Report:

Task Force on Medical Education for the National Rural Health Mission

Ministry of Health and Family Welfare
Government of India
Nirman Bhawan, New Delhi-110001

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Abbreviations

A

AIIMS-All India Institute of Medical Sciences
ANM- Auxiliary Nurse Midwife
ASHA- Accredited Social Health Activist
AWW- AnganWadi Worker

B

BPL- Below Poverty Line
B.Sc- Bachelor of Science

C

CBR- Crude Birth rate
CCM- Centre for Community Medicine
CEHAT- Centre for Inquiry into Health and Allied Themes
CGHS- Central Government Health Scheme
CHC- Community Health Centre
CHC, Bangalore- Community Health Cell
CHS- Central Health Service
CMET- Centre for Medical Education and Training
CMC, vellore- Christian Medical College, Vellore
CMO- Chief Medical Officer
CMP- Common Minimum Programme
CPR- Couple Protection Rate

D

DA- Dearness Allowance
DGHS- Director General of Health services
DP- dearness Pay

E

ESIS- Employees state Insurance Scheme
EAG- Empowered action Group
ENT- Ear, Nose & Throat

F

FRCH- Foundation for research in Community health

G

GDP- Gross development Product
GDMO- General Duty Medical Officer
GOI- Government of India

H
HA- Health Assistant
HIV- Human Immuno-deficiency Virus
HRA- House Rent Allowance
HW- Health Worker

I
IA- Information Awaited
ICDS- Integrated Child Development Scheme
ICMR-Indian council of medical Research
ICSSR-Indian Council of Social Science Research
IGNOU-Indira Gandhi national Open University
IMA- Indian Medical association
IMNCI- Integrated management of Neonatal & Childhood illnesses
IMR- Infant Mortality Rate
INC- Indian Nursing Council

L
LHV- Lady Health Visitor

M
MA- Medical Allowance
MBBS- Bachelor of Medicine & bachelor of Surgery
MCH &FW- Maternal Child Health & family Welfare
MCI- Medical Council of India
MoHFW- Ministry of Health & Family Welfare
MO- Medical Officer
MPW- Multi Purpose Worker
MVA- Manual vacuum Aspirator

N
NA- Not Applicable
NCMH- National Commission on Macroeconomics and Health
NGO- Non-Governmental Organization
NHP- National Health policy
NHS- National Health Service
NIHFW- National Institute of Health and Family welfare
NPA- Non Practice Allowance
NPP- national population Policy
NRHM- National Rural Health Mission
NSSO- National Sample Survey Organization

O
OB & G- Obstetrics & Gynecology
OOP- Out of Pocket
OPD- Out Patient department

P

PH- Public Health
PHC- Primary health centre
PSM- Preventive and Social Medicine

R

RA- rural Allowance
RGUHS- Rajiv Gandhi university of Health Sciences
RMP- Registered Medical Practitioner
RNTCP- Revised national Tuberculosis control Programme

S

SC- Sub Centre
SEARO- South East Asia Regional Office
STD- Sexually Transmitted Diseases

T

TFR- Total fertility Rate
TOR- Terms of reference

U

UPA- United progressive alliance

V

VMMC-Vardhman Mahavir Medical College

W

WHO- World Health Organization

CHAPTER I

OVERVIEW OF THE NATIONAL HEALTH SYSTEM

1.1 Health – A Basic Human Right

Health is a basic need of a human being and access to healthcare a basic human right. In a general way, our country has always recognized this fundamental claim of the citizenry. Article 47 of the Constitution enjoins the State to improve the standard of Public Health as one of its primary duties**.** However, with the distribution of power under the Seventh Schedule of the Constitution, under Entry No. 6 of the State List, 'Public health and sanitation; hospitals and dispensaries,' comes within the domain of the state government. Despite this Constitutional position, the role of the central government in the national health system has always been significant. While, on account of the fiscal squeeze, the state government expenditure on health over the 1980s and 1990s has dropped from 7% of the budget to 5%, the central government expenditure has remained steady at 1.3% of its budget over the 1980s and 1990s, and has latterly risen to 1.7% by year 2003-04. Currently, central government expenditure is around 30% of the total public health expenditure. Thus, the incremental resources that have been available to the national health system year-on-year have come through the central government's contribution. **It is widely accepted that the resource position of the state governments is not likely to dramatically improve in the foreseeable future; and in that situation the central government has accepted its fallback responsibility of trying to fund the minimum resource requirements of the national health sector.** It is in recognition of this position that from time to time the government has launched initiatives in the health sector, the most recent one being the National Rural Health Mission (NRHM). The Common Minimum Programme (CMP) of the United Progressive Alliance (UPA) Government has committed the government to an increase of resources up to the level of 2-3% of the Gross Domestic Product (GDP) over the remaining period of its current term.

1.2 Health for All Goal

In broad conceptual terms, India has always been committed to comprehensive health care for all. This gained formal articulation as the 'Health for All' declaration at Alma Ata in 1978. However, the all-encompassing declaration was expressed in the most general terms; in truth, the government never spelt out what constituted 'comprehensive healthcare.' With the goal itself being indeterminate in its contours, there was little systematic progress towards a standardized and sustainable health system. Progress, when it did occur, was sporadic and the result of fortuitous circumstances, or an accidental convergence of dedicated and competent performers.

1.3 Burden of Disease

Over the five decades since independence, the overall state of health in the country has, no doubt, improved. The trend over time of basic health indicators reveals this clearly: life expectancy at birth (years): 54 to 65 (1981-2000); crude birth rate (CBR): 41 to 26 per 1000 population (1951-1998); total fertility rate (TFR): 6.6 to 2.9 (1960-1997); Infant Mortality rate (IMR): 146 to 60 per 1000 live births (1951-2003). However, despite this improvement, the general health indices in the country are below the average for developing countries, and are also way below socially acceptable levels. The country still carries an enormous share of the global disease burden. With 17% of the global population, the country accounts for 20% of the total global disease burden, 23% of the child deaths, 20% of the maternal deaths, 30% of Tuberculosis cases, 68% of Leprosy cases, and 14% of HIV infections. India continues to bear a disproportionate portion of the global burden of the pre-transition communicable diseases – Tuberculosis, Malaria, Leprosy, acute respiratory illnesses, diarrheal diseases and other vaccine preventable diseases. Orders of magnitude of mortality figures for communicable diseases indicate 2.5 million child deaths and an equal 2.5 million adult deaths, in a year.

1.4 Revitalizing Primary Healthcare

From the above description of the disease profile and causes of mortality, it is clear that targeting these diseases does not require very high clinical expertise, or expensive and high-tech diagnostic aids – most of the target areas come within the broad ambit of primary healthcare services. This provides a credible pointer that it would be possible to meet the most pressing health needs of the country by revitalizing the broad-span, primary healthcare services in the country. **The NRHM covers many areas in its ambit, but the easily achievable target is of an accessible quality primary healthcare system. The recognition of this reality has prompted the central government to constitute this Task Force to make recommendations on the educational requirements for the health functionaries under the NRHM**.

1.5 Regional Variation in the Health Status

More significant than all these macro-level statistics is the fact that the average health indicators hide a wide range of variations between different parts of the country. This makes the task of putting in place an efficient and sustainable health system more difficult. As an illustration, IMRs in Madhya Pradesh (82) and Orissa (83) are more than eight times higher than that for Kerala (11). There is also a pronounced disparity between rural and urban areas – in Andhra Pradesh, the rural IMR is 67 compared to 33 in the urban areas; and, in Karnataka, and the rural IMR is 61 as against 24 in the urban areas. Abnormal IMR differentials also exist between the genders in different parts of the country–in Haryana, for instance, female IMR is 73 as against 54 for males. On the basis of the health status of the population, and the existing capacity of the health service delivery system, the states within the country can be divided into four main groups. The group with the highest health standards (Kerala and Tamil Nadu) covers 9.1% of the population; and at the other end of the spectrum, the group with the lowest health standards (Assam, Bihar and Jharkhand) covers 13.1% of the population. **To tackle these widely varying conditions, the country has to plan out and**

operate on a sustained basis, a health system that is appropriately structured for the situation. The high degree of variation of health indices is itself a reflection of the high variance in the availability of healthcare services in different parts of the country. The first level of healthcare services would be the primary healthcare services and, hence, the emphasis in the NRHM is on its improvement.

1.6 Family Welfare and Primary Healthcare

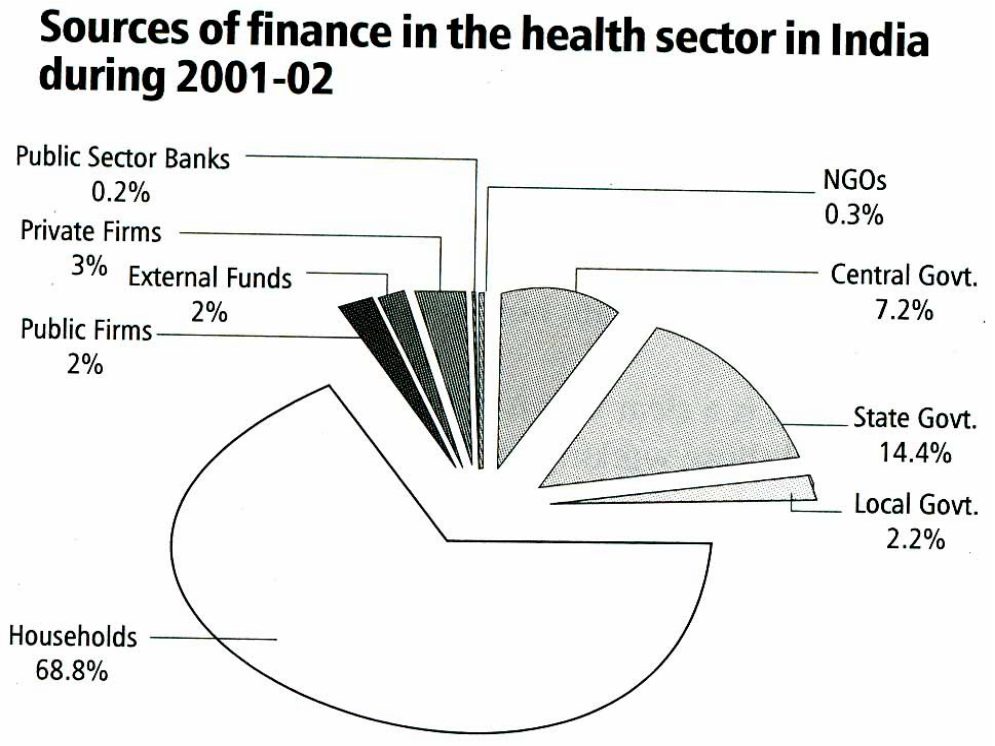
A major goal of the health sector is that of population stabilization. Though the annual exponential growth rate of population has come down to 1.93% in the 1991-2001 decade, an enormous gap still remains to be covered. The percentage of the population estimated to be in the reproductive age group is in excess of 58%. Even after a four-fold improvement since the year 1971, the Couple Protection Rate (CPR) is only at 44% today. Also, today, 45% of the increase in population is through children with a birth order of three and above. There is also a wide variation in the status of population stabilization between different states. Six states covering 11.4% of the population have already reached replacement levels of fertility. At the other end of the spectrum are eleven states, covering 60% of the population, that still show a TFR of over three. Out of these, five states – Bihar, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh–will contribute the larger part of the increase in population in the country over the next fifteen years. Looking to the current demographic profile, a massive effort would be required to achieve the targets of the National Population Policy (NPP) –2000 -for bringing down the TFR to replacement level by year 2010, and to achieve a stable population by year 2045. **The family welfare initiatives have always been closely linked with primary sector health services, principally in the public domain. The drive for population stabilization would, therefore, have to be an inherent part of the primary healthcare services; and most of this would have to be delivered through public service providers, or at least would have to be publicly funded. It is self-evident**

that the goals relating to population stabilization in the NRHM would be critically dependent on the efficient delivery of primary healthcare services.

1.7 Public Health Expenditure

One very adverse feature of the national health scene is the excessive dependence on private health expenditure. The total annual expenditure in the national health sector is of the order of 5.1% of the GDP, which is only a little lower than the average for lower and middle-income countries. **But, public health expenditure barely reaches 17% of the total health expenditure (i.e. 0.9% of GDP or Rs. 220 per capita); and the more regressive fact is that 68.8% of the total health expenditure is 'out-of-pocket' expenditure (OOP). (Figure-1)** This level of public health expenditure compares extremely unfavorably with an average public health spending of 2.8% of GDP for the low and middle-income countries of the globe, and 1.7% for even the impoverished sub-Saharan countries. Only four countries of the globe –Myanmar, Indonesia, Sudan and Nigeria – invest a lower percentage of their GDP as public health expenditure.

Figure-1



1.8 Health Expenditure and Poverty

The Table -1 makes it clear that only in a few states the public expenditure is significant in comparison to OOP. Though the OOP by itself is not insignificant in quantum, it does not provide any measure of health security. Also, the contribution of central Government is mainly confined to the National Health Programs. In view of the fact that only 11 % of the population of the country is protected by any type of health security scheme, improvement in quality and accessibility of health services provided by the government is likely to reduce OOP expenditure on health.

Private health insurance protocols are neither scientific nor cost-effective. Much of the diagnostic and treatment regimens are profit-driven. Individuals make private expenditure when the family liquidity position permits it, and not in any manner linked to the medical need. After the harvest is in, an individual may

spend liberally on even a minor medical condition, while in the lean season, even a dangerous condition may go untreated. Another significant aspect is that the average per capita expenditure is often not funded from current earnings or past savings. As has been indicated earlier, often the individual may not have funds available at the time of a medical emergency. On such an occasion the funds would have to be obtained by borrowing from the extended family, or even worse, from the informal credit market. In this situation the individual is inevitably sucked into a financial trap. Some startling conclusions of the extent of financial catastrophes on account of illnesses are: an Indian who is hospitalized spends more than 50% of his annual income on health; 24% of those hospitalized fall below the poverty line as a result of the financial blow; and, out-of-pocket expenses can push 2.2% of the population below the poverty line in a year.

Table 1: Household, Public and Total Health Expenditure in India (2004-05)

States	Household Exp. (Rs. Crores)	Govt. Exp. (Rs. Crores)	Other Exp. (Rs. Crores)	Aggregate Exp. (Rs. Crores)	Household as % of Total Health Exp.	Public Exp. % of Total Health Exp.	Other Exp. as % of Total Exp.
Central Govt.	0	14819	730	15549	0	95.3	4.7
Andhra Pradesh	6441	1696	640	8777	73.38	19.39	7.29
Arun. Pradesh	430	67	0	497	86.51	13.49	0
Assam	3054	672	52	3778	80.84	17.78	1.38
Bihar	11854	1091	202	13147	90.17	8.3	1.53
Delhi	1004	721	55	1780	56.41	40.48	3.11
Goa	524	116	22	662	79.17	17.48	3.35
Gujurat	4893	996	424	6313	77.51	15.78	6.71
Harayana	3385	421	175	3981	85.03	10.56	4.4
Himachal Pradesh	2126	306	40	2472	85.99	12.38	1.63
J&K	1759	471	47	2277	77.26	20.69	2.05
Karnataka	3847	1267	355	5467	70.36	23.18	6.46
Kerala	8373	1048	281	9702	86.3	10.8	2.9
MP	6432	1051	228	7711	83.41	13.63	2.96
Maharastrha	11703	3527	726	15957	73.34	22.1	4.55
Manipur	420	89	8	517	81.24	17.2	1.56
Meghalaya	58	94	8	160	36.45	58.37	5.18
Mizoram	38	58	0	96	39.39	60.61	0
Nagaland	1024	84	7	1116	91.74	7.57	0.7
Orissa	2999	684	111	3795	79.04	18.02	2.93
Punjab	3493	827	273	4593	76.05	18	5.95
Rajasthan	3399	1190	267	4855	70	24.5	5.5
Sikkim	72	55	0	127	56.89	43.11	0
Tamil Nadu	3624	1590	760	5974	60.67	26.61	12.72
Tripura	253	100	13	366	68.99	27.35	3.66
UP	17158	2650	550	20359	84.28	13.02	2.7
West Bengal	7782	1715	433	9929	78.38	17.27	4.36
U.Ts.	3160	325	227	3712	85.13	8.74	6.12
Grand Total	109308	32784	6636	148727	73.5	22	4.46

Source: Background Papers- Report - National Commission on Macroeconomics and Health, 2005.

1.9 Challenges for a National Health System

The above outline of the national health system makes it clear that it is not functioning satisfactorily. It is inadequately supported by state funding, and its structure provides no measure of health security. The number of trained medical practitioners in the country is as high as 1.4 million, including 0.7 million graduate allopaths. **However, the rural areas are still unable to access the services of the allopaths. 74% of the graduate doctors live in urban areas, serving only 28% of the national population, while the rural population remains largely unserved. In large parts of the country there is no semblance of a subsisting primary healthcare system.** For the ordinary citizen, in the public sector the preferred service centers are the hospitals, whether general or specialty. Because of the enormous burden of patients with ordinary ailments requiring only ambulatory services, these specialty hospitals also largely lose their specialist character. Since the primary service centers are generally not functioning, there is no screening of the primary care disease load, whether through a screening process or a referral process, and the unscreened burden falls upon the few and scattered tertiary care centers. As a result, the hospitals come to be inordinately overloaded –All India Institute of Medical Sciences, New Delhi has an annual turnover of 2.6 million patients and Safdarjang Hospital, New Delhi of 1.93 million patients.

