Addressing rural India’s insatiable need for basic medical doctors – the dilemma of opening more colleges or using the available doctors properly?
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Abstract
The present Board of Governors of the Indian Medical Council plans to open 500 more medical colleges in the coming few years hurriedly. Though India’s insatiable need for doctors and paramedics needs some radical measures this should not cause dilution of medical education standards or hurried production of half trained professionals. India needs to improve the way it plans for, educates and employs doctors, nurses and support staff, who make up the health workforce, and provide them with better working conditions.

KEYWORDS: World Health Report 2006, Bhore Committee, Basic Doctors, Rural Health, Board of Governors (BOG), Medical Council of India (MCI)

Health impoverished India is the largest supplier of foreign medical graduates to the United States and the United Kingdom. Yet, its own rural areas have remained chronically deprived of professional modern medicine doctors whilst rampant quack medical care by non allopathic doctors pervades the rural populace. 2, 3The historical antecedents of India’s health personnel shortages could be traced to a landmark health policy document, the Health Survey and Development Committee report, (Bhore Committee) which underlined that Universal Health Care is a basic human right. 2, 3That report constructed the concept of a ‘basic’ doctor as one trained through five-and-a-half years of university education. 2, 3 It presented statistics on the disease burden and attributed the poor state of health in India not only to inadequacies in medical services and health personnel but also to the prevailing social ills — poverty, illiteracy, poor nutrition and unsanitary conditions. Unfortunately even after sixty years after Indian independence the ills mentioned by them still prevail hence their report still finds its relevance.1, 2

Rural Health Provision by unqualified persons: Roughly, tax funded government public hospitals provide 60% of all hospitalizations, while the profit oriented India’s private sector provides 75% of all routine care. 2, 3India’s health care private sector is composed of an equal number of qualified doctors and unqualified practitioners, with a greater ratio of unqualified to qualified existing in less developed states in northern India. In rural areas, qualified doctors happen to be clustered in areas where government services are available. 3,4Indian Government publicly advocates plurality in health care delivery and utilizes non-allopathic doctors in curative services and national health programs while the statutes created by the government say that cross practice is illegal. All over the country, majority of Indians access the services of individual private medical practitioners for primary level care. 1-5

Unaddressed Disparities even within states of the vast country: There are vast disparities in people’s health even among the different states across the country largely attributed to the resource allocation by the state governments where some states like Kerala have been more successful than others. India’s performance is worse than its poorer neighboring countries-Bangladesh and Sri Lanka. 6
Doctors for export: India’s mammoth infrastructure of 300 plus medical colleges manufacture more than 31,000 medical graduates every year. About 600,000 physicians are registered to practice in India, although the actual number is probably lower because of emigration and retirements or refusal to practice allopathic medicine. The physician-to-population ratio in India is 60 per 100,000. The distribution of practitioners is heavily skewed toward urban areas. Most of the Indian dental specialists do not practice in rural areas of India and are based in elitist private hospitals. The Center for Enquiry into Health and Allied Themes estimates the urban physician-to-population ratio at almost six times the rural concentration of physicians. India’s allopathic physicians practice largely as private fee-for-service practitioners among the urban middle class—with an effective physician-to-population ratio among India’s better-off citizens is about 200 per 100,000. This explains why some observers report that “India has enough physicians,” while many Indians, in fact, never receive the services of allopathic physicians at all.

It is also reported that as a result of dismal and unequal spending on public health, the infrastructure of health system itself is becoming ineffective. The most peripheral and most vital unit of India’s public health infrastructure is a primary health centre (PHC), yet this tax-payers money run system, is unpopular among the middle and rich classes of Indians, and remains the most unused resource for an average Indian tax payer. In a recent survey it was noticed that only 38% of all PHCs have all the essential manpower and only 31% have all the essential supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs. Doctor and health worker absenteeism was the main culprit in most PHCs. So, it means that the poorest of the poor Indians depend on the PHC system, while the rich class goes to ultra-big hospitals in India or abroad, while the populous majority, the great Indian middle class chooses between government hospitals and the private hospitals depending on case-by-case affordability. Although there is a health infrastructure provided by the state, a considerable section of the Indian population accesses the services of Private Medical Practitioners for primary health care. Private practitioners are often preferred to the government run health care facilities primarily because staff at the facilities tends to change often, is less accountable and free medical supplies are very limited.

A toxic combination of bad policies, economics and politics is said to be largely responsible for a majority of the people in the world being deprived of good health that is biologically possible. In the report on “Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,” the World Health Organization’s Commission on the Social Determinants of Health says that health inequities – unfair, unjust and avoidable causes of ill health – have long been measured between countries. Data from the Indian National Family Health Survey-III (2005-06) clearly highlights the caste differentials in relation to health status. The 1998 Survey documented a similar picture of lower accessibility and poorer health statistics among the lower castes. The World Health Report 2006 notes that today’s manpower crisis is a binding constraint to health improvement in almost 60 countries globally.

