

8th HM Patel Memorial Lecture

Practising Medicine in an Unequal World

by

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Charutar Arogya Mandal

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Practicing Medicine in an Unequal World

I really feel privileged to be called to speak here in this prestigious institution.

My point of reference is that of a doctor who studied and did well in a good medical college of the country. I was someone interested in academic medicine and also interested in the whys and the hows of ill health. And thus when the opportunity came to work in rural India, I decided to move ahead and practice primary health care in the literal meaning of the phrase. Though I have continued to live a middle class life, my focus has shifted to the basic health problems of my country. In this process, I have constantly been learning about life and have continued to work with all the trials and tribulations of rural India.

At Jan Swasthya Sahyog, the group that I developed along with my friends, with service as our main objective, we also make new observations and learn about rural health care. We have this wonderful opportunity to see the society through the window of ill health and are able to make some analyses, identify basic problems and work out solutions.

When I was contemplating moving from Delhi to Chhattisgarh, my mother asked what was a genuine question to her- what will you do there? *Paddhey phaaarsi bechey tel*. I also thought then about the social debt repayment logic, and yet felt sufficiently, sacrificially great. Within a few years that aura disappeared, when one realized how people who live off the

land live, and how people live in a really unequal, or more correctly - an unjust world.

I am honoured to be here to share my perspective that I have developed from an experiential base. I wish to share the pleasures of working with the disadvantaged for over a dozen years of working and thus exhort you to take sides of the people. There is nothing new in this for you, as this is something which the founding father of this institution had mandated to be the underpinning of everything that goes under the umbrella of *Charutar Arogya Mandal*. More specifically, I wish to address those among you who are younger - in age or at heart to really share the worries and hopes - for I believe that it is far more difficult to be young and to take unusual life courses now than it was 20 years ago, but I am sure you all can do it.

I am a believer in Equity- Virchow, and the Gandhian talisman about getting a smile on the face of the poorest person as a measure of the effectiveness of one's work.

In today's talk, I would like to present first what we have done in rural Bilaspur. I will like to explore health care in this country through the lens of equity, and then finally present ideas of possible involvement of each of you in health care in this unequal world of ours.

B. What we do.

At JSS, which is an acronym for Jan Swasthya Sahyog, we began serving by first relocating to rural Bilaspur and then trying to understand the whys and hows of ill health. Bilaspur

lies in the middle of the marginalized area in Chhattisgarh, flanked,as you can see, by western Orissa, eastern Madhya Pradesh, northern AP and Jharkhand. Here with the primary idea of working in primary health care we tried to develop a community health program that has a referral centre at Ganiyari, 20 kilometers from Bilaspur town, 3 sub-centres in forest fringe or forest villages about 40 to 60 km away, and a village-health-worker-based intensive programme in 60 villages. The centre houses the Ward, OPD, laboratory, pharmacy, imaging, operation theatres, training centre and a Health Related Appropriate Technology Development Centre.

Here people from over 2000 villages with an estimated population of over 10 lacs drawn from eight districts of Chhattisgarh and Eastern Madhya Pradesh access it for their major health problems. Majority of the people are adivasis or Dalits who come from these forest fringe or forest villages where income, poverty, food shortage and inaccessibility of health care determine their health. Median Weights in men and women are 50 and 43 kilograms respectively. The median BMIs are 19 and 18.4 respectively for men and women as stark evidence of the prevalent chronic hunger in adults too.

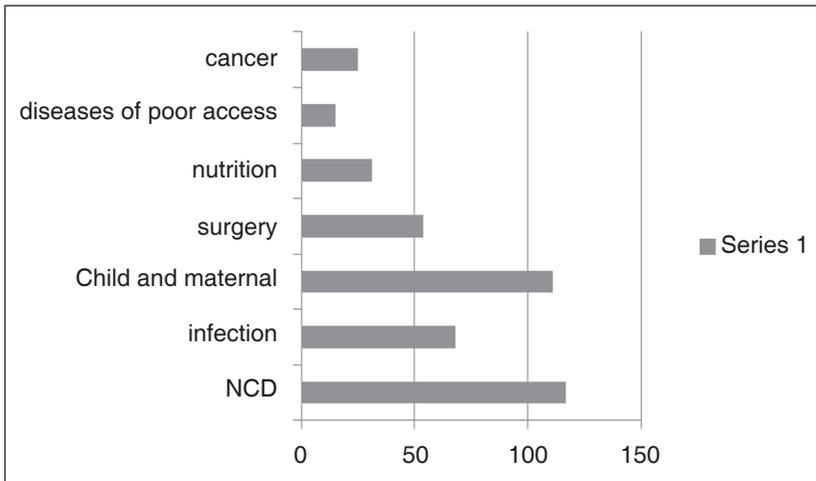
Approximately 270 to 300 people attend each OPD after waiting for an average of 4 days to get into the queue, another 25 emergencies are also seen every day. Each day is a veritable mix of complex problems spanning the spectrum from diverse communicable diseases to nutrition related problems, to non communicable diseases of all types, to diseases which could be called as resulting from poor and delayed access to health

