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GENERAL MEDICINE

Elective 2011

Elective Report – India 2011;

Narayana Hrudayalaya Hospital, Bangalore

Objectives:

1. How do common medical conditions present; what are the prevalent diseases in S. India?
2. How are common medical conditions managed and how does this differ between rural, government and private hospitals and how do these contrast with the UK?
3. How do the structures of government-funded and private hospitals differ? How is health care delivered to people in remote areas or who live below the poverty line?
4. Develop skills in cultural awareness and work on overcoming barriers produced i.e. cultural and language. Learn from team interactions in hospital settings. Actively reflect on patient and colleague experiences to further personal skills

This elective at Narayana Hrudayalaya (NH) was spent in three areas; firstly in Intensive Care (adult, paediatric and neonatal), secondly in cardiology, and finally in rural medicine at the Rural Development Trust (RDT) and the Social Education and Development Society (SEDS), 200 km from Bangalore. This provided insight into the cross section, and extremes, of healthcare provision in S. India. Like the UK, India has government funding to provide a (largely) free health service across the country, with further care available from non-government organisations (private and charitable); although both sectors experience considerable difficulties and drawbacks.

NH is an exclusively corporate 3200 bedded hospital, or rather 'health city' comprising of 4 hospitals on the main campus; a cardiac centre, a new cancer and multi-specialty centre, an eye hospital and Sparsh orthopedic hospital. It is a financially lucrative venture earning profits beyond that of the average American private hospital and the organisation also encompasses India's largest chain of dental hospitals. The main vision of NH is to bring 'affordable healthcare to the masses' offering prices lower than many of its competitors; although as a tertiary care hospital many treatments, particularly surgical, remain unaffordable for the majority of the population. It performs an impressive number operations and interventions and is considered a centre of excellence, particularly in cardiology and cardiothoracics, across India and Asia.

At the other end of the spectrum, The Rural Development Trust is a large non-government organization (NGO) started by a Spanish Jesuit priest, Vincent Ferrer, who dedicated the last 40 years of his life to eradicating poverty in the Anatapur region. RDT is funded by the government and influential figures of Spain and has a large fundraising department. RDT now boasts 3 hospitals and has set up numerous projects, largely in the field of ecology to reforest this largely barren and semi-desertic area. It also runs successful initiatives in healthcare and the empowerment of women, aiding nearly 2000 villages and over 2 million people, focusing particularly on members of the lowest socio-economic backgrounds or 'caste', which sadly is still a discriminatory factor in Indian society. It was an incredible experience and a privilege to witness the effect of charity, determination and commitment on such communities in meeting both the staff that work tirelessly for the RDT and the people who benefit so greatly from their work.

Differences in provision from the government are largely due to the shear volume of people in India; 1.2 billion compared to the UK's 60 million, which is as apparent in the streets of every town and city as it is in hospitals. 24% of Indians (15% of UK) also live below the National Poverty Line, practically excluding them from private healthcare. In India Rs 26,760 crore (£3.7 bn) is budgeted by the government for healthcare next year compared to £122 bn forecasted expenditure this year in the UK (7.9% GDP). This works out at £3.08 per person per year in India compared to £2033 in the UK. It is estimated that around 40% of poverty in India is as a result of healthcare costs. Many people have private health insurance and companies may offer healthcare insurance for their employees. Many schemes however, particularly for the poorest people such as farmers who in exchange for very low premiums have caveats and excluded conditions and procedures or, as in some government funded schemes, the company will pay a percentage of the costs but for many treatments the patient is still unable to pay the remainder.

Medically, India is in an almost transition phase between developing and developed country. Cardiology for example now sees a very high number of myocardial infarctions, nearly all with a history of type 2 diabetes, hypertension and/or obesity which are commonly thought of as 'Western' diseases. A high proportion of valvular heart diseases however are still due to Rheumatic heart disease, which in the UK and other Western countries has been practically eradicated thanks to the widespread availability of antibiotics for streptococcal disease. Many people, particularly from rural areas also present with tropical diseases such as malaria and Dengue fever during high risk seasons and a large proportion of medical admissions are due to infections including complicated pneumonias, abscesses, dysentery and tuberculosis.

By contrast in the UK there are a greater proportion of chronic non-infective conditions such as chronic back pain, atopic diseases, coronary heart disease, heart failure, and malignancies. Due to a government vaccination programme in India, similar to that of the UK, diseases such measles and polio are thankfully becoming less common. Type 2 diabetes however is on the increase now affecting over 40 million people in India and is predicted to rise to 69 million by 2025; a vast number more have a family history of the disease. It is a major contributing factor in the complication and pathophysiology of many conditions, particularly infections and cardiovascular disease and is an area where public health initiatives are desperately needed.

