

## Voice of the Expert

### Robust Indian Healthcare Reforming towards UHC



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**(1) Please comment on the Current Health Scenario in India in terms of service delivery.**

As the Father of our Nation said “India lives in villages”. Current Population of India is 1,349,841,263 (1.34 billion) as of January 23, 2018. About 72.2% of the population lives in some 638,000 villages and the rest 27.8% in about 5,480 towns and urban agglomerations.

Today Hi-tech Health Care is available in Metros and Big cities but even Basic health care (Primary care) is not available to more than 70% people living in villages.

**Health Care :**

**Primary Care:** Basic Health Care First line for routine ailments & identifying serious issues & Referral-80%

**Secondary Care:** Regular Medical, Surgical, Obstetrics & Speciality care 40%

**Tertiary Care:** High tech Cardiac, Neuro, Gastro, Nephro& Sub speciality care. 20%

**Family Doctor or Primary Care Physicians** are the first rank in Health care delivery for the population. They play a vital role in Preventive health, early diagnosis and treatment of acute and chronic medical conditions with timely referral in addition to up keeping of health records of family members in the community and providing continuity of care.

**Efforts by Govt of India to improve Rural/ Primary health care**

1. BRMS BRHC short term health workers course recommended - **withdrawn**

2. Posting AYUSH practitioners in PHC after undergoing bridge course.

3. Permitting Lateral entry for Health sciences.

**Quackery**

4. Creating Integrated System of Doctors/ Hybrid Doctors- NEP 2020 – Mixopathy

Right Efforts will be to reposition the Health system so that adequate Doctors are made available for Primary care but we are trying to sabotage the Health of Rural Indians by half backed AYUSH Doctors offering Modern Medicine.

**(2) Why do you think these efforts are being made presently?**

**GOI Views :**

1. Doctors Numbers are less
2. Doctors Not going to Rural areas
3. Modern Medicine Expensive
4. Promotion of our Ayush

**Many factors may contribute to the above gap :**

a. Failure to create Family Practice and Rural Health Practice Oriented Doctors by the system in place today. **MBBS as a degree has become irrelevant to the system.**

b. Paucity of Doctors. Doctor population Ratio is 1.62 per 10000 only as per WHO Norms only  
Faulty Recruitment - majority  
Less Production ?

c. Doctors not serving and settling in Rural areas?  
d. Lack of infrastructure facilities & safety

There are two dimensions that we should not lose sight when we critically analyse this issue. A

a. The **first** and foremost is that this inequitable access is not only due to Urban and Rural divide. There are social and economic factors which are the root cause of this discrimination. Levels of literacy and gender bias play a prominent part as well. **It is not by the geographical location alone that the Rural Indian is denied access to healthcare. Poverty and social stratification take away his voice.**

b. **The second dimension is that the consideration of patient safety is supreme and any relief should address it adequately.**

The gap that exists between Urban and Rural is both in infrastructure and in service delivery. *Public sector spending accounts for less than a quarter of health spending.* There has been a sharp reduction in capital investment in Public Hospitals and gross under funding of National Health Programmes. If one goes through the direction of health planning a clear shuffling is visible between primary health care and vertical programmes. This has confounded confusion right from policy level.

**But planning to fill this Gap by “Compromised Health Workers” in the name of ‘Crash Course to AYUSH’, Lateral entry/Hybrid Doctors will be detrimental to Health of citizen – Community Health & Life at Risk.**

**Two standards of Health care for the citizen of India :** This is against the fundamental right of the citizen of India. Blatant violation of Constitution against “Equality”.

Alma Ata Declaration 1978 has said that Primary Health Care should include at least: education concerning prevailing health problems, food supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health care, immunization and appropriate treatment of common disease.