care. Under-nutrition underpins all these conditions making us question several myths that abound about health status and burden of problems of rural poor. The astonishing numbers and complexity of these illnesses helped us explode this huge myth- that People in small places have small problems. In fact, what was very striking was that people living in deprivation don't have small problems and thus require significantly higher technical expertise and competence than you would require in an urban setting. Clinical and field level problems have challenged us constantly, keeping us on our toes all the time.

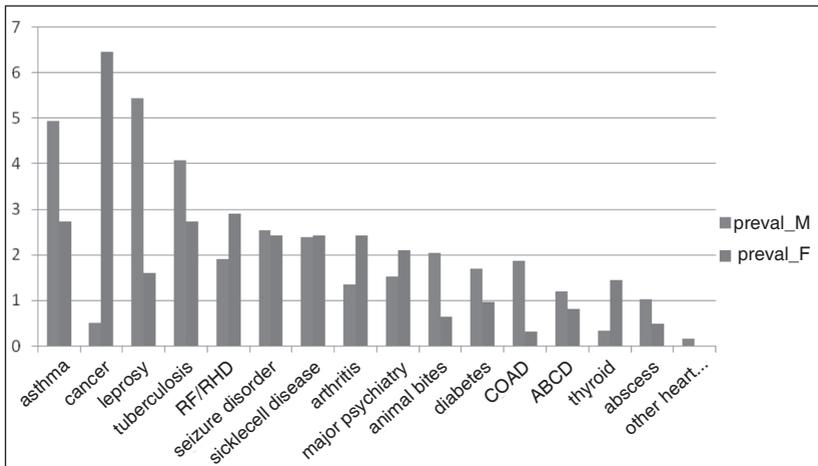
A perusal of the data from our clinics and the community programme show not only higher numbers but also high Prevalence of many chronic illnesses and incidence of acute illnesses. In the year 2011, the total number of selected illnesses that we saw were as follows (see table 1).

Illness	New Patients
Tuberculosis	587
Leprosy	132
Hypertension	478
Rheumatic heart diseases	89
Cancers	400
Surgery requiring illnesses	1473
Sickle cell disease	99
diabetes, mainly thin diabetes	258

Problems of all types abound. While maternal and childhood illnesses are naturally common, so are communicable diseases, and also we see a huge number of surgery requiring problems. Surgery has been the step child of public health!



While these are the data from clinic, the following figure shows the prevalence of selected illnesses in the community programme in the year 2011.



(all figures are in percent prevalence)

While the OPD and the in-patient care are the more obvious sites of health care, we learnt about the specific role that the laboratory plays in public health in reducing cost of health care, and in rationalizing care. And how much it helps in understanding clinic and field based problems. While we could confirm the role of the lab in the referral centre we could explore the role of the lab going to the people rather than they coming to it! Our slide courier system to ensure the availability of reports on malaria blood smears in less than 24 hours in the remotest villages is testimony to that. If Mohammed does not come to the mountain, then the mountain can go to Mohammed!

We have tried to develop an appropriate technology in health to answer specific questions in health care. As an example, it is the need of all communities to know whether the water they are drinking is potable or not, and if it is not potable, then what are the various ways in which such water could be conveniently disinfected using a cafeteria approach. We thus popularized a simple technique, hitherto developed, and made it possible for communities to find out about the potability of water at their hamlet level using a H₂S paper strip test and if contaminated, disinfect it using a Ultraviolet light based water disinfection apparatus. We have similarly developed certain technologies for the use of the village level health worker such as a breath counter for easy diagnosis of pneumonia in children and a 2 headed teaching stethoscope. We have also documented the superiority and cost effectiveness of using glass syringes in a busy health facility.

The overarching role of cheap and effective drugs for all

important illnesses came out very clearly for us. We could cut down health expenses that people spend largely by using quality generics, and by avoiding rampant commercialization of health. Simple documentation allowed us to learn about the risk of impoverishment that deregulated price regime would result in for already poor people. This led us to file litigation against the proposed Price deregulation part of the pharmaceutical Policy 2002, which was stayed subsequently. This would not have been possible had we not tried to develop a rational pharmacy.

