The ‘Basic’ Doctor for Rural India: A Failed Promise?

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An analysis of the landmark 1946 Bhore Committee report suggests that vested interests may have played a role in shaping India’s health system and the medical profession in such a way that the majority of the population remains totally neglected. Nothing short of legal action can begin to reverse the existing crisis of health human resources that rural India currently faces.

India is the largest supplier of foreign medical graduates to the United States (Educational Commission for Foreign Medical Graduates 2008) and UK (General Medical Council 2010) but its own rural areas have been chronically deprived of professionally trained doctors. We trace the antecedents of this situation to India’s first health policy drafted by the Bhore Committee in 1946. The committee imposed the construct of a “basic” doctor, trained through 5½ years of university education, on a country not yet ready for it. It abolished the shorter licentiate qualification and disregarded systems of indigenous medicine, even though licentiates formed two-thirds of the country’s registered doctors, and, together with indigenous practitioners, provided the bulk of rural healthcare. A few of the committee’s members put up a strong dissent against these recommendations. We present the dissenters’ comments and argue that even today India needs an alternative cadre of primary healthcare providers for rural areas.

The Bhore Committee Report
In October 1943, the government of British India appointed a Health Survey and Development Committee to study the state of public health in the country, and recommend future developments. The committee chaired by Joseph Bhore, a senior civil servant, comprised eight British and 16 Indian members. The Bhore Committee report, published in 1946, was meticulously drafted and reflected its members’ profound understanding of health matters. It presented valuable statistics on the country’s disease burden and attributed its poor state of health not only to inadequacies in medical services and health personnel but also to the prevailing social ills – poverty, illiteracy, poor nutrition and unsanitary conditions.

The report, best known for drafting the blueprint of a modern public health delivery system, also recommended that a “basic” doctor of modern medicine, with a 5½ year university education, would be central to this system. These were far-reaching recommendations that shaped the course of public health and medicine in independent India. However, a small group of the committee’s members raised serious misgivings about these recommendations and recorded their dissenting notes (Boxes 1-3, pp 26 and 27). On closer examination of the dissenting notes, we see the fundamental flaws in the Bhore recommendations.

1946 Scenario: Two Classes of Practitioners: There were two classes of medical practitioners (of western medicine) at the time of the Bhore survey: University graduates who went through a 5½ year degree course in medical colleges, and licentiates who went through a shorter three-four year course at medical schools, graduating with a Licence of Medical
Practice (LMP). According to the committee’s estimates, there were 47,524 registered medical practitioners in the country of which the majority-nearly two-thirds (29,870) were licentiates and one-third (17,654) were graduates.

From descriptions of health services in the report we learn that registered medical practitioners were unequally distributed in rural/urban areas. For example, in Bengal the ratio of doctors to population in urban areas was 3½ times more than in rural areas and in urban Sind it was 49 times more (p 14, Vol 1). Nonetheless, much of rural healthcare was delivered through subdivisional hospitals and dispensaries that were managed mostly by licentiates. Indigenous practitioners formed another large body of healthcare providers who according to the report provided affordable and accessible healthcare to the masses (ibid).

Blueprint for a Modern Health System – No Role for Licentiates or Indigenous Systems: The Bhore Committee proposed a three-tier district health scheme for post-independent India. A primary unit would be at its periphery, a secondary unit at the subdivisional headquarters would provide more specialised services, and a district headquarters organisation would supervise all health activities in the district.

Though conceptually well organised, a primary flaw in this scheme was that it was designed to cover only around one-fourth of the population in the first five years (78,080,000 out of projected 315 million in the report) and less than half the population over the next 10 years (1,56,200,000 out of projected 337.5 million). The report was silent on how health needs of the remaining population would be met.

Nevertheless, the committee decided to abolish the licentiates qualification and recommended the upgrading of all medical schools into colleges. It reasoned that as resources were stretched, they should all be directed into the production of only one type of doctor in the country (Box 1). He or she would have the highest level of training – 5½ year university training, similar to what the Goodenough Committee had proposed for Great Britain as the gold standard. The committee also rejected the inclusion of indigenous systems of medicine and its practitioners in the new medical scheme; they considered these systems “static in conception and practice” (Box 3).

