PARLIAMENT OF INDIA
RAJYA SABHA

65

DEPARTMENT-RELATED PARLIAMENTARY STANDING

COMMITTEE ON HEALTH AND FAMILY WELFARE

SIXTY-FIFTH REPORT

ON

THE PROPOSAL TO INTRODUCE THE BACHELOR OF SCIENCE (COMMUNITY HEALTH) COURSE

(PRESENTED TO THE RAJYA SABHA ON 19th MARCH, 2013)
(LAID ON THE TABLE OF THE LOK SABHA ON 19th MARCH, 2013)

RAJYA SABHA SECRETARIAT
NEW DELHI
MARCH, 2013/ Phalguna, 1934 (SAKA)

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C O N T E N T S

*to be appended at printing stage

COMPOSITION OF THE COMMITTEE
(2012-13)

RAJYA SABHA

1. Shri Brajesh Pathak - **Chairman**
2. Dr. Vijaylaxmi Sadho
*3. Dr. K. Chiranjeevi
4. Shri Rasheed Masood
5. Dr. Prabhakar Kore
6. Shri Jagat Prakash Nadda
7. Shri Arvind Kumar Singh
8. Shri D. Raja
9. Shri H. K. Dua
10. Shrimati B. Jayashree

LOK SABHA

@11. Shri Ashok Argal
12. Shri Kirti Azad
13. Shri Mohd. Azharuddin
14. Shrimati Sarika Devendra Singh Baghel
15. Shri Kuvarjibhai M. Bavalia
16. Shrimati Priya Dutt
17. Dr. Sucharu Ranjan Haldar
18. Mohd. Asrarul Haque
19. Dr. Monazir Hassan
20. Dr. Sanjay Jaiswal
21. Dr. Tarun Mandal
22. Shri Mahabal Mishra
23. Shri Zafar Ali Naqvi
24. Shrimati Jayshreeben Patel
25. Shri Harin Pathak
26. Shri Ramkishun
27. Dr. Anup Kumar Saha
28. Dr. Arvind Kumar Sharma
29. Dr. Raghuvansh Prasad Singh
30. Shri P.T. Thomas
#31. Shri Chowdhury Mohan Jatua

SECRETARIAT

Shri P.P.K. Ramacharyulu	Joint Secretary
Shri R. B. Gupta	Director
Shrimati Arpana Mendiratta	Joint Director
Shri Dinesh Singh	Deputy Director

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* ceased to be Member of the Committee w.e.f. 28th October, 2012.
@ ceased to be Member of the Committee w.e.f. 9th January, 2013.
# nominated as a Member to the Committee w.e.f. 14th December, 2012.

PREFACE

I, the Chairman of the Department-related Parliamentary Standing Committee on Health and Family Welfare, having been authorized by the Committee hereby present this 65th Report of the Committee on the proposal to introduce the Bachelor of Science (Community Health) course in the country.

2. The Committee, at its meeting held on 18th January, 2011, took note of the media reports regarding Government's move to introduce Bachelor of Rural Health Care (BRHC) course (now Bachelor of Science (Community Health)) to overcome the shortage of the doctors in the country. The Committee felt that it would be in the fitness of things to take up the subject for detailed examination for studying all the pros and cons of the proposed move of the Government, since the Committee felt that shortage of doctors looming in the country is a cause of serious concern and needed to be addressed immediately.

3. The Committee deliberated on the issue in its meetings held on the 27th January, 06th May, 1st July, 22nd , 27th December, 2011, 20th March, 09th April , 8th November,2012 and 8th February,2013.

4. During the course of examination of the subject mentioned above, the Committee heard the views of Secretary, Department of Health and Family Welfare along with the Chairman, Board of Governors and Medical Council of India on 27th January, 22nd December and 27th December, 2011 and 8th November, 2012. The Committee also had the benefit to hear the views of certain experts in this field during its meetings held on 06th May and 01st July, 2011 **(List of Experts at Annexure-I).** The Committee expresses its wholehearted thanks to all the witnesses who enlightened the Committee with their views.

5. During the course of the examination of the subject under reference and finalization of its Report thereon, the Committee relied upon the following documents/papers:-

(i) Status Note and Concept Note received Department of Health and Family Welfare and Medical Council of India (MCI);

(ii) Report of the Task Force on Medical Education for the National Rural Health Mission headed by Shri Javid Chowdhury, Ex-Secretary, Ministry of Health and Family Welfare

(iii) Oral evidence tendered by the Secretary and other officers of the Department of Health and Family Welfare and representatives of Board of Governors, Medical Council of India;

(iv) Write-up received from Prof. K. Srinath Reddy, President, Public Health Foundation of India and Dr. Meenakshi Gautham, Post doctorate fellow with the Institute of Health Policy and Management, Erasmus University, Netherlands.

6. The Committee at its meeting held on the 13th March, 2013 considered and adopted the Draft Report.

7. For facility of reference and convenience, observations and recommendations of the Committee have been printed in bold letters in the body of the Report.

NEW DELHI
13th March , 2013
Phalguna, 1934 (Saka)

BRAJESH PATHAK
Chairman,
Department-related Parliamentary Standing Committee on Health and Family Welfare

LIST OF ACRONYMS

ANM- Auxiliary Nurse Midwife

BRHC- Bachelor of Rural Health Care course

B.Sc (CH)-Bachelor of Science (Community Health)

BPHP- Bachelor of Primary Health Practice

BRIC- Brazil, Russia, India and China countries

CHCs- Community Health Centres

CHOs- Community Health Officers

DGHS-Director General of Health Services

GDMO-General Duty Medical Officer

IMA- Indian Medical Association

MCI-Medical Council of India

MDGs- Millennium Development Goals

MHPs- Mid-level Health care Providers

PHFI- Public Health Foundation of India

PHCs- Primary Health Centres

RHS-Rural Health Care System

SCs- Sub Centres.

REPORT

I. Introduction

Taking *suo motu* notice of the media reports that the Government was considering the proposal of introducing "Bachelor of Rural Health Care" (now Bachelor of Science (Community Health))course to cater to the needs and requirements of the rural people and also to bridge the gap of patients: healthcare professionals ratio in rural areas, the Committee discussed the issue in its meeting held on the 18th January, 2011 and keeping in view the wider ramifications of the introduction of proposed BRHC course for the delivery of healthcare services to the rural people of the country, decided to examine and report on the same. The Committee in the first instance asked the Ministry to furnish background Note on the proposed course.

2. The Department of Health and Family Welfare in its status Note, explaining the background of the proposal stated that the said proposal for setting up of a Rural Medical Corp., having three year training was first mooted in the Ministry in November 2009 and Medical Council of India (MCI) was requested to prepare a draft proposal. It was proposed that the said Corp., would act as a pool of medical professionals who can be posted at Sub-Centre/Primary Health Centre level.