For us, primary health care is not second rate medicine for the have nots. On grounds of equity, it is the entire spectrum of health care for all common and important illnesses that the people suffer from using the strategy of community participation and developing appropriate technology.

Due to certain measures like a single day consultation plan and rational therapy, the median direct expense incurred by people on care for chronic and acute illnesses for one month's treatment was Rs 91 in 2009 and Rs 54 in 2004. However we found that too was impoverishing the people. If rationality and cost cutting that we could put in place still did it, then how can curative care be possible for the poor without a welfare state? We could show thus that privatization is not the answer for health care in an unequal world. All forms of privatization, whether direct, or through private-public partnership or allowing private practice by public functionaries is, in our opinion, inimical to the interest of the dispossessed.

While cost and quality are of primary importance in provision of primary health care, it is lack of access which is a major stumbling block in large parts of our country. And then transport also costs money. The three poor states of Chhattisgarh, Madhya Pradesh and Jharkhand have disbanded their public transport systems on grounds of cost effectiveness and have gone in for private licensing of buses. While calculating for effectiveness they did not account for health benefits. As a result, most rural areas in these states have poor and completely unaccountable public transport systems and thus public transport for health is very expensive. In our study, transportation for illnesses results in almost 25 % of the total expenses people incur. Even now the only form of transport for health in people's imagination is an *ambulance*. Realizing the health impact of public transport, we started running a bus that started from the remotest village in the forest towards our centre in the morning to return back in the evening to people's homes. While in our own small area it was a runaway success, we have not succeeded in shaming the state into restarting a public transport system once again.

In our community programme, we chose village women to become health workers in their villages. Since our experience showed that literacy levels are class related, we chose not to have a minimum level of literacy as a selection criterion since that would have excluded many deserving and more socially appropriate yet less educated women from becoming health workers. We chose to rather change the pedagogy to more pictorial or doing by hand techniques. We also realized that one can train village health workers in far

more knowledge and technical skills than it is conventionally done. The Mitanin programme in Chhattisgarh, which later was to become a herald programme for the national ASHA programme borrowed much from our small programme.

While we realized that it is absolutely essential that there be a village level functionary if people have to have primary health care, there are limits to their abilities. The gap between the absentee doctor and them, presently filled up by the informal practitioners, variably called a quack or jhola chhaap doctor needs a more specific solution. We thus started training senior health workers at this middle level, as also Auxiliary nurse midwives. We train the informal practitioners in rational and effective care. We have also supported the development of the three year doctor course.

Perhaps one of the biggest things that we have learnt and to which I wish to draw your attention here-- is in our realization about what **public health** actually means and how it is different from an **individual person's health**.

We feel that Public Health is not fundamentally different from clinical medicine. For us, it is a continuum extending from that of an individual to a *community* of individuals. Thus the ethics and other yardsticks should be similar for both. We have grown up seeing the divide between clinical medicine and public health in our medical training, seen the arrogance of the clinicians and sometimes the reverse arrogance of the public health experts too, each one insecure about their turf, and at the same time deriding the other.

We feel that the tools for each may be different: history taking and examination versus surveys, focused group discussions, etc. Fast vs. slow, some times more money spent sometimes less. statistical inferences vs. clinical decision-making and examination, counseling vs. health education, quick and repetitive vs. slow and persistent. However, the issues of quality, access and cost are similar. So are the underpinning principles such as treatment, prevention and cost effectiveness.

Perhaps the fundamental difference between them is in the scale of things, one is at the individual and the other is at the community level. Thus, in an equitable system, when we need to scale up any strategy or intervention, we should do so but not by dumbing down the effectiveness or the yardsticks or ethics.

