

Medical Education

Bachelor of Rural Health Care: Do we need another cadre of health practitioners for rural areas?

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INTRODUCTION

The National Health Policy (NHP), 2002 envisages that keeping in mind the availability and spread of allopathic graduates in their jurisdiction, state governments would consider the need for expanding the pool of medical practitioners to include a cadre of licentiates of medical practice, as also practitioners of Indian systems of medicine and homoeopathy.¹ Simple services can be provided by such practitioners even outside their disciplines, as part of the basic primary health services in underserved areas. The NHP also envisages that the scope of the use of paramedical manpower of allopathic disciplines, in a prescribed functional area adjunct to their current functions, would be examined for meeting simple public health requirements. This would be on the lines of the services rendered by nurse practitioners in several developed countries. These extended areas of functioning of different categories of medical manpower can be permitted after adequate training and subject to the monitoring of their performance by professional councils. Health manpower has been described by various authors as 'the heart of the health system in any country',² 'the most important aspect of health care systems'³ and 'a critical component in health policies'.⁴ There is a consensus that despite their importance, human resources have been a neglected component of health system development in many countries, and India is no exception.

MALDISTRIBUTION OF THE HEALTH WORKFORCE

Nearly three-fourths of the population of India resides in rural areas. As per the 2001 Census, 72.2% of the population lives in about 638 000 villages and the remaining lives in more than 5100 towns and over 380 urban agglomerations.⁵ According to Census estimates, there were approximately 2.17 million health workers in India in 2005.⁶ The density of health workers per 10 000 population is about 20, against the recommended 25. Nurses and midwives form the major chunk of the workforce, followed by allopathic practitioners, AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy) physicians and pharmacists. The distribution of healthcare workers is highly skewed. Nearly 60% of all health workers reside and practise in urban areas. The number of allopathic doctors in urban areas is 4 times that in rural areas. The unequal rural-urban distribution of physicians is a persistent barrier to rural Indians' access to healthcare. The country has more than 600 000 villages, thousands

of which are located at a distance of more than 10 km from a primary health centre.

VARIOUS CADRES OF HEALTH WORKERS IN INDIA

Since Independence, various cadres of health professionals (*see* Box) have been developed in India to provide access to quality healthcare and to remove the disparities between rural and urban health infrastructure. The role of these workers can be expanded.

LATEST INITIATIVE TO BRIDGE THE GAP

The government has failed to attract doctors to work in rural areas. The Ministry of Health and Family Welfare and the Medical Council of India (MCI) are still trying to discover the best possible way to serve the rural population. A medical degree awarded in three-and-a-half years by institutes set up in rural areas has been proposed as a solution. The Government of India, in consultation with the MCI, is planning to introduce a three-and-a-half year course in modern medicine, by the name of 'Bachelor of Rural Medicine and Surgery' (BRMS). The BRMS degree would be offered to graduates from medical schools to be established at district hospitals. The undergraduate BRMS degree would be acquired in two phases and at two levels—community health facility (one-and-a-half years) and subdivisional hospital (two years). The idea of a new degree course in medicine of a shorter duration is to encourage students from rural areas to take up medicine and then provide services in their local areas. It is planned that the annual intake of students per medical school will be between 25 and 50 students. Admission will be based on the marks secured in the senior secondary examination. Only students from notified rural areas who have taken science subjects at the senior secondary level will be eligible. They should have done their entire schooling in a rural area.