1.10 The Challenge for NRHM

There is an acute shortage of the physical infrastructure in the public health sector. The deficiencies as a percentage of the normative entitlement, for different levels of service centers in year 2004, were as follows: Community Health Centre (CHC)–68%; Primary Health Centre (PHC)–31%; Sub Centre (SC)-29%. Providing additional service centers in rural areas based on the norms would require an additional capital expenditure of Rs. 9700 crores, and an additional recurring expenditure of Rs. 3500 crores. Large though these infrastructure gaps appear, these can easily be bridged under the NRHM, considering the increase in public funding up to 2-3% of GDP promised by the

Common Minimum Programme of the central government of the United Progressive Alliance.

1.11 Health Manpower in Rural Areas

The norms for public health service providers have been set long ago and can be considered very inadequate by today's requirements and expectations. Despite these outdated norms, the public health functionaries are markedly short, as seen from the Table 2 and Table 3. Table 2 indicates an overall shortfall of 13% in the doctors at PHCs. Table - 3, in turn, shows a shortfall of 38% of Specialists – clearly an alarming situation. It is because of this large shortfall of Specialists that CHCs are unable to deliver the larger part of the Primary Healthcare package. It is important to note here that doctors/specialists in position does not necessarily mean that doctors/specialists are physically present at their respective centres and performing their duties; in fact, absenteeism is very high.

An interesting point to note is that public health qualified physicians, who were available in larger numbers in the first decade after Independence, have progressively disappeared from the system. This has occurred largely on account of greater allocation of posts under the health services to the clinical cadres rather than public health cadre.

Table 2: Health Manpower in Rural Areas – Doctors at Primary Health Centres - as on 31.03.2001

Sl. No.	State/UT	Doctors at PHC		
		Sanctioned	In Position	vacant
1	Andhra Pradesh	1895	1495	400
2	Arunachal Pradesh	80	80	0
3	Assam	610	610	0
4	Bihar #	2121	2121	0
5	Chhattishgarh	*	*	*
6	Goa	113	105	8
7	Gujarat	972	949	23
8	Haryana	935	935	0
9	Himachal Pradesh	354	326	28
10	Jammu & Kashmir	158	158	0
11	Jharkhand	*	*	*
12	Karnataka	2143	1901	242
13	Kerala	1239	1131	108
14	Madhya Pradesh #	1760	1469	291
15	Maharashtra	3441	3160	281
16	Manipur	95	95	0
17	Meghalaya	96	86	10
18	Mizoram	58	49	9
19	Nagaland	29	29	0
20	Orissa	2636	2351	285
21	Punjab	484	424	60
22	Rajasthan	1639	1537	102
23	Sikkim	48	41	7
24	Tamil Nadu	2899	2648	251
25	Tripura	161	120	41
26	Uttaranchal	*	*	*
27	Uttar Pradesh #	3787	2263	1524
28	West Bengal	1841	1547	294
29	A & N Islands	29	28	1
30	Chandigarh	0	0	0
31	D & N Haveli	6	6	0
32	Daman & Diu	3	3	0
33	Delhi	6	6	0
34	Lakshadweep	6	6	0
35	Pondicherry	45	45	0
Total		29689	25724	3965

#: Figures are prior to re-organization of States.
*: Data not available
Source: PHS SECTION, MINISTRY OF HEALTH & FAMILY WELFARE, GOVT. of INDIA, 2002.

Table 3: Health Manpower in Rural areas – Total Government Specialists - as on 31.03.2001

Sl. No.	State/UT	Total Specialists{Surgeons, OB&G, Physicians and Pediatricians}		
		Sanctioned	In position	Vacant
2	Arunachal Pradesh	3	0	3
3	Assam	200	200	0
4	Bihar #	NA	NA	NA
5	Chhattishgarh			
6	Goa	13	9	4
7	Gujarat	308	138	170
8	Haryana	256	25	231
9	Himachal Pradesh	115	108	7
10	Jammu & Kashmir	16	4	12
11	Jharkhand	*	*	*
12	Karnataka	357	244	113
13	Kerala	154	148	6
14	Madhya Pradesh #	485	100	385
15	Maharashtra	1152	1032	120
16	Manipur	40	19	21
17	Meghalaya	2	2	0
18	Mizoram	4	4	0
19	Nagaland	12	0	12
20	Orissa	707	435	272
21	Punjab	315	315	0
22	Rajasthan	754	555	199
23	Sikkim	20	3	17
24	Tamil Nadu	54	54	0
25	Tripura	0	0	0
26	Uttaranchal	*	*	*
27	Uttar Pradesh #	1152	577	575
28	West Bengal	310	133	177
29	A & N Islands	0	0	0
30	Chandigarh	7	7	0
31	D & N Haveli	0	0	0
32	Daman & Diu	0	0	0
33	Delhi	1	0	1
34	Lakshadweep	0	0	0
35	Pondicherry	4	4	0
Total		6617	4124	2493

#: Figures are prior to re-organization of States.
*: Not Available
Source: PHS SECTION, MINISTRY OF HEALTH & FAMILY WELFARE, GOVT. of INDIA, 2002.

1.12 Nursing Resources

For the year 2004 the Nurse-Population ratio in India was 1:1250. This is very inadequate compared to Europe (1:100-200), and is even less than developing countries like Sri Lanka (1:1100) and Thailand (1:850). The Nurse-Doctor ratio in the country is 1.35:1 as compared to 3:1 in the developed countries. The adverse statistics in respect of nurses confirms the earlier observation of the Task Force, that the graduate doctors excessively dominate the national health system.

The current strength of government staff nurses in rural areas is 27,336, while 17% of the positions are vacant. The NRHM itself has generated an additional requirement of 1,40,000 staff nurses. The capacity of institutions within the country for training of nurses is quite substantial – 20,000 graduate seats and 40,000 diploma seats. However, the standard of skills imparted to fresh nurses is grossly inadequate. Supervision over the nursing institutions is unsatisfactory and training standards are uneven. Also, the nursing resources in the country are subject to considerable attrition, as many trained nurses seek careers abroad for monetary considerations.

1.13 Public Sector Services

Public sector provides 18% of the total outpatient care, 44% of the inpatient care, 54% of the institutional deliveries, 60% of the pre-natal care visits and 90% of the immunization. Considering ours is a struggling developing country, the quantum of public delivery of health services is low in several categories, particularly outpatient care. The data from the National Sample Survey Organization (NSSO) Survey (1995-96) reveals that the public heath services are reasonably focused on the lower consumption quintiles, particularly the Below Poverty Line (BPL) category. **Public health services are generally of poor quality. This is particularly true for those provided at the CHC/PHC/SC levels;** at the tertiary service centres, quite often, the professional skills of the service providers is very good, even though the physical infrastructure and quality of nursing care may be

extremely poor. Beneficiaries of these facilities also frequently complain of the poor work culture and indifferent attitude of the public service providers.

1.14 Private Sector Services

Now turning to the private sector, this provides 58% of the hospitals, 29% of the beds in the hospitals and 81% of the doctors. The quantum of health services it provides is large but is of poor and uneven quality. Health services in the country, whether public or private, are largely unsupervised and unregulated. These services, particularly in the private sector have shown a trend towards high-cost, high-tech procedures and regimens. Another relevant aspect borne out by several field studies is that private health services are significantly more expensive than public health services – in a series of studies, outpatient services have been found to be 20-54% higher and inpatient services 107- 740% higher.

1.15 Non-Governmental Organizations (NGO) Sector

One strand of empirical evidence deserves to be recounted, as it highlights encouraging possibilities for primary sector healthcare services. Studies of the operations of successful field NGOs have shown that they have produced dramatic results through primary sector healthcare services at costs ranging from Rs. 21 to Rs.91 per capita per year. **Though such pilot projects are not directly up scalable, they demonstrate promising possibilities of meeting the health needs of the citizenry through a focused thrust on primary healthcare services.**

1.16 Strengthening Primary Healthcare

On a conceptual level, it is quite clear that no national health system can work through only a network of tertiary care hospitals. The remedies for most of the deficiencies of the health system narrated above largely fall within the ambit of

primary healthcare- whether they are in the promotive, preventive or curative category. **There is, therefore, a dire need for strengthening primary healthcare services in the country. By primary health care services we imply, principally, primary sector services (promotive, preventive and ambulatory curative services), along with a small package of inpatient services in general hospitals. Family Welfare services would also largely come within the purview of primary healthcare services**.

1.17 Investing in Development of a Primary Healthcare System

The primary care sector public expenditure comprises 50% of the total health expenditure (2003-04). Expenditure in this sector being the most cost effective would deserve to be preferentially boosted in a resource-deficit country. Also, success in the Primary Care Sector reduces the disease load for the secondary care and tertiary care sectors. However, primacy has not always been given to investments in the primary care sector. In the past, in the period between 1985-86 and 1998-99, public expenditure in the primary and secondary care sectors has increased by only 50%, while that in the tertiary care sector has increased disproportionately by 100%. **More worrisome is the fact that the public sector services have a very small base in the national health system, and their role seems to be reducing over time.** It is seen that between 1985-86 and 1995-96 the private sector share of outpatient services rose from 74% to 82% and that for inpatient care rose from 40% to 56%. Looking to the existing disease profile, the need of the country is to focus the healthcare system on the pre-transition communicable diseases. However, despite this need, the expenditure on communicable diseases has shown a regressive trend and this has reduced from 58% in 1988 to 47% in 2001. This trend fits in with the earlier observation that the emphasis in the period has been excessively placed on the tertiary care sector.

The National Health Policy –2002 considered the issue of the relative size of the three sectors of the health system and recommended an increase in public

expenditure in the primary care sector from the current level, to 55% of the total health expenditure. With such considerations in mind, government has been anxious to strengthen the primary healthcare delivery system, particularly in the rural areas. The National Commission on Macroeconomics and Health (NCMH) has also recommended in its report the implementation of three healthcare packages of progressive sophistication. First, is a Core Package covering all the national health programmes, childhood diseases, ante and post natal care, preventive and promotive health education, etc. The cost of this package has been estimated to be Rs.150 per capita per annum. The second is the **Basic Package** covering, diabetes, hypertension, respiratory diseases, injuries, surgery, etc. The estimated cost of the **Basic Package** is **Rs. 310 per capita per annum.** And, third is the **Secondary Care Package** that covers vascular diseases, cancer and mental illness at the general hospital, with a larger component of inpatient services. This **Basic Package,** along with the **Core Package,** is one possible module of a primary healthcare package (i.e. preventive, promotive and curative ambulatory care, with some element of inpatient care in a general hospital). The principal thrust of the NRHM is on such a module of primary healthcare services, substantially composed of outpatient services. **If the NRHM is to achieve any measure of success, a concerted effort will have to be focused on primary healthcare. In the current health system there are several obstacles to deeper penetration and an even spread of primary healthcare over the country**.

CHAPTER II

TASK FORCE ON MEDICAL EDUCATION

Some of the major problems in primary healthcare relate to training and capacity building of health service providers in foreseeable future. It is in this background that government set up a Task Force to review the effectiveness of medical education currently imparted to different categories of health service providers, and also to explore the alternative training opportunities and capacity building of the health functionaries to bridge the gap generated by NRHM.

2.1 Constitution of the Task Force

Ministry of Health and Family Welfare (MoHFW) under order No.14011/4/2005 EAG, dt. 18th August, 2005 constituted the Task Force on 'Medical Education for the National Rural Health Mission' consisting of the following members:

1. Mr. Javid Chowdhury. Ex-Secretary, MoHFW;Chairman of the Task Force.
2. Mr. Deepak Gupta, Additional Secretary, MoHFW.
3. Mrs. Bhavani Thyagarajan, Joint Secretary, MoHFW
4. Dr. N.H.Antia, Foundation for Research in Community Health (FRCH), Pune.
5. Dr. Gauri Pada Datta, Member, Planning Commission, West Bengal.
6. Secretary, Medical Council of India, New Delhi.

7. Principal and MS, Nizam's Institute of Medical Sciences, Hyderabad. Andhra Pradesh.

8. Dr. Shyamprasad, Vice President, National Board of Examination, Chennai

9. Director, Shri Ramachandra Medical Institute, Chennai, Tamil Nadu.

10. Nominee of DGHS (Principal of any Central Medical College).

11. Dr. H. Sudarshan, Karuna Trust, Bangalore.

12. Dr. C.S. Pandav, Professor & Head, Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi

13. Dr. Sudipto Roy, President, Indian Medical Association (IMA).

The task force decided to invite the following experts to its subsequent meetings.

(i) Dr. Ravi Narayan. Community Health Adviser, Society for Community Health Awareness, Research and Action, Bangalore.

(ii) Dr. L.M. Nath, former Professor and Head, Centre for Community Medicine and former Director, AIIMS, New Delhi.

(iii) Dr. A. Rajasekharan, President, National Academy of Medical Sciences, Chennai.

The Centre for Community Medicine, AIIMS, New Delhi assisted in carrying out desk studies of the literature on the subject under consideration and also assisted in drafting of the report.

2.2 Terms of Reference

The terms of reference of the Task Force are as under:

Term of Reference – 1

- **To examine the possibility of revamping Medical Education with reference to the requirements of medical professionals under the National Rural Health Mission.**

Term of Reference – 2

- **To examine the feasibility of a short-term certificate course in medicine for creating a cadre of Health Professionals for rendering basic primary health care to underserved rural population. If found feasible, the Group would recommend on the following;**

  a) **The duration of such a course.**
  b) **Whether it can be an integrated course containing the basic principles of various approved systems of medicines.**
  c) **Whether it can be covered under the provisions of the respective Acts governing existing approved systems of Medicines or a separate legislation would be required at State level.**
  d) **Criteria for admission.**
  e) **Syllabus of the course.**

Term of Reference - 3

- **In order to make rural service attractive for doctors, the Task Group would give its recommendations on the following;**
  a) **The various incentive schemes, which could be prescribed for this purpose.**
  b) **Whether the medical graduates before grant of permanent registration by Medical Council of India (MCI) should be made to serve in the rural areas as a part of extended internship.**
  c) **Whether rural service should be made an eligibility requirement for doing the Post Graduate course.**

Term of Reference – 4

- **In order to promote opening of medical colleges in the rural and other underserved areas, the Task Group would give its recommendations on the following;**
  a) **Whether certain relaxations could be provided in the norms of MCI for opening of medical colleges in such areas in terms of infrastructural requirements, staff complement and the clinical material without lowering the standard of education.**
  b) **To encourage private entrepreneurs to move towards rural areas for new medical colleges. whether opening of medical colleges in the urban and the well served areas can be discouraged by enforcing strict norms.**

Term of Reference – 5

- **In order to promote opening of medical colleges in rural areas, the Task Group would recommend whether a joint venture could be permitted whereby the government hospital at district level is**

allowed to be used for teaching purposes subject to the condition that the hospital continues to be run by the government while recurring expenditure is borne by the private body.

Term of Reference – 6

- **The Task Group would also recommend on the modalities of strengthening the infrastructure of existing government medical colleges particularly in the Empowered Action Group (EAG) and North Eastern States.**

CHAPTER III

TERM OF REFERENCE – 1

- **To examine the possibility of revamping Medical Education with reference to the requirements of medical professionals under the National Rural Health Mission.**

3.1Medical Graduate Curriculum Issues

3.1.1 There is a widespread perception in the country that the MBBS curriculum is too theoretical in its content. After 4 ½ years of the main course and I year of internship, the finished graduate has very little 'hands-on' experience. Most graduates are not confident enough at that stage to even provide primary healthcare services independently. **The MBBS curriculum is closely linked to a tertiary care hospital. And, therefore, the graduates cannot function in a setting where there is no multi-disciplinary support, or advanced diagnostic hardware.** A large percentage of the graduates treat that stage as a launching pad for the post-graduate course. It is generally assumed that the clinical experience to equip the doctor to deliver medical services is only gained at the post-graduate stage. Whether this situation is inescapable, has never been critically examined. The medical graduate course of 5 ½ years is one of the longest professional courses**.** Lawyers undergo a 5 year course (after 12th standard), Masters of Business Administration a 2 year course (after graduation), Engineers a 4 years course (after 12th standard), etc. These other courses equip the individual to pursue their professions independently, though, of course, the standard of performance improves with time. **It is only in the case of the medical graduate that an assertion is made that even 5 ½ years of professional training is not enough, as the management of health of a human being is a uniquely complex and demanding responsibility**. As a

solution it is suggested that the duration of the course be further extended in order to provide more intensive clinical experience.

3.1.2 The Task Force has carefully examined this issue and feels that the claim of clinical complexity of the medical profession is an over-stated one. **Any professional course should equip the fresh graduate to practice his profession at the level of the more common tasks and services. If the medical graduate does not have the requisite skills and confidence at the time of graduation, the fault lies with the curriculum and the pedagogic methodology.** In a later chapter the Task Force will examine the syllabus and the system of teaching to determine whether it is appropriately structured to provide medical graduates confidence to practice their profession in the more common and simple settings. **The Committee was of the view that a fresh graduate must at least be able to deliver services contained in the primary healthcare package.** The suggestion that the duration of the course be extended to give more intensive clinical exposure is not a practical proposition. As it is, the graduate medical course is one of the longest professional courses, and the students and their guardians, are exposed to a prolonged financial and familial burden. With the extended time and substantial financial resources involved in a medical education, graduates are increasingly drawn towards the more lucrative specialisations, their choice often being in direct conflict with broad community requirements. Increasing the duration of the graduate course would only worsen those pressures.

3.1.3 The Pre-clinical, Para-clinical and Clinical subjects are taught in compartments, and the pedagogic methodology does not connect the elements of these disciplines with the diagnostic and therapeutic aspects of the clinical topics. In most institutions, the teaching methodology is not problem-based and does not integrate the various non-clinical and clinical subjects. The Pre-clinical and Para-clinical subjects, no doubt, form the bedrock of a scientifically sound approach to clinical diagnosis and therapy. However, in a practical sense, the total time allotted to the clinical subjects (in all the modes of teaching–lectures,

postings and internship) would have to be balanced with the need for adequate clinical exposure to equip a medical graduate to function as a competent working professional. **There is an overload in the syllabus on the information content at the cost of clinical skills.** As a result, the graduates are well equipped, with a sound theoretical base, to go into post-graduate specialization; however, they are not adequately equipped to begin providing health services, at least for the common and uncomplicated conditions in the primary healthcare setting.