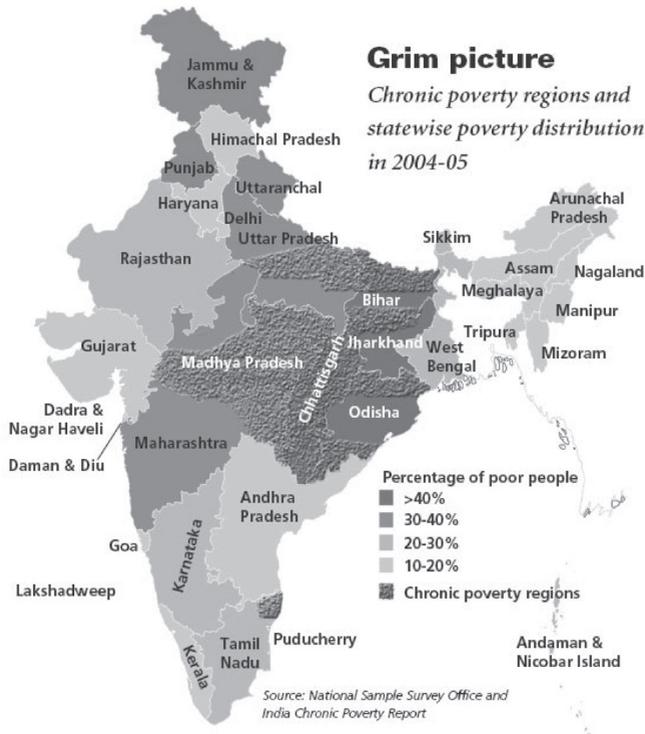
C. Problems with health care situation seen through the lens of equity

I would now like to share my understanding of inequality or injustice in public health. When one scrutinizes the field of health through the lens of equity, I come up with these, and I shall explain my points with an example each.

1. There is a **real crisis in rural health**. With rising *Gini* coefficient in our country, we see that the situation of large sections of our people has actually worsened. Our own IMR has increased by 60% in our villages in the last one year. The proportion of all major illnesses seems to have increased in our villages. For example, in tuberculosis, we saw 471 patients in 2010, and we

saw 587 in 2011. Even where we have the denominator, like in our intensive village programme, the number of tuberculosis patients increased from 36 to 68 over a year. Look at the NFHS data for children or other *HungaMa* making national data, the levels of nutrition have not shown any significant improvement in several of the states or certain people like the *adivasis*. Cry o beloved country! Among many sections of people we have more problems. Even the determinants don't seem to be improving either. There are clearly two *Indias*. Look at the chronic poverty report. Much of rural Central India lives in chronic poverty and chronic ill health.

- 2. Marginalization:** The problem of poor health is not merely increasing. There is a persistent marginalization of rural health problems. I would like to call these as *diseases of poverty*. Women in cities complain of too many sonographies and hysterectomies while women in rural India still die of obstructed labour, the only sign of obstetric care in many villages is iron- folic acid and injection Tetanus toxoid. Little importance is given to snake bites and care for other animal bites. *Falciparum* malaria is the ignored child of public health, officially it is still so difficult to die of malaria. The estimated annual burden of malaria deaths varies from 200,000 done by independent researchers to a ridiculous low of 1000 estimated by the National Vector borne diseases control programme. Look at the problems of the under-3 year old child. There is no programme that looks after her. The Anganwadi programme is structurally incompetent to look after this age group child; it merely offers take



home rations for the family. Ask any child care providers, and they would opine that the nutritional damage that a child at this age would suffer due to chronic hunger may be irreversible. Why do we have all the hospitals in cities and mere health centres in the rural areas? Is it that people in rural areas have fewer illnesses or less complicated illnesses than city people? Do people in cities have more complex illnesses? As I have shown before, profound levels of deprivation and chronic hunger tend to cause all illnesses in higher numbers, in more complex forms and with worse outcomes. Yet we have this inverted logic, and the mythology around health problems of rural India continues to flourish.

- 3. Trivialization of problems:** Like adding salt to the wounds, the marginalised health problems of the rural poor are getting increasingly trivialized. 'Give them an ASHA and all will be well' is one such unsaid prescription for rural crisis. Of course all of us who work in primary care have been crying hoarse that we need a village-based functionary for effective intervention. But we never said that we only required an ASHA! The mantra followed for health care needs of the public is to scale up by second rate interventions which may measure well on accounts of efficiency as advised by some health economists and the new crop of health governance experts. Efficiency is allowed to trump equity. Look at the tuberculosis programme - we continue to use an intermittent frequency of drug administration for both categories 1 and 2 patients with tuberculosis in our national programme while WHO, on whose advice the RNTCP came about in 1997 has already said that in 2007 and again in 2010 that the frequency of administration should be daily. Thus trivializing the importance of the most important single agent disease that affects the poor. Our women deserve better obstetric care at birth. Thus we suddenly offer institutional care, but end up offering four bare walls as an institution, and humiliating the poverty of people by offering Rs 1400 as an incentive for these confinement in these inadequate set ups.
- 4. Commercialisation of health care:** Allowing commerce to enter this profession has been a sad happening and it has happened primarily because the state disowned it's

primary responsibility of taking sides with the people. The state has chosen NOT to take sides of the people. And thus a service - that health care is, which should have reduced inequity is now allowing the powerful in this interaction between the provider and the provided to misuse it for their own gains. Those who decide don't have to pay, and those who have to pay don't have a voice or choice. This aspect of health care - much has been spoken about it - is what embarrasses me. At the cost of sounding holier than thou, I appeal to all those practicing medicine to refuse all gift, incentives and any other benefit from the pharmaceuticals, devices, vaccines and diagnostics companies, and this appeal is to every formation - individuals, academies, institutions, student and resident and nurses unions.