Students enrolled in the proposed BRMS course will be taught clinical examination, and the basics of anatomy, physiology, pharmacology, medicine, obstetrics and gynaecology, orthopaedics, paediatrics, surgery, epidemiology and public health. They will also be taught about common diseases of the eye, ear, nose and throat. Further, training will also be imparted in trauma management, care of the newborn, drainage of abscesses and vaccination. The teaching would be 'modular' in all phases. The graduates would be registered with the concerned state medical council in a separate 'schedule' created exclusively for the purpose of providing healthcare in rural areas. The accruable registration shall be on a 'year-to-year' basis for a period of up to 5 years, renewable at the end of each year on an appropriate certification by the designated authority to the effect that the candidate has rendered rural healthcare services in a 'notified rural area' of the state. After 5 years, the practitioners can start private practice, but only in rural areas. Each 'medical school' would be affiliated to

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an examining university, which would confer the 'BRMS' degree on successful completion of the course by the candidate. The graduates would be under the disciplinary jurisdiction of the registering state medical councils vide the 'Code of Medical Ethics' notified by the MCI.

The BRMS graduates would practise only in notified rural areas and are not supposed to call themselves doctors. They will not be allowed to perform surgical procedures. They will be provided with registration in a separate register of the MCI and state medical councils. The government has planned to start 300 medical schools at the district level, the majority in the present year. A workshop was conducted in New Delhi on 4–5 February 2010 to fine tune the strategy. This was attended by the deans of nearly 300 medical colleges, vice chancellors of medical universities and directors of education of all the states. The MCI has endorsed the government's viewpoint, but has proposed a change in the name of the course to BRHC (Bachelor of Rural Health Care). All other provisions, including registration in the concerned state medical council, have been retained.

PROBLEMS WITH THE NEW COURSE

The introduction of a rural medical course and creation of a cadre of rural medical practitioners is a policy decision of the government. Like any other new healthcare cadre, this course has its pros and cons. It will improve healthcare in rural, remote and tribal areas by providing qualified healthcare practitioners. It will improve infrastructure in rural areas by increasing the number of medical colleges, hospitals and schools, and developing housing, roads, electricity, water supply and communications. It will decrease migration from rural to urban areas by enhancing the earning potential and creating more jobs in rural areas. It will possibly counteract the menace of quackery.

However, the proposed course will undoubtedly produce 'half-baked' healthcare practitioners. According to Ved Prakash Mishra, chairman of the previous academic cell of the MCI, 'Their skills

would cover only 60 per cent of those of an MB,BS doctor.' The government itself is allowing these 'semi-qualified healthcare practitioners' to practise in rural areas, while well-qualified doctors serve the urban population. The training of these rural healthcare practitioners will be a major area of concern. It is doubtful as to how overworked, poorly staffed, ill-equipped district hospitals, which cater to thousands of patients and exist in more than half the districts of the country, can become training grounds for healthcare practitioners. Doctors or 'proposed teachers' posted at district hospitals and community health centres are not well versed with national health programmes, their current status of implementation and the latest guidelines. Training imparted in this milieu can hardly convey the essentials of anatomy, pathology, microbiology and pharmacology, which are essential for a basic grounding in medicine. The framing of the syllabus for BRHC would be a tricky job. If these graduates cannot perform surgical procedures, how will they manage road traffic accidents and surgical emergencies? It will be difficult for these 'half-qualified' healthcare practitioners to manage agricultural mishaps, quite common in rural areas. They will be of no use if they cannot deliver emergency obstetric care. It is even more improbable that new healthcare practitioners from rural areas would fail to be lured by urban practice. How will it be ensured that BRHC graduates practise only in rural areas and do not become 'trained quacks' in urban areas?

REVIVAL OF LICENTIATES: AN ALTERNATIVE

The revival of the licentiate system—preparing a cadre of non-doctors authorized to conduct limited professional practice—was recommended by the NHP 2002 and by a Task Force on Medical Education in 2007.⁷ Nurse practitioners and medical assistants manage patients in rural areas in Canada, parts of the USA and the UK.⁸ In the erstwhile Licentiate Medical Practitioner (LMP) scheme, students were trained for about 3 years, awarded a diploma and asked to meet rural healthcare needs. It was

Various health workers and their roles in national programmes

National Rural Health Mission—Accredited social health activist (ASHA) (Class VIII pass): Provides primary medical care for minor ailments, depot holder for oral rehydration solution packets, iron-folic acid tablets, chloroquine, disposable delivery kits, oral contraceptive pills, condoms.