3.1.4 Several studies have identified the shortcomings in the field of graduate medical education. **One landmark study was that by WHO-SEARO: "Inquiry–driven strategies for innovation in medical education in India–Curriculum Reforms, 1995". This study noted a disconnect between the focus in the syllabus by way of teaching/examinations and the actual morbidity pattern observed at the ambulatory level.** The disease pattern from three different perspectives – actual morbidity pattern observed in ambulatory setting; diseases as prioritised during teaching; and, the diseases as prioritised during examinations – is depicted in the **Figure 2.**

Figure 2: Mismatch between Curricular Content & Morbidity Pattern in Ambulatory Setting (OPD)

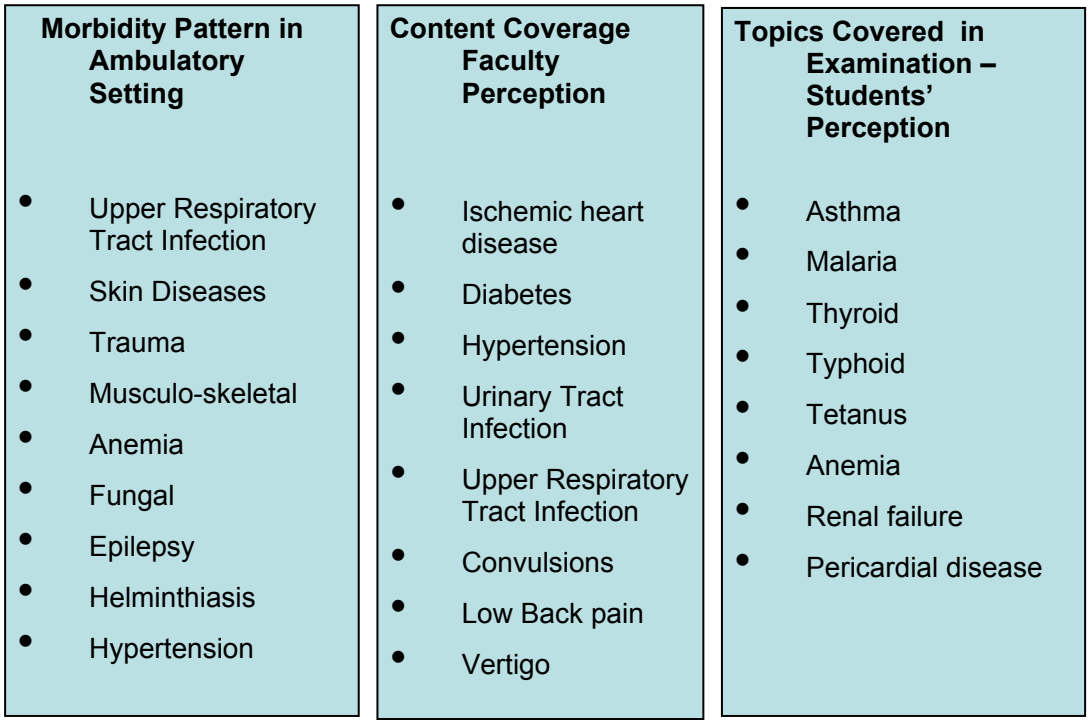


Figure-2 reveals that the priorities accorded in the three situations, are very different. In order to ensure that fresh graduates are competent to operate in the primary healthcare setting, an attempt should be made to achieve as close a match between the morbidity patterns as observed in the ambulatory setting and the priorities reflected in the course of teaching/examination. The study highlighted that the conditions relating to primary healthcare which are not given adequate attention in the course of teaching/examinations, included: ante-natal care; normal labour; pre-ecclampsia; nutrition during pregnancy; normal menstruation; cervical cancer; vasectomy; neo-natal tetanus; prematurity; primary complex tuberculosis; protein energy malnutrition; Integrated Child Development Services (ICDS); etc. **About two-thirds of the fresh graduates felt that their skills in medicine needed improvement for them to operate independently; about 30% of the graduates expressed lack of confidence in**

providing services independently, and one third of these were not even confident of providing the services under supervision.

3.1.5 In 1992 the National Institute of Health and Family Welfare (Status Study of Training in MCH &FW in Medical Colleges of India, NIHFW, 1992) carried out another significant study on the effectiveness of the training given in the graduate course on issues relating to Maternal and Child Health and Family Planning**. This showed that a large number of fresh graduates had no knowledge of simple procedures and conditions, like: immunization; nutritional advice; IV Fluids; oral pills; IUCD; etc.**

3.1.6 Another survey conducted by Community Health Cell-Bangalore, focused on medical graduates with at least two years experience at the primary care level. The survey showed that they required improved knowledge and skills in many areas, including: basic nursing procedures; emergency medicine; minor surgical procedures; obstetrics; and local anesthesia. They also needed to gain experience in running a small laboratory, assessing community health needs; delineating simple programmes for training health workers; etc. The graduates suggested some improvements in the graduate curriculum: integrated teaching focusing on common problems and clinical applications; reduction in the basic science subjects; and increase in responsibility and decision-making in the course of ward work.

3.1.7 The shortcomings perceived by the fresh medical graduates are principally the outcome of their urban orientation and the skewed pattern of their aspirations. Most of them have only lived and trained in the urban setting. The few with a rural background acquire an urban mindset in the course of their training that is focused around a tertiary care hospital. They do not have the confidence to function in a setting in which there is no multi-disciplinary support or advanced diagnostic hardware. Most graduates aspire to spend their career in the same urban ambience that they are familiar with. This is, in a way, a distant ripple effect of the macro-

trend of the commodification of health services observed globally over the last two decades. It is often felt that it is because of this fixed mind-set that the young graduates fail to position themselves comfortably in the social ambience of the country, and also fail to recognize health services as a fundamental requirement of the community.

3.1.8 For medical education to serve the community, it would have to be socially oriented towards primary healthcare. The pedagogic methodology would have to be problem-based – where the non-clinical principles would have to be meshed with clinical training. In short, it is felt that medical training should largely be in a decentralized setting outside a tertiary care hospital, in close proximity with the public health and social environment. **And with a different orientation to the curriculum, and a community-centric pedagogy, one can reasonably expect a much more even spread of service providers over the country.**

Package of Reform:

'The Task Force discussed the shortcomings of the MBBS curriculum in detail and came to the conclusion that certain significant modifications / additional elements are required to be introduced immediately. The recommended additional features of the syllabus are discussed hereafter.'

3.2 Introduction of Modules for exposing students to Social Sciences and Allied Disciplines.

3.2.1 The introduction of the following modules in the curriculum is suggested:(a)Communication Skills; (b) Management Skills; (c) Psychology (d) Political Science, Anthropology and Sociology; (e) Health Economics; and (f) Ethics & Human Rights.

A health practitioner has to function in a multi-faceted universe. He must be equipped to comfortably place himself in the diversity of that universe. It is, therefore, of importance that he is given at least an introductory exposure to the various other facets of the universe that he will have to interact with. **In this context, the Task Force recommends that modules of a total duration of 60 hours on the subjects listed in Table 4 below be introduced in the curriculum.**

Table 4: Topic-wise break-up of Modules.

No.	Topic	Duration (Hours)
1	Administrative Management	10
2	Communication Skills	15
3	Sociology and Psychology	15
4	Political Science, Civics and Local Administration	06
5	Anthropology	04
6	Health Economics	04
7	Ethics and Human Rights	06
8	**Total**	**60**

3.2.2 The modules could be scheduled at different stages of the graduate course, as they would require varying levels of background knowledge to absorb the contents. The modules for Political Science, Psychology, Anthropology, Sociology, Ethics and Human Rights could be scheduled for the 1st & 2nd semesters, while the modules for Communication Skills, Management Skills and Health Economics could be scheduled for the 7th semester. The Task Force feels that it would be of value to draw up national modules for these introductory subjects. These could serve as a basic framework around which individual medical colleges could finalize their own modules in the context of their perceived needs.

3.2.3 The Task Force is aware that certain medical education research institutions - Community Health Cell, Bangalore; CEHAT, Mumbai and Pune; Achutha Menon Centre, Trivandrum; and some Medical Colleges -AIIMS, New

Delhi; Christian Medical College, Vellore; St. John's Medical College, Bangalore; Mahatma Gandhi Institute of Medical Sciences, Sevagram; JIPMER, Pondicherry-have acquired significant experience in designing and experimenting with such modules. The Ministry of Health & Family Welfare could consider the launching a participatory exercise along with representatives from these resource centers and medical colleges, also involving some health educators, academics from the field of social sciences, to draw up such national modules. The group engaged in the exercise could draw upon the experience of the institutions that have been experimenting in this field.

3.2.4 At present in most medical colleges, the different curriculum subjects are taught as independent bodies of knowledge. At a different point in this report, the Task Force will comment on the desirability of adopting an integrated teaching methodology with a problem-based approach. When this pedagogic methodology comes to be adopted, the modules mentioned above could also be merged in the integrated teaching methodology. In fact, most of these topics are of a nature where they would best be understood when taught in an integrated manner, along with the conventional clinical and non-clinical subjects. **However, the introduction of these modules on the listed subjects brooks no delay and should be started as stand-alone modules till such time as the integrated pedagogic methodology is put in place. The Curriculum Committee/Medical Education Cell/Academic Committee of the respective Medical College should be in-charge of implementing these curricula. The performance of the students during the course of the modules should be evaluated.**

3.3 **Inclusion of a six-week Rural Orientation Package in the MBBS Curriculum**

3.3.1 The Task Force has earlier commented on the attitude of the medical graduates that are produced by the existing educational system. By and large they carry the values of the urban middle class. Even those from a rural

background are unwittingly co-opted into the urban milieu, discarding their social roots. As a result, fresh graduate doctors have no concept of broad community healthcare needs. Their professional world-view, regardless of whether they pursue a career in the public or private sector, is of providing curative services with considerable high-tech backup. Professionally they aspire to specialise in one or the other clinical disciplines, and their skills are organically linked to the back-up infrastructure of a tertiary care hospital. The Task Force sees the lack of an understanding of broad community health needs in the fresh medical graduates, as a critical deficiency. This results in a misconceived approach to primary healthcare, whether in the public or private sectors. There is an inordinate reliance on curative care and high-tech diagnostic tests on the part of the service providers.

In the context of this deficiency the Task Force feels the need and recommends the introduction of a rural orientation package of six weeks duration under the Community Medicine Department for the second year MBBS students (3rd & 4th Semesters). The suggested elements of this rural orientation programme are given in the Table-5 below.

Table 5: Rural Orientation Package

Time frame	Training	Location
½ week	Briefing	Medical college
1 week	First Aid Certificate Course	Medical college
2 weeks	Rural orientation camp	Field
1 week	ASHA* + AWW*	Field
1 week	HW* +HA* +MO*	Field + PHC
½ week	Debriefing	Medical college

*** ASHA-Accredited Social Health Activist**
AWW-Anganwadi Worker
HW-Health worker
HA-Health Assistant
MO-Medical Officer

3.3.2 The training should be in batches of 20-25 students. The training package should include an exposure to the principal facets of the rural community, covering aspects like: agriculture, other occupations, local-self-government institutions, health & education facilities, markets, transport & communication, family structure and dynamics, caste and communal dynamics, cultural and religious traditions, festivals, local maternity and child health practices, etc. The students should also undergo training on the roles of the various public healthcare functionaries (Health workers, Health assistants, Anganwadi workers and ASHAs) by attachment to these functionaries. This would expose the students to the national health programmes as implemented at the ground level.

3.3.3 The four weeks of field activities shown in the above schedule should require actual stay in the villages. Medical colleges should make reasonable arrangements for the stay as are appropriate to a rural setting. Past experience has shown that students do not pay adequate attention to the portion of the syllabus connected with Community Medicine. To discourage this tendency, the Task Force recommends that 20% of the total marks of internal assessment in Community Medicine be allotted to the assessment of the student during the rural orientation training.

Some medical colleges - AIIMS, New Delhi; St. John's Medical College, Bangalore; Christian Medical College, Vellore; Mahatma Gandhi Institute of Medical Sciences, Wardha; and JIPMER, Pondicherry - have experimented with such rural postings and they could be associated in the exercise for drawing up national guidelines for other institutions.

3.4 Reallocation of duration of study time/postings in different disciplines

3.4.1 The Table-6 lists the duration of study time allotted for lectures in different subjects in the current syllabus. On reviewing the time allotted in the syllabus for

lectures to the different disciplines, the Task Force feels that the overall distribution of study-time between Pre-clinical / Para-clinical subjects and clinical subjects is appropriate in the ratio of 1/3rd and 2/3rd. This norm would result in transfer of lecture time from non-clinical-subjects to clinical subjects. The Task Force has noted that within the time allotted to non-clinical subjects, a considerable portion is going into practicals. It is felt that in some of the non-clinical disciplines-Pharmacology, Biochemistry –little purpose is served in allotting a significant portion of time. The Task Force is of the view that the allocation of time to non-clinical subjects may be reviewed and should be made pertinent to applied aspect, and any excess that may be found should be transferred to lecture time.

Table-6: Minimum Teaching Hours in various disciplines

	Subjects	Lecture time allotted (in hours)		Clinical postings (In hours)		TOTAL (%)	
		MCI - 1997	MCI- 2004**	MCI –1997	MCI 2004**	MCI –1997	MCI-2004**
Pre-Clinical Subject	Anatomy	650 (16.2)#	650 (14.9)#	N.A.	N.A.	650 (9.9)	650 (9.2)
	Physiology	480 (11.9)*	480 (11.0)*	N.A.	N.A.	480 (7.3)	480 (6.8)
	Biochemistry	240 (6.0)*	240 (5.5)*	N.A.	N.A.	240 (3.6)	240 (3.4)
Para-Clinical Subject	Pathology	300 (7.5)*	300 (6.9)*	N.A.	N.A.	300 (4.6)	300 (4.2)
	Pharmacology	300 (7.5)*	300 (6.9)*	N.A.	N.A.	300 (4.6)	300 (4.2)
	Microbiology	250 (6.2)*	250 (5.7) *	N.A.	N.A.	250 (3.8)	250 (3.5)
	Forensic Medicine	100 (2.5)*	100 (2.3)*	N.A.	N.A.	100 (1.5)	100 (1.4)
Clinical Subject	General Medicine	300 (7.5)	350 (8.0)	468	504	768 (11.7)	854 (12.1)
	General Surgery	300 (7.5)	350 (8.0)	468	504	768 (11.7)	854 (12.1)
	Paediatrics	100 (2.5)	130 (3.0)	180	216	280 (4.3)	346 (4.9)
	Orthopedics	100 (2.5)	130 (3.0)	180	216	280 (4.3)	346 (4.9)
	Community Medicine	310 (7.7)	310 (7.1)	216	216	526 (8.0)	526 (7.4)
	Obstetrics and Gynecology	300 (7.5)	300 (6.9)	360	396	660 (10.0)	696 (9.8)
	TB and Chest diseases	20 (0.5)	20 (0.5)	36	36	56 (0.9)	56 (0.8)
	Ophthalmology	100 (2.5)	100 (2.3)	180	144	280 (4.3)	244 (3.5)
	Psychiatry	20 (0.5)	20 (0.5)	36	36	56 (0.9)	56 (0.8)
	ENT	70 (1.7)	70 (1.6)	144	144	214 (3.3)	214 (3.0)
	Skin and STD	30 (0.7)	30 (0.7)	108	108	138 (2.1)	138 (2.0)
	Radiology	20 (0.5)	20 (0.5)	36	36	56 (0.9)	56 (0.8)
	Dentistry	10 (0.2)	10 (0.2)	36	36	46 (0.7)	46 (0.7)
	Anesthesia	20 (0.5)	20 (0.5)	36	36	56 (0.9)	56 (0.8)
	Emergency Medicine	---	150 (3.4)	72	72	72 (1.1)	222 (3.1)
	Medical Ethics	---	15 (0.3)	N.A.	N.A.	-	15 (0.2)
	Tropical medicine	---	15 (0.3)	N.A.	N.A.	-	15 (0.2)
	Common Poisons	----	10 (0.2)	N.A.	N.A.	-	10 (0.1)
	TOTAL	4020(100)	4370(100)	2556	2700	6576(100)	7070(100)

***Includes Laboratory training; # Includes laboratory and dissection classes ; N.A.- Not Applicable;**
**** MCI proposal of 2004.**

3.5 Prioritizing the Curriculum and Enhancing Skill Development.

3.5.1 The medical colleges in India have traditionally followed a curriculum stuffed with information. With the explosion of medical knowledge in the last half-century, the students are faced with an ever-increasing burden of information. It is necessary to find a way to cope with this problem so that space can be found in the curriculum to impart to the students the clinical knowledge and hands-on experience that is so necessary. One way would be to prioritize all the information in the medical field so that appropriate attention can be given to the different categories. **Conceptually, the categories could be as under:**

- **Must learn/ essential.**
- **Useful to learn/ should learn.**
- **Nice to learn/ may learn/ additional – but does not need to be given the same emphasis.**

Given these categories, one could even hypothesize as to how much study time should be given to each category. In order to provide adequate skills to operate independently in the primary healthcare domain, **as a subjective assessment of the Task Force, we would suggest the allocation of study time to the three categories in the ratio of 6:3:1.** Such an allotment of study time would enable the student to concentrate on the 'hands-on' skills for providing service in the primary healthcare area. More study time would be available to acquire the various essential skills for independent functioning - psychomotor and performance skills; attitudinal and communication skills; judgment to take decisions on balance, without access to accurate evidence.

