Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

use hydroxychloroquine for the treatment of home-bound patients with COVID-19.[4] It is questionable why Indian authorities have continued to promote the use of hydroxychloroquine in combating COVID-19 while ignoring overwhelming medical evidence against it.

The Indian Health Minister, himself a registered physician in allopathic medicine, caused huge national upheaval when he claimed on national television, without any scientific basis, that Coronil, a herbal drug, can actually prevent and cure COVID-19.[5] Even the Indian Medical Association, usually a close ally of the Indian Health Ministry, had to criticise such reckless promotion of a questionable therapy by the health minister.[5] There is no doubt that India urgently needs to change its course to curb the ongoing rampage by the second wave of infections by boosting the existing vaccination policy in a transparent manner and implementing meaningful measures to minimise virus transmission. Unfortunately, these crucial changes to save tens of thousands of Indians are not likely to happen until the deep-rooted corruption in the Indian medical system is eradicated.

KS is the founding president of People for Better Treatment. Further details of competing interests are available in the appendix.

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1 The Lancet. India's COVID-19 emergency. *Lancet* 2021; **397:** 1683.
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For the **Integrated Disease Surveillance Programme** see https://idsp.nic.in/

See **Online** for appendix

Time to reimagine India's health system

The denialism behind the ongoing SARS-CoV-2 outbreak in India[1] has been aggravated by the invisibility of public health professionals in epidemic response strategies. Indian public health associations were sidelined early on in the outbreak because they demanded responsibility from politicians; primarily, they demanded restraint from assembling crowds at political meetings.[2] India's outbreak response has had a mostly clinical approach. Surveillance, a key public health strategy, was weak, with decision making based on non-systematic data without denominators, and which has minimal use for informing disease control strategies. The Integrated Disease Surveillance Programme was established in India with investment from the World Bank in 2004. Although the goal of this programme was to strengthen disease surveillance, this agency was out of the picture until quite late in the outbreak.

A second public health approach, of community engagement and public communication, has also been relegated to the sidelines. Convincing populations to use face masks and implementing physical distancing in the seventh most densely populated country in the world requires an understanding of human behaviours and introducing context-appropriate interventions. The development of human resources with multidisciplinary skills was encouraged in the early 2000s, when considerable public resources went into the establishment of schools of public health in India. These trained human resources are still unused.

The outbreak in India highlights the need to separate clinical and public health functions.[3] The *Lancet* Citizens' Commission,[4] entrusted to reimagine the Indian health system, could be an excellent platform with which to develop a blueprint for this restructured health system, with interacting yet dichotomous responsibilities that would be better organised to protect its citizens.

I declare no competing interests.

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Department of Error

GBD 2017 Diet Collaborators. Health effects of dietary risks in 195 countries, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. Lancet *2019;* **393:** *1958–72*—For this Article, Nayu Ikeda should have been included in the GBD 2017 Diet Collaborators. This correction has been made to the online version as of June 24, 2021.

Kirenga BJ, Byakika-Kibwika P. Excess COVID-19 mortality among critically ill patients in Africa. Lancet *2021;* **397:** *1860–61*—In this Comment, paragraph 3 should have said "It is common in low-income countries to have expensive equipment that is non-functional due to poor maintenance or lack of skilled human resources. It has been estimated that 40% of the medical equipment in many low-income countries is out of service." This correction has been made to the online version as of June 24, 2021.

The African COVID-19 Critical Care Outcomes Study (ACCCOS) Investigators. Patient care and clinical outcomes for patients with COVID-19 infection admitted to African high-care or intensive care units (ACCCOS): a multicentre, prospective, observational cohort study. Lancet *2021;* **397:** *1885–94*—In this Article, the ACCCOS Investigators list has been updated, and the appendix has been updated. These corrections have been made to the online version as of June 24, 2021.

Patel MG, Dorward J, Yu L-M, Hobbs FDR, Butler CC. Inclusion and diversity in the PRINCIPLE trial. Lancet *2021;* **397:** *2251–52*—The appendix of this Correspondence has been corrected as of June 24, 2021.