A health care delivery model focusing on development of a cadre of primary care physicians—Recommendations of Organized Medicine Academic Guild

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ABSTRACT

Organized medicine is the academic guild of professional medical organizations in India. It was founded at the annual conference of Indian Academy of Pediatrics (PEDICON) on January 7, 2018. Organized medicine is constituted by leading professional medical organizations and mandated to support the sustainability of health agenda of the Government of India. A group of experts on behalf of Organized Medicine Academic Guild (OMAG) of India was constituted to facilitate adequate theories and models on how to make primary care integral to participation of people and intersectoral collaboration in equitable delivery of health care. A subtle, flexible, and comprehensive approach instead of a “compartmentalized existing in silos” approach is likely to be needed. This paper is a formal recommendation on behalf of OMAG with an aspiration to deliver to the people of India, what they need, focusing on discrete objectives with long-term plans.

Keywords: Cadre, Health care delivery model, Organized Medicine Academic Guild, primary care physicians

Background

The national health policy of 2017 has been envisaged with the primary goal of the attainment of the highest possible level of health and well-being for all at all ages. The health policy plans to attain this goal through a preventive and promotive health care orientation in all developmental policies. The emphasis is on universal access to good quality health care services without anyone having to face financial hardship as a consequence. The implementation of universal access is planned to be achieved through increasing access, improving quality, and lowering the cost of health care delivery.

The national health policy document seems to have taken care of all issues to ensure Health in All for Health for All. However, the fundamental question remains unanswered. Does our current health care delivery system support the spirit of

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the national health policy? The question becomes all the more relevant in context of recent observations by Raman Kumar et al. wherein by 2024, India will reach the WHO standard of 1:1000 doctor (MBBS—modern medicine) and strongly argues for a paradigm shift in public health discourse and rightly so.\[2\]

The argument for shift in discourse is further strengthened by another important observation that by 2016 (only two years back), there was a minor shortfall of only 3244 of doctors at Primary Health Centers (PHCs), if matched against sanctioned posts; whereas, India has currently a capacity of producing 60,680 MBBS doctors per year, not to mention Indian students passing out from medical schools/colleges/universities located in foreign countries.\[3\] Therefore, manpower in terms of doctors does not seem to be a problem or at least it appears as such at the PHC level, as the number of posts sanctioned at PHCs across India is only 34,068 about half of the current number of MBBS doctors produced annually.\[3\]

**About Organized Medicine Academic Guild**

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**Context, challenge, and stakeholders**

Our fundamental understanding about Health in India is based on the following few assumptions:

1. Health, health care, and its delivery are not distinguishable from each other

2. The easiest way of measuring health is through measurement of deficit outcomes such as mortality and morbidity

3. The measurement of health care delivery is done through assessment of parameters such as the doctor–population ratio. However, for a larger part, these fundamental assumptions have not been found to be correct. In this direction, an excellent paper by Kumar et al. has built the edifice for redefining the governing principles of health care delivery in this country.\[2\]

    Heath is not the mere absence of disease although health does confer on a person or group freedom from illness; therefore, limiting its measurement of mortality and morbidity alone is not justified. Similarly, understanding the health of populations is to develop understanding of ill health and well-being, extent of socioeconomic disparities, health culture, reach of health services and quality and costs of care, and of course the biomedics of health. Based on the above principle, health care should not cover medical care only but comprehensive health care comprising of preventive, promotive, and rehabilitative care. Limiting healthcare to care rendered by or financed out of public expenditure within the government sector, as being envisaged, may not be advisable or optimal.