3.5.2 Certain Medical Colleges and Health Institutions (e.g. AIIMS-New Delhi, RGUHS-Bangalore) have undertaken such exercises and the scheme has been incorporated in their syllabus. The MCI should build upon this and develop a model curriculum relevant to the NRHM. The classification of items in the

curriculum would assist the teachers in the medical colleges in creating course material in proportion to the importance of the three groups of knowledge.

3.5.3 The Task Force feels that in order to equip a medical graduate with the skill mix essential for providing broad-based community healthcare, the students should spend most of the time in the hospital/field rather than in the classroom. This objective would not be achieved if there were only a casual relationship between the medical college and the decentralized public health service centers. The participation of the students in the activities of providing service would only be effective if the service centers are under the management of the medical college.

3.5.4 **In this backdrop, the Task Force recommends that each medical college must itself undertake the responsibility of managing one CHC and four PHCs. The government should hand over the CHC/PHCs to the medical college along with the paramedical staff and the normative funds available to these service centers.** The medical college must provide its own doctors and use the caseload to give hands-on training to the medical students. The actual management of the service centers by the medical college would provide an opportunity to train the students in all aspects of operation of the centres – ranging from administrative management to independently providing primary healthcare services. In this manner, in the period of their graduate course, the students must acquire certain fundamental skills, such as: basic nursing procedures, immunization procedures and basic laboratory procedures.

3.5.5 Students should also gain hands-on experience in diagnosis and management of common health conditions, such as: cases of normal delivery; application of the module for Integrated Management of Childhood Neonatal Illness (IMNCI); management of fever cases; management of gastroenteritis and cholera cases in infants; management of Tuberculosis cases under the Revised National Tuberculosis Control Programme (RNTCP); etc. One can also expect

that the CHC/PHCs managed by the medical colleges, would provide high quality service, thus making these centers model units in the area they serve.

3.6 Integrated teaching of the non-clinical disciplines with the clinical disciplines

3.6.1 In most medical colleges the different disciplines are taught in isolation. Pre-clinical and Para-clinical specialties are, no doubt, very important as they form the bedrock for the understanding of the clinical disciplines. However, in the current pedagogic methodology, the interconnections between the features of the clinical and non-clinical disciplines are generally established in the minds of the students only in the course of subsequent medical practice, much after they have graduated. An integrated curriculum, along with a problem-based teaching methodology, would ensure that the interconnections between the clinical and non-clinical subjects would unravel as the curriculum is taught in the undergraduate course. The problem-based learning process would reveal the context of the relevant aspects of the subjects. The adoption of the methodology of integrated teaching would reduce the fragmentation of the medical course.

3.6.2 In the context of these considerations, the Task Force recommends that the medical colleges should be made to shift to an integrated, problem-based pedagogic methodology in a phased manner over time.

3.6.3 It would also be of advantage to associate general physicians in teaching the course, as their methodology of diagnosis and treatment relies on the integrated approach. It is realized that the change involves a massive exercise in reframing the course material.

3.6.4 Also, it is not a brief, one-time exercise – the teaching faculty of the medical colleges would have to evolve the course material in an interactive exercise with

the students over an extended period of time, based on the feed-back received. The MCI should set a phased time-bound, programme for the medical colleges to move to the integrated, problem-based pedagogic methodology. They should also monitor the progress made by individual colleges in adopting the new pedagogy, during the course of their periodic inspections.

3.7 Focusing the examination system on common conditions and 'hands-on' skills

3.7.1 The assessment system in medical education largely determines the graduate physicians it is producing. It is essential to move away from the knowledge-dominated examinations to more skill-oriented examinations. It is well known that the cases kept for examination are the so-called 'interesting' cases, which are the uncommon ones. No attempt is made to test the knowledge of the student in respect of the common conditions and the hands-on skills. In result, the fresh graduate does not have the confidence and skills for independently handling the common conditions coming beneath the umbrella of primary healthcare.

3.7.2 Looking to this undesirable trend in examinations, the Task Force recommends the MCI issue guidelines requiring that examination should be based on common disease conditions and hands-on knowledge. The MCI, in the course of its periodic inspections, should also review whether this particular aspect is satisfactorily ensured while conducting examinations. More marks should be allotted to internal assessments and practical examinations.

3.8 Modification of duration of posting of interns

3.8.1 In several parts of the report, the inadequate 'hands-on' skills of the fresh graduates have been commented upon. The typical mind-set of the fresh graduate is to look towards an opportunity for a post-graduate course. This

tendency in the health system is highlighted by two interesting statistics –the country has about 27,000 undergraduate seats in the various medical colleges, and against that there are as many as 10,500 post-graduate seats (39% of undergraduate seats). The herd instinct drives the fresh graduates to try to get admission into a post-graduate course in a clinical discipline, for which they have a reasonable chance looking to the large number of post-graduate seats. Many of those who do not get a post-graduate seat settle into general practice in a peri-urban or urban area with a tie-up with some high-tech, diagnostic service providers. Through this cycle of events, very few doctors are drawn into providing what is a conventional primary healthcare service. **The period of internship provides one whole year when the attention of the to-be-doctor can be turned towards the hands-on skills, which is meant to form the very foundation of his professional worth.**

3.8.2 The widespread impression is that the students do not take their internship seriously. In fact, most use the time to prepare for the post-graduate entrance examination. In the circumstances the Task Force has been at pains to devise appropriate conditions that compel the student to acquire 'hands-on' knowledge of the broad span of community health issues. This, in fact, was the very objective of the one-year of internship. The existing (MCI-1997) provisions describe internship as a phase of training when a graduate is expected to actually provide healthcare services and acquire skills, so that he becomes capable of functioning independently.

3.8.3 The MCI in its proposals of year 2004 has suggested an amendment so that internship is described as ***'a period to learn methods and modalities for actual practice'*** of medical and healthcare. A plain reading of this would imply that the expectation from the student after the internship, of providing services independently, is even further diluted. **It is the considered view of the Task Force that this suggestion of MCI-2004 is not an appropriate one, which should not be accepted by the Government.**

3.8.4 Another connected issue is that of the appropriate period of attachment to the Community Medicine discipline as a part of internship. The prescribed period has been 3 months since year 1983; prior to that it was 6 months. Again in the year 2004 the MCI has suggested a further reduction to 2 months. This period of attachment is at one of the levels of the decentralized structure of the public health system - CHC, PHC and SC. The attachments to the public health centre provide an ideal setting for gaining hands-on experience in primary healthcare, with or without supervision. The period of internship provides the best opportunity to expose medical students to the multiple facets of community healthcare. **In view of this, the Task Force suggests that the Government not accept the proposal made by MCI for reduction of the duration of internship in community health from the existing 3 months to the proposed 2 months.**

3.8.5 One central objective of the recommendations of this Task Force is to ensure that, to the extent possible, the training be located in the decentralized setting in the public health organizational structure. This is with the explicit objective of equipping the medical graduates with adequate practical experience to provide primary healthcare independently. Currently, the broad breakup of the internship period is: PHC –3 months; Secondary hospital- 3 months; and Tertiary hospital- 6 months. To reduce the baneful influence of Tertiary healthcare on the national health system, the Task Force recommends that the breakup of the period of internship be modified as follows: Tertiary hospital – 3 months; Secondary hospital/ District hospital- 6 months; and PHC – 3 months.

3.8.6 The Secondary hospital / District hospital selected for attachment of the interns should be well equipped and should have a substantial patient-load. The faculty from the medical college must be involved in the training at the secondary hospital and the PHC. Department of Community the Medicine colleges would be the appropriate nodal point for the training of the interns at these service centers.

3.9 Introduction of Evaluation at the end of Internship

3.9.1 The common perception is that the students fritter away the period of internship. This is a year when the theoretical training is over, and the student is expected to only absorb hands-on knowledge during the attachments to various departments. The Task Force has carefully considered the various steps possible to make internship a more serious period of training, and now makes the following recommendations:

3.9.2 Introduction of the requirement to maintain a logbook during internship. All the hands-on work performed by the intern during internship should be entered in the logbook. Already some Medical Colleges and health Universities have introduced log books during internship.

3.9.3 The curriculum of internship should include the requirement to write a dissertation on a topic encountered at the PHC /CHC level. This will make the intern focus on some community health issue, or on an issue relating to primary healthcare.

3.9.4 An evaluation of the 'hands-on' knowledge and skills should be made at the end of the internship. This will put some pressure on the students to concentrate on the events during the period of internship.

3.9.5 Permanent registration with the Medical Councils should be granted only after successful submission of the dissertation and passing in the evaluation.

3.10 Creation of Medical Education Cells and Faculty Development

3.10.1 The teacher is the cornerstone for any system of education**.** An appropriate method of selection and training in pedagogic methodology ensures that the teachers meet the objectives of the medical education system.

Unfortunately, teacher training is perhaps the most neglected of issues in medical education. There has been a virtual explosion in the last half-century in the area of medical knowledge. This poses challenges to the teachers to ensure that their pedagogic methodology continues to be relevant. The principal goal of a developing India is to prepare the medical graduates for providing primary healthcare to the community at large. Except in some scattered pilot projects the integrated, problem-based methodology has not been adopted. The Task Force has recommended a phased introduction of the integrated, problem-based teaching methodology, and for the success of that a large part of the responsibility rests on the dynamism and innovativeness of the faculty members. It is they who have to go through the painful exercise of restructuring the course material to integrate the various clinical and non-clinical strands. To carry out this task, the faculty members need to make an even greater effort than in the ordinary circumstances when there is a stabilized pedagogic methodology.

3.10.2 In view of all this, there is a dire need of adopting a systematic approach to faculty development. The MCI has issued guidelines for establishing medical education units in all medical colleges. **The MCI should monitor the activities of the medical education cells as a part of their periodic inspection.**

3.10.3 There is a need for reviewing the contents of the syllabus every five years. Medical knowledge is expanding at an unbelievable pace. Subjects like genetic engineering and biotechnology were scarcely known in this country a decade ago. To keep pace with the expanding areas of medical science, the MCI should periodically carry out an exercise of reviewing the syllabus on the basis of inputs received from the medical education units.

3.10.4 The Task Force is aware that some of these recommendations have been made in some form even earlier. These suggestions have become particularly urgent in view of the requirements of the NRHM. The present Task Force reiterates the urgent need to introduce these reforms in Medical

Education to make it more relevant to national priorities. If necessary, a small full-time action group should be constituted to work with the Ministry of Health and Family Welfare, MCI and the Medical Colleges to make these changes a reality.

3.11Experimentation with Alternative Model of Undergraduate Medical Education

3.11.1 While the above package of reforms will make the existing medical curriculum more relevant for achieving the NRHM goals, there is an urgent need to also provide some autonomy and space for more radical alternative models of under-graduate medical education. This has been done in many countries of the world, leading to the now well-known 'Network of Community-Oriented Health Science Institutions.' After over 50 years of medical education in India, only one college (out of the 242 colleges in the country) has qualified to be admitted as a member of this Network-- this innovative institution is the Christian Medical College, Vellore. The Task Force is aware that several novel experiments have been tried in the past –the Kottayam Experiment; the Alternative Curriculum suggested by Medicos Friends Circle, a radical group of doctors and health workers; and an alternative track curriculum proposed by the MCI to train doctors who are suitable for primary healthcare. All these experiments faced operational obstacles and never came to fruition. There is an urgent need to support more experiments of alternative models of Medical Education and to ensure that they get a fair field trial in order to assess their wider implementability**.**

3.12 New Proposal

3.12.1 A model has been developed and proposed by Dr. G.P. Dutta, a veteran medical educationist. The model shifts the fulcrum of medical education from the tertiary care hospital to the community. Under this model, 1 ½ years of the training is centered on a CHC, another 1 ½ years is centered on a secondary

care hospital, and the last ½ year's training is centered on a tertiary care hospital The philosophical underpinning of the model rests on the belief that a sustainable and effective health system has to be located in the community. The concept envisages a health system with the following elements: community health planning, community healthcare volunteers, socially–oriented graduate doctors and supervision of the healthcare services by local-self-government institutions and community groups. One element of this holistic model has also been included in the NRHM through the provision of ASHA, who would perform the role of community health volunteers. This proposed model curriculum has been approved by the MCI.

3.12.2 The Task Force has carefully studied the proposed model and finds much merit in it. However, it is observed that it has not been tried out on a pilot basis so far. The success of the model rests critically on the success of the health educators in preparing course material linked to teaching at the decentralized levels of the primary healthcare network in the rural sector. The Task Force feels that all opportunities should be made available to try out this proposed model in different parts of the country.

3.12.3 The Task Force also recommends that the government should encourage pilot studies of this model in government medical colleges. The MCI already having approved the syllabus should have no difficulty in granting registration to graduates from such institutions. On the successful completion of the pilot projects, the application of this model can be extended to privately managed medical colleges also.

3.13 Innovation in Medical Education

3.13.1 There is an urgent need for the creation of space and opportunity for experimentation in medical education in the country. Several novel experiments have been conducted - e.g. Kottayam experiment and MCI's Alternative curriculum; but these were in limited operational conditions. Institutions that have

capacity and a socially relevant approach need to be identified and given all support for their experimentation. With the increasing privatization and commercialization of medical education, and the drifting away from primary healthcare to technology-dominated medical care, experiments in primary healthcare are urgently needed, and Dr. Dutta's decentralized teaching module, deserves consideration.

CHAPTER IV

TERM OF REFERENCE – 2

- **To examine the feasibility of a short-term certificate course in medicine for creating a cadre of Health Professionals for rendering basic primary health care to underserved rural population. If found feasible, the Group would recommend on the following;**

  a) **The duration of such a course.**
  b) **Whether it can be an integrated course containing the basic principles of various approved systems of medicines.**
  c) **Whether it can be covered under the provisions of the respective Acts governing existing approved systems of Medicines or a separate legislation would be required at State level.**
  d) **Criteria for admission.**
  e) **Syllabus of the course.**

4.1 The Need for Three-level Healthcare

4.1.1 The need for reaching primary healthcare services to all corners of the country has been highlighted earlier. It has been seen that, despite all incentives and encouragement, graduate doctors have not been able to provide this in more than a small part of the country. As a result, even a half-century after independence, most of the citizens of the country are still without access to cost-effective and sustainable primary healthcare services, whether in the private or the public sector. The trend towards specialization of graduate allopathic doctors is increasing by the day, and there does not appear to be any reasonable possibility of reaching primary healthcare on a widespread scale exclusively

through graduate doctors. In these circumstances, community interest demands that a three-level healthcare system be put in place, with the first level of healthcare being limited to a restricted service package of primary healthcare provided by practitioners with appropriate training. The second level envisaged is that of graduate doctors; and the third that of specialists.

4.1.2 We have for too long clung to the belief that only graduate doctors can render competent healthcare, and that all other attempts to deliver health services are ill conceived and against patient interest. The Task Force is of the view that this bland assertion needs to be critically examined. On a macro-view, the contribution of graduate doctors to primary healthcare in the country has been limited. While the aggregate number of graduate doctors (0.7 million doctors) is not very low for a developing country, only 28% of them are located in the rural areas. As a result, in rural areas, health services, to the extent they are available, are provided by practitioners trained in alternative systems of Medicine (Ayurveda, Unani, Siddha, Homeopathy), or those who are not trained in any discipline at all. Even the practitioners trained in the alternative systems of Medicine indulge in, what is called, cross-practice i.e. using therapeutic drugs of the allopathic system when trained in an alternative discipline. In a study conducted in rural Uttar Pradesh in 1995, only 3% of medical practitioners were MBBS graduates or allopathic practitioners, while 68% of them had no training in any form of Medicine.

4.1.3 In this backdrop, **the stark reality is that a very substantial portion of the primary healthcare services are delivered by untrained providers.** Such providers are able to attract clientele for two reasons: firstly, there is no reliable graduate allopathic doctor in the proximate distance to whom they can turn, if allopathy is the discipline of their choice; and, secondly, because most of the medical conditions for which they require services are of the common type, for which the quasi-trained practitioners can often offer some relief. However, one must hasten to add that the medical services provided by practitioners, who

largely practice in a discipline in which they have no training, is in the broader context, highly damaging. Even for the common medical conditions, the treatment regimens of the untrained practitioners are almost always unscientific and cost-inefficient. Moreover, quite often, such practitioners are known to offer treatment linked to the financial capacity of the patient, rather than based on scientifically established regimens of essential drugs. The use of antibiotics based on the capacity-to-pay is, in fact, the one of the principal causes of drug-resistant mutant pathogens that has triggered off a self-propelled spiral of new diseases.

4.1.4 All in all, because of such factors the mode of delivery of health services in the country is highly detrimental to the quality of the national health system. All of us in the country, and particularly the graduate doctors' fraternity, need to reflect on why such an iniquitous and harmful mode of health service delivery exists over much of the country. Often it is argued that the financial rewards in the public health sector are too low to attract the graduate doctors to the scattered rural areas. Another reason cited is that the absence of minimal physical and social infrastructure makes it impossible for young medial graduates to serve in the rural areas, whether in public or private assignments.

4.1.5 It is the view of the Task Force that these reasons are only partially true. The emolument structure of public health doctors is not adequately attractive in all States. While it would be correct to expect that the compensation in Government for public health doctors should not be inferior to other Class 1 Services of the State Government, it would not be feasible to envisage a compensation structure for the health cadres completely different to that in other equivalent State cadres. Reverting to the second standing complaint, the Task Force noted that the inadequacy of social and physical infrastructure in the rural areas is itself a manifestation of underdevelopment. These handicaps cannot be removed selectively for the health sector. And, it is necessary to note that when, as a part of the process of development, such deficiencies are mitigated, by that stage the requirement of state-driven health services on such a broadband basis,

would itself have diminished. In other words, the providing of basic health services is itself an integral component of the development process that will eventually ensure that infrastructural and social facilities are more evenly available across the country.