3. The Department further stated that MCI made a presentation on the subject, and later held a National Workshop on 4th & 5th February 2010 wherein Vice-Chancellors of various Health Sciences Universities/deemed Universities, Directors of Medical Education of various States and Deans of all the medical colleges in the country were invited to participate and render their inputs pertaining to the "Alternative Model of Undergraduate Medical Education", primarily aimed at generating trained health manpower which would be catering to the needs and requirements of the rural masses in the country. The Department further added that based on the outcome of this event, MCI sent a proposal for Bachelor of Rural Health Care (BRHC) course to the Ministry on 28th February, 2010. According to the Department, the salient features of the proposed course were as follows:

a. The course is proposed to be conducted by a medical school attached to the district hospital and will be affiliated to an examining

university for conferring the degree. The medical practitioners will be registered with the concerned State Medical Council;

b. The duration of the course will be three years with six months of rotational internship;

c. The candidates eligible for the course will be those who have completed their entire schooling and passed their qualifying examinations (10+2) from notified rural area in the concerned district;

d. Admission will be district based as far as possible;

e. After acquiring this degree, the graduates will be employed only in sub-centres;

f. The quality of education will not be compromised;

g. The doctors acquiring this degree will handle common ailments compared to MBBS doctors who are competent to handle difficult ailments;

h. The Medical Officer with MBBS degree or/and PG degree with certain stipulated experience will be permitted to teach in the medical schools;

i. Medical college teachers who have superannuated from the medical college can also be re-employed till the age of 70 years etc;

4. It was further stated in the status note that the Ministry of Health and Family Welfare discussed the proposal with MCI and Director General of Health Services (DGHS) in a meeting held on 12th April 2010 and it was decided to reduce the duration of the course from 4 years to 3 and half years.

5. It was also stated that in May 2010, four sub-groups were formed to incorporate the desired changes and frame a draft curriculum for the BRHC (now B.Sc. (Community Health)) course. In consultation with the sub groups, DGHS readied a draft course curriculum of BRHC. The draft curriculum was sent to MCI on 28th October 2010. The course was discussed in the 11th Conference of Central Council of Health & Family Welfare held on 30th August 2010 and received an overwhelming support from the States. The proposal was again brought up for discussion in the State Health Ministers meeting held in Hyderabad on 12-13 January, 2011 and was endorsed unanimously.

6. The Department further stated that the comments of MCI on the draft course curriculum prepared by DGHS had been received on 30th December, 2010 and

DGHS would re-examine the draft in the light of these comments and, if required, revise the draft. Thereafter, MCI would be asked to notify the course.

II. Official Presentation

7. The Secretary, Department of Health and Family Welfare during the course of his presentation made before the Committee on 27th January, 2011 justified the need for introduction of Bachelor of Rural Health Care (BRHC) course, stating that the basic premise for the need for introduction of such a course was the paucity of doctors in the rural areas.

8. He stated that in the year 1950, there were 20 medical colleges in the country which has now increased to 314. These medical colleges have 35000 under graduate seats and 2000 post graduate seats in total. There was a huge gap in the doctor-patient ratio in the country. In some states there was only one doctor for 23000 persons. The ministry has, therefore, taken an initiative to introduce a scheme called the 'Rural Health Care Course' to provide trained health personnel for providing comprehensive health care in rural areas at the sub-centre level. According to him, the proposed BRHC course would basically complement and supplement the ANM working at the sub-centre level which would help in strengthening the health services existing in the rural areas.

9. Explaining about the modalities of implementing the course, the Secretary stated that in order to implement this course, some medical schools would be opened and in every district hospital there would be a provision for intake of 50 students. Reiterating the admission procedure mentioned in the status Note, the Secretary clarified that the BRHC graduates were not targeted to replace MBBS doctors at the PHC level, but to man the sub-centres and would be in addition to the ANM. On being asked whether the BRHC personnel would be doctors or paramedics, the Secretary categorically clarified that the BRHC personnel would be degree holders in community medicine but not doctors.

10. Not being satisfied with the presentation made by the Health Secretary on BRHC, the Committee asked him to furnish a detailed concept note on the entire spectrum of the issues involved in the BRHC. The Ministry, accordingly, submitted

a Concept Note on 1st March, 2011, salient features of the same are briefly enumerated below:

(i) The Bachelor of Rural Health Care (BRHC) proposal is currently still a matter under discussion. It has been raised with State Governments both at the meeting of Central Council on Health and Family Welfare in August, 2010 and at a meeting of State Ministers of Health in January, 2011. There was overwhelming support from the States, especially those States which are currently very poorly served with primary health care facilities. Assam has a 3 years course to train a Rural Medical Practitioner with adequate skills for primary health care; the Assam Rural Health Authority Act governs this arrangement. Chhatisgarh had begun, and given up, a similar programme but over 950 Rural Health Assistants with such qualifications have been employed by the State government. West Bengal has begun the training of nurse- practitioners.

(ii) The Lancet Issue of January, 2011 dedicated to the theme of Universal Health coverage in India point out to the poor health infrastructure in India and observed that:

> "India has a severe shortage of human resources for health. It has a shortage of qualified health workers and the work force is concentrated in urban areas. Bringing qualified health workers to rural, remote and under-served areas is very challenging. Many Indians, especially those living in rural areas, receive care from unqualified providers. The migration of qualified allopathic doctors and nurses is substantial and further strains the system. Nurses do not have much authority or say within the health system and the resources to train them are still inadequate. Little attention is paid during medical education to the medical and public health needs of the population, and the rapid privatization of medical and nursing education has implications for its quality and governance. Such issues are a result of under-investment in and poor governance of the health sector- two issues that the Government urgently needs to address."

(iii) International experiences suggest a minimum density of 250 health professionals per 1,00,000 population to achieve basic public health goals. This is only counting doctors, nurses and trained midwives. Based on 2001 census adjusted for only qualified personnel, India has about 62 doctors, nurses or midwives per 100,000 today, and of these about 38 are doctors and 24 are nurses and nurse- midwives. In order to reach the international norm we would at the very least, require, 6 lakh additional doctors and 12 lakh additional nurses. Even if MBBS doctors of the appropriate quality in sufficient numbers were produced, it would be impossible to keep them in public service in the rural areas.

(iv) The current proposal, therefore, is to create, not MBBS doctors but a cadre of graduate health workers with a degree of BRHC.

(v) There has been always a dialogue on whether in addition to the basic MBBS course a three year course should be made available to provide a public health oriented graduate with appropriate primary health care skills to serve in rural areas. The most recent of these was the study group of the Medical Council of India set up in 1999 under the chairperson Dr G.P. Dutta, a former president of the Indian Medical Association. The report on the alternative/Innovative model of medical education was approved by the executive committee, and subsequently by the General Body of the Medical Council in March 2000 and forwarded to the Government of India in June of the same year. The Ministry further stated that the study group of the Medical Council updated the model in December 2009, and held a wider national consultation in early February 2010, which enabled finalisation of the main features of the approach.

