Prescription for the future

Vector illustration in a modern flat style, health care concept. Doctor and medical bag. Flat vector illustration. | Photo Credit: iStock/Getty Images

The National Medical Commission Bill, aimed at reforming Indian medical education and practice, is in trouble. After countrywide protests by the Indian Medical Association, the Bill was referred by the Lok Sabha to a Parliamentary Standing Committee for a re-look. Whatever be the outcome of this exercise, the altered Bill is unlikely to please everyone.

This is because the questions it seeks to address are knotty, with no straightforward answers. First, how can India produce enough competent doctors to meet its evolving health-care challenges? Second, how can it minimise opportunities for rent-seeking in medical education and practice? So poorly did India's current medical regulator, the Medical Council of India (MCI), perform on both counts that policymakers believed the only way to redeem the body was to replace it.

The MCI's failures are well known. For years, it was mired in allegations of bribery and going soft on unethical doctors. Under its stewardship, the medical curriculum grew obsolete, resulting in a cadre of MBBS doctors who frequently couldn't perform basic procedures. This led to a rush among MBBS doctors to specialise, competing for a small number of post-graduation seats. Today, India neither has enough basic doctors, nor specialists.

Enter the National Medical Commission (NMC), intended by policymakers to be a dynamic regulator responsive to India's needs, unlike the opaque MCI. In contrast with the MCI, which does everything from advising universities on curriculum to disciplining errant doctors, the NMC distributes powers among four autonomous boards — those for undergraduate education, postgraduate education, medical assessment and rating, and ethics and registration. Also, unlike the MCI, the commission includes non-doctors like patient-rights advocates and ethicists, in line with the medical regulators of the U.K., Australia and Canada. These are all steps in the right direction.

Where the NMC bill trips up is in how it chooses the members of the new regulator. The authors of the NMC bill, a committee headed by ex-vice chairman of Niti Aayog, Arvind Panagariya, argued that the electoral process through which MCI members were picked was fundamentally flawed, because conscientious doctors tended to avoid such elections. Because there was no bar on re-elections, this had created a revolving door through which the same group of members controlled the MCI for years. Sometime around 2008, Gujarati urologist Ketan Desai was elected MCI president, even though he had been prosecuted in the Delhi High Court for abusing power as president in 2001. Further, corruption charges against Dr. Desai and his team led to the MCI being disbanded in 2010.

The NMC Bill's solution to the pitfalls of the electoral process is for the central government to select most of the commission's members. But this would tip the scales towards bureaucracy, say experts. "The babudom is now extreme," says Rama Baru, a health-policy researcher who served on the ethics committee of the MCI between 2012 and 2014. Such political hold on the commission is especially problematic, she adds, given the close ties that private medical colleges in southern India have with politicians. Ms. Baru is in favour of more elected members in the commission, but with limited terms of office, so that corrupt members aren't re-elected.

Another option to keep the NMC free from political influence is for an independent body like the Union Public Service Commission to select its members, says Sujatha K. Rao, a former Union

Health Secretary. Such a model is followed in the U.K., where the Professional Standards Authority oversees the selection of members to the General Medical Council. Whatever route the NMC takes, it is critical that its members are professionals of high integrity, something that isn't ensured in the current Bill. "Any law will succeed if it is implemented by good people. The best law, if implemented by corrupt people, can fail," says Ms. Rao.

The NMC Bill also misses an opportunity to plan for India's rural health- care needs in the coming decades. While it eases regulations to set up private medical colleges, a move that will hopefully produce more doctors, this measure isn't enough. As of today, India has one doctor for 1,700 people, compared to the WHO norm of 1:1,000. Most of these doctors are in urban regions, while close to 70% of Indians live in rural provinces. This gap isn't going to close any time soon. A 2015 Parliamentary Standing Committee report mentioned that even if India were to add 100 medical colleges per year for five years, it would take till 2029 to achieve the WHO prescribed ratio.

Even in States like Tamil Nadu, which has successfully attracted doctors to rural primary health centres (PHCs), tribal regions like Sittilingi are underserved and rely heavily on informal health-care providers, says Meenakshi Gautham, a health policy researcher at the London School of Hygiene and Tropical medicine. This is why India must think of quicker fixes to the doctor shortage instead of waiting for MBBS doctors to fill the gap. "We can't ask populations here to wait for ten years till we produce enough doctors. Neither can we wait for rural areas to become urbanised," she reasons.

Several sub-Saharan countries have successfully addressed this problem by training non-doctors in basic medicine and even surgery. Such non-doctors include nurses, or even informal health-care providers, often referred to as quacks. A 2016 study published in *Science* magazine showed that nine months of training led to a marked improvement in the ability of informal providers in West Bengal to correctly manage chest-pain, respiratory distress and childhood diarrhoea. International organisations like Médecins Sans Frontières and Red Cross have endorsed training programmes for non-doctors to carry out critical surgical procedures like caesarians and intestinal resections. Evidence from countries like Mozambique and Thailand shows that such training can be a safe, effective and cheap way to provide life-saving health care when no doctors are available. This is why even Chhattisgarh attempted to create a cadre of rural doctors in 2001, through a three-year programme. Even though the Indian Medical Association has strongly opposed such ideas, they cannot be off the table, given the evidence backing them. Ms. Gautham says it is time to recognise that MBBS doctors may not be the best means of health-care delivery in isolated parts of rural India. The NMC Bill should, at the very least, include a provision to debate this idea.

The 1956 Indian Medical Council Act, under which the MCI in its current form came to life, set the agenda for nearly 60 years of medical education and practice. The NMC Bill could do the same for the next few decades. If policymakers do not address the many questions that health-care experts have raised over the Bill today, they will miss their chance at truly game-changing reform.

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Only an overhaul resembling the industrial liberalisation of 1991 will work

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