

A Little Look Behind and a Longer Look Ahead: Public Health Yesterday and Tomorrow

Professor Deoki Nandan, Mr Amarjeet Singh, Eminent guests and honoured faculty, staff and students of the National Institute of Health and Family Welfare, Ladies and Gentlemen .

I feel honoured and humbled by the great compliment paid to me by Professor Deoki Nandan and his faculty in conferring this prestigious invitation to me. As you have already been told about the background and genesis of the Ved Prakasha Oration I will not say anything further about his many contributions but will point out that I feel humble as the Oration has a reputation for being delivered by very eminent thinkers. Last year, no less a person than Professor Deodhar delivered this oration. He spoke brilliantly and held us all spellbound when he shared the accumulated wisdom of his long spell as a Public Health specialist of renown. I must share with you that I delayed responding to Prof. Deoki Nandans' invitation for quite some time because I did not think I could match the previous orators. Prof Deoki Nandan persisted

and here I am – full of trepidation and still not sure what I want to share with you.

You will have, I am sure, noticed that older persons love to talk when given half an opportunity, they like to share their experience, recall their triumphs real or imagined and they give free advice. I am afraid that I will be no different but I will attempt to be cautious and not try your patience too much. I called the contents of my talk “A little look behind and a longer look ahead”

The look behind unavoidably focuses on a mistake my generation, or actually the generation just before me, committed. A mistake that I now see with the wisdom of hindsight has affected the status of our speciality, the learning of our students and the professional life of all of you. I refer to the fact that Public Health, the discipline with all its skills and knowledge has virtually been eradicated from the health system in our country

In a country of more than a billion, there are only 76 public health positions in the government cadre. Why would any bright medical student opt for specialisation in our discipline when he is only guaranteed scorn and a low status? All health decision makers pay lip service to the need

for public health skills in the health system: no health decision maker is willing to act to enable this! Yes the discipline is suffering, but only a handful of people care about that. More important than the discipline, it is the people of India who are being deprived of their right to good health care.

Today Gujarat (under the stewardship of the Chief Guest Mr Amarjeet Singh) and Tamilnadu are perhaps the only remaining states that still mandate that the Chief Medical Officer of Health of each District is qualified in Public Health! In every other state the Chief Medical Officer of Health can be any doctor with any specialisation. It is no surprise that the Public Sector Health System in most of India is reactive in its response to health conditions. In almost all instances it is the media or the local political leadership that informs the health system of a disease outbreak!

But even fewer persons seem to care that the community too is the loser. It is the people of our country that are paying the price of the health system being deprived of the skills of modern public health. The health system is reactive in the response to outbreaks and other large scale emergencies. They come to know about problems from newspaper reports and the complaints of the political system. Why is it that in Delhi, yes in

the capital where you are sitting just now, every year the local health system swung into action only after cases of dengue or chikangunia were repeatedly reported in the press. Why is it that they did not start their vector control measures in anticipation of the annual disease cycle?

Are you not bothered by the fact that the Chief Medical Officer of Health for the district does not need to have any special training or experience in any health related area. Just because they are experienced clinicians with immaculate academic credentials in some discipline together with flawless political clout, does that mean that they have no need for training in any health related area?

After all in Delhi, in the Ministry of Health and Family Welfare a Professor of Anatomy, without even one day of training in any health related discipline, was appointed as the person in charge of maternal and child health for the country.

I can give many such examples. Unless there is a sub-cadre or cadre for specialists in public health, the community will continue to be at a disadvantage as far as preventive, promotive health care and early detection and response to disease outbreaks is concerned. The status of the discipline will remain low and good human

material will only opt for the discipline if they are quixotic.

Incidentally this is the biggest scam being perpetuated on every medical student. If this discipline is not important to the health of Indians, then why is it that teaching in this speciality is made compulsory for every medical student in India, why does the student have to prepare and take an examination, why are MD degrees conferred in many medical colleges?

The Director General of Health Services in India does not need to have even a single day of orientation in health related issues. He can be an excellent neuro-surgeon but does that make him competent in epidemiology or public health?

It is often useful to get a historical perspective. As some wise person once pointed out those who do not learn from history are condemned to repeat historical errors. The history of Public Health in India dates back to a service founded by the British. The British were not overly concerned about the health of the masses – their focus was on their own troops and administrators. The British lived in isolation in cantonments and garrison towns. The initial perception then was that poor sanitation and impure water supply were the prime reasons why the British in India

fell ill and logically therefore it was important for the British to ensure an effective system of improved sanitation and potable water for their areas. The natural outcome of this belief was that originally public health was about sanitation and water supplies, actually Hygiene and Drains. This stereotype still affects the thinking about public health. It was only much later that it was realised the hard way that epidemic diseases did not respect cantonment boundaries and in epidemic situations those living in such areas were not immune from disease. This led to control of epidemic diseases being accepted into the domain of public health. (Incidentally the same logic has now rightly pointed out that international boundaries are permeable to disease such as SARS and H1N1 and the world is truly a global village).

