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THE DYNAMICS OF A CHANGING HEALTH PATTERN: SOME DISTURBING ISSUES

Bhattacharya, J

India

Abstract

As a recent article in the *New England Journal of Medicine* makes it evident, we seem to be living in a medical education bubble market. Moreover, as explored and pointed out by the *Lancet* and innumerable research works and huge number of activist groups, there is occurring a paradigmatic shift from the state-owned, public health-based *preventive* as well as low-tech programs to the corporate, individual health-based and high-tech *curative* programs. Graduates coming out from a great heterogeneity of medical colleges greatly share the psyche of buyer-seller philosophical position. I would try to address how to transcend this *Bharat-India* divide in health care. As methodology, I have done a literature survey of all sorts and made use of the reports of objective field surveys of rural as well as urban population and health care facilities, with trained personnel existing mainly in West Bengal. The conception of public health differs from individual clinical health in a significant way that the former is embedded in community life with its own characteristic cultural specifics and somewhat against the medicalization traits. These lesssons are not learnt exactly in the curricula of medical colleges. When a doctor takes into account the dynamics of a population's life and its changing patterns seriously, an honest approach to render assistance to population and health will come in the offing. Moreover, while addressing the basic questions of philosophical position of *public health* – taking into account peoples' community belonging, religious beliefs, shared livelihood, social assistance, to name only a few – must be differentiated from the philosophical position of *individual clinical health*.

Keywords: Public health, clinical health, curative programs, community, cultural specifics, Bharat-India divide.

INTRODUCTION

To any lay eyes it becomes quite visibly evident that over the years there is a sharp decline in the state health system (barring a few) and a stupendous rise in the growth and development of private hospitals and so called five star clinics in india. Most intriguingly, public health is provided by the state health system of India. The same is true for most of the countries. Notably, while *curative* health (of whatever price it may be) is the sole objective of these private hospitals and clinics, the delivery of both preventive and curative health, remain the objective of public health programs.

A few years ago, it was observed in an important journal that health care delivery in many countries has expanded over the past 150 years from a largely social service delivered by individual practitioners to an intricate network of services provided by teams of professionals. The problems of increasing resource consumption, financial constraints, complexity, and poor system design that have emerged as consequences of these changes have exacerbated many of the ethical tensions inherent in health care and have created new ones.[i] It was eventually accepted by the Tavistock Group – "Over the past 150 years, health care delivery has expanded from what was largely a social service provided by individual practitioners, often in the home, to include a complex system of services provided by teams of professionals, usually within institutions and using sophisticated technology."[ii] This declaration made a distinction between "individual" (or, clinical) and "public" health, which I believe, is of much importance. In my paper I shall try to focus on three fundamental issues and nuances related to public health in India.

First, I try to show how the 1978 slogan of "Health for All by 2000 A.D" emerging out of the Alma Ata Declaration (International Conference on Primary Health Care) gradually metamorphosed into "universal access to health care" and what consequences it did yield.

Second, how a deep distinction remains between "individual or clinical" health and "public" health and we should be careful to this distinction. Moreover, I try to show how all our medical curricula are devoted to the production of capable clinical health practitioner, not one dedicated to public health.

Third, taken the above two factors together into account, we should ask to know how it helps us to understand the divide between metropolitan India and the vast non-metropolitan rural *Bharat*.

Elaborating the Issues: First Question

To start with, the Alma Ata Conference (1978) on Primary Health Care was a visionary stepping towards a world where health became the concern of the state. Health was an achievable right and "to do" duty. The ocnference was held from 6th to 12th September, 1978.[iii] It was jointly sponsored by WHO and UNICEF. 134 countries, 67 international organizations and a good number of NGOs participated in the conference. It was held under the aegis of Dr. Halfdan Mahler, the then Director General of WHO. This conference also reflected his philosophical and ideological position to an extent. The 1st declaration was – "The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the **highest possible level of health is a most important world-wide social goal** whose realization requires the action of many other social and economic sectors in addition to the health sector." [Emphasis added]

Never before, though somewhat utopian it may sound, was so emphatically pronounced that "highest possible level of health is a most important world-wide social goal" and its realization depended on many a number of extra-medical and extra-health social, political, economic and cultural factors. In the 5th clause, it was explicitly stated – "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice."

