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Choose Primary Health Care: An address to young medical students and doctors

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I was invited to speak to medical students of Mahatma Gandhi Institute of Medical Sciences, located in Wardha, part of the Reorientation of Medical Education program.

I spoke on choosing primary healthcare as a career and life choice. I was overjoyed at the interest, understanding and deep concern for India's inequitable healthcare system among the students. If physicians are indeed "attorneys of the poor", I saw many attorneys in that room. That filled me with an unbearable hope.

Here is an excerpt of my address.

Hello dear students and friends,

I am so happy to be speaking to you today. Besides the joy of speaking to young students of a medical college that promotes a culture of service among its medical students, I have another important reason to be happy.

My own desire to get in Wardha Medical College

Thirty-six years ago, I was preparing to get admission to a medical college. And since MGIMS had its own medical entrance exam, I was preparing for it separately. One of the paper that you needed to clear for getting admission in MGIMS was Gandhian Thoughts. I read through Gandhi's autobiography and decided this is where I really want to study medicine. In the exams, I did well in Gandhian thoughts, but flunked in Biology! My dreams for studying in MGIMS shattered – I did study medicine though. I am therefore happy that I am speaking to students of the medical college, where I dreamt of studying, but failed to get admission!

Working in Delhi, exposure to misery and illness, and magic of modern medicine

Subsequently, I studied and worked at government hospitals in Delhi during my MBBS and MD, where I was getting exposed to realities of harsh lives that so many people lived. When they came to the hospital, they would be in tatters, no money in their pockets and no food in their bellies. Children would die of neonatal tetanus and measles.

However, I also learnt the beauty and magic of modern medicine: we could still snatch the kids out of jaws of deaths. Antimalarials would be magical, so would the correct treatment of Nephrotic Syndrome.

Udaipur, exposure to rural areas and advice

After my MD, I got an opportunity to live and work in Udaipur, at RNT Medical College, as a faculty in Paediatrics. At Udaipur, for the first time, I saw a real village, and understood how rural administration and health systems work.

However, I was still seeing much deaths, much misery among children and their families who would come to the hospital. While some would be treated, many others, I would realize would still fall ill again, return to the hospital again, as they had nothing to eat or no one to care.

Frustrated, I went to my mentor professor MK Bhan, one of the most beloved paediatricians and public health researchers that country has produced. He listened to me and then said “first get trained in public health, then we will speak”. I did take it seriously and took a year off to pursue MPH. It opened up new world for me, new skills, new perspectives.

UNICEF and exposure to realities of healthcare in remotest areas

During my stint at UNICEF in Rajasthan and Delhi – I was heading the child health and health systems work of UNICEF India Country Office, I would visit the remotest areas of India, where I found that our health services do not reach. No one reaches.

> A large population, tribals, dalits etc are left to fend for themselves. They do not have the money and means to seek healthcare, and when they do, high costs and indifferent, almost hostile behaviour they receive make them poorer.

That rankled me. Whatever we did at national or state level does not reach these populations. I realized that there are no easy answers, and solutions would lie in actually jumping in the field and finding answers.

Dilemma: Clinical care and public health

When I was a clinician I was happy that I could save lives: I was able to save lives of many children due to severe malaria, diarrhea, newborn sepsis, tuberculosis,

nephrotic syndrome. However, I was frustrated by the fact that many diseases I saw in children had social origins. When I saw child die of measles, I would think why did she not receive a simple inexpensive vaccine? That drove me towards public health. I wanted that I should spend my time and energy not in treating one child at a time, but should be able to improve health of the communities. It was a management problem to be fixed.

When I studied and researched public health, I was happy that I was able to influence health of the populations: when I led the health programs of UNICEF in Rajasthan, with some effective planning and execution, childhood immunization coverage in the state increased from 24% to 48% in four years-time. I presume that would have led to saving lives of thousands of children.

Social and political milieu affects health

However, I realized that why some people are healthy and some are not does not depend on new new drugs or new vaccines or because we did not know how to manage programs. It depends on social and economic inequities. No one cares for the poor populations, I learnt. For example, I found out from a research that a simple health service such as immunization is provided far from where poor people live, making it difficult for them to access. If it was an equitable world, health services would be closer to those who need it the most.

I also found that when people from under-privileged castes would reach a health facility, they would be treated poorly, shabbily. When we took over a Primary Health Center from government, people from so called higher castes would barge in the OPD, as if it was their entitlement to be seen before everyone else. Those from under-privileged families would keep waiting, as if this was their destiny. If after five years of running this PHC, there is one thing I am proud of, it is that we have changed that. It is first come, first serve. NO privileges, no preferences.