(vi) That the proposal also draws support from the Task Force on Medical Education of the National Rural Health Mission.

(vii) That the commission on Macro-Economics and Health, 2005 and the Knowledge Commission also made a similar recommendation for mid -level care providers.

(viii) This arrangement would in a few years time lead to a large organized force of health workers providing a service considerably more than that being provided today by ANM though not comparable with the service provided by an MBBS qualified doctor posted at Primary Health Centre. The Ministry was of the further view that given the alarming shortage of MBBS qualified doctors at the Primary and Community Health Centre level, the BRHC health worker would be in a position to refer serious cases to the district hospital **(Concept Note at Annexure-II**)

11. The Ministry of Health & Family Welfare allaying the fears that BRHC programme is an attempt to either water down the content of a medical education or institutionalize the provision of semi-skilled doctors in the rural areas, assured that a, "*BRHC health worker is not, and cannot be, a doctor*". A BRHC health worker will only be competent to function within the skills provided to him and with no pretence to any superior medical ability. The Ministry further stated that the great strength of the BRHC medical officer is that he will be available at the sub centre and will have a degree of formalized education and training much beyond that being currently available.

12. The Ministry, however, admitted that there are many issues of investment and governance that arise, which need to be addressed.

III. Views of Experts/Stakeholders

The Committee heard the views of some experts/ stakeholders to have the views of all concerned before taking a decision in the matter. Their views are given in the succeeding paragraphs.

Views of Dr. M. K. Daga, Director & Professor, Department of Medicine, Maulana Azad Medical College, New Delhi

13. Dr. M. K. Daga informed the Committee that a course akin to the proposed BRHC course was introduced in Chhatisgarh in 2001-02 under which a few hundred rural medical assistants were trained. However, only a few of those were posted as Medical Assistants in PHCs. However, the course had been stopped due to combination of various factors like lack of strong institutional support structures, lack of future employment opportunities and career path, low quality of training, improper communication and lack of focused training needed to address rural public health needs. Opposing the proposed BRHC course on the basic premise, he made the following submissions:

(i) there can not be two standards of healthcare for citizens of India - one state-of-art for urban population and a second sub-standard care for rural masses as it is a violation of Fundamental Rights of equal treatment;

(ii) even the Bhore Committee in the year 1946 had recommended the abolition of courses akin to proposed BRHC courses like LMP, LAM, MCPS, RMP which were subsequently stopped;

(iii) any move to introduce BRHC course would be a retrograde step;

(iv) there is no stopping such BRHC practitioners from migrating to cities after a certain number of years;

(v) as per statistics of the Ministry of Health and Family Welfare (2008) only in 4 States i.e., U.P., Maharashtra, Punjab and Assam, the number of doctors are less in the PHCs and Sub-Centres. In other States, there is a surplus of doctors at PHC level;

(vi) there is gross deficiency of Medical Specialists, Health Workers, Pharmacists and Lab Technicians;

(vii) training of BRHC is a major area of concern because as per the scheme the concerned District Hospital which is ill-equipped, poorly staffed and over-worked would have to train such rural practioners too;

(viii) such rural practitioners as per the proposed course would not be trained in performing surgical procedures which would be a handicap in situation requiring surgery like accidents and surgical emergencies, agricultural mishaps and emergency obstetric care; and

(ix) three & half years BRHC course would produce inferior quality doctors who would lack credibility to lead the team of other health workers like Nurses having diploma in nursing (three & half years)/ B.Sc. nursing (4+1 years) or Pharmacy (4 years).

14. Giving his viewpoint on solution to overcome the shortage of doctors in rural areas, Dr. Daga made the following suggestions:

(i) That there is a need to provide waiver or high concession in fees for those who join the MBBS course under bond and surety to serve in rural areas for 3 years after graduation and a job assurance in Government or private set up in the same areas and in case it is not possible, such graduates could be helped to set up practice in rural areas (with financial assistance);

(ii) alternatively, 25per cent reservation for candidates from rural areas (with population less than 10,000) in MBBS admissions may be provided with a pre-condition for those joining under the said quota to serve in rural areas for 5 years;

(iii) to improve present healthcare delivery system in rural areas, there is a need to undertake a comprehensive health care personnel manpower assessment;

(iv) enhanced budgeting allotment for healthcare;

(v) encourage Indian Medical graduates working overseas to return home;

(vi) amend Indian Medical Council Act, 1956 to lay down that doctors would receive only temporary licence to practise in the defined rural areas either in service or own practice for 3 years at least and permanent registration after 3 years;

(vii) reserve seats for post-graduation for the doctors serving in rural areas;

(viii) mandatory one year rural service for all MBBS graduates-prior to permanent registration;

(ix) increase the number of MBBS and post-graduate seats;

(x) full utilization of private medical sector;

(xi) opening new medical colleges in rural areas of Assam, Punjab, Uttar Pradesh, Maharashtra, etc.

15. Dr. Daga concluded that instead of introducing the proposed BRHC course, there is a need to strengthen the existing B.Sc. Nursing course which is a 4 years course with hands on training could be re-designated as Nurse Medical Practitioners. He also suggested that a one year training of AYUSH doctors to deal with common medical problems by posting them at District Hospitals may be mooted.

Views of Dr. T. Sundararaman, Executive Director, National Health System Resource Centre, New Delhi

16. Dr. Sundaraman advocated that it is important to introduce a mid-level care provider who not only has a strong public health orientation with a focus on preventive and promotive care but also has the ability to manage common illnesses, screen for serious diseases and follow up cases seen by specialists and medical doctors at the local level.

17. He further submitted that several third world countries had achieved the deployment of one medical service provider for a population of 5000, for example Brazil or Thailand. The country currently base health care provision at the 5000 population unit through two trained nurse-midwife (pre-service training of 18 months) and one male health worker. The male health worker is not in place in most States. Their main work is defined as disease control, in particular, malaria, TB and response to epidemics but this is only a very small part of disease control or the care provision that is needed at this level.

18. Dr. Sundaraman felt that India should move to a scenario by the year 2020 where mid level care provider is available at every single unit of 5000 population especially in those rural areas where expanding urbanization and connectivity to qualified doctors and nursing homes of urban areas are still a difficult proposition. The current allopathic medical officer in the PHC would also continue to be there and guide the mid level care

provider. The medical officers may be trained under family medicine courses and other short term courses to respond to referrals from the primary care level.

19. Giving his perspective on the often-suggested approach to overcome shortage of doctors in the rural areas, he stated that an MBBS post should be created in the health sub-centre or the MBBS should be made to stay at the PHC and visit the sub-centres in all working days; seats in the medical colleges should be increased to provide these extra doctors; monetary incentives should be given and rotational posting should be used to fill up the vacancies. Dr. Sundaraman also made the following submissions:-

(i) Currently, vacancies in PHCs are very high. In some states and districts it could be as high as 40 percent. Informal vacancy or absenteeism is even higher. One study puts it at over 50 percent. The reasons for doctors not serving in rural areas are many.

