PAEDIATRICS

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Elective Report

How are the paediatric services organised and delivered? How does this differ from the UK?

In the United Kingdom, healthcare is separated into primary care referring to the general practitioners (GPs), who is the first port of call for all illnesses and complaints, then secondary care which refers to the hospitals where the GP would refer the patient to for more complex cases and finally tertiary care, where secondary care hospitals can refer even more complex cases. There is a similar system here in Ahmedabad, with local doctors opening general practices and effectively working as general practitioners which is similar to primary care in the UK. Then there are hospitals providing secondary care, and with much more complex and severe cases there are tertiary centres to which these cases can be referred. The hospital I spent my time in was equal to secondary care.

However, the main difference is in the delivery of healthcare and how healthcare is accessed by patients. To see a specialist in whatever specialty you desire, you do not need to be officially referred by the general practitioners, one can simply go to the hospital and attend the out-patient department (ODP)clinics in whichever specialty that is required. For example, in Paediatrics, many patients would come to see the paediatrician as the first port of call for any childhood illness as opposed to seeing the general practitioner first. Then if the child came in for a dermatological problem then the physicians would advise the patient to go visit the dermatology ODP clinic. There would be no need of official referrals although this can be done if the case is deemed important. This system seems to make a lot of sense and also saves the patient money and time as they do not see doctors that may not actually be able to help. However, this system seems to work as the patients have to pay themselves to see the doctor, unlike the UK. In the UK, it is first more important for the patient to be seen by the general practitioner who will deem the necessity of the referral thus saving the local authority time and money in the long run.

The other main difference was in the way that the money is spent in resource poor settings. There are three types of hospitals in Ahmedabad – private, government and semi-private. The hospital in which I was based was a semi-private hospital. This means that although treatment and investigations are subsidized, the patients are still expected to pay a proportion of the actual cost. Therefore, the hospital also has good links with several charities that can help certain patients meet the cost of their healthcare. As a proportion of the patients may not be able to afford all investigations or only just scrape together the money. I was interested in finding out more about the charities and how they ask the occupation of all members of the family to means test the patient.

The patients are also required to provide a significant proportion of the equipment required in their care. This included having to provide the cannulas, the nebulisation kits, catheters and infant feeding tubes. Also all blood tests and investigations ordered, the patients and their families had to first pay for the investigation before it is carried out. Therefore, the clinician in India has to not only think which investigation to order to correctly diagnose the patient, but has to also be able to argue the necessity for each investigation.

When I began my elective a new scheme has also started throughout India called Janani-Shishu Suraksha Karyakram (JSSK) which literally translates to Mother-Infant Protection Programme. This scheme aims to ensure better facilities for women and child health services. This new JSSK scheme has been estimated to benefit more than one million pregnant women and neonates who access public health institutions every year. In this scheme, all expectant mothers can expect to receive free healthcare, which includes investigations and treatment for both normal deliveries and caesarean

sections, and this will continue until thirty days post partum in all Government health institutions. Then for the child, they will receive free healthcare including investigations and treatment until twelve months of age. This is a major breakthrough in the delivery of healthcare in India especially in the field of obstetrics, paediatrics and neonatology.

The free entitlements that would be included under the JSSK scheme would include: free delivery and free caesarean section, if required (this allows more women to give birth in institutions where it is safer, reducing maternal mortality), free treatment of the sick infant up to twelve months of age, exemption from service user charges, free medications, free diagnostic investigations, the free Provision of Blood, then also free transport from home to health institutions and also in the case of referrals they will arrange transport home from the other institutions to home after 48 hours stay. The benefits are the same for the infant.

What are the prevalent paediatric conditions in Ahmedabad?

Malnutrition is extremely common in India and considered to be a major cause for mortality and morbidity in children in India. The main types of malnourishment are protein energy malnutrition and deficiencies in micronutrients. A significantly large proportion of children were found to be anaemic due to malnutrition. It has been interesting to actually see the clinical features of certain deficiencies which I have only read about or seen in a picture in textbooks. However, in the UK, the problem with nutrition is the rise in childhood obesity. I did see a few cases of childhood obesity in India, but this was a rare occurrence and upon speaking with the parents, it was often due to money, with street food being cheaper than making food at home. Also, for many of the parents visiting the hospital in which I was based, there was a problem with education, and parents being unaware of what foods can or cannot be given to their child and when these foods can be given. Often, I saw patients who were deemed small and it turned out that the mother was still exclusively breastfeeding the child beyond six months of age and had not started weaning, thus leading to a malnourished child and a worried mother. Therefore, I did spend a lot of time talking with parents about what foods to feed the child and how much. However, during these conversations it was also important to consider what foods the family can afford to buy and feed their child, otherwise the advice given would have been without benefit.

Another condition I saw quite commonly was acute diarrhoeal disease with dehydration. This may have been due to the timing of which I arrived in India to do my elective. It is summer in India and the temperatures hover around forty-five degrees celsius. The heat makes it very easy for patients to develop dehydration. This is worsened by the patient develop acute diarrhoeal disease and being unable to keep hydrated.

Overall, I have learned many things during my time in India working in a semi-private hospital. I have seen diseases and clinical features of conditions that I have only read about. I have learned about the art of practicing medicine in a resource poor setting and where the clinician makes clinical decisions and recommendations with the cost at the forefront of a lot of decisions. This is something which I have not appreciated to this extent before my time in India.