Restructuring the Medical Council of India to eliminate corruption

The Medical Council of India (MCI) has been repeatedly criticized for providing opaque accreditation to aspiring medical colleges in India. Many of its members have been accused of taking bribes in order to fast-track accreditation. Bribes reduce the legitimacy of all accredited colleges and thereby compromise medical college quality overall in the country. Considering India's dearth of medical professionals, quality medical colleges are needed to fill the growing healthcare shortages.

Experts at NITI Aayog have proposed replacing the compromised MCI with a new National Medical Commission (NMC), outlined in a draft Bill known as the National Medical Commission Bill of 2016. In a new research paper, we look into this proposed Bill and suggest recommendations that would raise the integrity and overall quality of accreditation of medical education in India.

According to the World Directory of Medical Schools, in 2016, India, with 343 medical colleges, had the largest number of operational allopathic medical schools in the world. Brazil, was a distant second, with 193 medical colleges, and China, with a population comparable to India's, had less than half the number. Our analysis indicates that within the next three years, 76 new medical colleges will gain the "recognized" status from the MCI. It is imperative that India ensures that all these medical colleges meet a basic minimum quality standard.

Structural differences between the proposed NMC and MCI are enormous. The NMC would split the selection, advising, and actual accreditation process into three separate boards. By dividing power, the hope is to create a system of checks and balances. However, as per the current Bill, all members of the accreditation board are supposed to be ex-officio members of the advisory board. This defies the logic of good governance. Instead of creating different boards to watch and observe each other, the NMC would instead create a pair of Siamese twins—two different heads, but for the most part, a single potentially corrupt body. For this reason, we recommend removing all members of the accreditation board from the advisory board.

The accreditation board is not given direct jurisdiction over the accreditation process. Rather, it is given authority over four sub-boards that look into the four core areas of accreditation: undergraduate, postgraduate (PG), registrar of medical professionals, and compliance. The compliance wing is supposed to hire a third party to check that colleges meet standards set by the other sub-boards. We believe that the monopolistic nature of this service will produce unnecessary bureaucracy, stifle smooth accreditation and possibly raise the spectre of the old MCI all over again. In its stead, we recommend the creation of four regional medical councils. Creating these regional options will lead to competition and an increase in the quality of accreditation services overall. There already exist state medical councils which can be combined for the purpose. There is a great deal of variation in the quality of state medical councils across states. Competition for the accreditation business could ignite life into these bodies.

The World Health Organization has put out several drafts on standards for basic medical education, postgraduate medical education (PME), and continuing professional development. We believe the NMC would greatly benefit from being tied to these best practices. Countries like China and Thailand have already done so to the benefit of their medical education establishment. Although the standards set by the PME call for schools to balance teaching and research, the Bill needs to incentivize research. The dean of Ganga Ram Institute of Medical Education and Research found that the faculty at over 57% of medical colleges in India have published no peer-reviewed articles. Research is fundamental to PG medical education. The PG sub-board should only accredit schools that establish a research-based hierarchy for its faculty and assess students on their research.

The current MCI rules and guidelines prohibit qualified MBBS doctors without a PG degree from performing procedures such as ultrasound and interpreting chest X-rays. The NMC should revisit these rigid regulations to raise the effective availability of qualified doctors in India.

The other factor contributing to the shortage of medical doctors is the emigration of physicians. India is the largest source of physicians in the US and the UK, and the second and third largest in Australia and Canada. This brain drain is especially expensive because many of them are trained in colleges subsidized by the government. It is within the purview of the NMC Bill to recommend a policy to limit emigration of newly graduated doctors. Thailand successfully adopted such a measure in 1972. Their policy mandates three years of government work for all post-graduates. The first year is spent in provincial hospitals, while the second and third years are spent in rural or community hospitals. Statistical evidence indicates that this policy limited brain drain, and reduced medical professional density disparity between rural and urban areas. Closer home, Kerala implemented compulsory rural service for all MBBS and PG doctors studying in government medical colleges as a part of Arogyakeralam, its version of the National Rural Health Mission.

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This is the first in a four-part series on reforms in the healthcare sector.

Comments are welcome at theirview@livemint.com

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