(ii) Most entrants to medical colleges are from urban middle class backgrounds and there are both economic and cultural reasons why they and their families would consider a rural posting as a failure or loss of status. They tend to face a sense of social isolation when posted in rural areas.

(iii) Most medical graduates are taught the practice of medicine in a technology intensive setting, where peer support is plentiful. Their role models are very successful clinicians who provide high degree of specialist care and are often well known in the research world. The aspiration built up is therefore of becoming a successful specialist with a focus on diagnosing and treating diseases known for their complexity. They find themselves facing a sense of professional loss and professional isolation when they are posted in rural areas, and are practising with relatively limited support.

(iv) For patient satisfaction, it is not only necessary that there is a service provider available, it is also important that there is patient to provider bond. This requires that the provider is happy to be working in a rural area, and happy to be providing this level of service. Forcing, by either regulations, or rotation posting for a doctor to go for a short time to a PHC, is not the ideal way to fill the gap. The aim must be to find a person who is happy to work in such an area, and who finds himself professionally and socially fulfilled in working in such conditions. Any doctor in a rural area is not a solution. The aim must be to find the right person, with the right set of skills for the right place.

20. During the course of his oral evidence reiterating the submission made in his Note, Dr. Sundaraman backed the proposed BRHC course with an evaluation of the

Chattisgarh and Assam models of rural health service. He informed that the course for rural health practitioners in Chhatisgarh akin to the proposed BRHC course had to be stopped after three batches because the students of these batches, demanded government jobs and demanded to be designated as doctors, which was objected to by the professional doctors. However, these batches were useful to fill up all the vacancies in primary health care centres and were called rural medical assistants and were given government jobs and salaries. Many PHCs which were over 50 long years had never been able to get a doctor, now had the health workers. He felt that evaluation study showed that their knowledge and skills for primary care and patient satisfaction was the same as that of a regular medical doctor. With regard to the Assam model, Dr. Sundaraman informed that all 92 graduates from the first batch had been posted in rural sub-centres and there was strong support from the public for continuation of this Rural Health Practitioners programme. Moreover, there was no resistance from professional doctors for this programme. He asserted that the main lesson learnt from the above was that the three year proposed course can be very useful to fill up primary health care posts in public sector, even in PHCs. He suggested that selection to the said course should strictly be confined to rural locality with conditional licensing and on completion of the course they can be employed and paid by the Government. He also informed the Committee that in States such as Chhatisgarh and Assam performance and output of such rural health practitioners was comparable to that of five-year doctors in both clinical and quality and patient satisfaction and they had been rated better than doctors trained in traditional medicines, pharmacy, etc. The Committee was also informed that internationally this concept of rural health care practitioners was well studied and evidence was very positive in terms of increased number of graduates from rural background coming to practice in rural communities. Dr. Sundaraman further highlighted the fact that the objective of proposed BRHC course was to make universal access to primary health care, even in remote rural areas a reality by the year 2020. The idea behind BRHC course was to generate a cadre of mid-level health care providers who would be motivated to live in and provide comprehensive primary health care in rural areas at the health sub-centre level. According to him, such BRHC graduates would be able to address all public health priorities both preventive and promotive, treat minor ailments, address much of communicable

and non-communicable disease burden as required in primary health care. They could also act as appropriate referrals, acting as a responsive filter on 'who should go where for further treatment'.

21. However, Dr. Sundaraman also underlined certain challenges facing the proposed BRHC course. According to him, the biggest challenge was faculty development and development of a new approach to the teaching of medical science and of institutions to organise and manage this course. According to him, there was a need to develop a career path for such graduates where after five years rural service, they should be provided an option to take another two years of study and become an MBBS to reduce pressure on the few who need/ want to leave the area for various reasons. He concluded by stating that as apprehended, the proposed BRHC course would not result in discriminatory care for poorer or rural patients and would not result in lower standard of care; rather it would ensure having the right person with right skills in the right place. He further stated that the proposed course would not cut back on the current deployment of doctors, as the single doctor norm at the PHC would stay and BRHC graduate would be placed in Sub-Centre. He was of opinion that the said course would only add a 'doctor' where an ANM was available hitherto. The design of the said course favours students from families for whom this course favours social mobility. This course was conceived as a reform in medical education specifically aimed at generating a cadre of healthcare providers who by virtue of the way they are chosen, deployed and supported would be motivated to live in and provide comprehensive primary health care in rural areas. On being asked as to why there was a need to bring such a course at the central level when States (read Chhatisgarh and Assam) can legislate in the matter Dr. Sundaraman replied that funding is very important in introduction of the proposed course as a huge amount of funding was involved.

Views of Dr. Bir Singh, Professor of Community Medicine, AIIMS

22. Dr. Bir Singh, during the course of his presentation on BRHC course, informed the Committee that as per the existing health care system there was only one specialist plus GDMO available for a rural population of 15-17 lakhs at the district hospital level. At the block level (CHCs) the ratio was one specialist doctor

for 1-1.2 lakhs population. At the PHC, it was one doctor for 20,000/30,000 population. At the cluster of villages (Sub-Centre), it was 1 health worker (male or female) for 5000 population. At the village level, it was one health worker (male or female) per 1000 population. Therefore, he felt that the proposed BRHC course may lead to some benefits, such as it may lead to improvement in infrastructure in rural areas, may reduce migration of people from rural to urban areas and could counteract the quacks prevalent in rural areas. However, he was of the view that the proposed course may cause some major problems like the possibility of producing half-baked Health care practitioners, due to inadequacies in the proposed curriculum and training of the BRHC practitioners. He felt that restricted practice for these graduates will render them less effective. He also stated that it would be difficult to prevent their migration to urban areas. He, therefore, suggested that for the time being, instead of introducing the course at the National level, it may be introduced as a pilot project in one State like UP or MP and its efficacy be evaluated after 5 years. In addition, he felt that there was a need to strengthen the existing 3-tier Rural Health Care System (RHS) with high quality health care by strengthening facilities at the Sub-Centres by way of refresher training for Health workers already available at Sub-Centres, and by correcting the unequal distribution of MBBS doctors in Urban and Rural areas by seriously considering introducing a bond for doctors to work in rural service, giving incentives for setting up of rural practice and reserving PG seats for those working in rural areas. He was, therefore, of the view that if the shortcomings in the existing health sector dilineated above were suitably addressed then perhaps there would not be any need for any additional system such as the proposed BRHC course.