Cassandras in the Committee: Six members of the committee, five Indians and one Briton, put up a brave dissent. They repeatedly argued that in view of India’s manpower shortages, the country should use every possible means, including the shorter licentiate course, to increase the number of trained personnel. They pointed out that England had abolished licentiate teaching only after 100 years and Russia relied extensively on “feldshers” (medical assistants) to run 48,000 dispensaries.

They noted with anguish that since the new scheme would benefit only a section of the Indian population, “Public health over the remaining four-fifth to one-half of the country…will atrophy. There will be no personnel like the licentiates even to help the regions and institutions which will come under neglect” (Box 2).

Post-Colonial Migration of Doctors: The dissenters’ views proved prophetic. They said that the “basic doctor would not willingly fit into the rural scheme”. History stands witness that Indian doctors have integrated more easily into the health systems of the richer western countries, than they ever did in rural India. In the 1960s, when the rural health scheme, as envisaged by the Bhore Committee, should have served at least half the Indian population and employed

Box 1: Only One Type of Doctor and Single Portal of Entry

Bhore Committee: Having regard to the limited resources available for the training of doctors, it would be to the greater ultimate benefit of the country if those resources were concentrated on the production of only one and that the most highly trained type of doctor, which we have termed the ‘basic’ doctor.

There should hereafter be a single portal of entry into the medical professions and that portal should be the Universities. We are confirmed in this view by the reasons advanced by the Inter Departmental Committee (the Goodenough Committee) on Medical Education in Great Britain in support of University Medical Education.

Dissenters’ Comments: In view of the overall shortage of doctors we feel that the early realisation of this ideal must be sacrificed to the immediate needs of this country. We should be prepared to use every possible means in India, including the adoption of a shorter licentiate course, to increase the production of trained medical personnel. Once the output of such personnel has sufficiently increased, then it will be possible to place greater emphasis upon the quality and length of training and to insist upon the production of basic doctors only.

Nearly two-thirds of the total number of registered medical practitioners in India are licentiates and the rest graduates. The former have been an important feature of the growth of western medicine in India and no section of the profession in the country have greater service of humanity or medical science to its credit.

The “basic doctor” will not willingly fit into the rural scheme, except under conditions of destitution. The decisions of bodies, like the Health Survey and Development Committee, are often taken not so much on facts garnered or their evaluation, but on ideologies which dominate the minds of their members. They must have the Goodenough Committee findings prevails, even though there be so little in common between the educational, economic, political or medical developments of England and India. Russian experience and achievements must be ignored, nay rejected, even when the fate of institutions common to both Russia and India, such as medical schools for licentiates, was concerned.

The question of post-war improvements in medical education has been considered recently in England by the Goodenough Committee. Two classes of medical practitioners, licentiates and graduates, have existed in England, as in India, for over a century. The Goodenough Committee has recommended the abolition of licentiate teaching in England. This recommendation has influenced greatly several members of our committee. In a hurry to conform they have unfortunately ignored the fact that the GE Report describes the abolition of licentiate teaching as the “final stage” of an “evolutionary development”. We are of the opinion that the final stage of evolutionary development is not one of India’s achievements yet. From the point of view of medical development, India is said to stand today where England stood 100 years ago, the USA 75 years ago, and Russia in 1917. England was in no hurry in the last 100 years to abolish the production of licentiates doctors, why should India be coerced to take this step on the eve of momentous changes in its future?

An important feature of evolutionary development in England was progressive urbanisation. Only 20% of England’s population was rural before this war. It is 90% in India. England with her high urbanisation percentage, is only contemplating giving up licentiate production now. If Japan with 50% urbanisation stuck to licentiate production, if Russia with vast stretches of territory and a vast rural population has perfected rural medical relief by strengthening enormously her production of Feldshers (medical assistants), why must India abandon a well tried and useful institution?

