

Alternate Service Providers for Primary Health Care:
- **The rationale and design elements of the three year BHRC
(Bachelors in Rural health Care) course:**
o **T. Sundararaman**

Abstract:

The crisis in human resources for health is one of the main causes for the inadequate performance of the public health system. One dimension of the crisis is the poor availability of skilled services providers in many of the more challenged states. The other dimension is the challenge of attracting and retaining the services of skilled service providers in rural and remote areas of the nation. Regulatory measures and incentivisation schemes and improved workforce management practices would be useful to reduce this problem and are being tried, but international experience and preliminary national experience is suggestive of educational measures as being the most effective in the long run. This three year course called the bachelors in rural health care is such an effort. To achieve its objectives it is not so much the duration of the course which is critical but the other essential elements of its design: a) training on a well defined package of essential skills, b) selection bias and teaching approach which builds in rural preference- including teaching the course in the state languages, c) a conditional licensing to practice only in the public sector and only in such areas and building a positive practice environment for those working there and d) a new pedagogy that is able to give professional pride and focus to primary health care. The course is neither a back door entry to medical practice, nor is it the provision of a poorer quality doctor for rural areas. On the contrary it adds to the posts already existing for doctors in rural areas and provides a more appropriate primary health care provider who would be professionally and personally more satisfied with such practice.

Keywords: *Human Resources for health, rural retention of health professionals, rural medical practitioners, rural health care providers,*

The Context:

Despite steady improvements, India's health status remains a matter of deep concern. By international comparisons, for the same level of poverty and for much lower levels of economic growth, many other nations have achieved a better health status.

Two major reasons for this situation are very low levels of public health expenditure and the acute shortage of human resources for health care. In both these areas India remains amongst the weakest in the world. Total health expenditure in India is at 4.5 % of the GDP, but public health expenditure is estimated at 0.9% to 1.2 % of the GDP. The public share of total health expenditure is only about 22% and this figure is one of the lowest in the world ... only about 8 countries in the whole world are lower. In the nineties this low public health expenditure could be partly explained by the fiscal crisis and the lack of resources for the health sector. But this decade the economy has been buoyant and the funds are potentially available. However the public health system has been unable to absorb these funds, and one of the main reasons for this has been the inadequate number

of skilled professionals and managerial cadre in the system. Internationally about 50% of the health budget would go to paying salaries for its staff, and where staff is so depleted, and turnout from professional colleges are so inadequate, it becomes almost impossible to catch up.

International experiences suggest a minimum density of 250 health professionals per 100,000 populations to achieve basic public health goals¹. The most liberal estimate would show current Indian health professional level levels anywhere between 80 to 140 health professionals per 100,000 population. It is estimated that in order to reach these international norms we would at the very least, require, 6 lakh additional doctors and 12 lakh additional nurses.

The problem in India is further compounded by the tremendous skew in distribution of existing human resources for health and even in the generation of new resources.

The figure below (see at the end of the lesson) taken from the study by Krishna Rao and Peter Berman shows us how the skewed level of achievement in basic indicators such as institutional delivery and infant mortality correlates closely with the densities of skilled health professionals available in states.² The same pattern of achievement would also be seen in population stabilisation, where a large number of states have achieved or are well on the way to achieving replacement rates of fertility, but just nine states lag far behind.

These northern, north eastern and eastern states which are poor performing on health indicators and which have the poorest health human resource densities are also precisely the same states which have the least medical and nursing colleges. Over 70% of the seats in medical and nursing education are situated in just the six southern and western states.

The problem of attraction and retention in rural and other under-serviced areas.

The problem is not only those of numbers. Just adding to the numbers would not solve the problem of access to health care providers unless the huge urban-rural imbalance and within this the challenge of more remote rural areas are also simultaneously addressed. Though we have a doctor population ratio of about 1: 1507 at the national level, we are still struggling to have a doctor physically available in many rural primary health centres serving a population of 30,000 population and where no other qualified private provider is available.

For most of India's rural areas, the public health system remains the main hope. The qualified formal private sector has almost no penetration into rural areas. The public health system is however unable to attract or retain skilled professionals in rural areas. The reasons for this are not difficult to seek. The majority of medical students come from urban middle class backgrounds and tend to perceive entry into the medical profession as an opportunity for upward social mobility. The orientation they receive in the medical schools, and their role models there reinforce the need to practice a form of medical care which is technology intensive, specialist curative care and where working with preventive and promotive aspects of primary level curative care is considered to have a very low professional status. Their demands for working conditions in rural health facilities are exacting, but even where it is made available, their urban aspirations, the problems of social and professional isolation and the cultural gap between providers and the people they serve, limit their ability to serve as primary care physicians of the poor. Absenteeism and poor performance plague the system.

