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as expected to do the needful while urgency needs it. The attention of the minister of health department and of the Chief Minister is earnestly drawn to look to their responsibility, as the people can't wait any more.

The country is really sick of speeches, tall talks, schemes and committees but they need action only. Independent India wants people who are alert, active, alive to their responsibilities and duties and sympathetic towards suffering humanity. No indifference, apathy and lethargy can be tolerated any longer.

No doubt there are difficulties in converting existing charitable dispensaries and hospitals vested on the local authorities by private individuals for their maintenance. But when such conversion is considered good for the sake of the people no body will object and legal difficulties may also be solved by adoption of "regulations for emergent circumstances." The Director of Health Services selected doctors and health assistants and these doctors and health assistants got training upto March last. But it is reported no other classes were taken up in April last as expected. It is further stated that those who got training are not being employed to draw their pay and allowance. Thus a great injustice has been done on the doctors and health assistants who are in great difficulty to maintain their families. Any how or other they may be immediately deputed for anti-malarial survey when they may gradually organise centres, at least 3 miles off from one another to be attended once a week for 2 to 3 hours to give medical aid, to attend village schools to educate children hygienic principles and to deliver magic lantern lectures once a week at H. E. or M. E. schools where all people may attend. If these works are taken up half the work will be organised.

It is really a difficult problem to have adequate accommodation in villages for these doctors. But from personal experience I may say that if the doctors approach rich people still residing in West Bengal villages, they will certainly accommodate them temporarily and doctors may gradually induce them to establish charitable dispensaries at their cost while the Government will contribute for the health works. Thus the plan as drafted by the Director of Health Services may be effective to give medical aid to the rural people.

During a period of 23 years in the District of Faridpur, I had to organise charitable dispensaries to raise the number of the same from 0 to 130. I had to adopt similar policy to depute doctors to certain villages to open 3 centres for treatment. Gradually local people came and provided for dispensary buildings and equipment while Union Board and District Board and Government contributed for the recurring expenditure. It is only to educate village people and to show them how they are benefited by such institutions. Everybody co-operated with the doctor. If the people insist on the Government, doctors have adequate remuneration in due course.

Local authorities have failed to manage works for the medical aid and health work. So the Government have been compelled to take up the responsibility, while the Government of India agreed to contribute. The Editor of the J.I.M.A. is certainly justified in stating that if suffering humanity cannot get the desired relief, highly paid officers of the state have no justification to continue with their inefficiency but should hand over responsibility to abler, energetic persons with wider vision and sympathetic outlook.

In West Bengal annual deaths for malaria alone comes to 1,11,000 out of a total population of 2,11,00,000. If the mortality rate is calculated at only 1 per cent, it appears that the total number of persons suffering from malaria alone comes to 1,110,000 per year. Now if we consider the economic loss due to death, treatment cost, loss of working days, funeral cost, loss of efficiency in work, it would be a fabulous sum.

Lt. Col. Sinton the late Director of Imperial Malaria Research Institute worked out these costs for whole India which comes to Rs. 10,850 lacs annually (Rs. 108.5 crores).

As regards the location of sites for 130 new Union Centres, they should be very cautiously considered. Besides the Thana headquarters and the existing charitable dispensaries within Union Board areas, they are to be established at a central place within 2 or 3 Union Board areas where people from such areas can be conveniently treated.

As regards the recruitment of doctors, it is certainly regretted that none can be expected to join on Rs. 150/- plus 45/- with quarters, as one can hardly meet monthly expenses for family at less than Rs. 300/- even in a village. There will be no difficulty in recruiting medico at the present moment while refugee doctors have got a chance for Registration and about 1000 may have registration within 31.12.49.

V

OPINION OF THE INDIAN MEDICAL ASSOCIATION ON THE CHOPRA COMMITTEE'S REPORT ON INDIGENOUS SYSTEMS OF MEDICINE

Preface

The Indian Medical Association is the representative national association of the medical practitioners of India possessing registrable qualifications in scientific or so-called 'Western' medicine and is recognised as such by the Government, the World Medical Association and the World Health Organisation of the U.N.O. The chief objects of the Association are the "promotion and advancement of the medical and allied sciences in all their different branches" and the "improvement of Public Health and Medical Education in India."

