

Role of Family Medicine Education in India's Step Toward Universal Health Coverage

Sajitha M.F. Rahman, Ruby P. Angeline¹, Kirubah V. David, Prince Christopher

Departments of Family Medicine and ¹Community Medicine, Christian Medical College, Vellore, Tamil Nadu, India

ABSTRACT

India's commitment to universal health coverage has grown stronger with the submission of High Level Expert Group report by the Planning Commission in 2012. With this report comes the commitment to increase the primary health-care workforce to meet the population needs. However, the focus should not be just to increase the number of health workers, but to produce better health workers. Doctors, nurses and community health workers trained in primary and secondary health-care facilities can make a significant contribution in responding to the needs of the local community. The role of family medicine education is worth exploring in this context to equip the primary care health workers with the competencies of providing person-centered, comprehensive and continuous care.

Keywords: Family medicine, family physician, universal health coverage

Introduction

In 2005, World Health Organization (WHO) defined universal coverage of health services as securing access for all to appropriate promotive, preventive, curative and rehabilitative services at an affordable cost.^[1] This WHO resolution incorporates the extent of population coverage and the extent of health services, complementing financial protection. The level of public spending, the extent of population covered and the range of health services provided varies between low and middle income countries.

According to WHO 2012 report, India has the highest maternal mortality rate (212/100,000 live births) and infant mortality rate (47/1000 live births) among the Brazil, Russia, India and China (BRICS) countries.^[2] In addition to this the rapid rise in noncommunicable diseases account for two-thirds of the total morbidity pattern and 53% of total deaths. This is coupled with the widely prevalent communicable diseases as well. The WHO country cooperation strategy is to equip primary health-care facilities and hospitals to deliver the services towards universal health coverage (UHC).

High Level Expert Group 2011

In keeping with the WHO recommendation, High Level Expert Group submitted its report on UHC for Indian citizens in 2011.^[3] Among the six critical areas to be addressed in fulfilling the vision of UHC, improving the availability of human resources in delivering primary care is well-emphasized. The report aims to increase the availability of trained primary care health workers (doctors, nurses, and mid-wives) to achieve WHO norms of at least 23 health workers/10,000 populations. However, the concept of a family physician for every Indian Family to provide health-care from cradle to grave and beyond for families has not been envisaged. This reflects the current Indian health scenario that has not witnessed established family medicine services. The principles of family medicine include first-contact primary care and beyond.^[4]

Primary Care Work Force in India

India is a signatory to the Alma Ata declaration 1978. Subsequently in 1983, National Health Policy was constituted to establish comprehensive primary health care. Evidence thus far tells that it is a selective primary health care approach towards the marginalized.^[5] An effective, efficient, sustainable health system is not in place for delivery of integrated health services. Various steps are in progress to improve manpower

Address for correspondence: Dr. Sajitha M. F. Rahman, Department of Family Medicine, Low Cost Effective Care Unit, Arni Road, Vellore - 632 001, Tamil Nadu, India.
E-mail: sahuja100@hotmail.com

Access this article online

Quick Response Code:



Website:
www.jfmpc.com

DOI:
10.4103/2249-4863.141594

at primary health centers (PHCs) like the training for rural health practitioners and compulsory rural service for medical graduates after medical school. Simultaneously, distance learning certification in managing common problems has become mandatory in many states to improve the clinical skills of medical practitioners in government service. It is not enough to increase manpower at PHCs and community health centers (CHCs), but it is very important to equip them with skills necessary to meet the common health care needs of the community served. The above steps are stop-gap solutions and unlikely to generate competent generalist physicians who can provide first-contact comprehensive care. Family medicine graduates as trainers and clinicians in CHCs and PHCs are a better option as proved internationally.