Several countries have achieved the deployment of one medical service provider for a population of 5000. In India, we currently base health care provision at the 5000 population unit through a trained nurse- midwife (pre-service training of 18 months) supported by minimally trained community health volunteers. This is barely sufficient even for delivery of RCH services, but if our goal becomes comprehensive services then we could hardly make do with the 18 month trained ANM. There is a case for a doctor at the level, and the only reason we are not able to propose a doctor at this level, is because we are so hopelessly short of achieving a doctor even at the one per 30,000 PHC level, especially in the northern and north eastern states, where the gaps are the most.

Strategies to fill rural vacancies

A recent review by World Health Organisation of the strategies to retain skilled professionals in rural and remote areas, categorises the strategies into four groups³:

- a. Regulatory strategies: various forms of compulsion and licensing arrangements that makes rural service mandatory. In India the most common approach tried is rural service bonds made at the time of admission into medical colleges. Tried over the years, this has almost always failed.⁴ Mandatory rural service as a condition for post graduate admissions, have helped to attract doctors to rural areas, but failed to retain them. Also young doctors obliged to give such service, while preparing for post graduate admissions may often get a person notionally available, but not in body and spirit. This closely matches with the international experience too.
- b. Incentives: These could be financial or it could be non financial- like better promotion opportunities, or marks in the post graduate entrance examination. In India we have many examples of such efforts, but very little evidence as yet as to whether it works. It is still too early and we need to implement many proposals and stay with it for some time. International experience however suggests that though it may provide succour to those already posted in such areas, there is little evidence that actually doctors or nurses are retained in such areas attracted by the incentives. If at all it has to make a difference then the incentives have to be quite high to make such a difference. In India though in principle it is almost always conceded, in practice there is great reluctance to implement, because of concerns of parity with non health employees. Also perhaps, because it is the most powerless within the professions who are posted there and there is reluctance from the powerful within the system to make them the greater beneficiaries of the system.
- c. Positive Practice environments: Another set of measures which have helped is building a positive environment through workforce management policies. In India greatest attention has gone to putting in place fair and transparent posting and transfer policies, such that every public doctor and nurse gets to do a term of rural service. In practice, this too has been easier said than done, due to huge governance constraints and the relationships of power alluded to earlier. Another set of measures that has worked internationally is to develop programmes of interaction with the community and distance education and skill upgradation such that it breaks the professional and social isolation that the urban doctor in a rural milieu faces. This measure needs to be tried out in India, and though by itself would be insufficient could contribute to achieving this objective.
- d. Educational Strategies: The most successful approach internationally has been to develop a professional education strategy that develops a set of health professionals, specifically

selected, trained, licensed and deployed to work in rural and remote and other medically under-serviced areas. Other measures like compulsion and incentives and rotation of workers may force a provider to go to the rural area, but are inadequate to secure the bond of trust between community and the provider. Effective primary health care needs more than just any doctor physically present for a few hours. It needs a relationship with the community, a set of skills that make him or her effective and an attitude where the provider feels rewarded and successful in providing this level of care. The health care provider must want to serve there and be rewarded in doing so. Increasingly there is recognition that in order to achieve this goal of the “right person with the right set of skills in the right place”, we need to turn our attention to reform and innovation in medical education.

The Evolution of the Concept:

Reforms and innovation in professional education is not a new concept. 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 first of these was in the Bhore committee⁵ itself which finally decided against continuing with the three year course, as it expected the 5 year course to become available so widely that the number of doctors needed to reach a deployment at 1 per 5000 population would become possible. That was overly optimistic, but such was the mood of the nation. By the 1960s we were already realising that the increase in numbers did not result in their rural availability.

The most recent of these efforts at medical education reform was the study group of the Medical Council of India set up in 1999 under the chairperson Dr GP Dutta, a former president of the Indian Medical Association and for long the editor of the IMA's professional journal. The report on the alternative/Innovative model of medical education was approved by the executive committee⁶, 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. This was essentially a proposal for revamping the five year course. This study and its recommendations got revived in the context of the proposal for a renewed three year course. A study group of the Medical Council updated the model in December 2009 as a three year course syllabus⁷ and held a wider national consultation in early February 2010, which enabled finalisation of the main features of the approach.