Further, National Commission on Macroeconomics and Health reports that India has a persistently adverse nurse population or nurse doctor ratio. Only an estimated 40% of registered nurses are active because of low recruitment, migration, attrition and drop-outs due to poor working conditions. Non registered and unlettered nurses dominate the nursing arena, and many nurses are certified by ill-equipped local doctors or local hospitals. This means that the quality of nursing care in rural areas of India is
not uniform; and it may be at times substandard in absence of a centrally sponsored clinic or hospital accreditations system. 12-14
The growth of private healthcare sector has been largely seen as a boon, however it adds to ever-increasing social dichotomy in a plural medicine dominated largely uneducated society. The dominance of the private sector not only denies access to poorer sections of society, but also skews the balance towards urban-biased, tertiary level health services with profitability overriding equality, and rationality of care often taking a back seat. The increasing cost of healthcare that is paid by ‘out of pocket’ payments is making healthcare unaffordable for a growing number of people. The number of people who could not seek medical care because of lack of money has increased significantly between 1986 and 1995. 14 The proportion of people unable to afford basic healthcare has doubled in last decade. One in three people who need hospitalization and are paying out of pocket are forced to borrow money or sell assets to cover expenses. Over 20 million Indians are pushed below the poverty line every year because of the effect of out of pocket spending on health care. In the absence of an effective regulatory authority over the private healthcare sector the quality of medical care is constantly deteriorating. 14 Indians have inadequate access to quality healthcare, and this is particularly true for the poor, those residing in rural areas, tribal areas and women. According to the 2010 Confederation of Indian Industries (CII) report, about 7-8 per cent of Indian households are pushed below the poverty line because of expenses incurred on healthcare. There are also critical gaps in infrastructure especially with respect to the presence of healthcare centers and well-trained staff.22-24

UNPLANNED AND UNREGULATED GROWTH OF THE PRIVATE HEALTH INDUSTRY:
The growth of private health sector has been unplanned, unregulated and unaccountable in the form of hi-tech hospitals and medical colleges in urban areas.15-17 The professional councils are either defunct as far as implementing ethics is concerned or are misused by the dominant vested interests of the profession or are toothless monsters barking but unable to bite. 15-17

NEED TO FOCUS ON BASIC HEALTH PROVISIONING: India needs to prioritize interventions and targets. A range of low cost solutions like peer education, access to condoms, use of anti-retroviral drugs would help in tackling HIV/AIDS. Other strategies include life style modification and better hygienic practices. Recruiting and retaining physicians to serve in rural areas is a difficult challenge due to the expectations and attitudes of medical graduates and post graduates. Incentives to prospective health workers would be more effective in the form of packages, cuts as in Kerala. 15 India needs to improve the way it plans for, educates and employs doctors, nurses and support staff, who make up the health workforce, and provide them with better working conditions. India needs to reign in its money making medical college hospitals, rich catering private hospitals, and stop employing Indian system of medicine doctors in allopathic workplaces.17
Health worker and Medical teacher incentivisation, will also attract efficient staff to stable institutions. Emigration of high quality Indian physicians and senior nurses who could potentially serve as teachers in Indian colleges may lead to further declines in the quality of graduates produced. This needs to be stopped by the Indian governments. 15-17To address regional inequities for medical training and related availability of doctors, firstly, it may be useful to set up adequately staffed medical research and training institutions in economically backward areas. Secondly, the government could subsidize the medical
education of individuals living in backward areas, perhaps by combining such a subsidy with a bond to serve in the backward areas for a limited number of years. 15-20

Representatives of most medical associations have always stressed that the first priority of any government should be to fill up the existing vacancies in all government hospitals. 17,22 The services of the retired doctors, retired medical and nursing teachers should be extended to offset the teacher/medical trainer shortages. Merely increasing the ages of teaching faculty to 70 years as recently proposed by the Board of Governors may not suffice. 20-22 The government can issue an ordinance to relocate major hospitals of medical colleges in rural areas of the country, to help the accessibility. Half of the elite medical college hospitals are clustered in cities where they serve the urban populations who have enough doctors to approach in the private sector. 20-21

Meanwhile, hurriedly projecting a need for 500 medical colleges in the next five years, the Medical Council of India (MCI) Board of Governors Chairperson Dr. Sarin in September 2010 has recommended that such institutions should each have at least 10 acres of land for a college and hospital and not more than 250 students.23-25 Unscientific measures as this and increasing the retirement ages of medical teachers from the present 65 years to 70 years have been criticized by the younger generation of doctors and have asked for time bound promotions.24,25

Eminent medical educators have felt that the solution to India's doctor shortages does not lie in building more medical colleges.19-22 A better alternative would be to draw from other countries' experiences of developing mid-level practitioners by training and retraining the ayurvedic, homeopathic physicians as well as the dentists in Clinical Medicine in the Government Medical Colleges. In the short term; India must also upgrade the skills of existing unlicensed rural practitioners and empower registered B.Sc nurses to take on additional tasks by allowing them to undergo a 3 year hands on training in Clinical Medicine and Therapeutics at reputed medical colleges.19-22

Medical and health sciences education needs attention: "There are four wings on which a medical student has to grow - knowledge, skills, clinical problem solving ability and attitudes and behaviors. Unfortunately only knowledge and skills are emphasized in both teaching and evaluation.19-22 The clinical problem solving ability is given less emphasis and attitudes and behaviors is not at all given any place in the formal process of teaching and evaluation," says the noted rheumatologist, Joy Philip. Currently Anatomy, physiology and biochemistry are being taught using "abstract and raw facts" with no proper correlation to actual applicability in diagnosing and treating patients, Dr. Philip adds.19-22

The current medical education system and the curriculum that we now have does not produce doctors for our rural Indian society; where all modern medicine doctors are driven after specialization leaving hardly anyone except quacks to look after health care, primary and emergency services. 21 Rural based knowledge would prepare doctors for the rural populace hence the need is to develop a rural oriented MBBS curriculum, and give emphasis to concepts of family medicine.20-21 There is an urgent need for many policy changes to bring out more people friendly family doctors especially for the impoverished among the rural or urban masses. 15,17-22

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