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Strengthening subcentres for universal health coverage: A study

India is a signatory to the Alma Ata Declaration and is committed to attaining Health for All. Primary healthcare is the point of entry for a person to the national health system.¹ A health subcentre is the most peripheral facility that connects the primary healthcare system and the community.² While India lacks adequate healthcare infrastructure, it is also a fact that the available public health system remains largely underutilized, and curative treatment is mostly provided by under-regulated private healthcare providers.^{3,4} Strengthening of the public health system for delivery of promotive, preventive and curative health services is required in India.⁵ To achieve universal health coverage, the primary healthcare system will need to reinvent itself. Thus, it is imperative to assess the functioning of subcentres which were established to serve people in rural areas.

We did a cross-sectional study in the district of Jhansi, Uttar Pradesh from June 2011 to June 2013. Of the eight community development blocks, two—Badagoan and Chirgoan—were selected for the study. Ten subcentres from each block were selected to get a representative sample. The data were collected by the facility survey and interview technique on a schedule designed as per the Indian Public Health Standards (IPHS) norms for subcentres.^{2,6}

The average population covered by each study subcentre was 4282 (median 4170, range 2012–6868), the average number of villages per subcentre was 2.5 (median 3, range 1–6) and the distance of two blocks from the medical college was 12 km and 30 km, respectively (Table I). No subcentre had separate utilities for men and women, nor did they have a suggestion and complaint box. A hand pump was the major source of water supply at most subcentres, and only 9 subcentres had functioning hand pumps. No transport facility was available for staff or patients at any of the subcentres. Only 3 (15%) subcentres had a second or additional auxiliary nurse midwife (ANM) and 4 (20%) had a *safai karamchhari* (a person for cleaning) on a contractual basis. A male health worker was not present at any subcentre. Most ANMs cited lack of electricity, their husband staying at another location, and education of their children as the reasons for not staying at the subcentres.

TABLE I. Physical infrastructure (location) of subcentres (SCs) (n=20)

Item	Subcentre (%)
Located within village area	9 (45)
Located at an easily accessible area	15 (75)
Distance of subcentre from farthest village (in km)	3.9 (median 4, range 1–10)
Time taken to reach the farthest village (in minutes)	30 (median 30.1, range 10–80)
Distance (in km) between PHC and SC	11.7 (median 9.5, range 2–25)
Distance (in km) between CHC and SC	17.7 (median 15, range 3–35)
Number of rooms	2 (median 2, range 1–5)
Designated government building available for the SC	13 (65)
What is the present condition of the existing building?	
a. good	9 (45)
b. satisfactory	6 (30)
c. needs repair	5 (25)
Prominent display boards in local language	5 (25)

PHC primary health centre CHC community health centre

Investment in infrastructure and manpower is required to meet rural healthcare needs. However, many subcentres lack basic facilities such as water, electricity or toilets, thus raising questions about the quality of care being provided. We need to reduce or delay the occurrence of many diseases and also decrease the referral load of secondary and tertiary care centres for complications that arise from delayed detection or absence of early care. Universal healthcare can be achieved only by strengthening primary healthcare in rural areas as a first step.

REFERENCES

- 1 Report of the International Conference on Primary Healthcare. Alma Ata, USSR, 6–12 September 1978, reproduced in UNICEF/WHO Joint Study on Primary Health Care. Special Series, No. 1. Jointly sponsored by WHO and UNICEF.
- 2 Indian Public Health Standards (IPHS) Guidelines for Sub-Centres, Revised 2012. New Delhi: Director General of Health Services, Ministry of Health and Family Welfare, Government of India; 2012.
- 3 Prinja S, Kaur M, Kumar R. Universal health insurance in India: Ensuring equity, efficiency, and quality. *Indian J Community Med* 2012;37:142–9.
- 4 National Health Accounts Cell. *National health accounts India 2004–05 (with provisional estimates from 2005–2006 to 2008–09)*. New Delhi: National Health Accounts Cell, Ministry of Health and Family Welfare, Government of India (in collaboration with WHO India Country Office). September 2009.
- 5 Reddy KS, Patel V, Jha P, Paul VK, Shiva Kumar AK, Dandona L for The Lancet India Group for Universal Healthcare. Towards achievement of universal health care in India by 2020: A call to action. *Lancet* 2011;377:760–8.
- 6 Ministry of Health and Family Welfare, Government of India. *District Level Household and Facility Survey under Reproductive Child Health Project (DLHS-3) 2007–08 SC, PHC, CHC & DH Manual*. New Delhi: Ministry of Health and Family Welfare, Government of India.