5. **Privatisation of health care:** In short, profit motive can't work in an unequal world. We are defending the undefendable if we agree for more privatization. We are already a highly privatized health care system, and can't afford more of it. If I am made the health minister of this country, the single thing I will do is to ban private practice by government functionaries. And if brilliant people threaten to quit and join the private set up, I will rather advise giving them a golden handshake with a nice kick on their generous backsides to expedite their exit. How can we allow a clear conflict of interest in such an unequal world?

6. **Worsening education:** another manifestation of an unfair health infrastructure is the abhorable health and

medical education scenario in the country. Flourishing of capitation fee medical colleges are not only a sign of increasing inequity of opportunities in higher education, it ensures irreversible commercialization with a pressure on all graduates to recover their investment. The same goes for nurses and nursing education. Third, look at the other cadres of health professionals such as laboratory technicians, pharmacists and physiotherapists. Not only are most of these courses expensive and out of reach of most poor families, they are of extremely poor quality due to little regulation. Speaking of Chhattisgarh, most of the graduates in pharmacy can't even tell the number of milligrams in a gram, or most of the lab techs may not have peered down a microscope. Even the training of village health workers leaves much to be desired. Like primary school teaching, training of VHW too is difficult. But in most programmes the training is farmed out to such formations that have never even touched the pulse of a person or have ever cared for a sick person! How can we allow this as a society?

7. **Policy level issues** about inequity: my biggest angst is that even at the policy level there is an allowance for inequity that gets translated into unequal practices. Let me illustrate with three examples
 - a. Where is the **information about the burden of illnesses** with which people in poor areas live with and die due to? Except some data on a few illnesses, the only data available is from the few peri-urban villages of a few medical colleges. In this sense the medical

academia has failed the people in not being able to produce such data. In the absence of such data, myths flourish, and wrong decisions about infrastructure and human resource needs are taken by governments. Who for instance decided that there should be no ECG machine at a PHC level? Don't people have ischemic heart disease there? Why don't we have blood transfusion set-ups at PHC and CHC levels in a situation where there is so much anemia, sickle cell disease and malaria? Who decided that closed mitral valvotomies should not be taught to general surgeons and cardiac surgeons? We choose not to have any caste or class disaggregated data on illnesses, why? In the absence of reliable data, we end up making baseless assumptions about the problem such as people in small places have small problems or that the problem is too big, or too small, or too complicated.

- b. **Tuberculosis:** I will now like to explore the ethics of the programme to control arguably the largest single agent disease control programme- of tuberculosis, which is as someone said pithily is the true captain of death. The RNTCP was launched in mid 1990s, in response to the poor situation of people, in the context of a programme that was allowed actually to die over the previous years. Concerns about the total burden, drug resistance, poor diagnostic availability, high rates of default and poor logistic support were the basis for the new programme. The strategy for this very vertically controlled programme was
 - I. multi-drug treatment with three categories, given

thrice a week and this from a completely unreferenced document.

- II. Microscopy centres
- III. Logistic chain
- IV. Directly observed treatment, short course

Later in 2006, DOTS plus, a special programme was launched to address this; it was argued that easily 99000 new patients with MDR emerge every year, of which in the last 6 years less than 5000 people have been put on treatment. Of this number only 30% have finished treatment. This DOTS plus programme recommended the following:

- A. Special labs to test the sputums
- B. drugs for these resistant bugs

This programme has frankly started picking up only now.

There are major problems with this programme, and I would not put them in the realm of mistakes, but actually in ethics of planning and prescription, since this has been done even in the wake of alternative suggestions and practices.

1. RNTCP categories and intermittent treatment. Why can't we have full treatment? Intermittent treatment was offered, but higher than acceptable rates of disease coming back. WHO has modified its guidelines but India has not.
2. Drug resistance testing: Even now we don't have such

data available. Every one knows that if we have an accident, and fall unconscious, we should have a CAT scan of the head. If for a disease like tuberculosis, where your bugs may be killed by the drugs you get, or may not be killed, then would you not advise drug resistance testing, particularly when you know that the treatment with the alternative medicines may cost 50 times more? We don't offer such testing to people, and assume that all is well.