Views of Dr. Vinod Kumar Paul, Prof. & Head, Division of Neonatology, Department of Pediatrics, AIIMS

23. Dr. Vinod Kumar Paul argued that the BRHC would go a long way in empowering the rural people as it would improve the health and with one-third of seats reserved for girls for the proposed course as it would change the rural scene in many ways. During the course of his presentation, Dr. Paul highlighted the issues like (i) mismatch between doctor : population ratio; (ii) huge shortage of Medical Officers at Primary Health Centre and Sub-Centre level; (iii) need-based curriculum of BRHC; (iv) ideologically aligned faculty for BRHC; and (v) need for a National

Task Force to roll out the programme, etc. Dr. Paul opined that the course of MBBS was not directed to core health needs of rural population. He also stated that in the current scenario of doctor: population ratio, the number of doctors required in the rural areas was enormous and target of one-doctor-for-1000 population cannot be met before 2035 and, therefore, introduction of BRHC was warranted. In reply to a question regarding posting of MBBS doctors in rural areas, Dr. Paul opined that due to their different orientation and mindset, MBBS doctors were unlikely to stay and serve in rural areas. Dr. Paul also felt that there was a need for a National Board for Quality Assurance and Accreditation in this regard. Dr. Paul wanted that the Board should be steered by educationists/professionals and should include people with grass-root experience.

Views of Dr. Devi Shetty, Chairman, Narayana Hrudayalya, Bangalore, Karnataka.

24. Dr. Shetty, during the course of his presentation, informed the Committee of the reasons behind India having the worst indicators in respect of health, vis-à-vis, other BRIC (Brazil, Russia, and China) countries. He stated that India is the only country in the world managing healthcare totally dependent on M.B.B.S doctors and where an ICU nurse with 30 years experience was not allowed to give an IV injection. In contrast, in U.S.A, a nurse anesthetist can independently anaesthetize a patient for major heart surgery without any anaesthetist around the hospital; a dialysis nurse effectively manages the dialysis centres. While in India a doctor with M.D. and having 10 years experience was not allowed to manage dialysis without a doctor with DM in nephrology. It was a travesty of justice that even after 100 years when the first heart surgery was conducted, India which needs at least 2.5 million heart surgeries a year, could manage to conduct approximately only 90,000 heart surgeries a year. He was of the view that the main problem was not lack of money, but the shortage of manpower in which there was need for the Government to keep the interest of the patient paramount over the interest of doctors. He informed the Committee that at present India was short of one million doctors and if 100 new medical colleges are added every year for the next 5 years, India will be able to have adequate number of doctors by 2025 only. The limitation of existing infrastructure in producing adequate number of doctors in future was compounding factor in this regard. Given the current scenario, there would not be any applicant for our PHCs

in three years' time. To top it, female doctors who constitute more than 60 percent of the medical students, were unwilling to take jobs at PHCs in the absence of adequate supporting infrastructure there. Further, a significant number of doctors do not practise medicine. A good number of IAS officers are doctors, adding to the problem of the already overburdened health care system.

25. Dr. Shetty suggested a dual strategy for rural health viz. Rural doctors course and one year bridge course for AYUSH doctos to prescribe allopathic medicines. The rural doctors course, to begin with, can be undertaken as a ten year pilot study and afterwards a bridge course to join the main stream service after serving for 5 years in a rural area. If need be technological tools in this regard can be used to bridge the gap. He suggested that instead of waiting for MCI to notify the said course, which seemed a remote possibility, IGNOU School of Medical Sciences is the ideal organisation to conduct the rural doctors course. The respective State Health Ministries could create a body to monitor the quality and ethics of rural doctors. Replying to a query as to what was the guarantee that BRHC like MBBS doctors, would not migrate to cities, Dr. Shetty stated that BRHC would get jobs in the Sub-Centres in the designated areas and if they migrate to the cities, their licence would not allow them to practise there. He concluded his discussion favouring introduction of the BRHC course with the rationale that the ultimate aim was to retain trained healthcare providers in rural areas and provide good health to the patients residing there and opined that the proposed BRHC course may well become a means to achieving that end.

Dr. Shyam Prasad, Executive Director, National Lutheran Health and Medical Board.

26. During the course of his presentation Dr. Shyam Prasad, explaining about the benefits of introduction of the proposed BRHC course, stated that India had only four years left until the 2015 deadline to achieve the Millennium Development Goals (MDGs), which presented a critical opportunity for action to increase investment and support to countries to strengthen their basic health systems, including their health work force to deliver essential health services that could save the lives of women and children. However, survey data confirm that many countries continue to retain a medical monopoly over essential clinical functions,

despite having inadequate numbers and inequitable distribution of doctors. He informed that the latest report on Millennium Development Goals reveals a dark picture of India with distressing trends on education, child mortality and maternal mortality rates. He felt that in order to reduce the child mortality/maternal mortality rates there was an urgent need to introduce the proposed BRHC course. He cited the success of mid-level health practioners, who are akin to the proposed rural health practitioners in Malawi, Ethiopia, who have successfully implemented such course. In support of his claim, he cited the success of treatment of patients by paramedical staff instead of by doctors in Chhatisgarh, according to a study conducted by Dr. Srinath Reddy of the Public Health Foundation of India. He felt that favorable report of Task Force on Medical Education Reforms of National Rural Health Mission for introduction of the proposed course further strengthen the move. He informed that though there was an elaborate public health delivery system for rural areas i.e. Sub-Centre for 5000 population serviced by 1 ANM and 1 Male Health Worker, Primary Health Centre (PHC) for 30000 population serviced by minimum 1 doctor, 14 paramedical staff and Community Health Centre for 120000 population serviced by 1 Surgeon, 1 Obstetrician, 1 Physician and 1 Paediatrician, but the PHCs and CHCs were plagued by huge shortfall of doctors. Quoting from the Bulletin of Rural Health Statistics in India, Government of India 2009, he informed that out of 23391 PHCs, 2320 PHCs were with a single doctor. Similarly, shortfall of specialists at CHC level was to the tune of 67.9 per cent. Citing the findings of an assessment of Primary Health Care Providers in Chhatisgarh by K.D. Rao, according to which patient-satisfaction with the services of a Medical Officer and Rural Medical Assistant was almost at par, Dr. Shyam Prasad stated that lesser but well-trained mid-level healthcare providers can be competent doctors in primary health settings. He further stated that while global standard set by the World Health Organisation for doctor patient ratio was 1:250, this ratio was 1:34000 in rural areas in India. He argued that there was an urgent need to place a healthcare provider for every 1000 population so that unnecessary deaths could be stopped in rural areas. He summarized that in the last six decades MBBS Doctors had failed to serve three-fourth population of the country by stating that the debate over whether non-physician clinicians were a reasonable substitute for physicians misses the point

because the correct comparator was not the physician but the situation where no physician was present.

27. He concluded by stating that even the Delhi High Court in its judgment of December, 2010 had ordered to start this course within eight weeks from the date of the judgment.