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Reforming the Central Government Health Scheme into a 'Universal Health Coverage' model

Health in India is a state subject; so even with modifications and reforms, it may not be possible to cover the entire population by the Central Government Health Scheme (CGHS). Yet, the scheme can be

made more effective by covering all the Central government employees, especially the pensioners, who need inexpensive, effective and efficient healthcare in their old age. I have worked in two of the central health schemes and offer a few suggestions on the CGHS in addition to those made by Sarwal.¹

The cost of drugs can be reduced without any loss of quality in healthcare by dispensing only those included in the WHO Essential Drug List. Ideally, we should have followed the National Essential Drug List prepared by the Union Health Ministry. It was updated every year to reflect the changes in drug prescribing practices. Unfortunately, it is now not being revised even once in 2 years, whereas the WHO list is revised every 2 years. We also need to educate clients on the meaning of an 'essential drug'. My experience shows that retired group A officers have wrong notions about the drugs. We will need to inform referral hospitals that only drugs in the essential list will be reimbursed for CGHS beneficiaries so that prescriptions from hospitals at the time of discharge conform to the list as far as possible. Specialists in private hospitals are known to prescribe more new drugs than the older ones, and are more susceptible to promotional efforts of sales representatives of pharmaceutical companies.²

Second, CGHS dispensaries should introduce cumulative health records for all beneficiaries since they continue to be under the care of dispensaries for a long time, unlike patients in state government hospitals and dispensaries. This will help in quicker decision-making in the outpatient department. This will also help avoid unnecessary repetition of investigations on each visit. These records can be in the form of an exercise book—one for each family—maintained by the beneficiaries, if the cost of printed records is an issue. These dispensaries should be equipped with basic diagnostic equipment such as blood glucose monitors and ECG machines, which are easy to use and do not require any additional staff to operate. These will reduce referrals to private laboratories and will save both time and money.

Third, the Labour Welfare Organization under the Ministry of Labour has dispensaries in small towns and some in rural areas where doctors are even now posted from the health ministry. These dispensaries can serve the central government employees (including postal employees) and pensioners by contributing the *per capita* cost of treating serving or retired central government employees. Or, these dispensaries can be taken over by the health ministry, which will benefit those central government employees who reside away from cities covered by the CGHS.

Finally, doctors in the CGHS (and also those in other schemes mentioned) hardly have any incentive to excel. They get their time-bound, periodic pay increases, and higher pay scales without any change in the workload. It is true that past decisions regarding time-bound promotions to these doctors cannot be now reversed. However, all the higher pay scales are now given as 'non-functional' grades. It may not be difficult to convert a few posts into 'functional grade' posts with higher responsibilities—for example, Chief Medical Officers (CMOs) in charge of dispensaries (instead of posting the senior-most non-functional CMO grade medical officers as at present), a few selection grade Assistant Directors can be put in charge of a group of dispensaries (instead of the CMO non-functional selection grade at present) and even 'functional' Additional Directors to be in charge of the CGHS offices in CGHS covered cities and at the headquarters of Labour Welfare Organizations. Although the pay differentials in the 'functional' and 'non-functional' higher grades are small, they may be incentive enough for medical officers who are willing to work a little bit extra and wish to have more work satisfaction.

None of these require much additional expenditure, but only willingness among the bureaucrats (and some technocrats) in the Ministry of Health.

REFERENCES

- 1 Sarwal R. Reforming Central Government Health Scheme into a 'Universal Health Care Coverage' model. *Natl Med J of India* 2015;28:29–37.
- 2 Roy Amit S (ed). The political economy of medical practice in India. In. *Medicines, medical practice and health care in India in the era of globalization: The Independent Commission on Development and Health in India*. New Delhi: Voluntary Health Association of India; 2004.