Around 1948, soon after independence and influenced by the Bhore Committee report, there was a well meaning 'reform' in the health system. To improve the status of the Public Health Service it was amalgamated with the Curative services; The Director Public Health became part of the staff of the Inspector General of Civil Hospitals. In effect the public health cadre was abolished in this well meaning attempt to raise the status of public health in the country. This step all but eradicated Public Health!

Incidentally the IGCH became the Director General of Health Services, and the change went down to the district level where the Civil Surgeon became the Chief Medical Officer of Health (CMOH). This well intentioned change has unfortunately resulted in the abolishing of Public Health as a service and has all but removed the skills of Public Health from the list of benefits available to the vast majority of the people of India.

People in Public Health have neither the political clout nor the power of money to compete with clinicians – soon all senior level jobs traditionally earmarked for persons with a public health background were ‘liberated’ and became available to clinicians no matter from what speciality. To be a clinical specialist suitable certification in that discipline was and is needed; to occupy a public health position one only needs to be a doctor with adequate seniority!

When our colleagues and peers train a neuro-surgeon or an ophthalmologist both the faculty and the student know what is planned. They know that they will occupy jobs that only they can fill and they are trained to do that job. The ophthalmologist will fill positions for ophthalmologists and the neuro-surgeon will fill jobs demanding neuro-surgery. Even if the

ophthalmologist has better marks and more connections he/she cannot occupy a neurosurgery vacancy. In contrast a person trained as a specialist in Preventive and social medicine only has exclusive rights to faculty positions in departments of P&SM in medical colleges (and that too is not without its exceptions). For almost all other public health jobs the competition is with every doctor, no matter what postgraduate qualification they have. Both our friends the neurosurgeon and the eye specialist can and do fill positions demanding expertise in health care rather than medical care.

The error in doing away with the Public Health Cadre in the majority of the country was soon realised by some farsighted people but unfortunately not by implementers and decision makers in health for India. The Mudaliar Committee came out strongly in support of establishing a Indian Medical Service to replace the IMS. We included the need for a Public Health Cadre as a part of the “Calcutta Declaration” and subsequently of the Agra Declaration in 2000. It was also featured in the report of the Macro-economic Commission on Health and was the theme of my paper published as a part of Commission Report. The National Human Rights Commission has also commented on this issue. It has also been raised more than

once in the Central Council of Health and Family Welfare. Dr. Harcharan Singh did so during his stint with the Planning Commission and many years ago I was gazetted as a public health specialist and appointed an expert member of the Central council of health and Family Welfare as one of the core members. I raised this issue. Like most Central council decisions, nothing came of this attempt also.

Nothing has been achieved so far, the lobby against it is strong with both clinicians who do not want to lose so many senior positions and the administrators who realise that the presence of public health specialists next to them will inevitably reduce their power.

At the same time the lobby of Public Health is inconsequential because it is too busy fighting amongst itself for turf rights. Like many persons in this august audience, I too am a life member and also a Fellow of both the Indian Association of Preventive and Social Medicine and the Indian Public Health Association. Many of you will recall the several attempts made to get these two wings of public health professionals to act together in the interest of the discipline. All attempts have failed because it seems that the “rights” of various officials of the two organisations were threatened. Perhaps we need

to agree that there will be two positions for every office! Sadly it is the same persons who rotate to hold office in the two organisations – today's office bearer in one is tomorrow's office bearer in the other and yet we can't unite. Is it any surprise that the Public Health Community cannot influence health decision makers –neither the politicians nor the bureaucrats.

My look behind us in time brings to the fore yet another error made – and this time we have no one to blame but our own peers, your predecessors. We the teachers of Public Health in the medical schools opted for another name lest we be tainted with the stigma of Public Health. We thought of a new name that would not carry the baggage of a low status past. We called ourselves members of the discipline of Preventive and Social Medicine and a few years later opted for Community Medicine. All was going to be rosy and we would be equal in prestige and status to our clinical peers.

Our status has not changed. Nobody knows what we do and if the truth is to be told, not all our own fraternity knows what they are doing or supposed to be doing! I am not condemning you who belong to the faculty of departments of Preventive and Social Medicine or of Community Medicine. I am not even commenting on the

quality of human resource that has settled (like sludge) into departments of PSM. Even if I was, you would have to forgive me as I would only be talking about myself and my peers. Today I am merely sharing with you my thoughts improving our profession. In the about 14 years since I retired from my faculty position I have had the luxury of stepping back and getting a broader view, perhaps less coloured by personal biases and considerations. This distancing from active academic life and politics gave me the opportunity to cogitate and think of the lessons learnt from a long professional career as a teacher in a medical college.