Anyway, that led me to pursuit of origin of these inequities. I understood how the cutting of jungles for economic gains and centuries of exploitation by privileged castes have led to food insecurity, and scarcity of water in the tribal areas, leading to rampant malnutrition and disease. It is not because people did not know what to eat: if they did not, civilization would not have survived for thousands of years. Such an understanding led me to explore social sciences and economy and politics.

All these perspectives: clinical, public health and socio-political were correct, when looked in isolation. Modern medicine could treat people and alleviate their suffering; effective public health programs could save thousands of lives, and addressing the social and political arrangements would correct historical inequities.

Primary healthcare is one discipline where public health, clinical care

and social development merges beautifully.

Where does one begin then? Primary healthcare seemed to me to be the best fit.

We set up AMRIT Clinics in remote, rural and tribal areas of South Rajasthan. They provide preventive, promotive and curative care. We conduct relevant research and we advocate for more responsive health systems for the poor.

Primary healthcare is healthcare of the people, for the people and by the people. It is no coincidence that democracy has the same definition, replace healthcare by government.

Primary healthcare system provides preventive, promotive, curative and rehabilitative care. It uses evidence based care. It does not fragment a patient into different systems but looks at a person as a while, in context of his or her family and community. It tries to understand and address social (and political) determinants of health.

Here I seemed to have found a path; that integrates clinical medicine, public health and social development.

Primary Clinical care is exciting because it **looks at the patient as a whole** and does not fragment him or her into different systems. For example, a person with TB has malnutrition. Family would have needs for food, and maybe a single woman who needs connect with the pension.

It is **evidence based** so you need to keep reviewing scientific evidence: for example, few years ago, there was a conclusive evidence that Tranexamic acid helps in managing PPH. Or that community KMC helps in reducing deaths among LBWs.

It requires **clinical courage**, how else would you deliver a primi with breech with five grams haemoglobin with no place to refer to? It requires a deep understanding of communities and their customs, otherwise how would you manage a situation where the customs do not allow you to conduct a childbirth, which is considered to be polluting in front of a temple?

It requires **understanding and engaging communities** in their own health, and development.

It requires **understanding of public health** to prevent and manage malaria epidemic in your community. It requires **understanding and addressing social determinants**: to promote food security for example.

And finally, it **requires addressing political determinants** and raise your voice, using your credibility and grounded understanding, to raise voice against social injustice. Why don’t health centers function in areas where marginalized people live?

Myths associated with primary healthcare

There are several myths associated with primary healthcare.

Firstly, that primary healthcare means **managing a few priority or simple illnesses**. It is farthest from truth. In primary health care clinics that we run, nurses and young physicians treat anything from diarrhea, severe malaria, diabetic ketoacidosis, rheumatoid arthritis to delivering a primi with breech.

Second, and a related myth is that providing primary healthcare **requires much less skills than a specialist** or a super-specialist (the term super-specialist is used only in India- everywhere else it is called sub-specialist!). An absolute lie. You require knowledge and skills of different kinds, and have to be ingenious as you have to really apply all your knowledge and skills. Also a range of social skills, since you are embedded in the community. And management skills.

Another one, (I find new lies peddled from time to time), that **primary healthcare is less effective than specialised care**. Several studies have confirmed that counties with strongly evolved primary healthcare systems have much better health outcomes (at a lower cost), than those which have strong primary healthcare systems.

Specialising in primary healthcare

You are an inferior doctor if you are not a "specialist" of some kind. You can of course "specialise" in community medicine, public health or family medicine. And spend months and years in practicing primary healthcare in different settings. A travel fellowship convened by Tribal Health Initiative offers that opportunity.

My own journey and joy

I have enjoyed every moment of my journey in primary healthcare in rural areas for last ten years –a proof I have spent ten straight years without looking back. I had never spent more than five years in one job before that!

I have grown as a person because I got enormous opportunities to love and be loved, by the patients, by community members and colleagues. Every day, I am moved, and challenged to do more. I have honed up my clinical skills, have built some lovely networks, and have conducted some relevant research.

Our organization has hosted some wonderful young people, with wonder in their eyes in fire in their bellies. Some have stayed back and others have moved on to do more work in more areas that need it. And we travel to work among beautiful jungles, ponds, waterfalls and sunsets.

> With my own experience I can say that primary healthcare is a wonderful, joyous, glamorous and wholesome option for young medical graduates like yourselves. A path to grow, soar and serve.

Lots of luck and blessings for your future!