Doctors for rural India

Nearly 600 million people in India, mostly in the rural areas, **have little or no access to health care**. A widespread disregard for norms, a perpetual failure to reach targets, and an air of utter helplessness are what mark the state of rural health care today. One can add to this another fact: the country is short of nearly five lakh doctors.

Among the range of measures that have been suggested in the past decade is a rather promising proposal which has been sidelined. If properly implemented, it may provide rural India with a lasting pool of primary care physicians.

A few years ago, the Union Health Ministry drew flak when it put forth a proposal to train a new cadre of health professionals. Under this plan, these professionals, after undergoing a short term, 3-3.5 year course in modern medicine, were to serve the health needs of the rural population, with a focus on primary care.

Such short-term courses aren't new in the Indian health-care scenario. In the 1940s, primary care physicians — who were trained under short-term courses, and broadly termed Licentiate Medical Practitioners (LMPs) — would deliver quality services in the rural sector until the Bhore Committee (1946) recommended abolishing them in the idea that India would produce enough MBBS doctors.

Breathing life into health care in India

The committee made certain laudable recommendations in connection with the public health system. Back then, however, nobody could have anticipated the country's miserable failure in achieving most of the targets prescribed by the committee, even years after Independence. While a profit-driven, private health-care sector continued to denude the public health system of its qualified physicians, its medical education system kept losing touch with the actual health needs of the country.

Starting a short-term course in modern medicine can provide an opportunity to design a medical curriculum that is much more relevant to the nation's needs. Its entry requirements could be based less on sheer merit and more on an aptitude for medical service and preference should be given to applicants from within the community. Further, a provision for learning in the vernacular languages can be made.

Short-term courses in modern medicine have been consistently equated with producing "cheaply made, poor quality doctors". However, one begs to differ with this. LMPs cannot be called quacks if they be adequately trained in their field (primary care) and have a well-defined role in health care. The present MBBS curriculum includes a good amount of superfluous detail, including subjects such as forensic medicine, that is of little relevance to primary care physicians. Here, we should also note that even though nurse practitioners and pharmacist medical practitioners may be capable of serving the same functions as LMPs, they cannot be expected to make up a lasting pool of dedicated grass-rootlevel physicians.

Another concern is that the rural population would be made to feel like second class citizens by appointing a lower tier doctor to treat them. This can be put to rest by not letting LMPs replace MBBS doctors but instead work in a subordinate capacity.

A few changes in the public health system can be envisioned here: LMPs be employed in sub-centres where they perform both clinical and administrative functions at the sub-centre level. This would also allow easier access to primary and emergency care and keep the post of medical

officer for MBBS doctors, thereby deterring any competition between the two cadres of physicians.

Medical officers (MBBS) could be employed in primary health centres (PHC), and new recruits imparted mandatory further training of a sufficient duration in basic clinical specialties. Also, inpatient facilities at PHCs can be scaled up. PHCs should deal with cases referred to them by sub-centre LMPs and also supervise their work.

This has many advantages. With LMPs working at the grass-root level, a single PHC would be able to handle a bigger population, allowing for more resources to be concentrated on individual PHCs for manpower and infrastructure development and also for increasing the remuneration of medical officers.

Ancillary responsibilities can be taken off an MBBS doctor and their skills put to better use. Quality emergency and inpatient attention can be made available at the PHC-level. Today, less than a handful of PHCs provide inpatient care of significance. Concerns about the clinical and administrative incompetence of fresh MBBS graduates appointed as bonded medical officers can be put to rest.

LMPs could be allowed to take up a postgraduate course in primary care as an option to study further. Those with a postgraduate qualification could choose to move higher up in the public health system, establish their own practice, find positions in hospitals, or serve as faculty in medical colleges training LMPs.

Therefore, reviving LMPs can help address the dearth of trained primary care physicians in rural India. The logistical entailments of implementing this idea would require separate deliberation.

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Positive developments are taking place with regard to female genital mutilation

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