There is the example of Russian prisons. 1% of the people were in jail, and then there was this massive epidemic of tuberculosis, where besides incarceration, only the first line drugs were offered, knowing very well that they may not work, and thousands of people came down with MDR TB, and large numbers died. Working in the Chhattisgarh I get similar pangs.

3. DOTS provider: The onus is still on the patient to take the drugs, introduce a technology of a provider- why not a family provider. Why don't people take drugs? - side effects, non availability, not explained well, etc.
4. Food: Food was removed from the treatment on specious grounds. With weights that our people have, and with problems they have, we still have no provisions for food, while small countries like Haiti and Vietnam offer food in addition to anti-tubercular drugs.

My questions are: Who advises the governments? Why don't our medical leaders see reason? Why can't we have DOTS

plus in a scale-up mode? If I get TB now, I will not be willing to take the RNTCP prescribed regimes. How then can I provide them to anyone else in the public? I think it can only happen because people in position don't have to suffer from this. I am sorry to say but in this case, the academia has failed the people by limply raising the questions about the technical issues, and then sulked into a state of isolation. That is why many medical colleges have their own regimes and don't use the Gol guidelines.

c. **Leprosy:** As you would all know, leprosy is a disease that has its maximum presence among the poorest, and that if untreated, can cause damage to the body because of the damage to the nerves, thus maiming the people.

Due to certain pressures, the illness was declared *eliminated* as a public health problem. In the context of diseases, elimination means that no more new cases of the disease are diagnosed even though its causative organization may still be present in the environment. But with chicanery, this was used for prevalence in leprosy, not about new cases, and that too for an arbitrary figure of 1 per 10000 population.

All means fair and foul were used for achieving this. Goal posts were changed, registers were fudged, indicted by the Comptroller and Auditor General, and on the stroke of midnight when 2005 ended, leprosy was declared eliminated. At JSS, we see 180 new patients every year. Well we are in Chhattisgarh, and some pockets like Bihar and Chhattisgarh will have higher numbers anyway. But if you look at the official data, then still it emerges that the incident cases are

still rather high, and even in 2011, 14 states have reported that the incidence has increased compared to the previous year and that more than 10 % of the new cases are among children, which would imply active transmission. Yet nationally, we don't have a programme.

The only good reason seems that the funding organizations for this programme were giving up. A very vertical programme was being given up to the public health system without it being prepared to handle it. And thus people were left to their own devices.

Disbanding of the entire programme why?

Second point about drug treatment in leprosy.

If you are in Canada or USA, and if you get leprosy, then you get MDT. So will you if you get it in India. But there is a difference. There you will get daily rifampicin. And in India you get the rifampicin once a month. There are no studies which actually compare the two rigorously. But the American website mentions that it is merely the cost consideration that has led to such a prescription. Can we accept that? Are we different animals?

d. **Non communicable diseases:** My anger will not be vented out if I do not talk about the ethics of the intervention in what are called NCDs. As opposed to the infections which almost all are linked to poverty and deprivation, these illnesses such as diabetes, hypertension, cancers, coronary heart diseases, mental health problems were observed in the urban people first, and there an association with overweight and

sedentary lifestyle was made. Later similar observations were made in peri-urban areas of our rural areas. It was thought that these illnesses were happening due to the nutrition transition - from less food to excess food that in turn was leading to an epidemiological transition, in which a country like India was now facing a double burden of illnesses- the still uncontrolled scourge of infections supplemented by the NCDs in the urban areas, and some rural areas. Due to the enormous health care costs that management of these chronic problems would entail, screening programmes and preventive programmes were launched to stem it. These preventive programmes were to focus on changing the lifestyle to eating less, exercising more and stopping tobacco. I have, again, no quarrels so far with this process. But when we look at the data for NCDs in poor marginalised areas as ours, we find completely different evidence and determinants of NCD, such as

1. 16 per cent prevalence of hypertension in women between ages of 30 and 50., one third of them severe. And they are not obese or overweight.
2. Two thirds of hypertension that we see are in women.
3. We see 250 new diabetes patients every year, and more than 80% are underweight or normal weight. They have more complications and require more insulin than their urban sisters or brothers.
4. Huge numbers of heart diseases, but most, over 75% of them rheumatic heart diseases, which clearly are diseases of the poor and the undernourished.
5. The second most common group of illnesses, next only

to tuberculosis, is cancer. However, more than half of those are cancer of the cervix, which again can be shown to be one that is associated with deprivation.