**What does the current model encompass**

Health care in India is widely accepted as a public service rendered for the larger public interest. Its demand and supply cannot, therefore, be left to be regulated solely by the invisible hands of the market. The health care model in India was designed to provide a standardized package of basic health services as primary care to the population (prioritizing women's and children's health) with an effort to provide for equitable access through targeted services to underserved areas. The graduate medical curriculum in India was primarily supposed to be oriented toward training students to undertake the responsibilities of a physician of first contact who is capable of looking after the preventive, promotive, curative, and rehabilitative aspect of medicine.\[3\]

However, the group understands that this health model over past few decades has become as follows:

1. More “Urban friendly.” This may be because the health care delivery model in practice, even though conceived with primary care emphasis, is more oriented toward secondary and tertiary health care. Therefore, this model puts greater barriers in rural areas to preventive, primary, and emergency care. The reasons for this could also be that the rural populations experience different geographic, demographic, environmental, economic, and social health risks than their urban counterparts. An estimated 80% doctors, mostly specialists (MD), are concentrated in urban areas.\[5\] In the rural sector, 70% of the posts for specialists (MD) are lying vacant\[5\]

2. Speciality driven: Partly driven by the demand for postgraduation and partly fuelled by political will to create more postgraduates. MBBS has now become a mere stepping-stone for postgraduate (MD/DNB) entrance

3. Hospital centric: A rising culture of MD consultation is rapidly becoming a norm. The Rise of Private Medical Education Sector has ensured that there is great disparity in
the skill sets acquired by the postgraduates. The deficiencies in skill sets are being overcome by development of a hospital centric patient care in urban and semiurban areas. The era of standalone private practice is almost over
4. Apathy toward employing in public health care: The last decade or so has seen a continued emphasis on production of specialist doctors and an attitude of apathy toward employing medical practitioners in the public health care delivery system, more specifically in the primary care
5. Held captive by the system design: Population has to travel long distances to urban cities to avail basic medical facilities
6. Predominantly curative: Public health policy is not serving public interest. It appears that the current model is helping promote trillion-dollar health care/pharmaceutical industry
7. No role for primary care physician (PCP): The current system has relegated the primary care physician to the periphery of academics and patient care
8. No gate keeping. The current system promotes consultation of even basic health problems by the specialists and super specialists
9. More economic and less health centric. Health audits are based on budgetary allocation against spending targets
10. Referral insensitive. The current system does not allow for a community sensitive healthcare referral
11. The factors listed earlier have rendered health care “Compartmentalized and existing in silos” with almost no connect with the population it proposes to serve.

The group opines that the Implementation of all clinical management guidelines (a strong component of “Compartmentalized and existing in silos” approach) shall remain challenged at the ground level till delivery of comprehensive primary care services is redesigned and oriented to address population needs approach rather than outdated target-oriented delivery-focused model mostly run through vertical programs.

Therefore, what probably is needed is a “Novel health care delivery model” providing quality health care services, from health promotion to prevention, treatment, rehabilitation, and palliative care across geographies through emphasis on development of a primary care team, as no matter how many medical graduates we produce; the health divide will continue to persist.

**The suggested model**

The model suggests that the public health policy should address local and national health priorities and should align to achieve global goals and should not serve a select few stakeholders. It should be based on a long-term strategy toward addressing pressing population needs by strengthening the general health system. The policy should not overemphasize on meeting the priorities set by international donors.

**Principle**

What makes for a just health care system even as an ideal? Four criteria could be suggested: First, universal access, but the access has to be at an adequate level and without excessive burden, financial or otherwise. Second, fair distribution of health resources and fair rationing of care and capacity with a constant search for improvement to a more just system suited to population needs. Third, adequate deployment of training providers for competence empathy and accountability, to ensure quality care with use of the results of relevant research. Last, focused attention to vulnerable groups such as children, women, disabled, and the aged.

**Architecture**

The suggested model integrates the traditional piecemeal public approach being followed in India through development of a cadre of PCPs. Herein, a word of caution is mandatory. We have to guard the system against use of practitioners of alternative medicine or mid-level health care providers as the PCP (as is being proposed by some public health experts), as it defeats the very principle of ensuring equity in health care across geographies or populations.

To overcome the design challenge of integrating program-based healthcare with person-centered health care, a continuity of care is required. Referral and back referrals will be the key in ensuring this continuity. This will ensure that community-level services delivery is not at high risk of fragmentation and inefficiency. The development of a cadre of PCP will not only strengthen selective clinical care for all components of population but also ensure synergy with other existing national programs reducing resource wastage. Good quality primary care ensures that services are comprehensive, continuity of care is present, and the care is person-centered.