Keeping in view the very urgent need for doctors and more doctors, we are strongly of the opinion that the production of Licentiates should continue till the increased number of medical colleges has produced “basic doctors” in the proportion of at least 1 to 1,500 of the population. Until such time provinces must not be coerced into closing the existing Medical Schools – Sir Frederick James, Vishwanath, P N Sapru, N M Joshi, Pandit L K Maitra, Khan Bahadur A H Burt.
around 29,000 graduate doctors, there was a large-scale migration of Indian doctors to the UK. They went in response to Health Minister Enoch Powell’s call to save a rapidly expanding National Health Service (nhs) from a staffing crisis. In November 2003, a BBC documentary “From the Raj to the Rhondda: How Asian Doctors Saved the nhs” researched and documented the contributions of nearly 18,000 such migrant doctors from the Indian subcontinent, many of whom worked in Britain’s most deprived and difficult areas. One such area was the Rhondda valley – a former coal mining valley in South Wales.

Today, the second largest proportion of doctors registered with the UK’s General Medical Council (gmc), are those qualified in India. They form around 11% of all doctors registered with the gmc, second only to British qualified doctors. India also provides the largest pool of International Medical Graduates to the United States. There are more than 50,000 doctors registered with the American Association of Physicians of Indian Origin (2010).

## Dissenting Counter Arguments

**Reason 1: Competence of Licentiates**

Our basic doctors’ training includes, as an inseparable component, education in the community and preventive aspects of medicine. A hastily manufactured doctor is not likely to be able to find time for effective training in these departments of health activity. … Whether the ultimate benefit derived from a smaller number of better trained doctors, will not be greater than that resulting from a larger number of doctors, who by their inadequate training, would be unfitted for the wider duties which the doctor of the future must be capable of discharging.

**Reason 2: Consequence of Increasing Numbers by Reducing Training Standards**

The value: (of having a corps of less completely trained medical men) even as an interim expedient, is open to varying assessments. Whatever may be the intentions of the exponents of the view that there should be two grades of doctors, there will always be the temptation to increase numbers by lowering the standard of training. Such a tendency might well lead to deplorable consequences.

Aneez Esmail (2007), in his work on emigration of Asian doctors, has pointed out that the move to enforce a single model of medical education for India, identical to that followed in Britain, was geared more towards meeting gmc requirements. In a lecture based on his research he argued that Indian degrees were quite suitable to working in England, but “probably totally irrelevant for working to the benefit of the vast majority of the Indian population”.

## Need for a Mid-Level Cadre

In its present design, India’s rural health infrastructure consists of a sub-centre with an auxiliary nurse midwife (ANM) for every 5,000 population, a primary health centre (PHC) for every 30,000 population with at least one medical doctor, and a community health centre (CHC) for every 1,20,000 population that should offer specialised care through four specialist doctors (GoI 2008). Consistent with the Bhore recommendations, the “basic” medical doctor at the PHC provides the first level of comprehensive outpatient care for village communities. However, with only 23,458 PHCs and 4,276 CHCs, this infrastructure is far from adequate to address the health needs of India’s rural population of more than 700 million (Census of India 2001). The system has, moreover, suffered from chronic shortages of doctors, as lamented in many of the country’s five-year plans (GoI 2008b). Currently there are 18.8% vacancies in the positions of PHC doctors and 51.6% vacancies in the positions of CHC specialists (GoI 2008a).

## Dissenter’s Views

While a majority on the Health Survey and Development Committee can abolish the licentiate, they cannot prevent other practitioners, practising a variety of systems of medicine, taking his place. This has already happened in Congress Provinces, particularly those that have banned licentiate teaching. So far as the indigenous systems of repute like the Ayurvedic and Yunani are concerned, their teaching is passed on to institutions which combine elementary courses of training in basic subjects of the medical curriculum with Materia Medica and Therapeutics of the indigenous systems. Sociology and economics often determine the patient doctor relationship. Under existing conditions the licentiate will be replaced mainly by Vaidys and Hakims.
More than 75% of India’s medical professionals work in the private sector, and these are no more available in rural areas than those in the public sector. Most private medical professionals are concentrated in urban areas (GoI 2005).