Quite importantly, as military conflicts and incessant wars among countries dry up resources for a given period, this declaration aimed towards a peaceful world. As a result of military armament and conflicts, there remains very little to invest in the growth, promotion and extension of health and "comprehensive primary health care." It was clearly enunciated, "An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of *independence, peace, détente and disarmament* could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share." [Emphasis added]

We can safely assume at this juncture that there were three or four fundamental and core arguments worked upon throughout this document – (1) attainment of health and extension of primary healthcare have been succinctly defined and elaborated; (2) primary healthcare was specifically suggestive of "comprehensive health care", not "selective primary health care", as was propounded later on; (3) the onus of promoting and ensuring health for all citizens, as viewed in the declaration, remains with the state and government, not entrusted with the "free market"; and (4) health is a right of citizens of all societies across the globe.

Summarily, the declaration gave birth to a new vision of health and determination to overcome challenges confronting its materialization. Moreover, this was a

priod when "cold war" was not over, and the world was neither unipolar too.

Around the same period of the Alma Ata conference, a number of important articles, analyses and commentaries appeared in the *New England Journal of Medicine*, *Wall Stree Jornal* and other international conferences. In 1977, Allan Enthoven prepared a plan "A National Health Insurance Proposal Based on Regulated Competition in the Private Sector", which was later published under the title "Consumer-Choice Health Plan (in two parts)" in *New England Journal of Medicine* in 1978 in 23rd March and 30th March issues of the journal. Prior to this plan, in 1965, Medicare and Medicaid – third party insurance-based healthcare – were adopted by the US government. Later on, echoing his earlier views, Enthoven unequivocally stated, "The main thing that I had in mind was to open up the *market* to the alternative delivery systems, including new models not yet invented, a market in which *consumers* would be fully cost-conscious at the margin." (Keynote Address for the Conference "Consumer choice in health care: the right choice?", Erasmus University, Rotterdam, 30 November 2006)

According to an estimate published in an article in the *Wall Street Journal* (27 December 1979), the net earnings of health care corporations with public stock shares rose by 30-35% in 1979 and were expected to increase another 20-25% in 1980. In 1979, more than $15 billion was expended only for laboratory investigations in the US, and this expenditure was anticipated to rise by 15% annually at a compound rate.[iv] In the same article, Relman let us know, "In theory, the free market should operate to improve the efficiency and quality of health care… *We Americans believe in private enterprise and the profit motive*."[v] [Emphasis added]

In 1979, Walsh and Warren published an article with the title "Selective Primary Health Care".[vi] In their paper, Walsh and Warren quoted the then World Bank president Robert McNamara to have said, "How then, in an age of diminishing resources, can the health and well-being of those "trapped at the bottom of the scale" be improved before the year 2000?"[vii] Moreover, according to them, as resources available for health programs are usually limited, "the provision of *comprehensive health care* to everyone in the near future remains unlikely."[viii] [Emphasis added]

At this juncture, it must be remembered that if the idea of "health" is to be substituted with the idea of "health care" as "consumer-choice", and, additionally, if to be placed in the currents of free market, two pre-conditions should be fulfilled. These are – first, instead of depending on local and indigenous resources, health care must be technologically driven, and, second, the concept of "comprehensive primary health care" must give way to "selective primary health care". Following the atomic explosion and technology used for this purpose, very advanced and high-efficiency technology like nuclear accelerator, CT scanner, MRI and others were already in possession of American giant companies. If these could be successfully applied in the realm of medicine and health and exported, there would come up the most assured area of profit, as expressed by Relman. Substituting the idea of "comprehensive primary health care" by the idea of "selective primary health care" would meet out this purpose. Elsewhere, Relman let us know that in the late 1970s US has been already in possession of more than half the scanners in the world. Moreover, as Relman commented policy should be taken "that would strengthen free market forces and allow for allocation by pricing."[ix]

A few caveats may be raised here. In 1982, Oscar Gish published his review paper "Selective Primry Health Care: Old Wine in New Bottles".[x] In his paper he critiqued Walh and Warren on two basic issues – (1) "the lack of analytical rigor" of the paper, and (2) "they slip over from 'health care' to 'health services', which differ especially if they are to be 'comprehensive'."[xi] In another research paper "selective PHC (SPHC) approach" was found to have been "favorably received by the World Bank and UNICEF, USAID and the Ford and Rockfeller Foundations. WHO, on the other hand, has warned against it."[xii] The paper stressed that development debate had shifted from a technocratic preoccupation with investment as the key to everything, to one which focused on the nature of poverty.[xiii]

Summarily, there is no easy going for SHPC which has been adopted and being implemented by most of the countries of the world to a great extent.