4.1.6 Looking to the nature of complaints of the fresh graduates, it is unlikely that government can radically relieve these in a generalized manner in the near future. **The shortcomings perceived by the fresh medical graduates are principally the outcome of their urban orientation and the skewed pattern of their aspirations. Most of them have only lived and trained in the urban setting. The few with a rural background acquire an urban mindset in the course of their training that is focused around a tertiary care hospital. They do not have the confidence to function in a setting in which there is no multi-disciplinary support or advanced diagnostic hardware. Most graduates aspire to spend their career in the same urban ambience that they are familiar with. This is, in a way, a distant ripple effect of the macro-trend of the commodification of health services observed globally over the last two decades.** It is often felt that it is because of this fixed mind-set that the young graduates fail to position themselves comfortably in the social ambience of the country, and also fail to recognize health services as a fundamental requirement of the community.

4.1.7 As a result, primary healthcare comes to be neglected and high-tech tertiary care is the single preferred option. It is often emphasised that to fulfill the basic requirements of the broad-based community, the social orientation of the students would have to be altered. **For medical education to serve the community, it would have to be socially oriented towards primary healthcare. The pedagogic methodology would have to be problem-based – where the non-clinical principles would have to be meshed with clinical training.** In short, it is felt that medical training should largely be in a decentralized setting outside a tertiary care hospital, in close proximity with the public health and social environment.

4.1.8 Conceptually, private health services were always visualised to be distinct from other commercial services. It is obvious that health services would only be delivered on payment, as no one can expect it to be a charitable activity. **However, with a different orientation to the curriculum, and a community-centric pedagogy, one can reasonably expect a much more even spread of service providers over the country.** The government has previously tried any number of initiatives to improve the spread of the graduate service providers in the public sector at least. Compulsory rural attachment for fresh graduates has been tried out in several states; priority admission to the post-graduate courses after a stint of rural posting has been offered as an incentive; and, enhanced allowances, with an assurance of a rotational transfer policy, so that those who serve in the rural areas, can expect a more socially congenial posting at a later stage, have also been attempted. However, all these attempts have failed on account of brazen defiance, subterfuge, nepotism, etc. As a result, even five decades after independence we face an indefensible situation in which we are not able to provide trained primary healthcare over large parts of the country.

4.1.9 A democratic polity has its own internal dynamics, visible evidence of which may only surface very slowly. In the past, it has often been noted with surprise that there was no discernable countrywide demand for improved health services. After all, the most basic interventions a citizenry can demand of its government are services in the education and health sectors. Yet, despite the appalling poverty and pervasiveness of ill health, no strident demand has been heard from the northern states for improved health and education facilities. By contrast, the status of the health system in the southern states is much superior. It is seen that in the southern states, the health issues have come to occupy space in the political arena. The citizenry expects better health services, and the dynamics of a democratic polity ensures that this is at least delivered in some measure. The churning of fresh expectations, and the raising of demands in the social sector, is always early evidence of the maturing of the polity. Whilst in the first four decades after independence, such demands in respect of the health sector were

not seen to be emanating from most parts of the country outside the southern states; signs of change are now visible. Increasingly, we seem to be receiving signals from several under-developed parts of the country, that the citizenry has acquired an appetite for development services in the social sectors; an increased insistence on improvement in availability and quality of health services is now apparent.

4.1.10 We are now seeing the early signs of these democratic impulses being reflected in the dynamics of the polity. The near complete absence of healthcare facilities in a large part of the country cannot be ignored any longer. Even if comprehensive healthcare for all remains a distant dream, at least a modest spread of primary healthcare services would be the irreducible minimum expectation of the citizenry. As has been discussed in detail earlier, one major shortcoming in the current health scene is the non-availability of graduate service providers in vast tracts of the country. **Given this insurmountable problem, the Task Force addressed the issue whether we could create another category of trained service practitioners who would be given the responsibility over the domain of primary healthcare. The course for such service providers could be a shorter one, with a focus on the clinical conditions, situations and treatment regimens within the primary healthcare domain.**

4.1.11 At a conceptual plane, it is possible to visualize a health system with health services provided at more than one level. It is always possible to arrange a continuum of levels of public health initiatives and conditions requiring a progressively increasing level of skill and training. At the practical field level, however, it would not be convenient to adopt several such levels, as that would require separate defining of service modules, and independent regulation of the services within the authorized packages. However, we can quite conveniently divide the health services in three levels: one level can be the more common health conditions and public health initiatives coming within the purview of the short-course practitioners; the second level can be the more complicated conditions (and procedures not included in the first category) which would remain

in the exclusive domain of the graduate doctors; and the third would be the level of the Specialist. A commonly prevailing misconception is that the specialist provides the best treatment, regardless of the nature of the medical condition. In other words, there is a subconscious belief that the best health system would be one arranged through a consortium of specialists. Such a view is ill conceived. An array of specialists offering health services to the general community would be a very costly and inefficient arrangement. The elementary concepts shaping an efficient organizational structure would require that the more common medical conditions be screened out at the general practitioner level, and the more complex conditions be referred to the specialist level. The system of functioning of several public tertiary care institutions, like AIIMS, New Delhi provides evidence of the inefficiency caused by exposing the specialists to a general mix of patients at the first contact point. The functioning of tertiary care institutions is not only rendered needlessly inefficient, but serious transactional problems also arise at the interface between different specialist disciplines when unscreened patients have to be attended to.

4.1.12 Health Practitioners with limited training in a package of primary healthcare can competently handle most common diseases that have not advanced to a complicated stage. For the typical conditions coming within the package of primary healthcare, no value is added if a graduate MBBS doctor provides the services, rather than a short course practitioner.

4.1.13 In the above backdrop it would be logical to conceive of three levels of health services in the health system. The three levels would not constitute different degrees of superior and inferior standards of clinical treatment, but would be demarcated on the basis of the complexities of the medical condition. One level can cover common ailments, family welfare initiatives and other conditions requiring ambulatory services; the second level could cover complicated variants of conditions listed in the first level, non-communicable disease cases and surgery cases; and the third level would be the conditions requiring the services of a Specialist. **The appropriate medical education**

required for service providers of the first level would be less elaborate than that required for a graduate MBBS degree, but it is considered entirely feasible to ensure that the skills available to a short-course service provider would be fully adequate for the common conditions included in that level of healthcare.

4.1.14 As a legacy from the British times we had Licentiate Medical Practitioners (LMP) who had to undergo a three-year course. These practitioners were registered with the Medical Council of India and were authorized to practice over the entire range of medical conditions. With the intention of improving the standard of medical services in the country, the cadre was discontinued after 1964. However, subsequent events have shown that instead of improving the availability of skilled medical services to the citizenry, this, in fact, reduced it. While graduate doctors may have increased in number, this did not improve the access of the citizenry to skilled medical services. The other category of quasi-trained allopathic practitioners that exist in almost all States of the country are the Registered Medical Practitioners (RMPs). For this category the minimum qualification is 6th Class and no formal training in the science of Medicine is required. Typical RMPs could be Sales Assistants in chemists' shops or Compounders attached to doctors. These practitioners, who are found in vast numbers over the country, are unquestionably quacks. In this background the Task Force notes that the effort of the State to provide medical services only through graduate doctors, has inadvertently generated a vast army of quacks.

4.1.15 The Task Force would like to clarify that the variant examined by them is not of a short-course health practitioner with an open license to practice in the entire universe of allopathy; the option under examination is of a short-course training after which the practitioner would be licensed to provide medical services within a notified package of primary healthcare. A statutory council would monitor the functioning of the short-course practitioners. The scheme envisages a training course that would adequately equip the practitioners to competently deliver primary health services. In other words, the

capacity of the practitioner would be up to the skills required for primary healthcare services. This attempt to create a package of simple health conditions requiring a lesser degree of theoretical knowledge, and to license the short-course practitioners to provide the services for these conditions, is conceptually very different from the span of services of a graduate MBBS doctor. Equally, the short-course practitioners would also be very different to the quacks masquerading as RMPs. For the optimal treatment of many medical conditions the level of training imparted to graduate MBBS doctors, is not required. **The attempt is to segregate medical services at three levels – one, which is the level of primary healthcare services that can be delivered with an optimal level of competence by the short-course health practitioner; the second category of the balance of the medical conditions (as also the complicated cases of the first category), where only the graduate MBBS doctor would be licensed to deliver services; and the third is the domain of the Specialist with post-graduate qualifications.**

4.1.16 In all professions, different grades of service require different levels of skills and training. An average engineering diploma holder does not possess the same level of skills as the average degree holder. The same differential is observed in the case of lawyers who practice in subordinate courts vis-à-vis those who practice in the High Courts/Supreme Court. The argument is often advanced that in the case of the other professions, if the practitioner oversteps his level of competence, he would merely blotch an assignment without causing any grave damage. On the other hand, it is asserted, that if a medical graduate oversteps his competence level and mishandles a case, the damage may be irreversible and life threatening. However, the Task Force feels that such a conclusion would be an overstretched one. **Health practitioners of all levels, whether graduate doctors or others, need to be sensitized that they must venture to provide services only within their area of training and competence, and to refer the cases to a level of higher competence if the circumstances are more complicated.** Some doubt is always raised that the

short-course practitioner would never restrict himself to the primary healthcare situations, and would feel free to practice over the entire domain of medical conditions. In other words, for much of his practice he would be indulging in quackery. It needs to be recognized that today most of the practitioners in the rural areas are quacks in as much as they have no training in allopathy, which is the discipline they are practicing in. The concept examined by the Task Force is to train the short-course health practitioners in the Allopathic discipline for delivering services limited to the domain of primary healthcare. There would also be a statutory authority, similar to the MCI for graduate doctors, which would monitor the working of the short-course health practitioners. **It is the considered view of the Task Force that in the suggested scheme the risk of quackery would stand reduced, rather than increased. Also, it would result in good quality primary healthcare services being delivered to the citizenry on a much wider scale than is available through graduate doctors today**.

4.1.17 The operation of a three-level health system, with the requisite regulatory controls, would not result in a 'twin-track' health system. On the contrary, service providers with three levels of appropriate skills would service the medical requirements specified for the three levels. This would result in a more equitable spread of service providers over the country; and, more importantly, the providers for the first level of medical services would be well positioned to spearhead the national primary healthcare campaign on a countrywide span. At a later stage of the report, the Task Force will spell out the detailed outline of the suggested scheme for introduction of short-course practitioners for delivery of primary healthcare services in the national health system.

4.1.18 The Task Force is aware that this particular issue has been the subject of much discussion in the past. The fraternity of graduate MBBS doctors has been averse to it on the ground that this would create a 'twin-track' health system under which the elite would have superior health services, and the others would have sub-standard health services delivered by inferior service providers. Such

criticism has been answered in detail in earlier sections of this report. **The Task Force would like to record its considered view that the health system in the past, in trying to provide comprehensive curative services only through graduate MBBS doctors, has created an impasse where no health services of any acceptable quality can reach a vast number of the citizenry. By insisting on health services through graduate doctors, or nothing, the medical fraternity has created a situation in which vast numbers get nothing.** The Task Force is aware of the growing feeling that it is indefensible to accept a situation in which even primary healthcare cannot reach all. Increasingly, people are getting impatient with the insistence of the graduate doctor fraternity, that health services are only acceptable when delivered through them. The delivery of primary healthcare services through the short course community health practitioners runs no untoward risks. In fact, if the delivery of primary healthcare services were further delayed, the un-served population would have reason to believe that the restriction, which is purportedly being enforced in their interest, is actually the vested interest of a group. In this backdrop, it is time that the graduate doctors' fraternity accepts the ground reality and endorses the option of trained Community Health Practitioners delivering services within an authorized package of Primary healthcare. This would reaffirm their commitment to the community, which is a relationship that is sacred to their vocation.

4.2 Short-term Course for Training Community Health Practitioners for providing Primary Healthcare

4.2.1 The Task Force has deliberated at length as to the structure of the module of service delivery at the first level of healthcare. It is felt that the practitioners at this first level of healthcare must go through a three-year degree course –B.Sc. (Health Science) -qualifying them to be called Community Health Practitioners. The Task Force suggests that the syllabus of the short course could be broadly as under.

First year -

- Basic medical sciences: Anatomy, Physiology, Biochemistry, Pharmacology, Microbiology and Pathology, along with an introduction to Public Health and Psychology.

Thereafter -

- Study of common clinical problems through integrated problem-based teaching
- Training in clinical assessment, therapeutics, and other clinical skills.
- Addressing rural health crises- obstetric and mental health emergencies, rural trauma and farming and industrial accidents.

4.2.2 The course must encourage students from the underserved areas, whether rural or urban. To that end, 25% of the seats should be reserved for candidates from the rural areas, and another 25% for those from the same district. Minimum educational qualification for admission to this degree course should be 12^{th} pass from the Science stream, with at least 50% marks in Physics, Chemistry and Biology. The training should be over two years in the institution and one year internship, both in the allopathic discipline. The course should include both clinical and non-clinical subjects. However, since the duration is much shorter

than the graduate course, the detail in which the subjects are taught would be much less.

4.2.3 The pedagogic methodology would be an integrated, problem-based one covering the medical conditions and other initiatives relating to the primary healthcare package. This is a departure from the methodology currently being used in graduate medical courses where the subjects are taught in isolation. Separately, the Task Force has recommended that, even for the graduate medical course, the pedagogic methodology be shifted to the integrated, problem-based one. However, it will take considerable time before this is successfully put in practice in the existing medical colleges. In the case of the proposed short-course, it is possible to introduce this from the start, as the course material would have to be created afresh. The integrated, problem-based methodology would be particularly suited to the short-course where the emphasis is on 'hands-on' experience and independent work-skills.

4.2.4 At the end of the course the students would be expected to independently provide allopathic services covering the entire primary healthcare package wherever it is required in the country, whether urban or rural. Considering that the primary healthcare package has large components of promotive and preventive aspects, the trained practitioner would also be equipped to lead initiatives in these areas.

4.2.5 An independent statutory body, similar to the MCI, would oversee the training of the practitioners, and their work in the field. To ensure uniformity all over the country, the structure of the body would have to be created centrally through statute leaving the application of the law to the state. The state unit of the central statutory authority will carry out the day-to-day operations. These operations would include: registration of institutions authorised to run the short course; registration of practitioners who have passed the short course; evaluation of the working of the training institutions and the hospitals attached to them;

taking of disciplinary action against the registered practitioners for misconduct; etc. The states that wish to adopt the law may notify it for their territory.

4.2.6 The graduates from the alternative systems of medicine, who have subsequently taken the short-course, can, in addition to providing service under the allopathic discipline, continue to practice the alternative system, for which they will be under the purview of their respective regulatory authority.

4.2.7The institution running the short-term course must also manage a hospital, of the minimum size of a district hospital, for imparting clinical training to the students.

4.2.8 The government could enter into joint-venture agreements under which the district hospital (or other government hospitals) is attached to the teaching institution.

4.2.9The running expenses of the hospital must be borne by the institution organising the training course in lieu of use of the government facilities for training the students.

4.2.10 Each community health practitioner should be linked to a MBBS graduate doctor for the purpose of referral. All the conditions and situations that are outside the primary healthcare package, for which the practitioner is authorised to provide services, must be referred to the graduate doctor with whom the community health practitioner is linked.

4.2.11 A variant module of this course could be a 2-year course for graduates of Ayurveda, Unani, Homeopathy, Pharmacy, Dentistry and Nursing. These graduate students would join the course one year after its start. The three-year course should have a section for the non-clinical subjects, which would be taught in the first twelve months. The graduate entrants (Ayurveda, Unani, Homeopathy,

Pharmacy, Dentistry and Nursing) need not go through this, as they would have covered it in their earlier graduation. For the remaining 2 years they would undergo a clinical course with fresh entrants. The 2 years of clinical course should be structured to focus on acquiring hands-on clinical experience. The focus on hands-on training and acquisition of practical skills should be reflected in the evaluation system.

4.2.12 Government health functionaries –Auxillary Nurse Midwives (ANMs), Nurses and Multi Purpose Workers (MPWs) – should be encouraged to undertake the short course after they have put in a minimum of five years service in the rural area. This would improve their capacity to discharge their current functions. They should be sanctioned study leave with pay to undertake this course.

4.2.13 At PHCs where government is finding it impossible to place graduate doctors, community health practitioners could be placed to provide services within the authorised span of primary healthcare services.

4.2.14 The short-course could be conducted by any health university, ordinary university with a health science faculty, medical college, dental college or nursing college that is able to satisfy the conditions set out by the statutory body for the running of the short-course.

4.3 Critical Gaps in Skills for Primary Healthcare-

4.3.1 In almost no part of the country are surgical procedures, even of a minor character, conducted in CHCs/PHCs. The principal reason is the non-availability of Anesthetists and Radiologists. Even routine caesarian operations cannot be conducted in CHCs/PHCs because of large-scale shortage of Anesthetists in the rural health organizational structure. One would expect that

graduate doctors would be able to provide the services that are normally considered a part of the primary healthcare package. However, even the recommendations of the Task Force in regard to modifications in the graduate syllabus, will only change the range of skills of graduate doctors in the long run. It is imperative that the skills required–clinical, surgical and other support procedures - for effective service delivery at the primary healthcare level, becomes widely available as early as possible. To this end, it would be of advantage if a series of one-year duration Certificate Courses were drawn up and launched in the deficit disciplines for strengthening primary healthcare services. The package of services that the certificate-holder could provide would have to be designed and notified. The Ministry of Health and Family Welfare would be the agency to authorise institutions to run such Certificate Courses and issue certificates. The areas in which short courses could be considered are: Pediatrics, O&G, Rural Surgery (i.e. General Surgery in conditions with limited infra-structure support), Anesthesia and Radiology. MBBS graduates would be eligible to undergo this certificate course. These Certificate Course would provide additional skills to graduate MBBS doctors to independently provide health services.