The proposal also draws support from the Task Force on Medical Education of the National Rural Health Mission. This Task Force chaired by Shri Javed Chowdhury, submitted its report in 2006.⁸ Endorsing the idea of a three year course the task Force laid down certain important qualifiers. One important qualifier worth quoting is that –

“The variant examined by them is not of a short-course health practitioner with an open license to practice in the entire universe of Allopathy; the option under examination is of a short-course training after which the practitioner would be licensed to provide medical services within a notified package of primary healthcare.”

Also that it is the considered view of the Task Force that in the suggested scheme (the short duration course) the risk of quackery would stand reduced, rather than increased. Also, it would result in good

quality primary healthcare services being delivered to the citizenry on a much wider scale than is available through graduate doctors today.”

In parallel to these developments at the national level states had also been working on this concept.

West Bengal was one of the pioneers in this effort, but it soon got snagged in legal issues. With great effort this was revived and a bill that gave legal sanction for this was approved, but this bill has of date not got national sanction.

The Chhattisgarh story⁹ is much more insightful of both the strengths and pitfalls of this approach- and a full length documentation of this is available for reference. In short, the three year course was started off in a hurry, and overcame the first legal challenge by declaring itself a course in alternative medicine. This claim became unstuck when its students demanded to be recognised as doctors and when it was obvious that the course was anyway around modern medicine. A legal bill Chhattisgarh Chikitsa Mandal Bill 2007, was passed, but this was never utilised for the course. On the other hand a paramedical council bill which allows paramedics to give such remedies as they are trained to give provided some support. Eventually, through a process of negotiation, it was decided to absorb these students as “Rural Medical Assistants” in primary health centres without doctors and this proved to be an amicable solution. Many PHCs which had never over 50 long years ever been able to get a doctor, now had one, and for the first time the vacancies in PHCs were closed. But these were not open to private practice, nor formally given the title of doctors. A recent rigorous study showed that for all primary health care services, their knowledge and skills were on par with that of the MBBS doctor and patient satisfaction was the same¹⁰. Clearly the lesson was that if policy planning is able to separate the trend to make the three year course a back door entry into medical private practice, from the need to use the three year course as a way to get doctors to man the peripheral public health facilities in remote areas, then this approach would be successful and useful. But where it cannot, it fails. At the time of writing, the course in Chhattisgarh had been discontinued, but with the renewed understanding of the BHRC programme, the state would like to get this programme back on rails.

In Assam, which had the benefit of Chhattisgarh to learn from, the three year course was started with legal support, clearly distinguished from the five year medical course and becoming a doctor, and opened only to candidates selected from rural areas, and licensed only to those who would work in public service in rural areas. The response this time around has been positive and traditional professional resistance to this has been negligible.

It is in these backgrounds that we may now consider the proposed design of the three year “Bachelor in Rural Health Care course” . This course is conceived as a reform in medical education specifically aimed at generating a cadre of health care providers who by virtue of the way they are chosen, trained, deployed and supported, would be motivated to live in and provide comprehensive primary health care in rural areas.

The Conceptual Framework:

There are four design principles on which this BHRC course is mooted:

1. **The essential skills package:** The skills needed for the provision of comprehensive primary health care can be provided without any compromise to quality in a three year period. The present MBBS course has a number of areas of knowledge which are suited for laying the foundations for becoming specialists and teachers of medical science, but which are not essential in creating the primary care provider. Such foundations of medical science as needed would however be an integral part of the curriculum. Underlying this is a principle that any person can provide the skills that he is trained and certified to be able to provide. It is only because in licensing as a doctor, we sort of give an unlimited license to do whatever he thinks best for the patient. That does not apply to the three year course- there is a specific set of skills that the person is certified for and practice remain within this set.
2. **A pro-primary health care pedagogy:** Teaching of the rural health care provider should occur in settings similar to where they would have to live and work. Their role models would be primary care physicians serving communities with the limited tools available, rather than specialists focussed on addressing a very limited range of diseases with an impressive, almost awesome array of resource intensive technological tools . The pedagogy would ensure that these rural health providers would be competent in a set of essential skills (listed in annexure) , with no compromise in quality. In addition their training would ensure that there is a high professional status given to prevention and promotion of illness and relief of suffering in the patient as a whole and that this is built up as a central value and aspiration. Creating such a faculty would of course be a challenge. Increasing the number of family medicine post graduate could help, but that is also a long process. Faculty development would remain a major challenge, but shifting the site of teaching to the district and sub-district hospitals would help.
3. **A selection bias and teaching approach which builds in rural preference:** The selection of students should be preferentially from communities that live in these under-served areas, and who would be comfortable in continuing to stay and work there. Studies from both India and abroad show local preference and community affinity as one of the most important drivers of rural preference for posting. The language of teaching must be the state languages, thus giving further access to students from these areas, and a greater likelihood of their staying within the same state after their education. (Thailand for example solved its entire problem of massive emigration of its medical professional by shifting medical education to the Thai language!!).The educational institutions would also be located within the same district or cluster of districts. A recently concluded detailed ethnographic study done in Chhattisgarh looked at that sub-set of medical doctors in public service who chose voluntarily to live and work in remote and rural areas. Though as a percentage such doctors are a minority, in absolute numbers there are many and by understanding why these doctors are different, policy on retention on skilled human resources for rural areas could be informed. The study showed roots in the local community and area as the single most important determinant- though there were many other determinants too that could be

learnt from. Basing itself on these insights, which are matched in international experience also, the insistence for the three year course, is that the candidates should have completed schooling from within that district itself.

4. **Conditional Licensing and positive practice environments:** On completion of the course the licensing of the graduates should specify exclusive practice within the public health system and in rural areas. The main facility where they would be posted is health sub-centres, especially in those where access to larger health care facilities is difficult. There was one suggestion considered that after five years of service these rural health providers would be eligible for entry to bridge courses which would over an additional three year period of training qualify them for MBBS certification. However the consensus currently is against such a modification- and as yet not allows any formal link between the two courses. The postings of these three year graduates would also be prioritised for those areas where it is presently difficult to get any doctor to serve. These rural practitioners could be provided with referral electronic and transport linkages to more qualified doctors and specialists to provide consultation and referral support to them. They could also be organised into mutual support groups and networks and provided the service conditions that would enable a positive practice environment..

Such a programme design recognises that there are two powerful drivers for expansion of medical education. One is to provide quality health care to increasing numbers of people to as close a place as they live and work and the other, is to provide access to families for sending their children into a professional education that would lead to an upward social mobility and a secure and economically remunerative vocation. These two drivers often work at cross-purposes and for millions of families the latter purpose is more important. Thus however laudable the intention of this course, there is a danger of perceiving this course politically as an opportunity for a back door entry into the medical profession and the graduates could eventually end up in urban nursing homes, providing assistance to specialists working there. Recognising this, the design of this course should consider all four of the principles enunciated above as equally important. It is not just the reduction of the duration from five years to three years that distinguishes this scheme, but all its other essential features as well. For students coming from under-privileged areas and backgrounds, even a three year course would be an upward social movement and the limitations caused by the pedagogy and the language of instruction and instruction received in rurally located institutions, and a secure albeit rurally located government job would be an attraction and not a limitation. But for the majority of the urban middle class, who aspire for a medical education, and a lucrative private practice it would not be as attractive an option. The opportunities for emigration would also be much less.

The scheme also recognises that such an approach should not trivialise the health care needs of the rural population, which are no less than that of the urban population, and often a great deal more. Nor is this an expedient of having to provide two different qualities of health care – one for rural and one for urban. Getting a doctor, to somehow work in rural areas does not achieve the goal of universal access. What one needs is to get the right person to provide the right service in the right place. This scheme aims to provide a three year trained health care provider who has more appropriate skills, and attitudes and motivation for this task, than the current MBBS doctor, thereby leading to improved health care provision in rural underserved areas. . There is a case for such a primary health care physician in urban areas as well. However given the urgency of addressing the

rural gap, where there are no other alternatives currently, reduction of this gap takes priority over urban needs.

Finally, this scheme does not propose reducing the current commitments on MBBS doctor deployment in the public health system. The primary health centre would continue to be led by the MBBS doctor. It is the sub-centre which is presently staffed by an 18 month trained nurse-midwife and a male worker with even shorter duration of training, where this rural health care graduates is to be located.