When the Indian Medical Association has to put forward its considered opinion regarding the Indi-

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genous or any other system of medicine, the Association has to bear in mind the ultimate cause for which medicine in any form or shape has to be utilised. The health of the nation and particularly the health of the poorer sections of the people in rural and urban areas is the most important consideration in the light of which such problems have to be taken into account. In this perspective the Association highly appreciates the following speech delivered by the Hon'ble Rajkumari Amrit Kaur, Minister of Health of the Government of India at the closing session of the Silver Jubilee session of the All-India Medical Conference held at Calcutta in December, 1948:

> "I viewed with grave concern the policy that is being enunciated by some of our provinces, in the matter of lowering still further the standards of qualification of your great profession. The argument advanced in favour of such action is the lack of aid to rural areas. That lack exists to our eternal shame, but to try to solve it by turning out half-baked medical personnel is to defeat the very object in view. Why should the poor men be given second best in any case? . . . Cheap Medicine and lower qualifications will not be cheaper even from the financial point of view. On the other hand, they will not only lower the standards of your profession but they will, in the long run, cause havoc to the cause of the nation's health."

The next important factors to be taken into serious consideration are the undertaking of certain responsibilities in the field of international health and the establishment of reciprocal relations with other countries of the world. Lately the Government of India has become an important member of the World Health Organization and India has been greatly benefited by this. The health services developed in this country should therefore, be such as to enable the Government of India to fulfil these international obligations. Dr. K. C. K. E. Raja, the Director-General of Health Services, Government of India has, rightly pointed out that "participation by India in the standardisation of diagnostic procedure, in the development of international standards in respect of biological, pharmaceutical and similar products or in the study and report on administrative and social technique affecting public health and preventive care will become impossible unless she (India) adopts the same system of medicine (the modern scientific system) which other nations have adopted for organization of "State Health Services".

Financial considerations would form the next important factors for judgment in such matters. The estimated cost of building and equipping a modern medical college now-a-days is well over half a crore of rupees. If separate modern teaching institutions for indigenous and other systems of medicine have to be built all over the country in addition to the new medical colleges for Scientific Medicine that are necessary, the cost of construction and equipment and recurring expenses on these is sure to prove to be prohibitive, unnecessary and wasteful.

In India, sick persons are treated by three classes of individuals, (*i*) those who possess registrable qualifications in modern scientific (western) medicine, (*ii*) those who are practitioners of the system of Ayurveda, Unani and Homœopathy and (*iii*) unqualified practitioners. It is sometimes said that in a democratic country, the individual citizen has the absolute right to take his ailments for treatment to anybody he chooses. If that be true, why a moratorium extending to a definite period of years was declared in China and Japan after which the practice of the indigenous systems in these countries would not be recognised. It may be further noted that national governments of Turkey, Iraq, Iran and Siam have also adopted an unified system of medicine based on modern sciences. Moreover, it is high time for our legislators to consider seriously the reasons for which Indigenous Systems are not recognised by the State as separate systems of medicine in any other country in the world.

Medical science is one and undivisible. It is a progressive science based on the fundamental sciences of Physics, Chemistry and Physiology and on research work carried out by scientists and medical men throughout the world. Modern scientific medicine should not be lebelled as "Western" simply because in the middle of the 19th century, medical science became progressive and was firmly established on a secure foundation initially in the western countries.

The word "Western" medicine has been used throughout the Chopra Committee's report to connote modern scientific medicine. If the stigma of "Western" or "Foreign" is applied to *allopathy* or modern medicine as practised in India to-day the stigma could equally be applied to all branches of modern science (including Physics, Chemistry and Engineering) which are being developed on the modern lines with State assistance. Moreover we cannot afford to ignore the invaluable contributions made by the eminent scientists and medical men of Japan, China, India and other eastern countries to the development of the "western" medicine.

During the British regime in India from 1757 to 1947 the health of India was of little consequence, in the eye of the Government and therefore, factors responsible for the low level of health were allowed to flourish with impunity. It is obvious that the gross inadequacy of provision by the state of adequate services by duly qualified medical practitioners in scientific medicine and the cheapness of charges made by indigenous and homœopathic practitioners and quacks for their drugs and services rendered are responsible for the continuance of these systems as well as quackery in this country. Till the other day it has been said by many that for a poor country like India, the training for the production of medical licentiates should be continued so that this cheaper class of medical practitioners would go to the villages and settle there to the benefit of the rural people. But fortunately for our country, this argument has

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been proved to be fallacious and steps have now been taken through India to stop further production of the licentiate type of doctors.

With the attainment of independence, it is just and proper to opine that measures for the protection and promotion of health of the people of our free country *should be given the highest priority in any scheme formulated by the Government*. We are strongly of the opinion that it would be unfair and unjust, on the part of the Government to deny to any one in this country the full benefit of the modern medical science merely because some other method of treatment is said to be cheaper. The question of cheapness would certainly not arise if the State can provide for employment of an adequate number of qualified medical practitioners in scientific medicine and for the establishment of a net work of modern hospitals in rural and urban areas.