**Planning, implementation, and mechanisms**

**Context of the new model**

In the new model, PHC is proposed to be the unit for planning, implementation, coordination, supervision, monitoring, and evaluation of health services. In effect, the PHC will function as Family Health Centers (FHC) catering to the comprehensive needs of the entire family and thereby delivering true primary care. Medical officers at the PHC are real practitioners of primary care. The model envisages an improved liaison between medical colleges and district hospitals/Community Health Center (CHC)/PHC/subcenter (SC) organizations. At the center of the new model is the PCP. The operational guidelines of the novel model have been provided in Table 1.

**Identifying the PCP**

Although practitioners of family medicine present an extraordinary opportunity to serve as the PCP, the limited development of family medicine as a specialty demands a cautious approach to their use at present. This despite the fact that the National Health Policy 2002 emphasized the importance of family medicine as a focus area of human resource development. The current training system (under the NBE (National Board of Examination)) is operating at multispecialty community hospitals under an internist
or a consultant physician. For family medicine to realize its true potential, flexibility in approach regarding (a) training location and (b) faculty eligibility is required. The family medicine specialist is expected to serve his best while delivering on the local needs of the community. The current regulatory mechanisms do now allow regional and local flexibility. Added to it is the tertiary care-based medical education that supports a monopoly of specialist doctors over medical education and service delivery, relegating the primary care physicians professionally.

The present model bases its premise on unrestricted patient inflow from underserved, rural, and remote areas to a specialist trained in primary care (as shown in Figure 1). For this, the model suggests that all medical officers currently working at PHCs can be enrolled as primary care physicians. No NEET examination will be required for qualification. Once enrolled, the PCP will undergo a customized training program evaluated through an exit exam. The time required to complete the program will be a minimum of 3 years. During the training program, the PCP is expected to undergo a rotatory posting at the tertiary care center for a period of 18 months followed by a posting at the PHC for a period of one year. The last six months of the program will be devoted to a specialty of choice for the PCP.

The six months specialty program will work as the career progress framework for the PCP with a specific design to improve the career development and job satisfaction for the PCP. The specialty program will not only ensure a continuous flow of workforce but also reduce the dependence of the primary care on the specialists. The framework will encourage individuals to take up new skills. These new skills will help them to take on extra responsibilities and thereby enable them to progress within the organization. For example, a PCP (through the specialty program) can obtain an additional skill in ultrasonography or management of noncommunicable diseases through a flexible customized training program.

| Table 1: Operational Guideline for the novel model |
|---|---|---|
| **Facility** | **Type of care** | **Packages of services** |
| Subcenter | Promotive | Health promotion for behavior change and counseling. Awareness generation regarding warning signals of common health problems. |
| PHC | Comprehensive | Health promotion for behavior change and counseling. Management of common health problems. Referral of complicated cases to district hospital/higher health care facility. Delivery of care for back referrals. *Detailed services are listed below |
| CHC/FRU | Integrated | Prevention and health promotion including counseling. Diagnosis through clinical and laboratory investigations. Management of health problems. Referral. |
| District hospital/Subdivisional hospital | Specialist | Diagnosis and management of patients with all diseases (outpatient, inpatient, and intensive care) including emergency services. Follow-up chemotherapy in cancer cases. Rehabilitation and physiotherapy services. Referral |
| Medical college | Multidisciplinary | Mentoring of district hospitals. Research and training. Management of referrals and back referrals. Hospice |

Figure 1: Diagrammatic illustration of the novel model
certain through evaluation. This will help to tide over the nonavailability of specialist, as currently 70% of posts of specialists are lying vacant at the CHC level.

The presence of a PCP with some specialist skills is a policy implementers dream. However, the skills of a PCP will be best utilized only if they are held accountable for establishing a time sensitive referral sensitive in place. From political standpoint, this will require developing a trusted referral network around the PCP with identified roles, workflows, and information systems to track and manage referrals.

The driving force behind this new model is the PCP. After completion of the program, the PCP will lead the primary care team comprising primary care nurses, pharmacist, and lab technician, who will form component A of primary care team. The component B of primary care team comprises health managers. This mixed staffing model integrated under PCP in rural settings will be useful in delivery of comprehensive care, as the primary care physicians will have experience of working in the Emergency Department and the primary care settings. The PCP ensures that a continuum of care is delivered from the community to the first referral point using components’ support provided by National Health Mission through a plethora of national programs. The PCP will function as the team lead at the PHC to deliver comprehensive care and as health management lead at CHC and District hospital to ensure a continuum of care approach without fragmentation in services to deliver integrated and specialized services.