I am sure that most, if not all, of us have experienced the look of puzzlement on the face of our social contacts when we describe ourselves as the faculty of the department of Preventive and Social Medicine or of Community Medicine. And if we describe ourselves as epidemiologists, as I sometimes do, they think we deal with diseases of the skin!

Mind you this is how our social contacts respond, well educated people important in their own right as lawyers, business leaders, engineers, IT professionals, corporate leaders and the like. What is worse, this is how many administrators respond. People do not know what social and

preventive medicine is. If the truth be told, in our hearts we too do not have a clear insight what the limits of our subject are. Reality shows are the flavour of the day – please describe to yourself how you will explain what one of our medical students is expected to do in real life with what we have taught him or her. Even more telling, ask the student after graduation what practical, useful knowledge was given to them by our department and be prepared to be embarrassed.

Ask the man in the street about a cardiologist, surgeon, even an ophthalmologist and they will give you a fairly accurate description of what they do. Ask about Preventive and Social Medicine or even about Community Medicine and they will just look puzzled. We do not feature in the list of health care providers for them; their healthcare would be just the same whether or not we exist. It is a depressing thought.

As I said earlier, our social peers, the administrators and the general public do not really know what Social and Preventive medicine or Community medicine is. On the other hand ask those very same persons from the public and our own social circles about the role and identity of Public Health. People recognise the term,

know what it is supposed to do and see the relevance to their one lives.

If my look behind was focused on mistakes and history, my thinking of tomorrow, the look ahead, is focused on wishful thinking and predictions. I realise that both are very infirm territory and dangerous to tread upon. But I am still an optimist and have not given up hope of a better tomorrow for health care in India, reaching out to all with dignity, equity and social justice.

Ladies and gentlemen face facts and take your heads out from under the sand. The brand name, both in India and internationally, is Public Health and not Preventive and Social Medicine or even Community Medicine.

Even the intellectual justification for giving ourselves that fancy new name is no longer valid. The public health of hygiene and drains has given way to what has been called the 'New Public Health' based on the socio-ecological view of health. In fact the new public health is so clearly and widely accepted in definitions that it is now appropriate to talk of public health today and the old public health as a distant evolutionary phase. Today's' Public Health is the New Public Health. This change in perspective has brought today's'

Public Health very close if not identical to Preventive and Social Medicine.

We made a mistake; it is for you to proclaim that the generations preceding you were wrong and that you know better. Yes, we were wrong. Let the current generation correct the early mistakes. Not all experiments succeed, and not all hypotheses are proven. There is no shame in trying an experiment and failing – the wrong lies in not realising and accepting that we were mistaken, that the hypothesis was proven incorrect. Changing the name of the department did not magically raise our status, and draw expertise into our discipline. All that happened was that we lost our focus on conventional public health also.

Ladies and gentlemen, dear fellow specialists of Public Health by any synonym, let us not be ashamed to admit that our speciality is PUBLIC HEALTH and our concern is preventive and promotive health and our focus is not on individuals but on populations

The difference now is very simple: clinical specialists focus on the health of individuals, public health people focus on the health of populations. I am even tempted to call the discipline population health but that might be too

forward looking to go down easily. What our academic departments should be doing is teaching Public Health and Primary Health Care.

If you all, united as the Public Health Community, do not together represent Public Health, the vacancy will be filled by someone else. It will then be too late to rue the fact that what India has as Public Health is not what your vision was and you have become perhaps an anachronism.

The person who this Oration honours, the late Ved Prakasha was, in the final analysis, an educationist and interested in human resource capacity building. I too must therefore focus on the teaching of Public Health. I would like to emphasize some topics that I hope will form an important part of tomorrow's curriculum. Incidentally equally if not more important than adding current topics to the curriculum is the dire need to remove redundancies from the list of topics covered. When was the last time any one of us actually made a slow sand filter?

Those who know me have probably heard me say that Epidemiology is the backbone of Public Health. I still have no doubt in my mind about that. It is sad that this subject is taught badly if at all in our departments. Not only are the skills of

epidemiology the basis for all evidence-based community evaluation and prioritisation of health interventions but even for clinical research these skills are indispensable. (And that is where your clinical colleagues will value your help). Epidemiology must not be taught by focussing on definitions, formulae or text book examples from the West. Epidemiology must be communicated by using real life example of relevance to the students of today and based on local research reports. It must not be taught like Latin – a dead language, but as an essential tool indispensable for all research and for converting data into information.

