Editorial

Revitalizing primary care is the key to people's health in the post-COVID era

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Abstract

Growing evidence shows that primary care–oriented systems achieve better health outcomes, more health equity, and lower costs. Despite this strong evidence, such care has been chronically underfunded. If a council focused on primary care had existed during the height of the coronavirus disease 2019 (COVID-19) pandemic, it could have helped rapidly mobilize primary care to address vaccine equity and shore up public health, particularly in rural and historically marginalized urban communities. We believe an infrastructure investment plan should include oversight, tools, and resources for rebuilding primary care. Researchers have tried to compare the number of deaths due to "neglected tropical diseases" and that due to COVID – total deaths in the former cases are greater than COVID deaths. We should take into consideration a few issues: (a) distinction between health (as a human right) and health care (as commodity), (b) "clinical health" and "public health," (3) primary health care (as the backbone of public health) as well as community-based *horizontal* program NOT to be replaced by selective primary health care or GOBI or any disease-centered *vertical* program.

Keywords: COVID-19 pandemic, India, medical curriculum, neglected tropical diseases, primary care, USA

Preliminary Remarks

In July 2019, an international study reported, "Consistent and growing evidence shows that primary care-oriented systems achieve better health outcomes, more health equity, and lower costs. Yet, despite this strong evidence that primary care is associated with the outcomes that policymakers and patients seek, such care has been chronically underfunded in the United States. On average, the United States invests 5%-7% of total health care spending on primary care. Health systems in other industrialized nations spend twice that or more (e.g., the average among OECD countries is 14%)."[1] Comparing US spending in primary health care (PHC) becomes relevant in the sense that the highest amount of gross domestic product (GDP) (18%) is spent in health budget in the USA. It is much lower in India and many other countries.

Earlier, Michael Marmot reminded us, "One important way to ensure that social determinants of health remain central to the concerns of those pursuing universal health coverage is to include social determinants in a monitoring framework, which is easy to implement and has two components. First, monitoring of all health and health-care measurements by socioeconomic position, sex, geographical distribution, or other relevant markers of health equity, such as education. If health and health care are to be universal human rights, then we need to understand how unfair the distribution is of both health status and health services."[2]

Kumar raised three important issues: (a) "Immediately after independence, India pushed aside the recommendations of the Bhore committee, which was for implantation of comprehensive primary healthcare. Instead, we opted for the path of selective primary care modeled on vertical disease–based programs

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under the guidance of international development agencies," (b) "Superspecialty care, fragmented public health programs, and quackery have become three pillars of the Indian health system," and (c) "Will the Indian economy be able to sustain the double burden of UHC and the vertical programs?"[3]

Barring the period of the historical Alma-Ata Conference (1978), big corporate players of the world have always pursued the path of technology-intensive vertical care programs. Since 1960s and even before, medicine and health/health care have become the focus to make it a commodity of open market and private insurance.[4] Two Nobel Laureate economists – F. A. Hayek and Kenneth Arrow – categorically advocated for such state policies. To Hayek, "there is little doubt that the growth of health insurance is a desirable development… Beveridge scheme and the whole British National Health Service has no relation to reality."[5] Arrow specifically emphasized, "the subject is the medical-care industry, not health." He even gave subtitle of one chapter as "A Survey of the Special Characteristics of the Medical-Care Market."[6]

Deaths from Coronavirus Disease 2019 and Related Concerns

Deaths due to coronavirus disease 2019 (COVID-19) in India stand at 530,965 (1.19%)[7] and occurred within a brief period of about 3 years. Consequently, they were very much *visible* and *discernible*. But there are a number of silent killer diseases and more people are killed by these diseases, though they are not *visible* and *discernible*.

During the peak of the pandemic, an article reported, "We must realize that in our crowded world of 7.8 billion people … We have created a global, human-dominated ecosystem that serves as a playground for the emergence and host-switching of animal viruses, especially genetically error-prone RNA viruses, whose high mutation rates have, for millions of years, provided opportunities to switch to new hosts in new ecosystems."[8] Moreover, the article went on, "We have reached this point because of continuing increases in the human population, crowding, human movement, environmental alteration, and ecosystemic complexity related to human activities and creations."[9]

Alternatively, "If a council focused on primary care had existed during the height of the Covid-19 pandemic in the United States, it could have helped rapidly mobilize primary care to address vaccine equity and shore up public health, particularly in rural and historically marginalized urban communities. Moving forward, we believe an infrastructure investment plan should include oversight, tools, and resources for *rebuilding primary care*."[10]