6. The weight profiles, socioeconomic background of all these NCDs as we see is almost similar to that we see among patients with tuberculosis, or malaria. It seems to us that even these NCDs are biological embodiments of deprivation and inequity.

It is in this context that I start getting worried. If you paint all the NCDs with the same paint brush and prescribe the trident of prevention - eat less, work more and stop tobacco, it is neither correct nor fair. Besides the fact that it will be bad epidemiology, it is yet another way to de-socialize illnesses, as germ theory did for infections, by allowing poverty off the hook as the cause of tuberculosis. Rural areas such as Bilaspur are suffering the twin burden of communicable and NCDs without going through the nutrition transition. Several young people are already going around doing blood sugars and checking pressures in rural Bilaspur as part of NCD programme for detecting diabetes using gadgets such as the glucometer. This is not funny at all, since rural Bilaspur can't check sugar levels of their patients with falciparum malaria when they are sick. Screening programmes for a new illness can check for glucose!!

D. The choices before a health worker and health professional

So what could a single doctor do with all these problems in an unequal world? Does this mean one has necessarily to

sacrifice one's professional desire and affluence, as it were? Does it mean that there is no role for specialists? Does it mean that one has to lead an insecure life? Does it mean that one has necessarily to move to rural areas?

I will like to say that it is eminently possible to work in this unjust world, and at the same time be happy with reference to family life, professional desires and income security. There are severaways to work, the The only requirement is the use of the talisman for evaluating that whatever one is doing : *is it reducing inequity?*

1. I suggest that all of us can do public health even while we care for an individual. I would classify a good health professionals, and I would take the example of a doctor, into three types. Type 1 doctor or medic is one who is approached by an individual. This doctor may ask some questions, examines him or her, makes a diagnosis of the problem, and then advises some treatment for healing the body or the mind, based on principles of rationality and affordability. She gives them the correct knowledge about the disease, counsels them, and plans for health prevention, and for some promotion. In as much a community is a collective of all the individuals, she or he is practicing public health.

Type 2 doctor is one who will look at the proximate causes of ill health, find out whether it is due to some deficiency, or some environmental disturbance, or due to lack of knowledge, or due to poor practices. Such doctors will collect information on the problem, do surveys, make

an assessment of the community problems, then make a plan of management and finally implement it like most departments of community medicine.

Type 3 public health doctor is the one who will also look at the root causes of ill health. Like asking for displacement, or amount of money that is going for rural development, or can see the injustice in the distribution of the determinants of ill health. My worry is that there are far too few of these. And yet all this is public health work. Thus there is scope for primary care physicians and specialists too in public health.

2. **Middle level health work.** Our entire focus has to shift from the doctor-centric human resource development paradigm. No more medical colleges, please. Doctors are not going to go to rural areas in any large numbers. So we need to either invest in specific training of these doctors, or invest in training of middle level workers. These could be
 - a. Doctors undergoing 3 year course,
 - b. Nurse practitioners,
 - c. Lab technicians,
 - d. Pharmacists and
 - e. Informal practitioners,and finally what we have been doing - training senior health workers. I defend the 3 and a half years training of doctors due to the new opportunity thrown up to train a new cadre of people in care of problems for which the present doctors are either not interested or not competent in.

Senior health workers would be public health workers who would be skilled in diagnosis and healing, in preventive and promoting work and in basic lab skills. This is my suggestion for focus - the middle level health worker. As medical practitioners and those committed to people, I urge you to consider this.

3. **Train people:** Lighting candles with another is the best force multiplier. And even in this, it is very clear that training village level health workers is far more difficult than training middle level workers which in turn is far more difficult than training doctors. Having trained all levels of health workers, I have absolutely no doubt in my mind about this hierarchy of difficulty in training. Change the pedagogy rather than have impractical and iniquitous eligibility criteria for trainees. Use more activities and visual media than auditory and written media. In many ways, it is taking sides with the poor and the dispossessed, when we choose whom we will train.
4. **Delegate:** My preaching would be incomplete without my mentioning this obvious suggestion. As far as possible, delegate and distribute your skills, let hitherto sequestered skills be available for as many non-specialists as possible without compromising quality- train and have assistants in orthopedics, vision care, surgical assistants who can do procedures, nursing assistants, physical therapy associates and for mental health. Try to change rules of certification and licensing without compromising quality and go ahead.