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Manjunath

With reference to the article by Dr A.C. Anand,¹ he deserves kudos for his essays in our *Journal*. He provokes thought and imparts information in a most welcome manner. He addresses each reader personally and in doing so, makes us a part of his intimate group wherein he reminisces, ponders and questions. His wisdom and enquiring mind make each essay mandatory reading.

The essay entitled 'Manjunath' is especially relevant as it deals with the worsening trend in commercialization of medical practice in India.

The questions raised by Dr Neeraj Nagpal and those raised by Dr Anand himself in his penultimate paragraph have troubled many here and elsewhere, now and in the past.

May I quote three respected authorities? These quotations will help resolve the dilemmas posed by Drs Nagpal and Anand.

The first is a respected American judge and Chief Justice of the 5th Circuit Court. Justice Elbert P. Tuttle died at the age of 98 years in 1995. In the obituary note on him, *The New York Times* pointed out that 'he brought honor to his calling and justice to millions of Americans'. His great work lay in restoring civil rights to black Americans.

The late Mr Nani Palkhiwala sent me Justice Tuttle's answer in 1957 to a question posed to him: 'Who is a professional?' I reproduce it below:

'The professional man, in essence, is one who provides service.

'But the service he renders is something more than that of the labourer. It is a service that wells up from the entire complex of his personality. True, some specialized and highly developed techniques may be included, but their mode of expression is given its deepest meaning by the personality of the practitioner. In a very real sense, his professional service cannot be separate from his personal being.

'He has no goods to sell, no land to till. His only asset is himself.

'It turns out that there is no right price for service, for what is a share of a man worth? If he does not contain the quality of integrity, he is worthless. If he does, he is priceless. The value is either nothing, or it is infinite.

'So do not try to set a price on yourselves. Do not measure out your professional service on an apothecary's scale and say, "Only this for so much." Do not debase yourselves by hoarding your talents and abilities and knowledge, either among yourselves or in your dealings with your clients, patients or flocks.

'Rather be reckless and spendthrift, pouring out your talent to all to whom it can be of service. Throw it away, waste it and in the spending it can be of service.

'Do not keep a watchful eye lest you slip and give away a little bit of what you might have sold. Do not censor your thoughts to gain a wider audience.

'Like love, talent is useful only in its expenditure and it is never exhausted.

'Certain it is that man must eat, so set what price you must on your service. *But never confuse the performance, which is great, with its compensation, be it money, power or fame, which is trivial.*'

The second quotation is from an address by Sir William Osler. Born in Canada, first professor of medicine at the newly formed Johns Hopkins University College of Medicine and Regius Professor of Medicine at Oxford at the time of his death in 1919, Sir William was a beloved physician in the English-speaking world.

'My message is chiefly to you, Students of Medicine, since with the ideals entertained now your future is indissolubly bound. The choice lies open, the paths are plain before you. Always seek your own interests, make of a high and sacred calling a sordid business, regard your fellow creatures as so many tools of the trade, and, if your heart's desire is for riches, they may be yours; you will have bartered away the birthright of a noble heritage, traduced the physician's well-deserved title of "Friend of Man", and falsified the best traditions of an ancient and honorable Guild.'

No Indian doctor can afford to forget the final quotation—the words of one of our finest physicians—Çaraka: 'The supreme ideal of a medical practitioner lies in selfless devotion (*nishkama karma*) to his own profession. He can attain the highest *dharma* by protecting his patients with the same tender care that he uses to protect his own children.

'The physician who, for the sake of his livelihood, sells treatment as an article of trade throws away heaps of gold and collects clods of clay in return for them. He, on the contrary, who devotes himself to giving treatment freely out of compassion for living creatures, attains *moksha* for there is no other gift in the world superior to the gift of life.'

If medical doctors in India consider themselves traders and businessmen, these quotations are irrelevant and meaningless.

If, however, we consider ourselves part of an honourable profession and life-long students of the art and science of medicine, they will guide us to the straight and narrow path which has, as its chief goal, the welfare of the patient under our care, especially when she is poor.