**(3) Do you think there is a shortage of doctors in India?**

- **Let us analyse the situational Facts:**  
**A. Doctor Indices**

Total MBBS Seats and Colleges in India		
Type of Colleges	MBBS	
	Total Colleges	Total Seats
Government Colleges	280	42710
Private Colleges including Deemed Universities	262	38690
Total Seats through NEET	542	81400
AIIMS & JIPMER institutions	15 AIIMS; 2 JIPMER	1350 (AIIMS) +200 (JIPMER)
Grand Total	559	82950

NMC data as on date says annually 82,950 Medical graduates are coming out of Indian Medical Colleges. 44,190 Post Graduate seats are available in Medical Colleges.

Annually around 39,000 Doctors sitting idle in Libraries **X 3 years and more around 1-5 lakh doctors unemployed.**

**Foreign medical graduates** 7500 pass out every year out of which 25% get registration in the national medical registry / year by passing the Qualifying exam.

**That means 5600 x 7 years = 39200 graduates are jobless.**

**But we do not have Doctors to serve in Rural or Urban areas. Why? Paradox**

Key reason is today’s Medical Graduates are trained and oriented towards Tertiary care with no exposure to primary care.

**(4) What are the challenges of rural health care?**

**Challenges in Rural Health**

- 8% of the PHC centers do not have Doctors or medical staff
- 39% do not have lab technicians
- 18% PHCs do not even have a pharmacist.
- 66% of rural Indians do not have the access to the critical medicines
  - 31% of the population travels more than 30 kms to seek healthcare in Rural India
  - More than half of all residents of Rural areas live below the poverty line struggling for better and easy access to health care and services & safe drinking water

• **Health issues confronted by Rural people are many and diverse:**

- Malnutrition
- from severe malaria to uncontrolled diabetes
- from a badly infected wound to cancer
- Postpartum maternal illness and contributes to maternal mortality,
- Majority of people die due to preventable and curable diseases like diarrhea, measles and typhoid

**Reality Scenario**

• As compared to their pre-independence levels, all health parameters have shown remarkable progressive improvement even in Rural India.

• States like Maharashtra are now producing surplus MBBS Doctors. The Government of Maharashtra has, therefore, decided to scrap the service bond to serve Rural

• Primary Health Centres (PHCs) are the cornerstone of Rural health delivery system. The number of PHCs has increased from 77 in the first plan (1955) to 23,887 in 2011, a 300 fold increase. No new PHCs in the past 25 years.

• 30 per cent PHCs have two or more Doctors and equal number provides 24 x 7 h services. The number of doctors at the PHCs has increased from 20308 to 26329 (addition of 1,200 doctors per year) in the period 2006-2011.

Table summarizes the profile of the Nurses and Allopathic Doctors that is expected to evolve by 2022.

**Projected availability of allopathic Doctors and nurses**

	2011	2017	2022
Allopathic Doctors, nurses and midwives per 1000 population	1.29	1.93	2.53
Population served per allopathic Doctor	1953	1731	1451
Ratio of nurses and midwives to an allopathic Doctor	1.53	2.33	2.94
Ratio of nurses to an allopathic Doctor	1.05	1.81	2.22
<a href="http://www.planningcommission.gov.in/">http://www.planningcommission.gov.in/</a>			

**(5) Where do the Medical Profession stand ?**

In the meantime, Times of India, New Delhi has come out with a message dated 8<sup>th</sup> March 2010 “Docs ready to work in Villages for PG Quota”. This outcome is following a world Bank sponsored collaborative study conducted in 10 Medical & Nursing Colleges of UP. This reveals the **mindset of the young Medical Graduates of India; their willingness to work in Rural India.**

The cat is out of the Bag. Solution is ready.

Around 1,00,000 young graduates are available in India in this pool. They will solve the issue of “Rural Health Crisis” today itself.

Alternate solution suggested by Public Health Activists is to reserve 25% seats in Medical Colleges to Rural students with a guarantee to serve in Rural areas for 5 years.

The 25% Reservation system will give MBBS Doctors after 5 ½ years.

The AYUSH promoted by GOI will offer poorly qualified Mixopathy Team

But the offer by young Medical Graduates will solve the crisis today itself. Thanks to the youth Medics.

According to the **Rural Health Statistics released by government of India.** As per 2016 there was a shortfall of Doctors at PHCs is only 3244 where India has currently capacity to produce 83,000 MBBS doctors per year.