Never before has the interdependence of all our health, finances, and social fabric been so *starkly visible*. Never before has the need for health-care reforms that ensure universal access to affordable care for all Americans been more apparent.[11] Further, "We may now have the opportunity to reform a flawed health care system that made the novel coronavirus far more damaging in the United States than it had to be."[12]

The disruption of fragile primary health-care services in different parts of the world wreaked havoc for common people. One article published in the *Lancet* explained, "In India … Not surprisingly, there have been dramatic reductions in essential public health and clinical interventions; data from India's National Health Mission indicate that there was a 69% reduction in measles, mumps, and rubella vaccination in children, a 21% reduction in institutional deliveries, a 50% reduction in clinic attendance for acute cardiac events and, surprisingly, a 32% fall in inpatient care for pulmonary conditions in March, 2020, compared with March, 2019. Similar reports are emerging from other countries, including disruptions to insecticide-treated net campaigns, access to antimalarial medicines, and suspension of polio vaccination."[13]

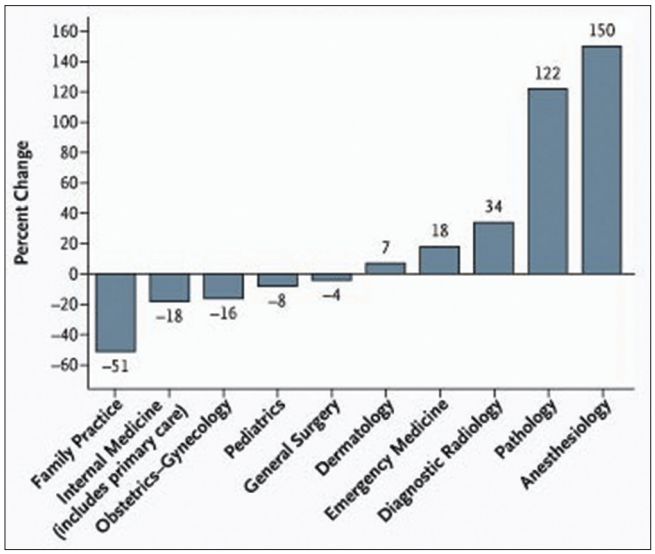
The Lancet Global Health Commission on Health noted that crises of any type can be transformed into *opportunities for PHC reform* if reformers are poised to act. In the UK, for example, the National Health Service was created following the hardship of World War 2. In Costa Rica, a 1991 measles outbreak led to employers across the country being forced to pay for private care for their workers due to weak public PHC. Employers then threatened to stop making their social security contributions, contributing to government investment in a *comprehensive PHC system*.[14]

From an Indian perspective, "Although it is impossible to transform its primary health care in a day or a week or a month, the right steps in this direction will definitely help in the future. The coming weeks and months are challenging for India and it needs to take strong actions to meet this emergency and its aftereffects."[15]

Notably, the crisis of health system during the pandemic was traced back to revitalizing/reviving primary care in almost all countries. To add, the proportion of US medical school graduates entering the three primary care specialties (*internal medicine*, *family medicine*, and *pediatrics*) dropped from 50% in 1998 to 38% in 2006 – that is, a loss from primary care of more than 1500 students this year compared to 1998 (see bar graph). Moreover, the percentage of third-year residents in internal medicine planning to become general internists who are not hospitalists *decreased* dramatically during this period, from 54% in 1998 to 27% in 2003, a year in which only 19% of first-year internal medicine residents were planning on such a career.[16]

Percent Change between 1998 and 2006 in the Percentage of U.S. Medical School Graduates Filling Residency Positions in Various Specialties.

Kumar draws our attention to the fact that after 21 years, a new MBBS curriculum has been released by the Medical Council of India (MCI), titled "Competency-based UG Curriculum for the



Percent change between 1998 and 2006 in the percentage of U.S. medical school graduates filling residency positions in various specialties. New England Journal of Medicine 2006;355:9

Indian Medical Graduates." This curriculum is to be rolled out from August 2019 across India. Overall, 2939 competencies have been proposed to be acquired by trainee MBBS doctors. Not to mention a formal introduction as discipline, the new MCI MBBS curriculum does not even mention the words "General Practice" or "Family Medicine" or "Family Physicians" throughout the voluminous document. The curriculum committee has also ignored the recommendations of National Health Policies (NHPs) of 2002 and 2017 of the Government of India (GOI). In practicality, it leaves the MBBS students in the road of no return of specialist and tertiary level hospitalist care. It deliberately deprives thousands of medical graduates of an invaluable autonomous career in community setting as practicing family doctors. Simultaneously, this new curriculum drafting exposes a treacherous hierarchical monopoly of hospital-based specialist doctors over generalist community-based primary care physicians within the health-care delivery system of India. Keeping out family physicians and general practitioners from the health system means a free flow of patients from community to expensive tertiary care facilities in the absence of any structured referral system. Family medicine and general practice are independent medical disciplines/specialties across the world.[17]