We feel it is now most appropriate time for not only stoppage of further development of quackery but also of further development of practitioners of indigenous systems of medicine and homœopathy. The necessary measures should be incorporated in an act and should be passed by the legislature at an early date, and those persons trained in indigenous systems of medicine who are in actual practice now and are having their livelihood from it, should be absorbed in future Government public health scheme as public health workers after adequate and proper training.

Note on Chopra Committee's Report

The Committee on the Indigenous Systems of Medicine popularly known as the Chopra Committee, was appointed by the Government of India in December 1946 under the Chairmanship of Col. R. N. Chopra. The Committee contacted and elicited the opinion of various scientific, medical and non-medical bodies and associations of the country, in order to evolve an improved and unified system of medicine.

The Chopra Committee recommended the formation of a statutory body which when created, is to be called the National Medical Board. This Board will consist of two autonomous sections—one dealing with Western Medicine and the other with Indian Medicine. It has also recommended that the first step will be an integration of the courses of study by arranging curricula in such a way that whatever is weak in the one system is supplemented and strengthened by the strong points in the other system. The second step, according to the Chopra Committee, should be the teaching of each subject by the same teacher, instead of by separate teachers as now, giving the students an unified view of the Indian and Western Medicines. The final step the Committee says, will be the field of research where experts of Indian and Western Medicines will work side by side checking and verifying the various hypotheses and theories, either rejecting or harmonising them. If they are such that they could neither be reconciled nor rejected, they are to be used as parallel hypotheses.

The Committee has sought to create substandard medical qualifications of five or six different categories—under the plea of absorbing the existing Vaids and utilising them for mass medical relief in rural areas. They have recommended a short term licentiate course in Indian Medicine of 3 years. A still shorter course of 6 months only to absorb the existing Vaids whether trained or untrained. The highest course or the degree course will be for 5 years. All these courses are to include varying quotas of instruction from modern medicine.

There are to be different registers for different classes of practitioners in Western, and Indian Medicine, subdivided into sections for 'institutionally' trained, 'non-institutionally' trained, and 'untrained' classes of them. Heaven alone can help India and her woe-begone people if such a state of affairs be actually brought into being.

Chopra Committee's recommendations will create a complete confusion not only in the standard of medical qualification and efficiency of medical relief, but will result in a multilateral administration of public health from which order and co-ordination will entirely disappear.

The I.M.A. is of the considered opinion that the steps suggested by the Chopra Committee should be considered in the reversed order. The first step should be to sift scientifically the grain from the chaff, after careful research and then to accept the grain of established truth and reject the staff as useless and injurious. After this, the second step proposed by Chopra Committee may be taken, whereas the first step proposed by the Committee will be apparently futile, as teaching must be clear, unambiguous and absolutely free from confusion and contradiction. The question of strengthening the weak points of each system does not, therefore, arise. The experiment made in this regard in the Government school of indigenous medicine at Madras for about a quarter of a century has resulted in hopeless failure and created nothing but confusion in the minds of the alumni of this school.

Terms used in the ancient books of Ayurveda are irreconcilable in their meaning and application—and differently interpreted even by veteran Ayurvedic scholars. They cannot threrefore be profitably utilised except by students of research and history. Yet, the Committee has continuously pleaded in favour of combining in their recommended courses of study, the curricula of indigenous systems of medicine, just as they are, with merely a spattering of western medicine by way of ornamental window dressing.

Col. Sir R. N. Chopra has himself said in his book on the Indigenous Drugs of India (1933) "when it is remembered that the Ayurvedic system of medicine has been practically stationary for about 1500 years . . . one would find it very difficult to reconcile the old theories of 2000 years age . . . with the recent advance of the world in science. After imparting instructions to the Ayurvedic students in

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modern Physiology, Bacteriology, Pathology, etc., to ask to apply them therein the doctrine of *Vayu, Pittah* and *Kafa* etc. to explain the causation of disease . . . can bring nothing but chaos and discord to their minds."

The opinion of the scientists of India can be gathered from the following speech of late Sir P. C. Ray, the father of scientific research in India, delivered on the occasion of the foundation day of the Calcutta Medical College in 1940:—

"I am afraid I am looking behind me, and this has been to a great extent, the bane which has checked the progress of the country. We must now look forward and judge where we stand in the present world which is based on scientific civilisation. Although I have referred to the Ayurveda, I should say that the policy of passing off the Indigenous system of medicine as scientific systems of medicine after putting a veneer of modern medicine like Physiology and Anatomy on them does not seem to me to be the correct course. The policy should rether be to accept the Western Scientific system of medicine as the nucleus round which the tested knowledge derived from the indigenous systems of medicine may be gathered, all our knowledge should be accumulated on scientific lines."