Another area of interest that must be covered by tomorrows departments of Public Health in medical colleges, or in institutions like this one, is medical ethics and the rights based approach to health. I know it is not listed in the MCI curriculum but please keep in mind that the MCI only mandates what constitutes the minimum that must be taught and does not rule out teaching more than the stipulated minimum. Let us not use the MCI as an excuse for not doing what is needed; after all a careful reading of the MCI undergraduate curriculum brings out interesting facts such as that tobacco is not mentioned at all (and tobacco in all its forms is perhaps the most important single contributor to morbidity and

mortality) and that the term non-communicable diseases (NCD) which now contribute 58% of deaths in India is never mentioned at all. No one can manage a health system or plan for the district health system without keeping Human Rights in mind.

The course taught by departments of Public Health (by any of its names) whether in a medical college or even in an Institute like this one, must also consider what the product is expected be able to do after graduation. Does the institution aim to produce a product ready for finishing as a doctor after further training, or is the objective to produce a basic doctor who is competent to function on his/her own in the community to take care of the majority of common illnesses independently and has the necessary skills and knowledge to update his/her knowledge to the postgraduate level given further training opportunities. I feel that the latter focus must prevail. If indeed the objective is to produce a basic doctor at the first instance then the skills and knowledge needed to function effectively at the Primary Health Care level must be kept in mind and doctors prepared so that they can undertake all the tasks needed by a doctor posted at the PHC, including the tasks mandated by the NRHM.

While engaged in wishful thinking about what I would like to see in the departments of Public Health as a part of my crystal ball look into the future I cannot avoid being generous to myself and throw in some other aspects also.

Can there be any excuse for a person trained in Public Health not being able to draw up a project implementation plan for a district or a PHC area? Various tasks mandated by the NRHM such as reports and health plans provide a unique opportunity for teaching/learning practical public health and must be utilised for relevant learning experiences.

The basic tenets of management and health administration must also fall in the zone of responsibility of those teaching Public Health. This can be initiated even during undergraduate public health but must form a significant element of post-graduate training in Public Health.

Physicians in Public Health are still the major decision makers in the discipline and they must realise that Public Health is essentially a team effort. Unless efforts are made to work as a team, teach as a team and respect each other as a team, new entrants into Public Health will find themselves handicapped until they learn better the hard way. (I am not forgetting for a moment

the unfortunate fact that today decision makers for the public sector health system are almost invariably the bureaucrats and those for private sector health care are most frequently corporate chiefs but let us pretend that trained persons decide about planning, evaluating or running health systems).

I look forward to the day when Medical College departments of Public Health make their presence felt in their Institutions. Why is it that so few of our colleagues venture to practice their speciality in improving the conditions in their own colleges. I saw this being done very effectively in Agra by Professor Deoki Nandan. It not only added to the prestige of the department in the eyes of the clinical faculty but also vastly improved the care available to patients coming to the Agra Medical College hospital. I see no reason why so many of us are diffident about showing that we know better, when we do know better. Participating in clinical research meetings is another important step that shows the value of our discipline. Most clinicians know little about research methodology – competent inputs would greatly improve the quality of their work and chances for publication.

While I am looking forward, I see that my dream of an adequate and respected public health

workforce in the country. I have already dwelt at length about the paramount need for a Public Health Cadre; I will not go over the benefits that would bring to health care in the country. I do however want to talk about meeting the manpower needs if public health does get re-recognised. Today the health decision makers have demonstrated their willingness to rethink constraints and norms in education. I suggest that if we are serious about augmenting the trained workforce in Public Health, the medical colleges must also play their part. The willingness to bend heretofore inviolate rules has been demonstrated by changing the MCI faculty norms allowing each faculty member to enrol two postgraduate students instead of the erstwhile one. I would like to suggest that all MD (PSM) courses be reorganised to have a 1+2 division. Admissions to the course should be increased to perhaps 4 times the normal; at the end of the first year those that pass should be given a basic Public Health degree or diploma such as an MPH/ MsPH/DPH. Those that want to go on for more advanced training or academic Public Health may be selected on the basis of performance to a limited number of seats to go on to a MD degree. Incidentally this scheme does not envisage the need for additional faculty or for drastically increasing the number of MD seats.

While I am dreaming , I might as well add one other component. The initial admission should be open to both MBBS graduates and those from associated disciplines such as social sciences, anthropology, communication, nursing and the like. If they are judged suitable they too should have the opportunity for further training but rather than an MD degree, they should work towards a PhD.

I am aware that I had promised not to try your patience unduly and time is running short. I want to add one more item to my wish list. We have a responsibility to the community we serve to ensure that we function to meet their needs . When we assess and evaluate how our department, organisation or institution are functioning we must not only evaluate the performance in terms of teaching/training students but also whether the core focus of the working of the institution meets the social objectives and needs of the community. A social audit is perhaps the most important evaluation we can do. Our institutions are largely funded by the people of our country; it is our responsibility that we keep in mind the people who we serve.

Thank you Ladies and Gentlemen for the patience with which you have listened to me. I realise that I have wandered here and there in my

dreaming of the departments of Public Health structured to meet the needs of the community, valued for their essential contributions to society and the health of India.