that the disease can be overcome; and to help dispel myths in the community.

- *Interpersonal level*

These interventions target the patients' environment and should aim to inform and support the families, neighbourhoods, and work environment of affected individuals. Home care teams may be constituted with local individuals, non-governmental organisations, and self-help groups as members.

- *Organisational/institutional level*

Stigma against essential workers should be recognised and addressed through legal measures if necessary, while lauding their efforts. Frontline workers must also be trained to avoid criminalising at-risk individuals while