In the absence of professionally trained doctors, informally trained and unlicensed private practitioners deliver much of healthcare at first contact in rural India (Kumar et al 2007), treating common illnesses mainly with allopathic medicines. The Bhore Committee dissenters had argued that “while a majority on the Committee can abolish the licence, they cannot prevent other practitioners, practising a variety of systems of medicine, taking his place”. Time has proved this also to be a prescient observation.

Village-based practitioners provide their neighbourhood communities with easy and all-time access to basic healthcare; an enormous advantage in rural areas where road and transport infrastructure is deficient, and the best way to travel is on foot. The clear message that comes through is that rural communities need a primary healthcare provider within easy walking distance from every village home.

There are around 6,00,000 inhabited villages in India, and around 60% of these are small ones with less than 1,000 population (Census of India 2001). Villages are scattered and each village may have smaller hamlets at a distance from each other. As this situation represents a huge need for primary healthcare providers, we consider it unlikely that the country’s present medical education model with its annual production of 30,000 urban centric doctors (Sood 2008), trained through an expensive 5½ year course, can meet this need substantially or cost effectively.

An efficient alternative for the long term would be to draw from the experiences of developing mid-level practitioners like clinical officers, medical assistants in Africa, and various types of nurse and non-nurse practitioners (Lehmann 2008), with clearly defined competencies. Mid-level cadres are usually trained for an average of three years following a basic schooling. They are not doctors but can diagnose and treat a variety of common illnesses. Studies (ibid) suggest that their performance and outcomes are in no way inferior to that of conventionally trained doctors.

**Legal Scenario and Current Developments**

The idea of mid-level practitioners trained over shorter periods has been mooted in the past in India too: by the country’s National Health Policy 2002, and more recently by a Task Force on Medical Education for the National Rural Health Mission (GoI 2006). Each time it has been shot down by the medical fraternity, supported by the Indian Medical Council (imc) Act of 1956 that prohibits any health cadre without a graduate medical qualification from practising modern medicine. Nonetheless a few Indian states have enacted new
legislation to start such courses. Chhattisgarh and West Bengal have invoked their special state powers under the Drugs and Cosmetics Act, to develop three-year diploma courses for “Practitioners of Modern and Holistic Medicine” in Chhattisgarh (GOC 2008-09) and “Rural Health Providers” in West Bengal (GOWB 2009).

In November 2009, the authors of this article initiated a public interest litigation (PIL) in the Delhi High Court challenging the MCI Act and asking the government to take action on developing primary health providers for rural areas, more specifically along the lines of its Task Force report recommendations. The health ministry responded positively, but chose to ignore the greater wisdom and expertise of its own Task Force report by placing the entire responsibility for this innovative and socially oriented endeavour on the Medical Council of India (MCI). The MCI is a professional association of medical doctors, with a long history of corruption in medical education (Pandya 2009). On these and other grounds the high court rejected the ministry’s rejoinders and sought repeated clarifications on the Task Force recommendations (Meenakshi Gautham and Anr vs Union of India 2010). The matter is currently sub judice. However, in another recent development, the Central Bureau of Investigation (CBI) has finally arrested the MCI president on corruption charges (Mudur 2010) and the entire body is under the CBI scanner. We hope that this indictment of the MCI will urge the ministry to reformulate its response, unfettered by any direct or indirect MCI influence, and guided only by the greater common good.

Ideally, state governments, guided by a central advisory body, should develop, implement and regulate the shorter courses so that they can be responsive to local conditions, rather than follow a one-size-fits-all formula prescribed by a central body. To bring immediate relief to our rural communities, such courses should necessarily begin by recruiting, training and certifying existing informal practitioners, ANMs, pharmacists and practitioners of indigenous systems who already live and practise in rural and remote areas.

We also hope that this article will encourage health practitioners and activists to question the relevance of existing medical education models and press for reforms that respond to local needs.

REFERENCES


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