4.3.2 Of late, some courts have taken the position that only a post-graduate practitioner can undertake certain types of procedures–for example administering anesthesia. In other words the courts have held that any mishap, when an ordinary graduate provides these procedures, would amount to professional negligence. As it is, graduate doctors show very little confidence in independently providing even primary health services, and with the threat of court action, they acquire a convenient cover for avoiding any initiative. It is felt that in the court cases, the State was, perhaps, not able to put across the point concerning broad public interest. The Task Force feels that in a suitable case, where the question of graded health services arises, the State can claim, as a matter of public policy that it is in favour of a three-level health system. This would, of course, be further elaborated to clarify that it did not amount to a ‘twin-track’ health system. **The**

Task Force feels that it should be possible to satisfy the Court that, a three-level health system, based on different complexities of medical conditions, along with three types of service providers with the appropriate level of skills, would, in broad public interest, be a desirable health system structure.

4.3.3 At this stage of the report the Task Force would like to make a clarificatory statement in regard to its general approach to the variety of suggestions that were made in the course of the discussions. It would not be an exaggeration to say that more than a hundred suggestions, small and big, were made. Many of these related to upgradation of skills of small categories of skilled personnel having niche expertise. Typically, the suggestions envisaged that the trained personnel be authorized to carry out differing degrees of functions particularly of the curative category. The Task Force has been quite conservative in suggesting new categories of trained personnel for use under the NRHM. Each new category of new trained personnel carries with it the requirement of drawing up of the curriculum, holding of examinations, monitoring of the performance of the trainees in the field, registration of the training institutions, maintenance of the training standards, etc. These are huge responsibilities. Increasing the number of skill development programmes increases the difficulty of maintaining standards and preventing abuse. Because of the extraordinary situation existing in the health system of the country, the Task Force has, as an exception, ventured to recommend two new levels of skills: Community Health Practitioners and short term certificate courses for deficit clinical skills. These recommendations increase the responsibility in respect of supervision and control. However, with the objective of making skilled primary healthcare more easily accessible, this approach has had to be adopted. At the same time several suggestions for creation of different levels of skill have had to be ignored because of the perceived problems in maintaining standards and control in a country as large as ours. For a health programme in a country as large as India some standardisation becomes necessary, or we risk anarchy. Thus, the Task Force

would like to make it clear that their reluctance to suggest other small-span, supplemental educational modules for health personnel is because of the inherent constraints in regulating large-span procedures and institutions.

4.4 De-valuation of Public Health and Community Health

4.4.1 At the level of policy, India has always thought in terms of a broad-based community healthcare system. The NHP-1983 - drawn up after the signing of the Alma Ata declaration of 1978 - aimed at 'Health for All by the year 2000 AD'. Subsequently, in the NHP-2002, realizing that the goal of comprehensive primary healthcare, in the widest sense, was an unreachable target, we settled for a package of broad-based community health services within the financial and managerial capacity of the country.

4.4.2 However, despite the several well-meaning policy declarations, the health system of the country has grown in its own ad-hoc and disjointed manner. With 83% of the total health expenditure being in the private sector, the dominant influence in the health system has been the private sector. The private sector, driven by the impulse to maximize profit, has drifted towards a system dominated by curative initiatives, increasingly dependent on high-cost, high-tech diagnostic support. This undesirable distortion went largely unnoticed because, even within the small public health sector, there is almost no expertise in the discipline of Community/Public health.

4.4.3 A few statistics will reveal the seriousness of the situation. Out of a total sanctioned strength of 4712 in the Central Health Service (CHS), only 78 (1.6%) posts exist in the Public Health Sub-cadre. The rest are General Duty Medical Officers (GDMOs) or clinical or teaching Specialists. The situation in the state public health cadres is even worse. **It is quite clear that within the government, there are very few who can be expected to analyse the health**

scenario, frame plans and offer policy advice on Community/Public Health issues. In order to restore the balance between the public and private sectors, and to play a meaningful role in policy-making relating to community healthcare issues, expertise in Community Health/Public Health has to be rapidly acquired.

4.4.4 In another part of the report, the need for giving the graduate syllabus a social orientation has been discussed. However, on a long-term basis, if government were to acquire a community/public health orientation, they would need to increase the pool of expertise available within the allied disciplines-Public Health and Family Medicine. To that end, as a long term goal, the Task Force recommends that 25% of the CHS posts be placed in the Public Health sub-cadre – this at current CHS strength would mean 1178 (25% of 4712) posts in the Public Health sub-cadre. While saying this, **the Task Force does not wish to give the impression that these doctors from the public health sub-cadre are to stop offering curative services as Chief Medical Officers (CMOs)/Medical Officers (MOs). It is felt that, if over time, 25% of the CHS cadre comes to possess post-graduate qualifications in the public health discipline, the entire mind-set and approach to health system planning, would stand strengthened.** The Task Force is conscious of the limitation that the number of post-graduate seats in Community Health/Public Health/ Preventive and Social Medicine in the country today are very few -163 degree seats and 106 diploma seats. The recent establishment of the Public Health Institute of India raises possibilities of increased post-graduate training in the public health discipline. However, if the extant eligibility requirements for recruitment to the public health sub-cadre are retained, it would be several decades before adequate number of candidates could be recruited in the sub-cadre. Though the extant eligibility requirements permit recruitment of both post-graduate degree holders and diploma holders, the required qualifying experience is 3 years for the former category and 5 years for the latter category. In view of these conditions it takes long before these doctors trained in the public health

discipline become available to the CHS cadre. Also, there are very few private job opportunities in the area of public health where graduate doctors can acquire experience before entering government service. Government's principal goal is to strengthen community healthcare, and without adequate number of public health specialists, its capacity to achieve that is greatly handicapped. **To remedy that, the Task Force recommends that 25% of the CHS posts be placed in the Public Health sub-cadre. The Task Force also recommends that the Recruitment Rules be amended so as to require only two years experience for post-graduate diploma holders, and not require any experience for post-graduate degree holders. The infusion of public health specialists, whether diploma or degree holders, would bring about a much-needed change in the range of skills and mind-set of the CHS, which is mandated to strengthen the community healthcare system in the country.**

4.4.5 The pathetic condition of the public-health sub-cadre in the CHS has also been noted in the NHP**–**2002. To give this discipline the required status and visibility in the national health system, the NHP-2002 had recommended that, government should progressively over time earmark up to 25% of the seats (both diploma and degree) at the post-graduate level for Community Health/Public Health/ Preventive and Social Medicine. This could be achieved by issuing a directive to the MCI to make necessary regulations to that effect. So far the government has not taken any action on the recommendation under the NHP**–** 2002. **The Task Force strongly reiterates the recommendation of NHP--2002 for reservation of 25% of the post-graduate seats (diploma or degree) for CCM/PH/PSM**. It is hoped that over a period of time, with the increase in post-graduate seats in the discipline of Community Health/Public Health/Preventive & Social Medicine and Family Medicine, and the gradual change in mind-set of health service providers, particularly in the public sector, there would be a shift away from the dominance of the curative services to an increased focus on community healthcare.

4.5 Training for Nursing Personnel

4.5.1 The Task Force has carefully considered as to what additional educational inputs can be imparted to nurses to equip them better for achieving the objectives of the NRHM. The first recommendation of the Task Force in this area would be regarding the up gradation of the skills of nurses. **An additional module of skills could be provided to the nurses in the form of a Certificate course. It is suggested that the course be of six-month duration for graduate nurses and one-year duration for diploma nurses. The contents of the module could include: hands-on training in maternal and child health and family welfare procedures; training in skilled birth attendant module; and training in integrated management of new born and child illness.** The curriculum should be drawn up and notified by the INC. The INC should also notify a package of procedures, which the certificate nurse would be authorized to provide independently under the NRHM.

4.5.2 The Task Force is aware that several developed countries, such as USA, Australia and UK, have introduced a cadre of Nurse Practitioners for supplementing healthcare services. It is the view of the Task Force that in India also healthcare practitioners can be gainfully sourced from the graduate nursing stream. The earlier mentioned proposal for training short-course community practitioners provides for entry from amongst qualified nurses. As mentioned there, nursing graduates can become qualified practitioners after a two-year training and diploma nurses can similarly qualify after a three-year training. Thereafter, the community health practitioners from the nursing discipline can provide healthcare services within the domain of primary healthcare, much like the Nurse Practitioners in the developed countries. This window of opportunity not only provides an avenue for career progression, but would also contribute to better access to skilled primary healthcare services on a widespread basis.

4.5.3 In year 2001 the INC took a decision to upgrade all diploma schools of nursing to graduate colleges, and to discontinue the diploma course from year 2010. The strength of the nursing cadre in the country is normatively short. Also, well-trained nurses are leaving the country to take up foreign assignments for better monetary prospects. The impact of the shortage will be most acutely felt in the rural areas which come under the purview of the NRHM. In this background, the earlier decision to discontinue the diploma course in nursing needs to be reviewed. **The Task Force recommends that the Government may consider postponing the implementation of this decision till the availability position of trained nurses shows a distinct improvement in the country.**

CHAPTER-V

TERM OF REFERENCE - 3

In order to make rural service attractive for doctors, the Task Group would give its recommendations on the following;

- **The various incentive schemes, which could be prescribed for this purpose.**
- **Whether the medical graduates before grant of permanent registration by Medical Council of India (MCI) should be made to serve in the rural areas as a part of extended internship.**
- **Whether rural service should be made an eligibility requirement for doing the Post Graduate course.**

5.1Incentive Scheme for Encouraging Rural Service

5.1.1 The doctors find rural posting unattractive as these areas lack facilities both in terms of individual and professional satisfaction. Hence, to promote rural services, the Task Force suggests that the Central Government / State Governments consider some incentives in order to attract graduate doctors.

5.2 Emoluments

5.2.1 The emoluments of doctors serving in the State Health Services, as obtained from some of the States, are summarized in the Table-7.

It is clear that the pay scales, gross monthly emoluments and other facilities vary widely. Also, it is observed that in several States – Jharkhand, Karnataka, Andhra Pradesh, Chattisgarh, West Bengal, Orissa, Meghalaya and Assam - the

overall compensation package is extremely meagre compared to the prospects in private institutions and private practice. In the liberalised economy, compensation packages in the organized private sector have increased unrecognizably. Public health service providers cannot altogether be insulated from this trend. It is recognized that the delivery of health services cannot be treated as equivalent to other commercial services that are driven entirely by profit. However, doctors, while catering to a basic human need, cannot treat their services as a charitable activity. To some extent, the ambient social atmosphere also influences the expectations of the public health service providers. Therefore, the compensation package offered by the state public health cadres must to some extent relate to the compensation package available in private employment.

5.2.2 In this backdrop, the Task Force is of the view that the pay scale of a doctor at entry level should not be lower than the lowest Class 1 scale in each State. The NPA also varies as between the States. The NPA is one allowance that can justifiably be offered to doctors without generating a competitive claim from other State cadres. The existing level of NPA for doctors of the Central Health Service is 25%. The NPA in the States is either much lower or not available at all. In a recent report on 'Retention of Health Manpower in Government Sector', an Expert Committee has recommended that the NPA be increased to 30% for the Central Health Service doctors, consistent with the recommendations of the Fifth Pay Commission. **The Task Force feels that for the doctors of the state health services the rate of NPA should at least be uniformly fixed at 25% of the basic pay, as in the Central Health Service at present**. While making this recommendation the Task Force is well aware that the bulk of the cost of the medical establishment is borne by the state governments. However, in order to ensure that skilled medical manpower is adequately available in the states, the Task Force feels that the state governments should sympathetically consider the possibility of offering a better compensation package for medical personnel.

Table-7: Monthly Emoluments at Entry Level in the State Health Cadre

Zone	State	Basic salary	NPA (Rs.)	RA (Rs.)	DA/DP (Rs.)	HRA (Rs.)	MA (Rs.)	Total Emoluments (Rs.)	PG seat Reservation
North	Haryana	8000-275-10,500	1,600	Nil	As per Central Govt	NO	250	18,000	50% seats reserved in government medical colleges after 5 years of rural service
	Delhi	8000-275-13,500	3,000	(-)	2,520(21%)	(-)	(-)	18,000	(-)
	Uttar Pradesh	8,000-275-13,500	1,500	100	2,423 DP- 4,750	1,355	(-)	18,328	(-)
	Jharkhand	6500-10,500	Nil	(-)	50%	15%	(-)	11,000	(-)
South	Karnataka		Nil	(-)	(-)	(-)	(-)	11,000	Eligible for PG entrance examination after 2 years
	Andhra Pradesh	11,000-330	(-)	1000	7.36%	10%	(-)	14,000	30% - clinical & 50% - non-clinical seats are reserved in PG entrance exam after 3 years of rural service
West	Maharashtra	6000-240-12,000	(-)	150	(-)	(-)	(-)	15,000-16,000	50% seats after 5 years, preference for rural experience
	Goa	8000-275-13,500	3,000	(-)	2,520	(-)	(-)	19,000	(-)
	Andaman & Nicobar	8000-275-13,500	3,250	@25% of basic pay, NPA & DP	5,625	(-)	(-)	23,000	(-)
East	Orissa	6500-150-10,500	Nil	(-)	`7000 for three backward tribal districts	8%	NO	10,000	50% seats reserved after 5 years (3years rural)
	West Bengal	8,000-13,500	1,700	Nil	50%	1,500	(-)	15,300	After three years 35 seats reserved
	Chattisgarh	8000-275- 13 000	Nil		59%	NA	(-)	13,000- 14 000	
North East	Meghalaya	6575-225	Nil	210	4777	500	350	11,842	After 3 years service
	Assam	6,970	(-)	(-)	(-)	(-)	(-)	8,000	(-)
ARMY		9,600-300-11,440	25%	(-)	50% - DP 21%-DA	Nil	Nil	18,000	After 5 years of service – 50% seats in Army

NPA – Non Practice Allowance
DA – Dearness Allowance
HRA – House Rent Allowance
(-) Information not available

RA – Rural Allowance
DP – Dearness Pay
MA – Medical Allowance

5.2.3 Certain allowances – Dearness Allowance/Dearness Pay; House Rent Allowance; Medical Allowance - cannot be raised exclusively for the medical cadres, as these are applicable to other State cadres, from whom similar claims would immediately be raised. However, one allowance available in certain States –the Hardship Allowance/ Rural Allowance – is particularly relevant on the State health cadres. This allowance would be generally applicable to all government servants in the North East and other hilly areas. All such areas encounter serious logistic and infra-structural problems. However, apart from these identified areas, the functionaries of the public health sector, who are posted in PHCs/Sub-Centres, face similar hardships over the length and breadth of the country. A large number of public health sector functionaries work outside district headquarters and other major urban habitations. To enable such health sector functionaries to cope with social and infrastructural shortcomings, it would be necessary to offer some monetary compensation by way a Hardship Allowance/Rural Allowance. Each State should identify the PHCs where they are finding it difficult to post personnel on account of weak social/physical infrastructure. The Task Force feels that the State governments should notify a Hardship Allowance/Rural Allowance of at least Rs. 3000/- per month to provide an adequate compensation for functionaries posted at these difficult locations.

5.2.4 The Task Force is of the view that a fresh graduate doctor should be inducted in Class 1 Service in any State, and should not be paid gross emoluments lower than Rs. 18,000/- per month. This figure should be a minimum of Rs. 21,000/- in the notified hardship areas.

5.3 Age at Retirement

5.3.1 The prospect of a career in the State health service is not found to be very attractive by young graduate doctors. **The Task Force feels that it would be in public interest to increase the attractiveness of a career in the state health service by increasing the age of retirement to 62 years against the current**

60 years. The government recognizes the principle of extended age of retirement in the case of technical professionals and scientists. Looking to the difficulty faced by state governments in recruiting and retaining doctors in the public health cadres, it would appear appropriate to increase the age of retirement. As it is, it is observed that several doctors with clinical skills privately practice or seek employment in private institutions after retirement. As a broad assessment it can be stated that they are physically fit to provide services at least till the age of 65 years.

5.3.2 In this backdrop, increasing the age of doctors in the state public health services till 62 years would be a step towards retaining their scarce expertise within the public health system. **Further, doctors above 62 years age and up to 65 years may be retained on contract basis on the consolidated gross emoluments last drawn, provided they are prepared to serve in the service centers located in the Hardship/Rural areas.**

5.3.4 To sum up, the Task Force recommends that the age of retirement of the doctors in the state public health cadres be increased from 60 years to 62 years. Also, the Task Force recommends that state public health doctors be retained on contract basis for a further period of three years (till the age of 65 years), provided they work in the notified hardship areas. During the contract period they should be paid a consolidated amount equivalent to their gross emoluments at the time of retirement.

5.4 Reservation of PG seats for doctors from State Public Health Cadres

5.4.1 The medical education scene in the country is characterized by an obsessive pursuit of post-graduate courses by the young graduate doctors. This obsession for post-graduation has to be harnessed to increase the attractiveness of the state public health cadres. Some states have tried to improve the attractiveness of the state cadres by providing reserved seats in post-graduate

courses in government medical colleges to government doctors who have rendered a minimum qualifying service in rural areas. The attempts have been sporadic and the scheme has not been seriously enforced.

5.4.2 The Task Force is of the view that the reservation policy should be imposed across the board in all states of the country. To make government employment reasonably attractive, **the Task Force recommends that 50% of the post-graduate seats (both degree and diploma) in medical colleges (both government and private) be reserved for government doctors who have served in rural areas for over five years. This can be carried out through a MCI notification making it compulsory for all medial colleges running post-graduate courses. Such a provision would make over 5000 post-graduate seats available to government doctors, and this would be a significant incentive for young doctors serving in rural areas.**

5.5 Facilities for Continuing Medical Education for Public Health Doctors

5.5.1 Government doctors need to be encouraged to continue their studies and updating of their knowledge. Though much of this will have to be done on the initiative of individual doctors, government can make a significant contribution by providing free internet access at each public service centre. This window to the scientific universe would facilitate the doctors in staying up to date regardless of their place of posting.