The Second Issue: "Clinical Health" Vs. "Public Health"

In an important article in *NEJM*, it has been asked "Are We Living in a Medical Eduction Bubble Market?"[xiv] The authors argued that in medicine, students buy their education from medical schools and residency programs (which pay wages that are lower than the value of the work that residents provide in return). This education is transformed into skills and credentials that are then sold to patients in the form of services. So long as it is believed that patients, or whoever purchases health care on their behalf, will keep paying more and more for physicians' services, students and trainees should be willing to pay more and more for the education that enables them to sell those services. Finally, they conclude, "That bubble will burst when potential students recognize that the costs of training aren't matched by later returns. Then the optometry bubble may burst, followed by the pharmacy and dentistry bubbles. At the extreme, we will march down the debt-to-income-ratio ladder, through psychiatrists to cardiologists to orthopedists . . . until no one is left but the MBAs."[xv]

Against the background of such an economic scenario, what could we expect from the bright medical graduates and post-graduates? One reflective essay asked. "What was the effect on us, as persons and as physicians, of the model of detachment that we saw around us in dealing with this profound human event?"[xvi] In their opinion "both the formal curriculum — what was overtly taught in the classroom and in structured settings on the wards — and the informal or "hidden" curriculum" prevent students becoming a healer. Rather, foremost is their tendency to avoid the sadness, hopelessness, and helplessness they had associated with dying persons is replaced by a sense of the approachability of the dying, an interest in the medical, psychosocial, and spiritual aspects of "the case," and a belief in the possibility of doing good work through such encounters. Unfortunately, "hidden curriculum" of contemporary medicine "especially the hurried, disease-centered, impersonal, high-throughout clinical years" still tends "to undermine the best intentions of students and faculty members and the best interests of patients and families."[xvii] In US, the presence of SHPC and insurance-based health economics lead researchers to a dissenting note, "We find it terribly and tragically inhumane that Mr. Davis and tens of thousands of other citizens of this wealthy country will die this year for lack of insurance."[xviii]

Public health, in sharp contrast to clinical or individual health, is an altogether different philosophical question. It demands introspection for cultural competence, respect for shared community bonding and values, religious proclivities and beliefs, gauging local resources and indigenous health patterns and, above all, an understanding of the person-community-interdependence-healer paradigm of health. Disease-centered learning and clinical detachment are almost irrelevant here and go contrary to the driving force of the spirit of public health.

Efficient public health programs, not the pursuit of any clinical health practice, may even be an abating factor in riot-affected areas. Roemer describes his own experience in the aftermath of serious outbreak of riot in Watts area of Los Angeles, Calfornia, in 1965, "I was appointed a public health consultant to the commission and, among other things, recommended the establishment of three or four community health centers for general ambulatory health care at "locations of greatest poverty" in the riot area."[xix] Moreover, over-dependence on conventional health practice and profit-oriented medical practice may be counterproductive in some aspects. Reviewing Cuban health system, a recent observation finds, "For a visitor from the United States, Cuba is disorienting…Cuban health care system also seems unreal. There are too many doctors. Everybody has a family physician. Everything is free, totally free — and not after prior approval or some copay. The whole system seems turned upside down. It is tightly organized, and the first priority is prevention. Although Cuba has limited economic resources, its health care system has solved some problems that ours has not yet managed to address."[xx]

The Third Question: *Bharat*-India Divide

A few years ago, one article in the the *Lancet* commented, "We live in an almost $100 trillion economy; therefore $2–3 billion committed as innovative, flexible, responsive, transparent, and accountable funds for comprehensive disease control should be considered a modest yet highly cost-effective mechanism for alleviating the poverty of people in the bottom billion."[xxi]