The total number of posts sanctions at PHC in India only 34068 about less than half of the current number of MBBS seats. Apparently there is over supply of MBBS Doctor for whom there is no jobs in Government Sector.

**Fact: There are very less sanction positions of doctors at PHC given the**

**Indian population and high morbidity levels.**

<https://nrhm-mis.nic.in>

**The current reasons for non availability of Doctors in Rural areas are following**

- Privatization of PHC in many states
- Gazetted regular services of Doctors converted into low paid adhoc contractual services by central and state agencies
- No housing and other facilities for Doctors in Rural areas
- Absence of professional satisfaction due to lack of opportunities in still development or clinical experience.

**(6) Why do you think rural areas often struggle to get good medical care?**

The non-availability of modern medical Doctors in Rural areas in sufficient numbers is due to multiple reasons:

1. There is less number of medical colleges in states where there is shortage of Doctors
2. The syllabi and curriculum of MBBS do not give exposure to a Medical student regarding Rural health scenario
3. The entrance examination system NEET for MBBS itself promotes city-based candidates to get admission
4. **The Doctor population ratio is not the only criteria for better health parameters**, e.g. Sri Lanka. It is the doctor, nurse, midwife, health worker population ratio which is more important. India has better doctor population ratio, the nurse, midwife, health worker population ratio is worst.
5. The Government instead of addressing all the issues related to Public Health, is trying to solve it by a single intervention of empowering AYUSH Doctors, which is going to have a deleterious effect on public health

Health workforce shortfall has been proved above as a Myth.

Myth: The shortage of Doctors in Rural is a misplaced argument

**What is our GOAL in Health?**

Doctors at PHC India Rural Health Statistics Government of India	2005	2016	2019
Doctors at PHCs Required	23236	25354	24855
Doctors at PHCs Sanctioned	24476	34068	32824
Doctors at PHCs In Position	20308	26464	29799
Doctors at PHCs Vacant	4282	8774	7715
Doctors at PHCs Shortfall	1004	3244	1484

### **Healthy India through UHC built on Primary Care**

Rural Health need Primary care qualified Physician and Public health worker

#### **(7) How to resurrect and strengthen primary care in our nation ?**

##### **1. Department of Family Medicine in UG Medical Education**

All medical colleges both Government and Private in India must have a department of Family Medicine.

We have NMC approved post graduate qualification MD in India without department of family medicine. Also DNB & Diploma in Family Medicine.

**This is the key Lacuna.**

##### **2. Faculty in Family Medicine:**

a) Competent Number of Family medicine DNB qualified specialities are available. They can be utilised as full time or part time Faculties.

b) Social and preventive Medicine specialities who have aptitude towards Family Medicine by Bridge course can be trained to be Faculty.

c) Public Health Specialists can be utilised the same way

d) Internal medicine and other broad specialities within interest in Family Medicine must be trained and posted.

e) Community experience should be counted towards faculty eligibility.

Faculty cadre of Family Medicine as Assistant, Reader, Professors to be created with promotional opportunities and a distinctive space in field of Medical Education & Healthcare.

##### **3. Training in Family Medicine :**

UG training in Family Medicine department in the medical college with 6 months Community training in PHC, CHC to be done. During Internship also 3 months training to be given in PHC and CHC not name sake but in real sense. Their posting in the Emergency room will help to be the first contact physicians in Medical Emergencies.

UG training in Family Medicine to be increased with at least 6 months exposure in community settings.

**Community Based Education must be strengthened than tertiary care based system.**

##### **4. Curriculum in Family Medicine :**

Like other Broad Specialties curriculum to be drawn and a separate paper in the pre final year to be included for Family Medicine.

Short term training programmes say 4-6 weeks, which can be developed by IMA-CGP and offer to in service Doctors posted at PHC/CHC as an immediate

measure. These programmes can provide credits which a doctor can accumulate and get counted when undergoing PG Diploma / Degree in FM.