Vision 2015

The visionary "Vision 2015" document by Medical Council of India (MCI) states the role of the MBBS graduate as physicians of first-contact in the primary care setting for the community.^[6] One of the steps suggested to fulfill this objective is to ensure significant clinical exposure at the primary and secondary level with compulsory family medicine training. MCI plans to accomplish this by linking to the local district and taluk hospitals along with primary and CHC for training in the community. The challenge here is the existing health system has failed to include the doctors in the PHCs/CHCs/district and taluk hospitals under the teaching umbrella of medical education. In addition, the intended outcome of introducing family medicine training in under-graduate curriculum is to generate multi-competent physicians. However, continuity of care, doctor-patient relationship and exploring patient symptoms in its earliest stage or in the familial or societal context is not part of the current curricular goals. Keeping away from core family medicine principles will translate to poor understanding of the generalist approach among MBBS graduates.

Medical Council of India also has increased the number of under-graduate and post-graduate seats to meet the needs of the country. However, the continuing trend toward specialization among medical graduates coupled with the health system that favors delivery of fragmented care has generated varying results. The cost and care of common medical problems are out-of reach for the common man. The end point is the lack of a high-quality generalist who has a holistic approach and can provide a basket of services for the management of common illnesses that accounts for 80% of disease burden

MBBS Graduates as Family Physicians

Our health system has witnessed the reality of MBBS graduates serving as "Family Physicians" forever. This existing set-up in our health system is not ready to accept distinct family medicine training in under-graduate course or further specialization in this specialty. Ambulatory services for episodic illnesses in the community remain the most common platform for providing

patient care by the self-trained family physicians for ages. However, the predominant focus of under-graduate medical education continues in the teaching hospitals. This has been reported in the white ecology of medical care published in 1961.^[7] It was found that less than one person in a population of 1000 was seen in the academic teaching hospital in an average month. Many deficiencies are identified in the overall medical professional education by the global independent commission. Among them are a mis-match of competencies to patient and population needs, minimal contextual understanding, episodic encounters and predominant hospital orientation at the expense of primary care. This has been attributed to fragmented and static medical education curriculum.^[8] Hence, family physicians as a sub-set who see the whole range of diseases from the mildest to the most severe, follow illness from its earliest symptoms to its latest stages and observe patients in their natural habitat are yet to be widely available and acknowledged in India.^[9]

Role of Postgraduate Training in Family Medicine

With MBBS graduates not adequately prepared for the generalist role in the primary and secondary care settings, further training in the specialty of family medicine is vital to generate the cadre of generalist physicians. It is not clear among the Indian medical fraternity that putting together a sum of training in adult medicine, pediatrics, obstetrics, and surgery will not generate competent family physicians.^[10] This poor understanding has often questioned the validity of three additional years of vocational training in family medicine. However, the whole is different from the sum of its parts. Family medicine is a unique blend of clinical skills, behavioral sciences and communication skills that is grounded in doctor-patient relationship. Family physicians' holistic approach to a broad set of symptoms is not defined by age, sex, organ or disease and values patients' perspective. Family physicians do not separate the disease from the person and the person from his environment. They have been at the forefront of primary and secondary care services in many parts of the world.

Family medicine has a long and rich history, as the earlier physicians were all generalists who provided holistic care, knew their patients over time and their diagnosis deepened by the knowledge of social and environmental determinants of ill-health. Countries with a strong primary care infrastructure managed by family physicians have better health outcomes at low cost and have significant better patient satisfaction.^[11] In BRICS countries like South Africa and Brazil, family medicine graduates are a very viable source in private and public health sector. The success of Brazil's family health program in providing comprehensive primary care services is pinned down to multi-disciplinary teams in the community headed by the generalist.^[12] Similarly, in South Africa the development of family medicine training has contributed to the strengthening of district health services and primary health-care.^[13]

Role of Family Physicians in Universal Health Coverage

India's commitment to UHC depends on policy makers, researchers, policy analysts, economists and undoubtedly on health-care delivery systems. Literature has shown that beyond clinical workforce nonclinical capacities of policy formulation and implementation are needed to respond to actual population needs.^[14] As mentioned earlier India, is currently facing the double burden of disease caused by changing life-style and the already existing communicable diseases largely attributed to social determinants of health. Episodic care of various ailments does not fit the type of model needed to combat chronic diseases. The need of the hour is a clinician to provide comprehensive patient-centered care to prevent and manage the chronic conditions, treat acute conditions, provide age-specific preventive care and health promotion and be responsible to guide the patient through the health system from first-contact to end-of life. This perspective has to be taught in medical colleges, assessed in exams, recognized and built as a specialty.