Revised National Tuberculosis Control Programme—Directly observed treatment (DOTS) provider: A reliable person (teacher, volunteer) who is not a family member but willing to work as a dispenser of antitubercular therapy.

Integrated Child Development Scheme—Anganwadi worker (AWW): Depot holder for drugs for common ailments, registers antenatal cases and refers high-risk cases.

Reproductive and Child Health—Multipurpose worker (male): Takes blood slides for malaria, administers antimalarial drugs.

Reproductive and Child Health—Multipurpose worker (female): Looks after maternal and child healthcare and childhood illnesses according to the Integrated Management of Neonatal and Childhood Illnesses guidelines.

Reproductive and Child Health—Health assistant (male and female): Supervises work of multipurpose workers.

Reproductive and Child Health—Auxiliary nurse midwife: Can conduct deliveries after training, can give emergency injections such as magnesium sulphate and oxytocin, can administer oral misoprostol.

considered a means to bridge the gap between demand and supply outside metropolitan India. The LMPs outnumbered MB,BS graduates and largely served in rural areas. Following the Bhore Committee report of 1946, medical courses were unified into the standard five-and-a-half-year MB,BS degree.

Were licentiates to be re-introduced, they would be akin to diploma holders in engineering. They would be eminently suited to give the first line of medical advice, provide basic treatment and make referrals. They would have no claim to be called doctors, but would function as a strong bridge, particularly if the advantages of telemedicine and mobile phones are used imaginatively.

OTHER WAYS TO PROVIDE MODERN HEALTHCARE IN RURAL AREAS

The most effective and lasting approach would be to correct the skewed rural–urban distribution of MB,BS doctors. This could be done in the following ways.

1. The government could grant a waiver or high concession in fees to those who join the MB,BS course under a bond and surety that they would serve in a rural area for 3 years after graduation. If the government is not able to offer a job due to any reason, it should be permissible for these doctors, under the conditions of the bond, to get a job in a non-government health facility in a rural area or to set up practice in a rural area.
2. To ensure compliance, the government should amend the Indian Medical Council Act, 1956 to incorporate a clause that such doctors who receive free/highly concessional medical education in government medical colleges will, for a period of 3 years, be given a temporary licence to practise medicine, either in service or in their own private practice, in the defined rural, remote, hilly or tribal areas. Only at the expiry of this 3-year period will they be eligible for grant of permanent registration with the medical council.
3. For those who are not able to get a job in a rural area, schemes for alternative avenues of earning can be started, including financial and other support for those willing to set up private practice in rural areas. Such support may be partly in the form of free initial aid and partly in the form of a soft loan from a rural development bank. Likewise, doctors starting a hospital in rural areas should be given financial and other incentives. More hospitals in rural areas will automatically mean more jobs for doctors there.

4. To make these schemes more attractive, doctors can be given other incentives, such as facilitated admission to postgraduate courses at the end of 3 years and, for their children, free quality education, including free boarding and lodging.

Other possible options are:

1. Strengthen the existing BSc nursing course, which is a 4-year course, with hands-on training. Such workers can be called 'nurse medical practitioners' and can be posted to primary health centres or community health centres to deliver primary healthcare—curative, preventive and promotive.
2. The timing of postgraduate medical entrance examinations could be adjusted in relation to the rural posting of MB,BS students so that their future plans do not get compromised and they devote adequate time and attention to the care of patients.

CONCLUSION

The proposed new group of rural healthcare practitioners will eventually succumb to the temptation of urban medical practice, leaving the rural populace where they are. Greater involvement of the existing health workers should be explored. The move to create the BRHC course is a retrograde step that can dilute the high standards associated with Indian healthcare professionals.

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