##### **5. Positions in Health System :**

After completion of MBBS their placement in the Health system will attract young Doctors. TO be posted in PHC, CHC, District Hospitals & NHM with large funding can utilise the MBBS doctors in the rural posting with high remuneration package.

Recruitment rules for MO/CMO position in state cadre to include special incentives for Family Medicine Specialities.

PHC (primary health centre) should be re designated as "Family Health Unit" which should provide comprehensive primary health care instead of disease focused Public health intervention.

Family physicians should be placed at front line as team leaders of the "Primary Care Teams"

Retaining programme for retainership of MBBS private doctors in rural area.

**Finance and position are the key to attract Doctors in Primary care**

**In Developed Nations, UK, Primary care Physicians/GP are the highly paid team with good incentives. Adopt the Global best.**

##### **6. Post Graduation:**

In today's demanding Health scenario every young medical graduate is compelled to do Post graduation. Now MCI approved three year institutional MD Family medicine is existing but taken by very few because of placements. Recently Two year Diploma in Family Medicine is introduced by NBE in addition to the existing 3 year course. **No undergraduate Department but PG is available. Great . In future sub speciality courses in Family medicine can also be introduced to create status for Family Physicians.**

When Department of Family medicine with positions in the system are in place youth would prefer Family Medicine. Remuneration must be compensatory for the rural working depending on hours of working

#### **(8) Do you think on line Post graduate Qualification in Family Medicine may be started?**

E learning in the order of the day in Education globally Telelearning.

When our Prime minister is promoting Digital India, Digital PG courses must be a reality in India.

Theory (Knowledge) component will be online. Skills (Clinical ) Component will be by month end clinical training in Medical colleges or Accredited Private Medical Institutions- Blended Learning.

The curriculum and syllabus will be vetted and approved by Government of India.

This approved Digital PG course of Family Medicine will attract Young Medical graduates to undertake Family medicine post graduation while continuing their self-practice or Institutional both Government and private assignments .

IMA College of General Practitioners (IMACGP) initiated by Indian Medical Association in 1963 to promote Qualified & trained Family Physicians in India, is the largest Professional body & initiated online PG qualifications in Family Medicine in the year 2013 & supporting Family Doctors ([www.imaiversity.com](http://www.imaiversity.com) ). First in the World .These courses to be evaluated & finetuned if necessary & approved by NMC.

This will solve the non availability of Medical Doctors in Primary care in cities and Rural areas.

Accessible and Affordable healthcare will reach for Indians.

**Will also offer equitable healthcare to Indians both rural and urban as per constitution of India.**

#### **(9) What is the Role of Digital Health in supporting Primary care?**

**Thanks to our Visionary Prime Minister for legalising Telemedicine. Adequate Training & providing Infra at Rural & Remote areas to Family Doctors will link them with Secondary & Tertiary care centres so that time is not lost in Healthcare Emergencies & distance is managed.**

**In the reverse the Health workers in PHC & sub centres at village level can be linked to Primary care Physicians & offer effective Healthcare.**

To be adopted actively

#### **(10) Ayush MS to do General Surgery, ENT, Ophthalmology, urology, Thoracic & Gastro Intervention surgery. This has been proposed by the GOI vide Gazette of India, 20<sup>th</sup>, November, 2020 notification. What do you think of that?**

**Let them do their Ayush described surgery & not Modern Medicine Surgery**

**Let Modern Medicine Surgeons not teach them.**

**Let then from Ayurveda Teachers their Surgery.**

Misguided policy will cut deep into Patient Safety..

Playing with the life of common man.

Will deepen inequality

Major Community Health issue

Should not be permitted to happen

Modern Medicine is Modern Medicine

#### **AYUSH is AYUSH**

**Limited resources and inequity in allocation AYUSH allocation and utilization of central fund in CRORES**

**Budgetary allocation for health – the key to improving public health**

- In 2015 budget, total health allocation decreased by 5.7 %

- **But out of 33,152 crore AYUSH gets 1,214 crore (3.7%)**

- **Whereas 0.5% of population use AYUSH for health care**

- The approved allocation of the AYUSH department has been increasing progressively over the years.