5.6 Provision of Infrastructure for Doctors

5.6.1 As has been mentioned earlier in the report, most graduate doctors have an urban mind-set and have aspirations that are linked to that mind-set. When a doctor is posted in a rural area the minimum expectation is for a residential accommodation of reasonable quality, with water and electricity connection. This would be possible in most PHCs scattered over the country. However, the quality

of water and the regularity of electric supply would be what are generally available in that area. It needs to be recalled that the quality of such services is not particularly high class even in most urban locations. In the totality of circumstances the Task Force recommends that special care needs to be taken that the accommodation and water and power supply provided to health functionaries in the rural areas is as good as is possible in the local circumstances.

5.7 Compulsory Rural Practice

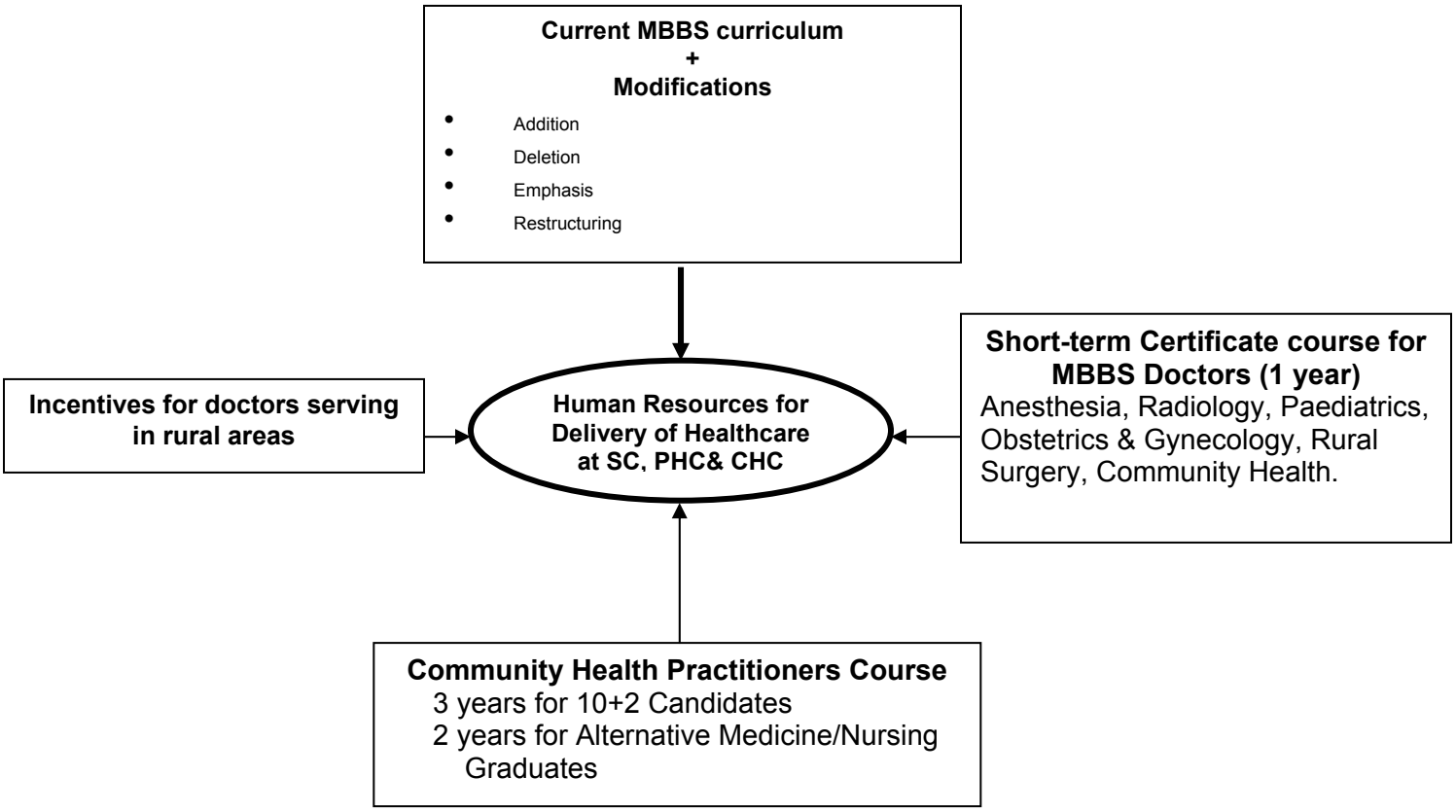
5.7.1 A large part of this report has been devoted to the attitude and the mindset of the doctors who graduate from the existing medical education system. To recapitulate in brief, the training is linked to a tertiary hospital, and is dependent on multi-disciplinary specialists and high-tech diagnostic aids. As a consequence, it is unconnected with the decentralized social and economic setting, and graduate doctors are unable to provide even primary healthcare services. The Task Force has made a number of recommendations to make the medical training more practical and hands-on. **In furtherance of that, the Task Force would recommend that each medical graduate should be made to undergo a two-year stint in a rural setting before he can register for a PG course.** The Task Force is aware that this has been tried out in some states though without visible impact. It has been found that the lack of success was largely on account of indifferent implementation. The young graduates were averse to this stint and brought pressure on the bureaucratic and political executive to not enforce it. Now a stage has been reached when it is accepted all around that the existing national health system is entirely failing to deliver even primary health services in the larger part of the country. What may have been considered a very severe condition earlier would only be considered the minimal acceptable today. The two years compulsory service in rural areas will ensure more doctors join the state health services at least for the qualifying period. For the rest, **who undertake rural private practice or work for a NGO/ Voluntary Agency/**

private institution in the rural area, at least it will be a period when the young graduate is exposed to the primary healthcare needs of the country at large.

5.8 Overview of Recommendations of TOR- 1, 2 and 3.

The Task Force has considered the various shortcomings related to the TOR-1,2 and 3.The recommendations made by the Task Force to better equip the graduate doctors to independently provide services, particularly for the primary health care package, which is an important component of NRHM are depicted in Figure-3.

Figure – 3
Schematic Presentation of the Recommendations of the Task Force



CHAPTER VI

TERM OF REFERENCE - 4

In order to promote opening of medical colleges in the rural and other underserved areas, the Task Group would give its recommendations on the following;

- **Whether certain relaxations could be provided in the norms of MCI for opening of medical colleges in such areas in terms of infrastructural requirements, staff complement and the clinical material without lowering the standard of education.**

To encourage private entrepreneurs to move towards rural areas for new medical colleges. Whether opening of medical colleges in the urban and the well served areas can be discouraged by enforcing strict norms.

6.1 Promotion of Medical Colleges in the Underserved Areas

6.1.1 The statistical details regarding the medical colleges in the country are given in the Annexure listed below:

i. State-wise distribution of Medical Colleges and Medical Seats–**Annexure 1**

ii. States with a very large number of Medical Colleges/Seats – **Annexure 2**

iii. Number of Medical Colleges/Seats in Empowered Action Group States (EAG) – **Annexure 3**

iv. Number of Medical Colleges/ Seats in North Eastern/ Hilly States – **Annexure 4**

v. Number of Medical Colleges/Seats in Jammu and Kashmir –**Annexure 5**

vi. Number of Medical Colleges/Seats in the Rest of India – **Annexure 6**

From the statistics given in the Annexures it is observed that the aggregate number of colleges/ seats in the country is not inadequate. However, a very large number of them are concentrated in the six states listed in **Annexure-2** (Maharashtra, Karnataka, Andhra Pradesh, Tamil Nadu, Kerala, and Gujarat). These States cover about 63% of the total number of colleges and 67% of the number of seats. In contrast to this, a disproportionately small number of colleges/seats are located in the Empowered Action Group States **(Annexure-3)** and the North Eastern / Hilly States **(Annexure-4)** – 20% of the aggregate number of colleges and 18% of the seats in the case of the Empowered Action Group States and 3% of the aggregate number of colleges and 3% of the seats in the North Eastern /Hilly States. The unbalanced regional distribution of the medical colleges and seats has certain adverse implications, which will be discussed hereafter.

6.1.2 The need for an even regional distribution of graduate doctors in the country has been discussed in another section of the report. There is an undesirable tendency for the graduate doctors to practice their profession only in urban areas. The Task Force has made several recommendations to alter the training pattern, so that the mindset of the graduate doctor is not unduly skewed in any one direction. It is hoped that by shifting the focus of the training from the tertiary hospital to the community setting, the skills and attitudes of the graduates would become much more broad-based. The Task Force is of the view that this thrust towards a social-orientation, would be significantly reinforced by ensuring the balanced spatial distribution of the medical colleges. If the entrants in a medical college come from a non–urban setting and are trained through a socially-oriented methodology, the chances of them opting for their future career in a non-urban setting, is much greater.

6.1.3 In this background, the Task Force feels that certain positive initiatives need to be adopted to induce promoters to choose locations for medical colleges that are much more widely distributed over the country. There are two obvious

advantages to this: firstly, as mentioned in passing earlier, the graduates are less likely to be obsessed with the urban setting; and, secondly, the teaching hospital linked to the medical college would automatically become a high quality service hub for an otherwise underserved area. Thus, the functioning of a teaching hospital in a backward area is expected to have a beneficial impact on the overall health services in the hinterland. For the reasons given above, the Task Force recommends certain incentives to set up medical colleges in the underserved areas i.e. EAG States and North Eastern/Hilly States. The specific recommendations are discussed below.

6.1.4 The norm for a plot - a minimum size of 25 acres for a medical college - is considered excessive for a North Eastern / Hilly State. In the three North Eastern states without a single medical college (Arunachal Pradesh, Mizoram and Nagaland), it would seem impossible to get a plot of land of that size in an urban habitation. Even other North Eastern States may find it impossible to conform to the norm for plot size at many other locations where they may want medical colleges. The terrain in that region is undulating, and the populations being sparse, urban habitations are of small size. Moreover, it would not be feasible to choose a location in the wilderness, as neither the patients nor the medical professionals would be prepared to go there. Therefore, if one were to examine the possibility of setting up a medical college in the North East, one would have to relax the norm for the plot size. Also, it appears that such a large plot size is not an absolutely irreducible requirement for a medical college. To a large extent a minimum built-up area would be one component of the irreducible infrastructure for a medical college. This could be ensured with a smaller plot size, by constructing multi-storied buildings. In this context, it would appear possible to reduce the norm for the minimum plot size for a medical college for this type of terrain. In today's world it would be considered a reasonable aspiration on the part of the smallest of States to set up a medical college within its territory. Such regional aspirations can only be ignored at the peril of the cohesion of the country. Also, at a practical level, a medical college in an otherwise backward

area serves as a developmental hub. **For all these macro-considerations, the Task Force is of the considered view that the norms for setting up medical colleges in such remote areas need to be relaxed.**

6.1.5 The committee has also considered at length the need for relaxation of other infrastructure and patient-load norms for hospitals in the North Eastern / Hilly States, and also in the EAG States. If one is aiming for a regional balance in the location of the medical colleges, one cannot realistically insist on a key norm of a 500-bedded hospital with 80% bed occupancy. A major recommendation of the Task Force is to change the fulcrum of graduate medical education from the tertiary hospital to the service delivery centers at lower formations, in order to give a social orientation to the training content. It is the view of the Task Force that the health needs of the country require a skill-mix amongst the graduates that the current training, linked to a tertiary hospital, does not adequately provide. In fact the training that would be available in the spatially dispersed medical colleges would, in the view of the Task Force, be much superior than what is available centered on a tertiary hospital. To take advantage of the rural orientation of medical colleges attached to decentralized service providing centers, one will have to ensure that, in practical terms, the rules encourage medical colleges to come up in the underserved areas. Under the current norms, one cannot entertain much hope that medical colleges can come up in the EAG States or the North Eastern/ Hilly States. In order to avail of the benefits of a social orientation, the government would, on balance, have to trade-off some of the marginal advantages that come from infrastructure norms linked to a high hospital bed-capacity and patient-load.

6.1.6 **In this spirit, the Task Force recommends that for EAG States and for North Eastern/ Hilly States, the infrastructure norm for a 50-seat medical college be reduced to a 200-bed hospital**. Hospitals in such areas can never have the same bed-occupancy in hospitals as is common in other urban or developed areas. While the disease-load in the rural areas may be as high as

anywhere else, the patients have a much lesser capacity to afford inpatient treatment, and for that reason bed-occupancy is seldom very high. In this context, **the Task Force further recommends that the norm for bed-occupancy also be reduced to 60% in North Eastern / Hilly States and 70% for EAG States. However, it is important to emphasize that these medical colleges should have well established and functioning field practice areas in their vicinity.**

6.1.7 In the case of the North Eastern /Hilly States, looking to the local constraints, the area norm may be fixed at 15 acres in not more than two plots, separated by a distance of not more than 5 km, and connected by an all- weather road. There appears to be no need for relaxation of the area norm for the EAG states as land is not a scarce input in the rural areas of the EAG states. For the North Eastern / Hilly States & EAG states, the other norms for facilities and faculty strength, linked to a 200-bed hospital, would have to be separately determined by the MCI. It is felt that any loss in value to the education on account of reduced size of the hospital and minimum patient load would be more than compensated by the improved social orientation when the medical college is set up in a decentralized setting.

6.1.8 In order to ensure that this does not set-off another race for proliferation of medical 'teaching shops', as has been experienced in certain states in the past, the Task Force would add a further condition that the relaxed norms should be available to only one 50-seat medical college in each district that has no medical college today. New medical colleges wishing to avail of the relaxed norms in EAG States must be located at a distance of at least 100 KM from the state headquarters, and a distance of at least 200 KM from the other nearest medical college. Because of the small size of North Eastern/Hilly States, this particular distance restriction is not recommended in their category.

6.1.9 It is the view of the Task Force that the suggested modifications in the medical college norms would bring about a more regionally balanced distribution of institutions in the country; and, at the same time the distancing of these institutions from large urban conglomerations would bring about a desirable social orientation in the value system of the young graduates. It is reiterated that the suggested concessions are only for the EAG States and North Eastern / Hilly States for setting up the first medical college with a capacity of 50 seats in a district. For any expansion of the medical college, they must conform to the general norm. In other words, if the three states that have no medical college, plan to have a capacity of more than 50 seats in the future, they must factor in the general norms right from the start. The Task Force feels that, limiting the relaxation to one college in each district without a medical college would not in any way prove a damper to the objective of regional balance as one medical college attached to a 200-bed tertiary hospital, would adequately meet the needs of the district for both medical education and good quality healthcare at the decentralized level. All in all, the Task Force is of the considered view that the relaxation of the norms as suggested above, would meet the broader needs of the national health system without in any way compromising the essential components of an appropriate graduate medical education.

6.1.10 The existing MCI norms for infrastructure and faculty strength have always been very high and stringent. The Task Force is of the view that these need to be reviewed so that that they are only retained at a level necessary to ensure that the quality of training is not compromised. All other aspects that are linked to the best international standards can be relaxed. Being a developing country, India has always tried to realistically link its norms in respect of the facilities in different types of institutions, to the irreducible functional requirements, disregarding the other esoteric features that may be found in the best international institutions. It may be mentioned that in the year 2004 the MCI had sent a set of suggestions for relaxing several aspects of the infrastructure and faculty strength norms. The Task Force has scrutinized these carefully and strongly recommends to the government that they be approved early.

6.1.11 Going beyond that recommendation, the Task Force is of the view that, at a subsequent stage, the government could also ask the MCI to revisit its proposals of the year 2004 to see whether any further cuts can be applied without loss of quality. The burgeoning cost of setting up a medical college in the recent past has lead to several undesirable trends. To recover their large investments, private promoters of medical colleges have resorted to a variety of unethical and illegal practices, such as clandestine levy of capitation fees, etc. Also, the new colleges are known to cut on expenditure by showing staff strength by fabricating their records. It would be in the interest of good order in the field of management of medical colleges if the MCI norms are pitched at the functionally required level, and, thereafter, these are strictly enforced. The scope and need for manipulation of the records would consequentially stand reduced. On scanning the existing norms of the MCI for a 50-seat medical college, the Task Force has observed that, prima facie, some of them could bear further reduction down to a minimal acceptable level. Some of the doubts that have occurred to the Task Force are listed below:

(i) Requirement for **air-conditioned** libraries/ lecture theaters in India - is this necessary?

(ii) Cannot the staff norms for clinical and non-clinical disciplines be reduced? Particularly, for non-clinical subjects, that are taught only in the 1st year, why are a minimum of three teachers necessary: Professor/ Associate Professor/ Asst. Professor?

(iii) Why do you need to provide for a research laboratory in an ordinary medical college?

6.1.12 The Task Force also feels that the MCI should be asked by government to expeditiously study and suggest staffing/infrastructure norms for the medical colleges in EAG States and North Eastern / Hilly States for 50-seat medical colleges (with 200-bed hospitals and reduced patient-load). The norms should be suggested looking to the objective of spreading the medical colleges so as to obtain a regional balance. For several years now there has been a rush of

medical colleges to certain states in the country. This is undesirable on many counts. It is necessary to restore a balance in the distribution of the medical colleges as soon as possible. With the further rationalizing of the infrastructure and faculty norms, it is expected that it would become possible to channelise the establishment of new medical colleges to areas where few are located. Recently, consequent upon the decision to introduce OBC reservations in professional training institutions, the Central Government has decided to increase the aggregate capacity for professional training in the country, so that the net number of seats available to the unreserved categories is not reduced. This occasion would be an appropriate one for introducing reduced norms for new medical colleges in EAG States and North Eastern/ Hilly States. The convergence of these two government decisions would lead to the resolution of the problem on account of increased reservation, and also provide an opportunity for setting up medical colleges in a balanced manner over the entire country.