But in a recent article it is shown that "According to the latest figures in "India: Malnutrition Report", available at the World Bank's South Asia website, 48% of children in India under the age of five are stunted, 43% are underweight, and more than one in four infants are born with a low birth weight."[xxii] Further, rural children do much worse than urban children in stunting in West Bengal, but not in child wasting. This essentially implies that the long-term health of children is considerably *worse in rural areas compared to that in urban areas. Both stunting and wasting rates diminish as households become richer.* [Emphasis added]

In another research paper, it has been pointed out, "the proportion of sub-centers without electricity and running water facility was 28.5% and 27.8% respectively as on March 2010. The respective proportion for PHCs was 14.2% and 12.4%. The number of PHCs and CHCs not working as per the IPHS (Indian Public Health Standards) norms was 11.8% and 16.6%. This proportion is of the existing PHCs and CHCs and not that of the required strength, which means that de facto number of functioning PHCs and CHCs gets further reduced by 11.8% and 16.6%."[xxiii] The paper reports that the rural population in the country stood at 833 million as per the 2011 census. This implies that there were only 42,584 doctors (much less than the number of medical graduates passing each year) available through the peripheral health services to ensure the health of 833 million Indians living in the rural areas. This amounts to a doctor – patient ratio of 1: 19561.4 for the rural areas as compared to the overall doctor patient ratio for the country that stood at 1: 2000. According to the authors, 'New Economic Policies' (NEP), that has reigned supreme over the last two decades, increasingly legitimized healthcare as a source of profit rather than a welfare obligation of the State towards the people. It is not that private healthcare came into being with the initiation of these policies. Indeed, the preeminent healthcare institutions constituted of the publically funded government medical colleges in the country directly fed into the large pool of private healthcare practitioners rather than recruit or train them for managing the rural healthcare system of the country.[xxiv]

One study published in the *Lancet* observed, "71% of health spending is out of pocket, and, every year, such expenditure forces 4% of the population into poverty. On the whole, the absence of adequately trained health-care providers in public and private sectors is a major cause for concern."[xxv] The article contends that The number of health workers per 10 000 population in urban areas (42) is more than four times that in rural areas (11·8). The number of allopathic doctors per 10 000 people is more than three times larger in urban areas (13·3) than in rural areas (3·9), and for nurses and midwifes (15·9 in urban areas *vs* 4·1 in rural areas). The shortage of health workers in rural areas is because of both the disinclination of qualifi ed private providers to work there and the inability of the public sector to attract and adequately staff rural health facilities. Many health workers prefer to work in urban rather than rural locations because, in urban areas, they can earn a better income, can work more eff ectively (because of better access to, for example, equipment and facilities), have good living conditions, and have safe working and living environments, and because their children can have better education opportunities.

Moreover, many doctors, nurses, and technicians emigrate from India, which contributes to the country's shortage of health workers. Indian doctors constitute the largest number of foreign trained physicians in the USA (4·9% of physicians) and the UK (10·9% of physicians), the second largest in Australia (4·0% of physicians), and third largest in Canada (2·1% of physicians). Migration seems to be substantially higher for graduates from the best medical colleges. The results of a study at India's premier medical college between 1989 and 2000 showed that 54% of graduates left the country; most went to the USA. Little private sector oversight has

led to practices that are detrimental to the quality of care. Evidence suggests that doctors in the private sector prescribe more drugs than do those in the public sector. Registered medical practitioners prescribe more drugs and antibiotics than do qualifi ed physicians. Caesarean sections were done three times more often in private hospitals than in public hospitals. Furthermore, untrained physicians and nurses were practicing in private hospitals.[xxvi]

SUMMATION

Finally, the paper concludes, "The education and training of health workers, particularly doctors and nurses, need to be oriented towards the public health needs of the country, particularly those of underserved areas and populations. Health workers in India receive little training to work in underserved areas. Faculty development programmes for more relevant curricula and teaching–learning programmes are therefore important. Continued education, accredibility, and regulation are urgently needed to improve provider quality. This calls for improved governance and draws attention to the failure of regulatory organisations such as the professional medical and nursing councils to implement such measures. Political will is needed to implement necessary legislations because opposition from organised and powerful professional groups (such as medical, nursing, and other professional councils) exists."[xxvii]

I also belong to the same opinion.

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