- The allocation of the 12th Five Year Plan of Rs.10,044 crore amounts to an increase of 235 per cent over the actual expenditure of 11th plan

#### **Failed Experiment :**

- Under NRHM, services of AYUSH practitioners are utilized for managing common childhood illness, counselling on family planning methods and as Skilled Birth Attendants (SBA).

- Allowing AYUSH practitioners as SBA will definitely result in mismanagement of new born.

- **The infant mortality rate has not decreased in the states where this has been done.**

#### **Legal Decisives :**

7.5 AYUSH Doctors in India. How to engage them in Health Care is the cause of the Healthcare Controversies; a big Agenda to be debated.

#### **(11) what are the important Legal Verdicts on this issue?**

#### **Supreme court Judgement :**

- Supreme Court Judgments that AYUSH Doctors cannot prescribe allopathic drugs are very clear in **Poonam Verma Vs. Ashwin Patel and Others (1996) 4 SCC 332**

**National consumer disputes redressal commission**

- Original petition no 214 of 1997

- As laid down by Apex Court in the Jacob Mathew case, we feel it is high time that Hospital authorities realize that the practice of employing non-medical practitioners such as Doctors specialized in Unani system and who do not possess the required skill and competence to give allopathic treatment and to let an **emergency patient be treated in their hands is a gross negligence.**

**So taking into consideration of the Supreme Court and consumer court judgments-constitutionally and legally AYUSH practitioners should not be allowed to practice or prescribe Modern Medicine.**

**Primary care & now Secondary care cannot be transferred to AYUSH**

**(12) What is the Way Forward?**

**Health to become a Constitutional Right of Indians**

**Health to become a Concurrent Subject**

**• Budgetary Health allocation should be minimum of 5%GDP with more share to Rural health**

**• Health care system has to be streamlined as PRIMARY, SECONDARY & TERTIARY care**

**• Department of Family Medicine in UG Education is the key**

**• Positioning of Family Physicians in Health system is needed**

**• Post Graduate Education in Family Medicine to be finetunes & strengthened**

**• Shortfall of MBBS Doctors is a Myth. Their utilization is the failure**

**• Doctors not going to Rural Area is a procedural lapse by GOVT.**

**• A simple immediate workable solution is Reservations in NEET for Rural Candidates with bond for Rural Service for 3 years.**

**• Upgrading sub centres to PHCs with 24X7 clinical services will provide primary care. The current structure suits India of 1950s.**

**• Immediate solution is utilizing the services of unemployed MBBS Doctors & Foreign Qualified Doctors for PHCs.**

**• NHM to be empowered as an Autonomous Institution.**

**• Doctors' recruitment to be kept in phase with the increasing population but it needs adequate Financial allocations.**

**• AYUSH Crash course & posting will also cost Public money spending. While spending Public money let us positively spend it.**

**• AYUSH to Rural India will be the greatest injustice we can do towards the Health of Rural Indians. It will be a blatant Constitutional violation too.**

**• Let us adopt Digital Healthcare actively to strengthen Primary care& reach to the unreached.**

**• Doctor must contribute as Doctor; Nurses must Contribute as Nurses; **No Lateral Entry****

**• Ayush must contribute as Ayush; **No Hybrid Doctors**; citizen can choose the system they need .**

**• **When India is emerging as an Economic power, our health care system cannot go in a retrograde manner by not adhering to international standards in the practice of Modern medicine.****

**• Primary care is Right to life**

**• Universal Primary care: A National Responsibility -UHC**

**• Empower MBBS in Primary care**

**• Rural health Care : A Governance issue**

**Universal Health Coverage (UHC) is only built on Primary care& not on Hybrid Doctors**

**Primary care in India to be offered by Modern Medicine qualified Doctors not by AYUSH or Hybrid Doctors.**

**Hence Strengthening Primary care with Modern Medicine in India is an Emergency need for moving towards Healthy India.**

**Thank you Prof. Dr. S. Arulraj for your answers. We appreciate the time taken by you and we are sure that our readers will be benefited immensely.**