First step in a long journey

Even as the spotlight shifts to a “maha-panchayat” of doctors under the Indian Medical Association getting ready later this month to challenge the National Medical Commission (NMC) Bill, 2017 (now before a parliamentary standing committee), it is pertinent to look at the Bill’s highlights. Article 47 of the Constitution makes it clear that the state is duty-bound to improve public health, but India continues to face a health crisis, with an absolute shortage of and an inequitable presence of doctors and over-burdened hospitals.

Although India has 10 lakh medical doctors, it needs 3,00,000 more in order to meet the World Health Organisation standard of the ideal doctor-population ratio. There is an 81% shortage of specialists in community health centres (CHC), the first point of contact for a patient with a specialist doctor. Those most affected by this are poor and rural patients who are then forced to consult quacks. Another fact is that 82.2% of providers of “modern medicine” in rural areas do not have a medical qualification. Rural India, which accounts for 69% of the population, faces another issue — only 21% of the country’s doctors serve them.

The quality of the health-care experience too needs attention. It is ironic that, while India is a hub for medical tourism (in 2016, India issued 1.78 lakh medical visas), it is a common sight in government hospitals to have patients sleep in corridors waiting for their outpatient department appointments.

The Bill, among other things, seeks to address these problems.

The insertion of Section 10A in the Indian Medical Council Act was followed by an exponential rise in the number of private medical colleges. This was encouraged as there was, and still is, a shortfall in the number of medical practitioners. However, the high capitation fees charged by these colleges can have a negative effect in terms of affordability of medical services.

The regulatory authority has been unable to act despite the fact that over half the 60,000 medical students graduating every year are from private medical colleges.

With corruption in the issuing of licences and regulatory requirements, many such academic institutions have a faculty of questionable standards, with obvious repercussions on the quality of education imparted.

The Bill puts in place a mechanism to assess and rate medical colleges regularly, with a high monetary penalty for failure to comply with standards. Three such failures will result in the de-recognition of a college. There is also an enabling provision for the government to regulate the fees of up to 40% seats in private medical colleges. NITI Aayog data show that this amount falls in a Goldilocks zone, wherein the regulation can be made revenue neutral for the college by nominally raising fees for non-regulated students.

The Bill goes a step further with a relaxation of the criteria for approving a college in specific cases. Currently, there is a blanket standard for establishing a medical college in India, which disregards the contextual realities in some areas such as difficult terrain or a low population density. For instance, Arunachal Pradesh, Mizoram, and Nagaland do not have a single medical college.

India has a well-thought-out, three-tier public health-care system which rests on a base of sub-centres (SC) and primary health centres (PHCs) which take care of common ailments. Patients in need of specialist consultations go up the chain to secondary centres (CHCs) , or tertiary centres, which are district hospitals (DHs) or medical colleges. However, because of a poor vanguard, patients who can be treated at the “base” (SCs or PHCs), go straight to the “apex” (CHCs or DHs).

Strengthening primary centres can ensure that the pyramid rests on its base again. With the government now planning to revamp 1,50,000 sub-centres into health and wellness centres by 2022, there is need for an equivalent number of mid-level providers. For this, India’s 7,70,000 AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy) practitioners can be tapped.

The Bill has facilitated this by providing for a bridge course for AYUSH/non-allopathic doctors. This course, to be designed by a joint sitting of all medicine systems, will ensure that non-allopathic doctors are trained to prescribe modern medicines in a limited way, within the scope of primary care. A parallel is the system of “barefoot doctors” in China.

Thirteen States now permit AYUSH doctors to prescribe varying levels of allopathic care. The NMC Bill will bring in a homogenisation of such rules without diluting the varied systems of medicines.

An added measure in the Bill prevents “cross-pathy” or the unqualified cross-over of health-care providers from one system to another. The Bill provides for two separate national registers – allopathic doctors, and AYUSH doctors who complete the bridge course, respectively.

In the end, the Bill seeks to make structural changes in a stagnant and increasingly exploitative health-care system. While it is no magic bullet, it should be looked at as a step in the right direction.

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The India-Japan economic relationship remains underwhelming in relation to strategic ties

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