Medical education must be reoriented towards equipping doctors for primary and secondary services. Only this can help India achieve universal health care.

The increasing visibility of the concept of Universal Health Coverage (UHC) in the public discourse on entitlements augurs well for the country. One auspicious sign was the appointment of a High Level Expert Group (HLEG) on UHC, headed by the highly regarded Dr. Srinath Reddy, by the Planning Commission. In a recent article (The Hindu, April 14), Dr. Reddy, along with another member of the HLEG, summarised its recommendations for achieving UHC. The ambitious goal is to deliver an assured “essential health package” to all citizens of our far-flung and populous nation. But our starting point is near the bottom among nations: 112th in the quality of health care and 145th in per capita health expenditure. Thus, UHC seems a much needed but overambitious goal for us.
India leads

However, there is one health-related resource in which India leads the world, namely the number of medical colleges. We have over 330 of them and the number is set to increase to at least 400; by then the annual output of medical graduates will exceed 50,000. This article argues that prioritisation of primary and secondary level health care is basic to UHC. And a reorientation of medical education to that end can mediate this transformation speedily and durably.

Ninety per cent of all health care needs in any community can be delivered through primary and secondary level facilities. These include Primary and Community Health Centres, taluk and district level hospitals and their equivalents in the private sector. We will refer to them as subtertiary care i.e., clinical services below the level of teaching and corporate hospitals and other speciality oriented centres. The major causes of mortality and morbidity can be identified and treated effectively in their early stages at the subtertiary level, at affordable cost and within easy reach. Also, through vigorous promotion of health education and public health measures, the subtertiary centres can reduce the incidence of these conditions.

But without such care, these diseases proliferate and reach catastrophic levels both in numbers and intensity. They then overload the scarce resources at the tertiary level, draining the finances of families and the state, and often with little prospect of relief or cure in the late stages. Thus provision of competent subtertiary health care is the foundation for UHC and without it, a superstructure of "world-class" tertiary centres is of no avail. A comparison of the U.S. and Cuba will readily demonstrate this.

Just as headmasters play a pivotal role in school education, the availability and competence of physicians are basic to the success of subtertiary care. Ensure the availability of “capable” physicians in adequate numbers at this level and half the battle is won. But this capability is no less demanding than any other branch of medicine. First of all, the physician needs to win the confidence and trust of the community by offering dependable medical care, covering most of the common health care situations within limited facilities. In addition, he has to provide leadership for a variety of health-related activities, mediated by a large team of diverse non-medicals, not all of them adequately equipped and motivated for their tasks. The physician’s performance as the conductor of this complex health care orchestra depends on how well the medical colleges prepare him for this role and also on societal recognition and rewards. In India, the academic discipline (or medical subject) that deals with subtertiary care is known as Family Medicine. Sadly, this discipline finds no mention in our MBBS curriculum. Naturally the emerging physician is ill-equipped for his role in subtertiary care. Nor does he find an informed public appreciation of this role.

Formative influence

Physicians are “formed” by medical colleges as much as priests by seminaries or army officers by defence academies.
The imprint of the priorities and practices of the teaching institution stays with them for life. At present, these emphasise speciality care. And that formative influence shapes not only the careers of physicians but ultimately the public perceptions of health care at large. For, it is the medical community which modulates society's perception of what good health care is. Thus if medical education is reoriented to prioritise subtertiary care, that shift in the fulcrum will eventually move the mountain of UHC through modulation of both professional and public perceptions. Increasing the number of medical colleges, inevitably in the urban centres, will by itself be of little avail for UHC till we agree that all colleges, old and new, should teach a kind of medicine which prioritises subtertiary care.

If we agree on this priority, we will have the means to bring it about. Over the last 80 years, the Medical Council of India has so consolidated its hold over medical education that we now have a very effective regulatory mechanism though there have been grievous lapses in its operation. Thus it will be possible for the Medical Council in the course of 10 years or less to bring about the changes in medical manpower that will sustain UHC in the years to come. Four essential and sufficient steps are outlined below.

**Family medicine**

All medical colleges must be required to have a Department of Family Medicine (FM) with a decisive role in undergraduate education and the potential, eventually, to offer postgraduate training in FM. In addition to the present teaching hospitals, all medical colleges must have attached primary and secondary health care facilities (in the private or public sector) whose clinical services they will help to strengthen and where students can effectively engage with subtertiary care under the supervision of the FM faculty. Speedy development of the initial faculty for FM departments is crucial. A crash programme will be required to produce the founding generation of postgraduates in FM. One option is to establish schools/institutes of FM in some 15 selected medical colleges, each capable of training about 15 faculty level family physicians every year. Some of these colleges could also be permitted to offer a combined MBBS-MD (FM) seven-year course, into which a significant proportion of undergraduates could be directly channelled.

For the transitional period, selected senior faculty from the general medical specialities (General Medicine and Surgery, etc.) could double as the transitional faculty in FM after suitable reorientation. When these steps are fully implemented, post-graduation in FM will become a challenging avenue for medical graduates across the country and it will have an adequate corps of well trained family physicians who, along with the new graduates trained by them, can take the subtertiary services to their full potential.

How can we bell this cat?

**Expand objective**

What is suggested is in effect a significant expansion of the objective of medical education and of the mandate of the
bodies which regulate it. From its inception in 1933, the MCI's educational function has been restricted to ensuring the “standard” of professional education. There was no attendant societal commitment except monitoring professional conduct. And this pattern has been followed by the other health-related Councils. Left to themselves, such bodies are hardly likely to initiate or implement the suggested transformation.

If such changes are really to come about and endure, the regulatory body must be directed by its enabling Act, “to ensure that education in the health professions will promote universal health coverage in the nation.”

By a curious turn of events, the entire regulatory structure for the health professions in India is being restructured. In the new structure, human resource for health must be seen not only in terms of numbers and professional standards but also as the agent for ensuring equity in health care. The Bill on the National Commission for Human Resources for Health is still on the anvil. Now is the time for socially conscious health professionals, civil society and the political leadership to work together with clarity of purpose and the required haste so that a commitment to UHC is embedded in the very mould which fashions health professions.

(\textit{The author was formerly on the faculty of Christian Medical College, Vellore. His email: p\_zachariah@hotmail.com})

Keywords: \texttt{medical education, Universal Health Coverage, health care sector}