May I leave you with one final thought? Members of the medical profession undergo a long period of education—school, college, medical college, postgraduation... We are literate and reasonably well-off. We have access to the products of great minds in a variety of fields including medicine, philosophy and literature. With such privileges we should be able rise above considerations of amassing lucre by jettisoning the principles of humanity, beneficence and ethical behaviour.

REFERENCE

- 1 Manjunath. *Natl Med J India* 2015;28:93–5

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Zoology and the tutor of so many doctors to be, he contributed his bit to the field of medicine by donating his body for teaching and research purposes—a laudable contribution indeed. As rightly said in the obituary, we applaud and appreciate organ donors, but heroes like Professor Pai go unsung.

The Anatomy Act, enacted by several states in India, provides for the supply of unclaimed bodies to medical and teaching institutions for the purpose of anatomical examination, dissection and similar educational purposes. Most bodies available to medical colleges in India are unclaimed bodies. Only a few are donated by the relatives of people who have willed to donate their body after death.

Patnaik² has rightly pointed out that the Anatomy Act is a state legislation, promulgated by the legislature and published in the state government gazette. It regulates the use of dead bodies for medical purposes. Looking at the variations in the Anatomy Acts of different states, especially the process of claiming bodies for medical purposes, Patnaik has aptly suggested that a model act be drafted to serve as a guide to bring about uniformity in the various state Anatomy Acts.

Several Indian states have now regularized the body donation programme by amendments to the respective state Anatomy Acts, notable examples being Odisha and Karnataka. According to *The Times of India*, S.C.B. Medical College, Cuttack received more letters of consent of people willing to donate their bodies after the amendment to the Odisha Anatomy Act that legalized voluntary body donation.³

In the UK, body donation is regulated by the Human Tissue Authority under the Human Tissue Act, 2004. It licenses and inspects establishments which accept and use bodies for medical education and research.⁴

In the USA, the American Medical Education and Research Association (AMERA) and the American Association of Tissue Banks (AATB) regulate this process and provide accreditation to such programmes/organizations.⁴

Prominent Indians, who in recent times have donated their bodies for medical education include Jyoti Basu, former Chief Minister of West Bengal and noted Communist leader; and Nanaji Deshmukh, Jana Sangha leader.⁵

Despite many medical schools pitching for virtual dissection, there is no substitute for hands-on dissection of cadavers to learn human anatomy. Dissection halls have a lot more to teach us than just anatomy. The numerous hours spent by medical students in these hallowed halls of learning could be the first place to invoke a sense of respect and reverence for human life and human suffering alike. On an entirely different note, the camaraderie that develops between six or eight freshmen on the same dissection table extends far beyond the 5 years of medical school and often lasts a lifetime.

I visited the websites of several medical colleges such as the All India Institute of Medical Sciences, New Delhi; B.J. Medical College, Pune; Vardhaman Mahavir Medical College and Safdarjung Hospital, New Delhi; M.S. Ramaiah Medical College, Bengaluru and Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh and found that details of organ donation, links, contact numbers and forms for body donation were readily available.

What caught my attention was the webpage of the department of Anatomy of PGIMER, Chandigarh, where they have put up a picture, a small write-up and a note of thanks for each body donor.

Interestingly, *The Hindustan Times* reported, in 2011, that some districts in Kerala were witnessing an upsurge in the number of bodies donated for medical education and research, primarily due to inflation and rising real estate prices. The price of a coffin and a vault in a cemetery have proved to be deterrents for some people who have instead opted to donate their bodies for medical education and research, thus leading to an unexpected increase in bodies available for teaching purposes in medical colleges. There are often taboos and hesitation among the relatives about the deceased not getting proper

Body donation for anatomy dissection in India

I read the obituary of Professor Ramdas Pai in the *Journal*.¹ Though I did not know him, he came across as a wonderful human being and a great teacher. What was really moving was that being a professor of

last rites, prayers or religious rituals. As wisely suggested by some nuns in Kerala, the bodies can be handed over to medical colleges after the rituals.⁶

However, the state of Gujarat seems to have a different problem, when it comes to body donation. Heads of anatomy departments of two medical colleges in the state have stated that they have received bodies far in excess of their needs.⁷ This should be an inspiration to set up a national committee that looks into sharing of such surplus bodies between states. It would be a pity if these valuable learning resources were wasted even to a small extent.