5. **Work at policy levels:** Since health care is deeply political, and we need to change things at the policy level, (as I have advocated with some examples), this is one way forward to practice health care in an unequal world, which those who have interest in policy level work can choose. to intervene. Deciding the development of health infrastructure, or deciding the drug regimens and schedules in our national programme or the drug pricing policy, all these are very important areas of intervention. As physicians, we should speak up with our views, our findings or outcomes of implemented programmes, and support those activists and advocates with technical information. For example, how will we argue for a rational drug pricing policy without support of information from good physicians about the rational drug regimens, the impoverishment their patients face when they have to buy from the open market etc?.
6. **Research:** While choosing topics in health research, if one applied the lens of equity, I would suggest that generating social class stratified data on burdens of problems that poor people carry, and its determinants and outcomes would go a long way in helping the cause of 'the nobodies'.
7. **Technology:** Developing appropriate technology using the same principles of science in health care, makes health care either much cheaper, or more effective or less mystified. This is a crying need of the country. Many of us who may want to continue to work in urban areas, and those who need overtly creative work to keep their

souls satisfied could go in for this kind of work. It is a huge area, and is presently a lonely area for many of us to populate.

8. **Commercialization:** While I am talking about public health, the reality of health care is moving away in the opposite direction towards commercialization. Move away from commercialization as fast and as definitely as we can. Otherwise how can we spend the last minutes before we sleep with our head on our pillows?
9. **Learn constantly:** For me these last 12 years, as a person who lives off the pen or my mind, I have learnt constantly from those who live off the land- as a city-bred fellow. I learnt about agriculture, about water, about poverty, about self-respect, about the structural violence that people suffer stoically. I feel when you are learning new things, you remain young.

Finally, I would like to say life is all about taking sides. Whose side will you choose?

The nobodies

Fleas dream of buying themselves a dog, and nobodies dream of escaping poverty: that one magical day good luck will suddenly rain down on them- will rain down in buckets. But good luck doesn't even fall in a fine drizzle, no matter how hard the nobodies summon it, even if their left hand is tickling, or if they begin the new day with their right foot, or start the new year with a change of brooms.

The nobodies: nobody's children, owners of nothing.

The nobodies: the no ones, the nobodied, running like rabbits, dying through life, screwed every which way.

Who don't speak languages, but dialects.

Who don't have religions, but superstitions.

Who don't create art, but handicrafts.

Who don't have culture, but folklore.

Who are not human beings, but human resources.

Who do not have names, but numbers.

Who do not appear in the history of the world, but in the police blotter of the local paper.

The nobodies, who are not worth the bullet that kills them

Brief Bio-data

Yogesh Jain,
MD Pediatrics, AIIMS
Public health Physician

PRESENT POSITION:

Secretary, and founding member
Jan Swasthya Sahyog (People's health Support Group)
Village and PO Bilaspur –495 112
Chhattisgarh

Primarily involved in “primary health care’- through developing a service based programme at Jan Swasthya Sahyog (People's health Support group) in rural Bilaspur in the state of Chhattisgrah where people from over 2000 villages access the services for their major health care needs, for the last 13 years along with a group of friends, many of whom studied at AIIMS together.

Involved and interested in addressing the issues - be they technical, operational or economic or political that determine the primary health care for the rural poor- through careful documentation, observational research studies, training, and lobbying, all based on the continual learning from this community health programme.

Involved in primary health care issues - of access, cost and quality of health care, and specifically in hunger and health, communicable diseases control programme- tuberculosis, malaria, leprosy, childhood infections, and technical aspects of women's health.

EDUCATION:

SSCE (School leaving), Delhi Public School, New Delhi, 1982

MBBS, All India Institute of Medical Sciences, New Delhi, 1982-1987

M.D. (Pediatrics), All India Institute of Medical Sciences, New Delhi, 1987-1990

FELLOWSHIPS & AWARDS:

- National Merit Scholarship, Government of India, 1980
- National Talent Search Scholarship, NCERT, 1982-1990
- Delhi Medical Association Award for the best essay, 1985
- AIIMS Scholarship for second position in MBBS 1985-1986
- New Zealand High Commissioner's Prize for the best undergraduate in Community Medicine 1987
- Sorel Catherine Award for the best postgraduate in Pediatrics, AIIMS, New Delhi, 1990

POSITIONS HELD:

Public health Physician, Jan Swasthya Sahyog, Bilaspur, Chhattisgarh since 1999.

Assistant Professor, Department of Pediatrics, All India Institute of Medical Sciences, New Delhi, till November 1999.