The Committee toured over provinces and States, met practitioners and representatives of various organisations. They issued questionnaires, which also were generously responded to from different parts of the country.

It is all the more deplorable therefore that the Committee lapsed into a morass of confusion, born out of a sheer disregard for the method of synthesis advocated by medical and scientific experts such as the Indian Medical Association, the Royal Asiatic Society, the Indian Association for the Cultivation of Science and last but not least the expert opinions of patriarchal scientists such as Sir Nilratan Sircar, Sir P. C. Roy and even Sir R. N. Chopra himself.

Recommendations

It should be the duty of politicians and medical men to build up an efficient system of medical relief, on par with the modern scientific standard of other progressive countries and not to manufacture more ill-qualified practitioners—and licensed quacks—and let them loose on the public—particularly in remote and helpless rural areas. There can be no mixed teaching, half-Ayurveda, and half modern medicine. Teaching must be standardised and uniform according to the recommendations of the Indian Medical Council. The result of barrowing of powerful medicinal specifics by untrained and ill-trained members, has been quite disastrous and has inflicted "serious injury on many patients"—to the knowledge of and in the words of the Chopra Committee itself.

Uniformity in the strength and standardisation of drugs and medical appliances is quite as important as uniformity in the standard of minimum registrable qualification as laid down by the Indian Medical Council. Therefore there must be compulsory registration of pharmaceutists and compulsory examination for persons dispensing drugs.

In conclusion, we do not think it a practical proposition, nor a desirable one, to have State organisations of public health and medical relief in the indigenous systems or in a number of separate systems. Apart from the fact that it will entail too heavy a burden on the State and on the people, it will only lead to confusion and defeat the main object, viz. the welfare of the masses to whom we consider, the scientific system should be made extensively and intensively available within the shortest possible time. There should, in our opinion, be one State system, and that should be a really scientific system based on the modern advances in the field of natural sciences. We will take into it those materials in Ayurvedic and Unani as are proved to be of value by modern scientific tests and experiments; but the basic teaching should be as in modern medicine (commonly called Western Medicine), for, it is the system which is keeping pace with advancements in science and includes many subjects and branch-subjects unknown to the indigenous system or entirely lost.

In the *one* system which we advocate, so much of the materials in our old systems as are "proved" by modern tests, will, as already stated, be assimilated and should be taught to the students in the medical college and medical schools. We suggest that for the purpose proper research institutions should be established without delay with capable investigators and experts. We also suggest that every University should have a Chair of History of Medicine including Indian Medicine, with facilities of research on Ayurvedic and other indigenous medicines and with provision of beds for this purpose in a teaching hospital.

We also reiterate the memorandum submitted by us and published in Vol. II App. C 6441 of the Chopra Committee's Report and desist from reduplicating the points and issues raised therein.

The I.M.A. must warn once again against all attempts at setting back the hands of the clock of scientific progress. It will be doing a grave disservice to India's millions as also the cause of preventive and curative medicine—the noblest branch of science applied to the alleviation of human suffering.

In the best interests of the people, we demand that our national Government must not tinker and temporise with the problem but provide the people with the essential requirements of medical education and medical relief as far as possible upto the standard of other progressive countries of the world.*

*The Working Committee, I.M.A. appointed a special Sub-Committee consisting of Drs. K. K. Sen Gupta, P. K. Guha, A. K. Sen (Convener), A. D. Mukharji (co-opted) and Dr. A. C. Ukil (co-opted). The Sub-Committee formulated a preliminary report which was circulated to all Provincial Branches of the I.M.A. and the members of the Working Committee. In accordance with the opinions received the final report was drawn, endorsed by the Working Committee and forwarded to the Government of India.

Voice of the Expert

Robust Indian Healthcare Reforming towards UHC

Prof Dr S Arulrhaj
National President API
Past National President, IMA, New Delhi
Past Dean & Chief Patron, IMACGP
Dr BC Roy National Awardee

(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 incapital 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 ofIndia. 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.

Annualy 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 × 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
http://www.planningcommission.gov.in/			

(5) Where do the Medical Profession stand ?

In the meantime, Times of India, New Delhi has come out with a message dated 8th 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 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 heath 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 carebased 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 highremuneration 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 vary 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.imaevarsity.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, Ophthalogy, urology, Thoracic & Gastro Intervention surgery. This has been proposed by the GOI vide Gazette of India, 20th, 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 Forwad?

Health to become a Constitutional Right of Indians

Health to become a Concurrent Subject

- **Budgetory 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. Arulrhaj for your answers. We appreciate the time taken by you and we are sure that our readers will be benefited immensely.