6.1.13 The broad recommendations for revised norms for medical colleges are depicted in the Table 8.

Table 8: Recommendation of norms for establishment of Medical Colleges

Variable	MCI (50 students)	Category I	Category II
Area	25 acres	Two plots totaling 15 acres, not more than 5 km apart, and connected by all weather road	Normal plot size of 25 acres
Number of Beds	500	200	200
Bed Occupancy	80%	60%	70%
Distance from state head quarter/ nearest medical college	No restriction	No restriction	100 KM / 200 KM

Category I: Manipur, Sikkim, Tripura, Arunachal Pradesh, Meghalaya, Mizoram, Nagaland, Uttaranchal, Jammu & Kashmir and Himachal Pradesh

Category II: Bihar, Assam, Uttar Pradesh, Jharkhand, Madhya Pradesh, Chattisgarh, Rajasthan and Orissa.

CHAPTER VII

TERM OF REFERENCE – 5

In order to promote opening of medical colleges in rural areas, the Task Group would recommend whether a joint venture could be permitted whereby the government hospital at district level is allowed to be used for teaching purposes subject to the condition that the hospital continues to be run by the government while recurring expenditure is borne by the private body.

7.1 Possibility of setting up joint ventures to establish Medical Colleges attached to Government General Hospitals:

7.1.1 The Task Force has examined this possibility and finds considerable potential in it. In the rural areas the only hospitals are the government hospitals, mostly district hospitals. The government can enter into joint ventures with private promoters of medical colleges. The district hospital would be required to have a minimum of 200 beds, or the private promoter would be required to install additional beds to make good the deficiency. The joint venture would also be required to separately obtain permission from the MCI/Government for running the medical college under the prevailing norms. This report has recommended a reduced norm for 200 bed hospitals in EAG States and North Eastern/ Hilly States. These norms would also apply to the joint ventures. The private promoter will bear the cost of running the district hospital. Under the joint-venture agreement, the medical college should be required to provide free medical services at the hospital.

7.1.2 Normally, the government has a standard policy of retaining substantial control over its institutions even as joint-ventures. However, in this case, the Task Force deliberately recommends that the management of the hospital be handed over, as it is felt that basic principles of efficient

management would require that the two principal divisions of the institution – the medical college and the attached hospital - be under a single management. In order to operate a medical college that meets MCI norms, it is quite likely that the private promoter would have to spend much more than what the government was earlier spending. Such an eventuality would result in improved services at no cost to the state.

7.1.3 In an earlier section of the report the Task Force has suggested that each medical college should be required to manage one CHC and four PHCs, which would also be utilized for the training of the students. If the joint venture conceptualized above materializes, the medical college would in effect be managing the entire public health organizational structure from the district hospital to the PHC. Such a comprehensive integration with the public health organizational structure would add to the quality of the training. Also, the medical college by running the district hospital, one CHC and four PHCs would be greatly improving the quality healthcare services in the district.

7.1.4 In the totality of the circumstances the Task Force recommends that as a pilot project the government may sanction four such joint-venture medical colleges in different parts of the country. The MCI should be directed to keep a close watch on the operations of the joint ventures. If the joint-venture arrangement stabilizes and proves sustainable, government can consider encouraging this modality on a larger scale.

TERM OF REFERENCE - 6

The Task Group would also recommend on the modalities of strengthening the infrastructure of existing government medical colleges particularly in the Empowered Action Group (EAG) and North Eastern States.

7.2 As no inventory of the present infrastructure in these institutes is available, the task force did not find it possible to address this TOR.

CHAPTER VIII

CONCLUSION

8.1 Imperatives for Change

8.1.1Though the new programme of the health sector is called the National Rural Health Mission, in practical terms, only certain elements of it can be implemented in the mission mode. The Task Force is of the opinion that one significant element which can be achieved within the fixed mission period is that of re-launching the primary healthcare system. It is recognized that the delivery of the primary healthcare services is an ongoing activity, and no milestone draws it to a closure. However, it is the perception of many, including the members of the Task Force, that as a conceptual package of efficiently delivered health services, the present primary healthcare system has practically become defunct. What can be attempted as a reasonable target within the mission period is to reactivate it, and to get it running as an efficient delivery system of health services, both in the private and public sectors. In order to achieve this derived mission target of reactivating the primary healthcare system, one of the significant initiatives that would have to be undertaken relates to the education system of health manpower. This is necessary to ensure that the manpower has the necessary skills and motivation to address the primary healthcare needs of the country.

8.1.2 The Task Force must be candid in admitting that it has faced considerable problems in addressing itself to the wide-span issues posed before it as the terms of reference. The members of the fraternity of health educationists, many of who are members of the Task Force, have a wealth of ideas. Their vision offers many radical alternatives to the structuring of the body of the health system. Many of these visions are rooted in their philosophical understanding of the nature of community relations, and the resultant mode of development appropriate to that. Many of the thinkers in the health sector, if given an

opportunity, would like to radically reconstruct not merely the health sector, but also the allied sectors, and even beyond that, if possible, the societal relationships.

8.1.3 Though the members of the Task Force empathised with these innovative visions, it was nonetheless recognized that the recommendations of the report must be of a nature that could assist the government in pushing forward its day-to-day programmes. Many of the alternative visions that were discussed in the course of the deliberations, would require a total dismantling of the existing structure, and the reinstallation of what the protagonists consider, a more humane and mutually-supportive structure of societal relations. While recognizing the conceptual value of these visions, the Task Force could not adopt them as a basis for their recommendations.

8.1.4 In the practical world, the health system of the country cannot be put on hold for a period of, say, five years in which the old is dismantled and the new is installed and commissioned. **The recommendations of the Task Force are, therefore, necessarily limited changes of a gradualist nature, taking care to ensure that they do not cause a major dislocation of the existing functioning in the short term. Within that ambit, of course, the recommendations are directed at core elements of the health education system.**

8.1.5 The thrust of the recommended changes in the graduate medical course has been on the need to meet the principal requirements of the national health system. Access to healthcare is a basic human right; and one of the principal duties of the state, as a part of its role of governance, is to make healthcare accessible to all. The most effective modality for making healthcare available widely is through the primary healthcare network. The healthcare services in the country are unequally divided between the private and public sectors – being heavily skewed in the direction of the former. Primary healthcare services in

much of the country are provided through untrained personnel, practicing, what may be called quackery. In this dismal situation the Task Force considered it appropriate to suggest changes in the graduate syllabus in order to make medical graduates better equipped for providing primary healthcare services, whether in the public or private sector.

8.1.6 The Task Force is aware of the viewpoint held by certain sections that medical education must target for technical excellence, regardless of all else. However, the Task Force feels that this desirable objective of technical excellence would need to be harmonized with the even greater need for providing healthcare to all. The physicians produced by the existing graduate course are characterized by an inadequacy of hands-on skills and a marked incapacity to deliver services independently. This is an unacceptable shortcoming in a profession, particularly in one with such a long study period. Tolerating of such a glaring deficiency in the practical aspects would not be justified on any ostensible grounds of pursuit of theoretical excellence. The approach of the Task Force in the course of framing its recommendations has been to make the graduate syllabus friendlier to the needs of primary healthcare. The higher levels of specialization will be reached through the post-graduate courses, as is the original intention. In other words, the recommendations in regard to the graduate course are intended to generate MBBS doctors who are competent general physicians, while the post-graduate courses will generate medical professionals that will serve as accomplished specialists. This approach envisages three levels of healthcare, without degenerating into two qualities of healthcare. The same approach marks the recommendation of the Task Force regarding the short course for community health practitioners. The span of the primary healthcare package does not cover very complex technical issues. However, it does require hands-on skills and a mental preparedness to work independently. Adequate skills to meet the limited requirements of the primary healthcare package can be expected from an appropriately trained practitioner, even when he is not a MBBS graduate. Matching different degrees of experience

with different situations is a common working practice in many professions. So long as the short-course practitioner provides services within the approved span of primary healthcare, he would be providing services of the same quality as a graduate medical doctor.

8.1.7 The Task Force is of the view that the short-course practitioners, who may include a large number who originated from the alternative systems of medicine, would be located in a much more spatially dispersed manner than the graduate medical doctors. In the rural areas, a large part of the ambulatory care that is provided by quacks today can be substituted by the services of the spatially dispersed community health practitioners. In the history of the country, the graduate medical practitioners have never provided a predominant part of the primary health services, and are unlikely to do so in the future also. The introduction of the trained community health practitioners in the domain of primary healthcare is likely to significantly remedy this deficiency. It would be a lasting contribution to community welfare if the graduate doctors, as also their representative professional body, the MCI, constructively encouraged the introduction of the short-course practitioners. A widespread perception, mentioned in passing in several sections of the report, is that the absence of even rudimentary healthcare services is now being viewed as an intolerable social situation. Democratic dynamics have their own inevitable outcomes. A situation, in which even such basic human needs cannot be met, is increasingly being seen by the sufferers as a deliberate dismissal of their needs by the powers that be. Such a feeling of disaffection, if wantonly permitted to grow, would have its own cathartic outcome. In this emerging situation, it would be desirable if the graduate doctors' fraternity avoided taking a position that may be interpreted as an insensitive denial of the irreducible needs of a large section of the population.

8.1.8 The Task Force for its two main recommendations –modifications in the graduate syllabus and introduction of a short course – has tried to think through

the proposals to a safe-stage from where it can be further developed by the MCI or the state governments, for the purpose of implementation. While it is convinced that the recommendations are feasible, the Task Force has, in a large measure, only responded to what they sense as the silent but strong signal of disapproval of the existing situation on the part of a large unserved constituency.

8.1.9 This Task Force report is largely in the nature of a consensus report. The representative of the MCI has had some reservations regarding some of the observations in this report. The comments of the MCI are reproduced in Annexure 7 to this report. With a number of public health stalwarts serving as members on the Task Force, if the report had to meet the full satisfaction of every one, we would have had to submit many versions of it! The report in its present form substantially represents a consensus document in constructive support of the National Rural Health Mission. **The Task Force would like to commend these recommendations to the government for their early consideration and implementation. It may be mentioned that in the approach to the recommendations, wherever there were competing alternatives, the Task Force has adopted the one that disturbs the present system the least**. With this in view, in their totality, the recommendations are not likely to cause any untoward disturbance in the system. Since most of the recommendations relate to changes in syllabus and course content, they can only be expected to have an impact on the primary healthcare system when the first products of the new educational modules move into the profession. It would be a major achievement if, during the currency of the mission period, the major changes suggested are put into operation and are stabilised. The fruits of the new initiatives would, of course only be visible later on. The attempt of the Task Force can be considered one to bring about a gradual and evolutionary change in the mind-set and the skills of the service providers in the country. The progress from year-to-year may not seem spectacular, but when the package of recommendations are implemented and stabilized, it is likely to result in a

changed health system that would be unrecognizably superior to the currently existing one.

8.2 From Recommendation to Action

8.2.1 Need for a Health Manpower Education Action Group.

While accepting inevitable diversity of experience and perceptions of the members of the Task Force, the experience of the Task Force brought out a unanimous sense of urgency in the need for reformative and remedial action in the area of Medical Education and Health Manpower Development to meet the goals of the National Rural Health Mission. In view of this urgency, the Task Force takes the initiative to suggest to the Ministry of Health and Family Welfare that these recommendations need to be followed up urgently by constituting a small, full-time **Health Manpower Education Action Group.** This Group could consist of some resource experts drawn from the medical education and nursing fraternity. The Group, which could be funded by the NRHM, could interact with the Ministry of Health and Family Welfare, the MCI and the other professional Councils to transform the Task Force recommendations into a practical, step-by-step action plan.

8.3 In the course of the Task Force deliberations, a large number of documents, publications and resource material were taken into consideration. These are listed in the Bibliography at the end of the Report.

8.4 In the order constituting the Task Force dated 18-8-05, the Ministry had asked for completion of the report by 30-10-05. Because of the vast span of the terms of reference, the Task Force was not able to complete the report by the indicated date. In the circumstances, it is requested that the Ministry may technically extend the period till the actual date of submission of this report.

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ANNEXURE – 1

State wise distribution of Medical Colleges and Medical Seats

Name of the State	Total no. of medical colleges	Total Number of Seats
Maharashtra	**39**	**4410**
Karnataka	**32**	**4005**
Andhra Pradesh	**31**	**3925**
Tamilnadu	**22**	**2515**
Kerala	**15**	**1650**
Gujarat	**13**	**1625**
Uttar Pradesh	**13**	**1412**
West Bengal	9	1105
Bihar	8	510
Madhya Pradesh	8	970
Rajasthan	8	800
Punjab	6	520
Pondicherry	5	475
Delhi	5	560
Orissa	4	464
Jammu & Kashmir	4	350
Assam	3	391
Haryana	3	350
Jharkhand	3	190
Chhatisgarh	2	200
Himachal Pradesh	2	115
Uttaranchal	2	200
Chandigarh	1	50
Goa	1	100
Manipur	1	100
Sikkim	1	100
Tripura	1	100
Total	**242**	**27192**

ANNEXURE - 2
States with a very large number of Medical Colleges/Seats

Name of the State	Total	Total No. of Seats
Maharashtra	39	4410
Karnataka	32	4005
Andhra Pradesh	31	3925
Tamilnadu	22	2515
Kerala	15	1650
Gujarat	13	1625
Percent	62.8 %	66.6%

ANNEXURE - 3
Number of Medical Colleges in Empowered Action Group States

Name of the State	Total	Total No. of Seats
Uttar Pradesh	13	1412
Uttaranchal	2	200
Bihar	8	510
Jharkhand	3	190
Madhya Pradesh	8	970
Chhattisgarh	2	200
Rajasthan	8	800
Orissa	4	464
Percent	19.8%	17.5%

ANNEXURE – 4

Number of Medical Colleges in North-Eastern/ Hilly States

Name of the State	Total	Total No. of Seats
Assam	3	391
Manipur	1	100
Sikkim	1	100
Tripura	1	100
Arunachal Pradesh	-	-
Meghalaya	-	-
Mizoram	-	-
Nagaland	-	-
Percent	2.5%	2.5%

ANNEXURE – 5

Number of Medical Colleges in Jammu & Kashmir and Himachal Pradesh

Name of the State	Total	Total No. of Seats
Jammu & Kashmir	4	350
Himachal Pradesh	2	115
Percent	2.5%	1.7%

ANNEXURE - 6

Number of Medical Colleges in the rest of India

Name of the State	Total	Total No. of Seats
West Bengal	9	1105
Punjab	6	520
Pondicherry	5	475
Delhi	5	560
Haryana	3	350
Chandigarh	1	50
Goa	1	100
Percent	12.4%	11.6%

Annexure - 7

Observations of the MCI on the draft report of the Task Force on Medical Education-NRHM, MH&FW, Government of India.

“The MCI has its reservations in respect of under mentioned inclusions in the draft report.

1. Chapter 3 Medical curriculum issues - The council does not agree to the so called “widespread perception in the country that the MBBS curriculum is too theoretical in its contents. After 4 ½ years of the main course and 1 year of internship, the finished graduate has little hands on experience” and other observations thereon. It is primarily because the council has formulated the medical graduate curriculum with due care and caution and desired inputs. The palpable limitations have been effectively tackled in the draft curriculum formulated by the council through 3 regional workshops and a concluding national workshop, wherein the deans of the various medical colleges, DMEs, Health Secretaries of various states and eminent medical educationists participated. The same upon due approval by the competent bodies in the council has been forwarded to GOI and is pending notification.
2. Introduction of a new short term course to train community health practitioners-the short term certificate courses in the certain primary health care disciplines in Para 4.2.3 of the report in the disciplines of anesthesiology, Radiology, OBS & Gynae, Pediatrics and Community health contemplates that, the certificates issued for the disciplines of anesthesiology and Radiology will need to be notified by the MCI as authorized to provide health care package. Such a notification by the council is not permissible under the provisions of the IMC Act, 1956, hence the reservation.
3. The short term certificate course in Medicine for creating a cadre of health professionals for rendering basic primary health care to underserved rural population included in the report is not feasible within the tenets of the

provisions of the IMC Act, 1956. The privileges that are accruable under the act for practicing modern Medicine are permissible only on acquiring the qualifications included in the Schedules appended to IMC Act, 1956. It is a statutory position that the modern Medicine can be practiced exclusively by a person who has to his credit the qualifications included in the schedules appended by the Hon'ble courts from time to time that a person with any health sciences qualification other than Modern Medicine is not entitled to practice modern Medicine.

4. The present scheme incorporated in the report entails the concerned individual to be under the "dual" control of the parent council which has registered him or her vide the qualification in its schedule and another registration by the newly contemplated statutory council for registering him or her in modern medicine after acquiring short term qualification. This will mean "dual" control of 2 statutory councils permitting use of 2 different therapies to be practiced by him or her which is neither open nor permissible in the eyes of the provisions of the present IMC Act and interpretation thereof vide pronouncements by the court of law.

5. The minimum prescribed requirements for opening of a new medical college being further relaxed is untenable especially in regard to the number of teaching beds and occupancy thereon. The hand on training is vital aspect of medical training. Any compromise on this count could not only result in dilution of the desired academic expertise but would also result in generating 'half baked' health personnel. The council upon due and diligent application of mind has proposed the desired alterations in the minimum requirements in the proposed draft regulations forwarded to the GOI in respect of the minimum requirements for opening of a new medical college for an intake of 50, 100 and 150 seats respectively. The contemplated relaxations in the draft report are bound to generate academic dilution which would not be a conducive to be desired standards of medical education in the country, hence reservations."