In terms of presentation to hospital, India is similar to the UK in that most complaints are treated in the community and where necessary people attend a hospital; government or private depending on the available funds of the patient and their family. However the term 'postcode lottery' is far deeper reaching than the issues we refer to in the UK: Under the NHS, where you live may determine waiting time or accessibility to the best available treatment for a condition depending on the local budget. However in India living in one village; small communities of people living usually in poverty and sometimes hundreds of kilometers from a city, could mean one has next to no health provisions, merely local 'nurses' and spiritual or tribal healers, who operate more on luck and common sense than science. Although epidemiological data is very hard to come by in these areas, it may be presumed that mortality, particularly infant and maternal and infectious diseases are considerably higher than in more affluent areas.

Many areas, including government funded hospitals suffer severely from a lack of resources, medications and equipment that we so often take for granted in the UK. Government hospitals give rise to the impression of 'survival', that efforts are only put in to those who are likely to survive and even the doctors are just surviving with their massive case loads. Many attendees to government hospitals do so out of desperation

and inability to afford anything else. Lifelines in the villages and poorest communities may be thrown however from organisations such as the RDT who, in as many regions as possible, provide doctors and basic healthcare provisions which are comparable to that available in the UK. They may also train members of the community, such as their community health worker scheme in becoming the equivalent of Health Visitors in the UK, dealing mainly with antenatal and infant care as well as basic first aid training and providing nutrition programmes for children and people with chronic illnesses. There are still millions of people who are not able to benefit from such programmes and unfortunately, due to the vastness and ever expanding population of India, charitable programmes could never be the main provision of healthcare in India.

Thus due to the poor quality of care and so often negative outcomes of government-funded medicine a branch of private healthcare must exist, and as such India has become one of the world's largest consumers of private healthcare. However even in NH, so often treatment and investigations that would be used first line in the UK cannot be because of financial issues: For example the use of streptokinase which has a 2.8% absolute reduction in mortality in MI is still widely used in NH where as it has not been used for some time in the UK, since the introduction of tPA and angioplasty which have greater reductions in mortality and ;wer side effects. Both however are available, but more costly, in NH. Patients who can afford it however receive world class healthcare and can benefit from the best available treatments, investigations and care; many people each year travel internationally to take advantage of this in hospitals such as NH, where healthcare is likely to be less costly than in private care in developed and surrounding countries. In essence with a predominately private healthcare system, the areas of emergency and preventative medicine suffer.

There are also striking differences in the ethics employed by doctors in both government and private cases, driven by situation. NH being essentially a business requires payment for everything from routine blood tests and consultations to operations; and ultimately produces a profit. In my short experience of NH I have witnessed 3 patients who have lost their lives due to their inability to pay for treatment, and particularly coming from a background where, to the patient, services are free, each were shocking scenarios. Doubtless however, as expressed by one resident, the scenarios such as these are far more common and dire in government hospitals. He expressed that after doing internship in such a government hospital one becomes more used to the concept of death, particularly in relation to financial problems.

This experience has demonstrated the value in a national health service which is free for all UK citizens but underappreciated by so many of them. Rajan Joshua, co-founder of SEDS, illustrated incidentally perhaps the problem of the NHS with a similar scenario about his work: In the initial stages of reforestation of the barren area of Penukonda, Andhra Pradesh, trees were planted free of cost to the local community. The trees were subsequently not cared for by the local people and were soon cut down or died. He then started asking for a small amount for the trees; a few paisas from each person which proved successful at creating a sense of ownership and they started caring for the trees, which have now become something towards a forest. Perhaps, as the UK government has previously suggested, charging a small amount for a consultation would help people stop abusing the system but may herald to path towards privatisation.

The relationship between the patient and the doctor has also been of interest. The education and literacy rates (99% in UK; 61% India) may play a role but similar to the doctor-patient relationship in the UK in the 1980s, the doctor in India is largely didactic with patients very frequently avoiding autonomy and listening, frequently unquestioningly to the doctors advice; most doctors act appropriately in the best interest of

patients but in some cases, additional and unnecessary tests or treatments are given as 'precautions', largely because a patient is able to pay for it. In the UK most patients are able to discuss their treatment and are more demanding of services, frequently questioning the doctor. This occasionally feels frustrating as patients are occasionally misinformed about a condition or treatment but autonomy over ones care can only be positive and encouraged.