Views of Dr. Asok Samanta, Vice President and Dr. Anusum Mitra, Executive Member, Medical Service Centre, West Bengal

28. During the course of their presentation, Dr. Samanta and Dr. Mitra informed the Committee that they were not in favour of BRHC course in India at the present juncture. To justify their claim, they stated, *inter alia,* that neither the Bhore Committee nor the Alma Ata Declaration had recommended any short course to create a cadre to stand for the MBBS qualified medical officers. They felt that the manpower shortage of doctors was not the main issue but infrastructure shortage in the field of health care was the main hindrance in assuring quality health care to Indian population. According to them, the current doctor-population ratio in India is 1:1440.97 taking only MBBS doctors; moreover, the Government of India had taken steps to implement vision 2015 to increase the number of MBBS doctors to achieve a target of 1:1000 for MBBS doctors. They felt that the real cause of lack of heath care in rural areas is the poor or unequal distribution of abundant health resources across the country. The inequitable distribution of resources in rural areas, vis-à-vis, the urban areas can be seen from the fact that the ratio of hospital beds to population in rural areas was fifteen times lower than in urban areas; the ratio of doctors to population in rural areas was almost six times lower than that in the urban population; the per capital expenditure on public health was seven times lower in rural areas, compared to government health spending for urban areas (national average is Rs.220/-p.a.). They instead suggested that there was a need to initiate move to introduce health and education as fundamental rights. They also suggested that time-bound community service should be made mandatory for all medical graduates. Concomitantly, remote area benefits, post-graduate training, neutral and transparent transfer policy should be implemented to do away with the problem of lesser presence of Health Workers in Rural areas. They opposed creation of BRHC

course stating that such an arrangement would create a half-baked doctor for the rural population.

Views of Dr. Vinay Aggarwal, President and Dr. D. R. Rai, Hony. Secretary General, Indian Medical Association

29. Dr. Vinay Aggarwal, and Dr. D.R. Rai were also not in favour of introduction of the proposed BRHC course. They informed the Committee that it was the duty of the Government to treat its citizens equally and the proposed BRHC course was violative of Article 14 of the Constitution viz. 'Right to Equality'. Moreover, the proposed BRHC course which is of three years duration impacts safety of the patient on the ground that the full $5^{1/2}$ years MBBS course equips the medical graduates to function as competent practioners of modern medicine and any deviation from the exacting standards and schedule would certainly impact patient safety. They further stated that the proposed course was fraught with dangers of becoming a non-starter as the Government was yet to come out with changes in the structure and strategy of primary health care delivery system to justify creation of BRHC course. Further, neither the NRHM nor the Planning Commission or the National Commission on Macro-economics and Health, 2005 have conceived a restructuring of primary healthcare. The representatives of IMA instead suggested (i) creation of an All-India Rural Health Service with short and permanent commission; (ii) provide financial and non-financial incentives for Government doctors in rural areas; (iii) compulsory rural service for promotion purposes in government services; (iv) retainership of private doctors to do public health duties in rural areas.

30. They also felt that if the Government was still keen on introducing the proposed BRHC course, the persons graduating under the said course may be declared as healthcare workers who may be registered under a Paramedical Council. The representatives of the Indian Medical Association, informed the Committee that in the last ten years, the Government of India has been able to establish few medical colleges in the Government sector. There are 300 districts in the country which have no medical colleges. About 50 per cent of the medical colleges are there in just four States of the country. They suggested to open medical colleges instead of medical schools in rural areas and admit students from rural and tribal areas to them, giving

them relaxation and making it mandatory for them to serve in rural and underserved areas at least for 3 years to tackle the shortage of doctors in rural and underserved areas. Giving their views on the charge that the doctors were not going to villages, he blamed lack of proper infrastructure and governance deficit for the problem. Elaborating further, they stated that absenteeism was an issue of governance and cannot be cited as a reason to create a cadre of half-baked doctors. They disputed the notion that over 20-30 percent PHCs do not have an MBBS doctor. According to them only 5.3 percent of PHCs were without a qualified doctor. They suggested one year's compulsory rural posting for rural MBBS graduates after internship. They also suggested that Government should come out with an Ordinance requiring 350 odd medical colleges in the country to accommodate 30 students from rural areas who should be selected separately not by common competition. Such students may also be asked to furnish a bond to serve in rural areas. This would negate the need for setting up new infrastructure to set up medical schools for such graduate health workers. There was a need to take a relook at the total health infrastructure. Moreover, the Rural Health Machinery Fund should be utilized in developing the rural infrastructure for which purpose this Fund was created.

Views of Prof. K. Srinath Reddy, President, Public Health Foundation of India

31. Dr. K. Srinath Reddy in his written submission to the Committee was in favour of the BRHC course. He outlined the reasons for the same. As per his written submission, the positioning of well-trained mid-level health care providers (MHPs) in the health system to provide essential primary health care to underserved populations was now a growing trend, especially in Africa and Asia but also seen in some developed countries. In India, there was need for MHPs to support and strengthen primary healthcare in both rural and urban areas. They should become part of the National Rural Health Mission as well as the National Urban Health Mission. According to him, the course should be renamed as "Bachelor of Primary Health Practice" (BPHP) and the course content, curriculum and competencies should be customized to the primary health care needs of the population (district) they were expected to serve. He was of the view that this could be achieved by linking their education to the district hospital and the district health system in their

home district or an analogous district in their home state. He has further stated that these MHPs were not doctors and should not be designated as such. Their training programme also should not be treated as 'MBBS Bonzai' but as a carefully constructed course emphasizing practical aspects of primary healthcare. If the rural BPHP course content is mainly tailored to infectious disease and other prioritized health needs of the rural population, the urban BPHPs may have a greater content of routine chronic care related to non-communicable diseases (such as cardiovascular diseases and diabetes) in their training. The licensing of such MHPs should be restricted to the local areas of their district/ adjoining districts. After a period of 5 years of service after their initial education, they may become eligible for instruction, through bridge courses, to obtain further training to become doctors or public health specialists, based on clearly defined eligibility criteria. Given the growing acceptance of alternate and complementary systems of health care as part of an expanded health service, the BPHP curriculum may combine essential and relevant elements of both allopathic and AYUSH systems. India may, thereby, be the first country to formally create an innovative fusion product of both systems at the MHP level. This complementarity is likely to be useful in primary health care. Studies conducted by PHFI's researchers in Chhattisgarh indicated that the MHPs who have undergone training for 3 years were competent to handle a range of primary healthcare problems like the diagnosis and treatment of malaria, diarrhoea, hypertension and diabetes mellitus and demonstrated the same competency as medical officers in treating several medical conditions commonly seen in Primary Health Centres. He was, therefore, of the view that the introduction of MHPs into India's health system through a well-designed BPHP programme can increase the outreach and performance of the health system and strengthen primary health care in both rural and urban areas. He opined that the proposed move of the Government was not meant to provide second-rate care to rural population but strengthen and enable the delivery of primary care for all.