Envisioning the success of the model: The success of this model will depend on its ability to sustain itself. Even the most well-intentioned and best-thought efforts and interventions can fail, if due attention is not paid to the core principles of the effort. The core principle for this model is the PCP. The PCPs as the champions of this model should be able to leverage their own credibility and encourage others to understand that discipline is worth engaging in. Therefore, ensuring political, social, economic, and historical commitment to the program (the model) will create and reinforce conditions favorable to the sustainability of the model. This will also ensure a long term and sustained flow of funds to the program.

Therefore, by establishing a chain from morbidity management at community level by making sure they get the information and the care they need to arranging and managing referrals, the primary care team will function as the vital cog of the entire health care system. Being at the center, this will help the PCP to track the progress in health care, establish relationships with different stakeholders, and service organizations in the community.

Primary health care

Services to be provided by the primary care team at PHC. The details of the services have been outlined in Table 2.

Conclusions

The intertwining of job responsibilities under care of a PCP builds up a specialist care-primary care partnership with an opportunity to leverage the partnership to address rural health needs.

Delivery of comprehensive care at the primary level with simultaneous pursuit of improving patient experience, improving health of populations, and reducing the cost of health care will serve as the safety net for the uninsured and underinsured.

Each PCP will also effectively function as an academic primary care consultant routinely engage in devising care coordination efforts. The PHC will be used as observation units for training of PCP.

Consistent with the need to address rural social determinants of health, PCP will explore other ways that the PHC can serve as communities’ medical and social safety net. Using the lens of the primary care, the PCP is expected to explore societal patterns of health inequity to identify and address social needs. With a traditional strength for delivery of preventive medicine, chronic disease management, and sustainable efforts to address patients’ social needs, the primary care team will have far-reaching role in improving population health.

The PHC under the PCP can serve as a hub for emergency care, primary and preventive care, and social services for improving rural population health. Our model does not aim to replace the existing outpatient-based PHC model but rather places a PCP in concert with community primary care to supplement and

Table 2: Package of services to be delivered at the PHC level

| Maternal and newborn health | Antenatal care, Delivery care, Postpartum care, Family planning, Care of the newborn |
|----------------------------|---------------------------------------------------------------|
| Child health and immunization | Universal Program on Immunization (routine and outreach), Integrated Management of Childhood Illness. Treatment of clinical malnutrition, Prevention of malnutrition, Assessment and prevention of malnutrition. |
| Public nutrition, Micronutrient, Supplementation | |
| Communicable disease | Treatment and control of tuberculosis, Control of malaria, Prevention of HIV and AIDS. |
| Mental health | Community management of mental health problem, Health facility-based treatment of outpatients and inpatients. Initial management of injuries. |
| Injury | |
| Disability and physical rehabilitation | Physiotherapy integrated into primary health care services. Disability awareness, prevention, and education. |
| Basic laboratory investigations | Routine urine, stool, and blood tests, Bleeding time, Clotting time, Diagnosis of RTI/STDs with wet mounting, Gram stain, etc., Spatum testing for tuberculosis (if designated as a microscopy center under RNTCP), Blood smear examination for malarial parasite, Rapid tests for pregnancy/malaria, RPR test for Syphilis/YAWS surveillance, Rapid diagnostic tests for typhoid (Typhi Dot), Rapid test kit for fecal contamination of water. |

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augment primary care capacity. The suggested model supports efforts to improve health outcomes by connecting patients to a regular source of care and social resources in all health care settings. This novel delivery model is not designed to replace primary care; rather, it links the primary care to all levels of health care settings, capturing patients with social needs regardless of where they present for care.

The PCP-led Health Care model may serve as new model for delivery of health care for all primary care settings. In many ways, this model manages to simultaneously be community, patient, and provider centric.

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Conflicts of interest
There are no conflicts of interest.

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