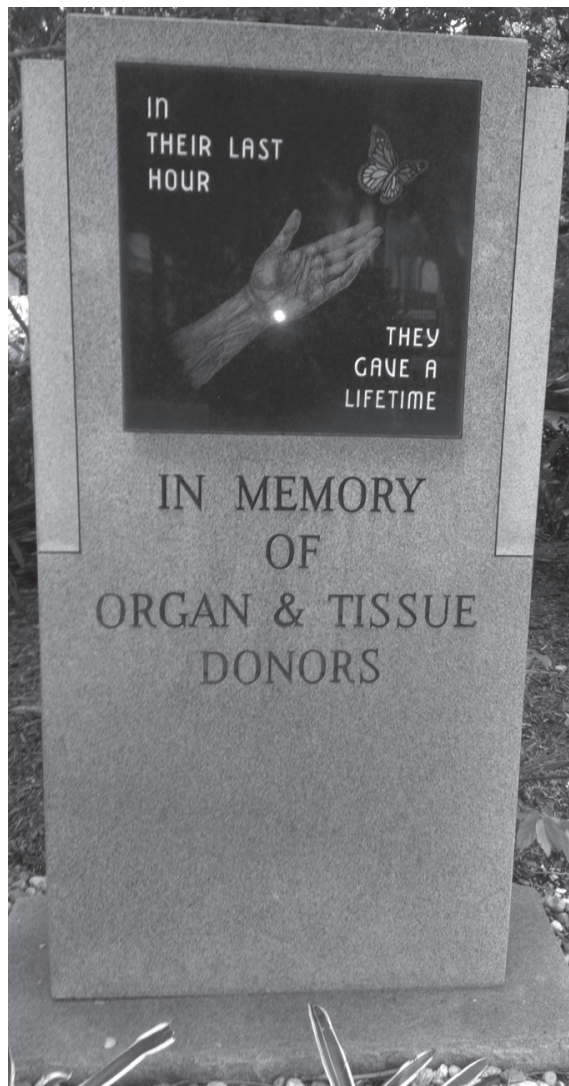
I would like to pay my respects to these unsung heroes with 'Mortui Prosumus Vita—Even in death do we serve life.'

REFERENCES

- 1 Pai SA, Ramdas M. Pai [Obituary]. *Natl Med J India* 2015;**28**:38.
- 2 Patnaik VVG. Editorial. *J Anat Soc India* 2002;**50**:143–4.

- 3 Law change spurs body donation. Available at <http://timesofindia.indiatimes.com/city/bhubaneswar/Law-change-spurs-body-donation/articleshow/20165649.cms> (accessed on 19 Oct 2015).
- 4 Available at https://en.wikipedia.org/wiki/Body_donation (accessed 19 Oct 2015).
- 5 Body donation: Buddha, Biman and many more ready to follow suit. *The Indian Express* 21 Jan 2010 (accessed on 19 Oct 2015).
- 6 Available at www.hindustantimes.com/.../body-donation...kerala/article1-755397.asp (accessed on 19 Oct 2015).
- 7 Available at <http://timesofindia.indiatimes.com/city/ahmedabad/Glut-of-donated-human-bodies-in-Gujarat/articleshow/3674134.cms> (accessed on 19 Oct 2015).

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Dr Ram Datar, a frequent contributor to the *Journal*, sent the above image after reading the obituary written by Dr Sanjay Pai for Mr Ramdas M. Pai,¹ who was lauded for his exemplary organ donation. This plaque honouring organ and tissue donors is situated on the campus of University of Miami's Miller School of Medicine, where Dr Datar serves as the Co-Director of the Dr John T. Macdonald

Foundation Biomedical Nanotechnology Institute (BioNIUM) and as Associate Professor of Pathology, and Biochemistry and Molecular Biology.

REFERENCE

- 1 Pai SA, Ramdas M. Pai [Obituary]. *Natl Med J India* 2015;**28**:38.