Challenges before the Scheme:

Constructing an appropriate pedagogy and a faculty that could impart it would be one challenge that this programme would face. A mechanical reduction of the current five year curriculum, with its underlying logic of basic, paramedical and clinical sciences would be most inappropriate. What is needed is a skill based problem solving approach to meet the bulk of primary health care requirement, which also teaches enough of the underlying principles of medical care. There are many professionals who have worked both in medical education and with local communities for long periods of time, and who have critically reflected on the problems of current medical education and practice. The state would need to carefully identify and empower such professionals for delivering on this task.

Conversion of the current district hospital and faculty into sites of an alternative framework of medical education would represent another major challenge. Hostels, class rooms, teaching aids would all have to be created from scratch and that too in underserved districts where currently district hospitals are very poorly functional This would need substantial investment, as well as organisational effort- but the collateral gains for better secondary and tertiary care in the district level would make it well worth the effort.

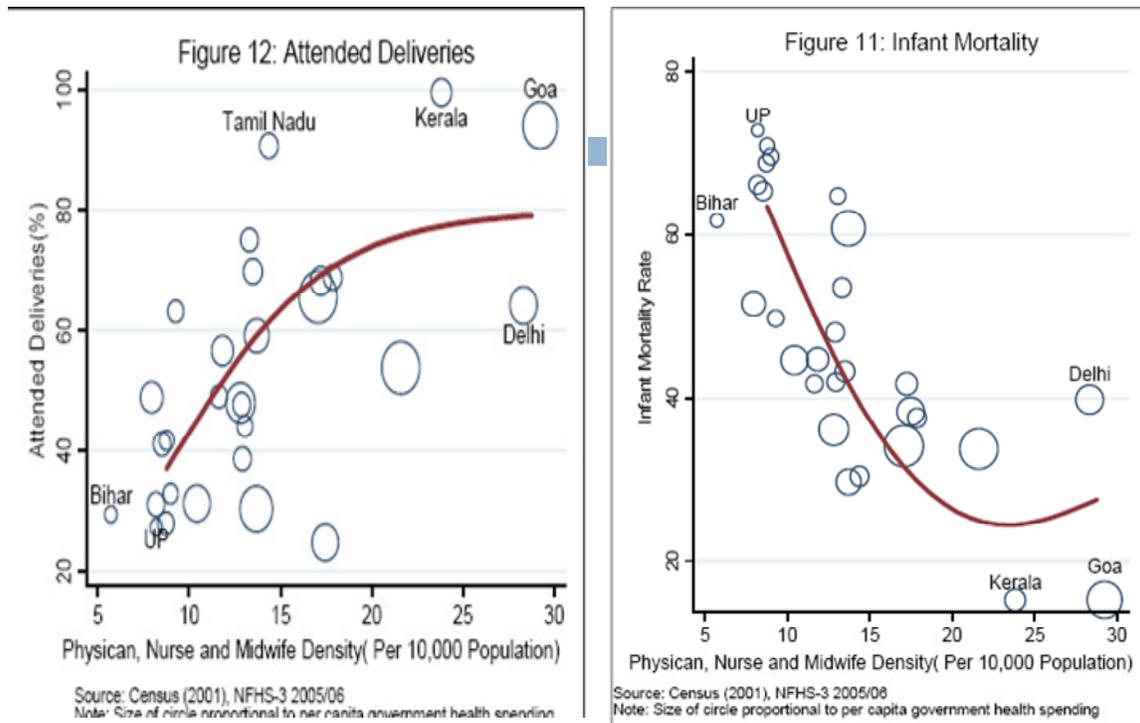
Once the course is rolled out, preventing a gradual or abrupt reversal of the key principles of design- especially the rural preference for selection of candidates, or the commitment to conditional licensing for service exclusively in the public sector and that too in underserved areas, and needless compromises on pedagogy, that would reduce useful and critical skills, would remain a challenge. Only a well informed professional and civil society support could prevent such reversals.

Curiously it is only political will that is pushing this programme past hesitations and resistance from some professional and civil society sections. But at a later stage, when political expediency could call for dilution, it would be precisely these sections that could safeguard the original design and purpose of this bold initiative. If scaled up systematically and efficiently, this reform has the potential, more than any other to make for universal access to comprehensive health care a realitywithin our lifetimes.

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Figure 1.



Is this norm valid in India:

India's Health Workforce – Size, Composition & Distribution ;PHFI & World Bank