Role of Family Medicine Nurse Practitioners

The traditional role of a nurse in Indian system is that of a village health nurse and auxiliary nurse midwife. Health system and hospitals have not explored the possibility of nurses as an integral part of multi-disciplinary teams in delivering out-patient care in primary and secondary level setting. In other BRICS countries like South Africa and Brazil, nurses are the first-contact and back bone of primary care in the health system.^[12,13] Further skills training for nurses in the routine management of a breadth of common conditions and authorizing them for drug prescription under supervision is needed. This can particularly help in the management of noncommunicable diseases where reinforcement of behavioral changes at every visit is time-consuming.

Conclusion

India is heading toward UHC with "health for all." Addressing health work force constraints to provide better primary and secondary level care needs policy focus and funding over a long period. Family medicine training at the under-graduate level, certification for those practicing primary care and postgraduate specialization in this discipline is one of the essential steps to reach that goal. However, the step toward teaching "the family medicine attitude" to medical students should be preceded by training the trainers. Faculty development, curricular content and goals, location of training and the type of assessment are the foremost challenges in this new beginning. With currently two medical institutions hosting academic departments in family medicine, the goal of establishing similar departments across

the country needs significant commitment and enthusiasm from all stake holders - policy makers, family physicians, and the rest of the medical fraternity.

References

1. Sustainable health financing, universal coverage and social health insurance. Vol. 58. World Health Assembly; 2005. p. 139-40.
2. WHO. Country cooperation strategy, India; 2011-2012. Available from: http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_ind_en.pdf. [Last accessed on 2014 May 15]
3. High Level Expert Group Report on Universal Health Coverage for India; Planning Commission of India; 2011. Available from: http://www.planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf. [Last accessed on 2014 May 15]
4. McWhinney IR, Freeman T. Text Book of Family Medicine. 2nd ed. Oxford University Press (NY) 1997. p. 13-5.
5. Report of the National Commission on Macroeconomics and Health; Ministry of Health and Family Welfare; Government of India; 2005. Available from: <http://www.who.int/macrohealth/action/Report%20of%20the%20National%20Commission.pdf>. (Last accessed on 2014 May 15)
6. Vision 2015; Medical Council of India; 2011. Available from: http://www.mciindia.org/tools/announcement/MCI_booklet.pdf. [Last accessed on 2014 May 15]
7. Green LA, Fryer GE Jr, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. *N Engl J Med* 2001;344:2021-5.
8. Education of Health Professionals for the 21st Century: A Global Independent Commission; 2010. Available from: http://www.u21health.org/sites/u21health.org/files/Julio_Frenk.pdf. [Last accessed on 2014 May 15]
9. McWhinney IR. Family medicine as a science. *J Fam Pract* 1978;7:53-8.
10. MacWhinney IR. Family medicine in perspective. *N Engl J Med* 1975;293:176-81.
11. Starfield B. Global health, equity, and primary care. *J Am Board Fam Med* 2007;20:511-3.
12. Harris M, Haines A. Brazil's Family Health Programme. *BMJ* 2010;341:c4945.
13. Mash R, Downing R, Moosa S, De Maeseneer J. Exploring the key principles of family medicine in sub-Saharan Africa: international Delphi consensus process. *SA Fam Pract* 2008;50:60-5.
14. Tangcharoensathien V, Evans DB. Beyond clinical skills: Key capacities needed for universal health coverage. *Bull World Health Organ* 2013;91:801-801A.

How to cite this article: Rahman SM, Angeline RP, David KV, Christopher P. Role of family medicine education in India's step toward universal health coverage. *J Fam Med Primary Care* 2014;3:180-2.

Source of Support: Nil. **Conflict of Interest:** None declared.