Views of Dr. Meenakshi Gautham, Post Doctorate fellow with the Institute of Health Policy and Management, Erasmus University, Netherlands

32. Dr. Meenakshi Gautham was also in favour of introduction of the proposed BRHC course. According to her, the idea behind the said course was not to develop a rural substitute for MBBS doctors but rather to fill a huge gap at the first level of

care existing in rural areas. She on the basis of research undertaken by her in different States came to the following conclusions:

(i) At a macro level, different States may show variations in the mix and density of different types of public and private providers at the primary level; more mobile informal practitioners in AP, more clinic-based ones in UP, more public sector ones in Orissa. These differences were also repeated in mix of qualified doctors available at level two in different states. Altogether these could reflect interstate differences in wealth (e.g monthly per capita expenditure was Rs 704 in AP and 460 in Orissa- NSS 2005-06) and number of medical colleges (33 in AP, 8 in Bihar and 6 in Orissa), among others. The important message was that even in high-income States like AP, with more private colleges and private doctors, the first part of call in villages was usually not a qualified allopathic doctor.

(ii) There are around 6,00,000 villages in India of which 60 percent are small and scattered with roughly 1,000 population. They represent a massive need for primary healthcare providers (almost one per village) who are within easy access, can be trusted by their local communities, and are trained to manage most common illnesses. For practical, social and economic reasons doctors produced through the current model of medical education were unlikely to meet this first level of need substantially, at least not in the next several years. There was a need to consider mid-level clinical care providers as a competent alternative for the first level of health care. This was also the conclusion of a recent study by the Population Foundation of India on the three-and-a-half years trained Rural Medical Assistants posted in remote PHCs in Chhatisgarh. The study found that medical officers and RMAs were equally competent to manage conditions commonly seen at the primary level.

33. She, therefore, concluded that the rural health providers' course can develop competent primary care providers in the long term, but in the short term Government must consider training, certifying and regulating selected providers who already live and work in villages. These could include eligible and willing informal practitioners, public sector paramedics, nurses and also AYUSH doctors. The planning of this course must be responsive to interstate variations and avoid a one-size-fits-all formula.

IV. Report of Task Force

34. The Committee also considered the "Report of the Task Force on Medical Education for the National Rural Health Mission". The Task Force was headed by Shri Javid Chowdhury, Ex-Secretary, Ministry of Health and Family Welfare and

presented its Report in the year 2006. In a comprehensive study and analysis of the various aspects like the possibility of revamping Medical Education with reference to the requirements of medical professionals under the NRHM; 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; making rural service attractive for doctors; promotion of opening of medical colleges in the rural and other underserved areas; etc, the Task Force has made certain recommendations basically focusing on the fact that the medical graduates were reluctant to work in rural set up owing to numerous reasons despite incentives and encouragements and a very substantial portion of the primary health care was provided by the untrained providers and often by quacks which could be handled by health practitioners with limited training. Supporting the idea of trained community health practitioners, the Task Force made certain recommendations. (**Annexure-III.)**

V. Further evidence of Health Secretary

35. The Committee also heard the views of the Secretary, Department of Health and Family Welfare along with the representatives of Board of Governors, Medical Council of India on 22nd December and 27th December, 2011 in order to have the latest status on the introduction of BRHC course in the country. The Secretary informed the Committee that the Ministry was now giving more focus on the primary health care services. In this context, the role of a Sub-Centre has to be much more than what was being provided presently. Besides ensuring full ante-natal checkup of pregnant mothers and detection of high risk pregnancies, focus was also being made on post-natal care. Further, he apprised that there was also a need for very close monitoring of immunization activity to ensure full immunization of children, home based new-born care to ensure timely detection of diseases and timely referral to high level sub-centres. He felt that there was also a need to very closely monitor low birth-weight babies because about 23 per cent of babies were low birth-weight babies. While the Ministry was making efforts to provide more facilities at the district level but when it comes to Sub-Centre level, there was difficulty in monitoring the same. In case of severe anaemic patient or mothers who give birth to low birth-weight babies, they also need to be monitored very closely so

that the next child was not the low birth-weight baby. He apprised that as far as communicable diseases were concerned, besides vector control, timely detection of TB, leprosy, etc., was also quite important which was not very adequately attended to. Gram panchayats were also assigned a role in this regard but they were not functional at all levels. In addition, Government was now focusing on non-communicable diseases. Further on a pilot basis, the Ministry started screening of persons for diabetes in 100 districts. But in addition to screening of person for detection of diabetes, regular monitoring in future was also required. He asserted that to strengthen all these activities related to primary health care, the sub-centre has to be substantially strengthened. And, this was not possible with only ANM who has limited scope and with focus on the midwifery. He stated that keeping this in view, there was a strong need for a mid-level health worker who would oversee the activities of ANMs and the male health workers. These health workers could look more on preventive healthcare side. Besides, he stated that there was also a need to take the new technology to the remote areas. In that case, Sub-Centre was also to be linked with higher level health facilities, so that they could, at least, consult in case of necessity.

36. He stated that keeping all these facts in view, there was a need for a more competent person than ANM at the sub-centre level. Therefore, the Ministry had conceived to introduce a mid-level public health worker who would primarily have a public health orientation and he would be more trained in preventive healthcare. He could be selected from the District and trained at district-level facility at the public health college attached to a district hospital. The person would be conferred a Bachelor's degree, viz., B.Sc. in Public Health. He further informed that the initial course curriculum was referred to the MCI which had raised a lot of issues. The matter was examined by the Ministry and was again referred to the MCI. The Secretary informed that the decision of MCI in the matter was still awaited.

37. The Members then sought clarifications on the proposed introduction of BRHC course, particularly with reference to the standardization of the course; notification of the course; monitoring of the exams/practice; ethical aspects; status of the revised course curriculum of BRHC; mandate of MCI to notify the BRHC course;

financial burden of BRHC course on the exchequer; mandate of MCI to standardize and define curriculum etc. The Members also sought queries covering a large number of issues related to the proposed course such as whether it was right to create two sets of doctors-one for urban population and one for rural population; details of any other country having a course similar to the BRHC course; details of the States which were in support or against the said course; whether the nomenclature of the said course was apt or required to be changed; capability of a BRHC Graduate to take care of the rural population with limited exposure. The Committee particularly highlighted the following observations made by Board of Governors, MCI with regard to the said course and sought to know whether it was ethically correct for the Ministry to send the same proposal to the new Board of Governors without acting on any suggestions made by the MCI:-

i) It would be appropriate to re-designate this course as B.Sc., Rural Health Sciences rather than the current nomenclature which is BRHC.

ii) The holder of this degree is not qualified to practice independently as a fully competent medical practitioner.

iii) There is a vast subject content spread over three years' course, which may not be feasible.

iv) The curricular logic sequence needs to be maintained in all the three phases. Phase II is system-based learning and unless it is fully integrated into the teaching of basic sciences and disease pathology, there will be disjointed learning. Phase III learning is department-wise, which is irrelevant in the primary care setting.

v) This course should be re-designed to meet the generalist approach to basic concepts of preventive medicines, symptomatology of disease approach to early management of common diseases, mainly acute conditions, and an early recognition of complicated and complex problems.

vi) This course needs to be integrated with early signs of warning of impending systemic malfunction in trauma, infection, and metabolic disease. The Board of Governors, MCI, recommends that this Course should be redesigned in view of the above comments and redesignated as B.Sc. in Rural Health Sciences. The MCI is not in a position to notify this course as it is not a medical course.