Evidence presented at the European Health Forum Gastein, Austria, from October 3 to 5, 2018, documented the need for new curricula, multi-professional settings, and organizational support. In the World Health Organization's (WHO's) report, it was clearly enunciated, "Globalization is putting the social cohesion of many countries under stress, and health systems being key constituents of the architecture of contemporary societies, are clearly not performing well in the manner they could and as they should." According to American experience, the greater use of primary care has been associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality.[18]

We are caught between a two-edged sword. On the one hand, the crisis in health system during the pandemic is finally traced to the fragility or nonviability of PHC system to confront the catastrophe; on the other hand, there is dearth in supply of primary care physicians or family practitioners growing out of a flawed medical curriculum.

Recovering from COVID and its Sequela

Many researchers have tried to compare the number of deaths due to "neglected tropical diseases" and that due to COVID[19] – total deaths in the former cases are greater than COVID deaths.

WHO, in their report on snakebite in India, has categorically stated, "The World Health Organization (WHO) estimates that about 5 million snakebites occur each year, resulting in up to 2.7 million envenomings. Published reports suggest that between 81,000 and 138,000 deaths occur each year. Snakebite envenoming causes as many as 400,000 amputations and other permanent disabilities. Many snakebites go unreported, often because victims seek treatment from non-medical sources or do not have access to health care. As a result it is believed that many cases of snakebite go unreported."[20]

Tuberculosis (TB) incidence in one state, two union territories (UTs), and 35 districts has declined by at least 20% since 2015. Two districts in India were declared TB free in 2020.[21] Despite this heartening news, there are some cautionary notes from the WHO – "An estimated 10.6 million people (95% UI: 9.9-11 million) fell in with TB worldwide in 2021, an increase of 4.5% from 10.1 million (95% UI: 9.5-10.7 million) in 2020, reversing many years of slow decline. Similarly, the TB incidence rate (new cases per 100,000 population per year) is estimated to have increased by 3.6% between 2020 and 2021, following declines of about 2% per year for most of the past 2 decades."[22] When translated into exact figure, TB deaths numbered 505,000 in 2021.

Budget 2023–2024 can be seen as the first Union budget since the recovery from the pandemic, in which the health sector did not receive much focus, unlike the previous 2 years. We can note a marginal reduction in the share of health in the aggregate union budget, which was 3.6% in 2021–2022, fell to 2.7% in 2022–2023, and stands at 2.4% in 2023–2024. The fact that draws even more attention is the 15% decline in the revised estimate of the union health budget for 2022–2023 compared to the budgeted amount for that year.[23]

We can benefit by focusing briefly on the historical trajectory of PHC. Comprehensive primary health care (CPHC) was the pivotal issue of the historical Conference of Alma-Ata in 1978. As a result of sustained pressure from giant corporates and multinational corporations (MNCs), CPHC was later reduced to "selective primary healthcare,"[24] then to growth monitoring, oral rehydration, breast feeding, and immunization (GOBI),[25] and so on. The Conference enunciated, "An acceptable level of

health for all the people of the world … can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share."[26]

Moreover, "All people, everywhere, have the right to achieve the highest attainable level of health. This is the fundamental premise of primary health care (PHC). Primary health care is a whole-of-society approach to effectively organize and strengthen national health systems to bring services for health and wellbeing closer to communities … Primary health care is widely regarded as the most inclusive, equitable and cost-effective way to achieve universal health coverage. It is also key to strengthening the resilience of health systems to prepare for, respond to and recover from shocks and crises."[27]

Finally, we should take into consideration a few issues which are of importance in today's medical cosmology and history: (a) distinction between health (as a human right) and health care (as commodity), (b) "clinical health" and "public health" – these two categories constitute different epistemological and ontological contents, (3) PHC (as the backbone of public health) as well as community-based *horizontal* program NOT to be replaced by selective PHC or GOBI or any *disease-centered vertical* program. Where mainstream approaches to development have been top down, rigid and orientated towards narrowly-defined economic goals, post-COVID-19 development must have a radically transformative, egalitarian and inclusive knowledge and politics at its core.[28]

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Conflicts of interest

There are no conflicts of interest.

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