38. Secretary, responding to the queries raised during the discussion, stated that the Government had never envisaged doctors at the Sub-Centre level so far. Doctors

are available only at PHC level and there are 23,000 PHCs and 1.47 lakh Sub-Centres. Providing a doctor at the Sub-Centre level had never been envisaged and could never be fulfilled also. So the Government was proposing either providing preventive care by the ANMs or by some higher level persons.

39. At its meeting held on 27th December, 2011, the Committee again heard the views of Secretary, Department of Health and Family Welfare along with the Chairperson, Board of Governors, MCI on the proposed introduction of the BRHC course. In his deposition, the Secretary reiterated that a BRHC graduate would not be called a doctor but a health worker. He further apprised the Committee that the MCI had been asked to standardize the course content and the final view on the course curriculum would be taken by MCI. He also apprised that it would be left to the State Governments to accept this course and implement it. He stated that even the Committee on Universal Health Coverage had recommended the course as a BRHC graduate which would help in strengthening the primary health care at sub-centre level and help in bridging the gap in availability of Doctors at Sub-Centre level by making available a qualified health worker especially in the Northern and Eastern parts of the country.

40. The Ministry of Health and Family Welfare vide its communication dated 13th September, 2012, informed the Committee that the curriculum for the said course has been revised and the nomenclature has been changed to B.Sc (Community Health)**. The Committee at its meeting held on 8th November, 2012 again heard the views of Secretary, Department of Health and Family Welfare along with the Chairperson, Board of Governors, MCI in the matter in view of the changed nomenclature and revised curriculum. The Secretary in his deposition before the Committee submitted that the proposal for the said course has been mooted keeping in mind the Sub-Centres (SCs) catering to a population of 5000-7000. In the present scheme of things 1.4 lakh Sub-Centres in the country are being manned by ANMs designated with the functions of pre natal and ante natal care of children; educating the mothers about basic child health care etc. The Secretary reiterated the fact that there was a need for a mid-level Health worker to strengthen the Sub-Centres so as to enable them to provide much higher level of primary health care than being offered at present. In pursuance thereof the Medical Council of India (MCI) constituted a Committee**

under the chairpersonship of Prof. Vinod K.Paul (Head, Department of Pediatrics, AIIMS) to develop a curriculum for the B.Sc (CH) course. The Committee was apprised that the said graduates would not be called 'doctor' and would be designated as Community Health Officers (CHOs), who would man the SCs. He also submitted that the course would be regulated through MCI in all aspects.

41. However, some Members of the Committee were of the view that (i) instead of providing doctors in the village the Government is coming up with a scheme to get the Sub-Centres manned by such B.Sc (CH) Graduates who may not be able to distinguish the nuances between a simple fever and jaundice; (ii) there is no clarity about the status of a person who has passed the exams in one state and has to migrate to other state due to reasons beyond his/her control and the validity of the degree in such a case; (iii) as per the information received from the Department, schools for training these graduates would be attached to district hospitals thereby raising serious apprehensions on whether the Government would be able to establish such schools in all the districts and how would the Government be able to provide teachers who would teach such graduates keeping in view the shortage of teaching facility in the country; (iv) serious apprehensions were raised on the clinical competencies of graduates who would be churned out of these schools; (v) how would the Government ensure that such graduates would not carry on private practice as can be seen from the fact that Government has not been able to rein in the government medical doctors from carrying on private practice; (vi) whether the opinion of the Law Ministry was taken on the issue of introduction of the said course as to whether a citizen of India staying in rural area should be treated by a second rung practitioner and whether it was not violative of his constitutional right to equality; (vii) Since the Planning Commission (in the 12th Plan) in concrete terms had mooted the proposal to set up medical colleges in each district, this would automatically ensure increased intake of doctors.

42. To frame its final view regarding introduction of the said course in the context of the foregoing, the Committee at its meeting held on 8th February, 2013 discussed the issue. Majority of the Members were against the introduction of the

said course on the ground that providing two different sets of Health facilitators for Urban and Rural masses was not only ethically wrong but also unconstitutional. The Members also raised the following objections (i) Infrastructure in the District Hospitals is woefully inadequate to train such students pursuing this course; (ii) production of half baked doctors by introduction of such course would endanger the lives of patients; (iii) there are severe inadequacies of the proposed curriculum and training of the B.Sc (CH) practitioners; (iv) restricted practice for these graduates will render them least effective, (v) probability of their migration to urban areas for illegal practice; (vi) the volume of curriculum including various advanced aspects which are not taught to MBBS graduates may not be a viable proposition for B.Sc course and (vii) such graduates, after completing their course and after being posted in the Sub-Centres, may start demanding better status and practice at other places etc.

43. In view of the above, majority of the Members were of the opinion that to mitigate shortage of doctors, there was a need to increase intake of MBBS graduates and provision for one year compulsory rural posting for MBBS doctors after internship instead of introducing the proposed course. The Members also made the following suggestions to address the issue of non-availability of adequate health care in the rural areas:- (i) more number of medical colleges may be opened to meet the shortage of doctors; (ii) possibility of posting of nursing graduates at sub-centres may be explored; (iii) intake of nursing graduates may be increased; (iv) to meet the immediate demand, graduates and post graduates in the AYUSH may be posted in the Sub-Centres.

44. However, a few Members of the Committee were in favour of introduction of the said course on the grounds of failure of the Government to provide adequate healthcare at Sub Centres; success of such course in States like Chhattisgarh and Assam and practically no resistance from the MBBS doctors in these States to such course resulting in patient satisfaction in rural areas, objective of the proposed course to make universal access to primary healthcare even in remote areas a reality by the year 2020; design of the said course favoured students from the rural background and hence ensures social mobility, etc.

VI. Recommendations

45. In view of the opinion of majority of the Members being against the introduction of B.Sc(CH) course, the Committee recommends that the Government should not go ahead with the proposal for introduction of the course.

46. The Committee is, however, constrained to note that a very substantial portion of primary healthcare is provided by untrained providers and often by quacks and there is acute shortage of health care professionals in rural areas. The Committee would, therefore, like the Ministry to devote its energies towards devising new strategies to overcome this gigantic problem. Keeping these fact in view, the Committee recommends that the Government should continue its focus on strengthening the existing Health care infrastructure by increasing intake of MBBS graduates and make provision for one year compulsory rural posting for them after internship which would help in providing healthcare for rural people. The Committee also recommends that the following measures may be taken to improve healthcare infrastructure in rural areas viz. (i) more number of medical colleges should be opened to meet the shortage of doctors; (ii) more nursing graduates may be posted in sub-centres; (iii) intake of nursing graduates may be increased in the nursing schools; (iv) to meet the immediate demand, graduates and post graduates in the AYUSH stream may be appointed.
