Anybody ill here and seen a doctor yet?

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GLOOMY PROGNOSIS: For the hardship that rural doctors have to endure, government service offers relatively little in terms of quality of life. Photo: Singam Venkataramana

Addressing the scarcity of medical practitioners in rural India is fundamental to achieving universal health care in the country

The Planning Commission’s draft 12th Plan for health has attracted much debate and controversy. Critics have been quick to direct their attention at two issues in it — the proposed increase in government health spending from one per cent to 1.58 per cent of GDP, and the “managed care model.” The spending increase was rightly felt to be grossly inadequate to move India towards achieving universal health care. The “managed care” model was expected to relegate the government’s role to a purchaser of services and undermine its role in the service provision. By focusing on these two issues, the debate on the 12th Plan for health, and indeed the Plan’s approach paper itself, ignores some of the more fundamental obstacles to achieving universal health care in India. For one, the scarcity of rural doctors currently prevents the delivery of even basic clinical services to needy citizens. Simply spending more or changing the way health services are purchased will not solve this problem.

Urban-rural divide

People deliver health services. Urban Indians can be forgiven for thinking that there are enough doctors in the country. Indeed, our cities are abundant with all manner of clinics, diagnostic centres and hospitals. But having a qualified doctor nearby is a rarity for the vast majority of Indians who inhabit the country’s rural spaces. According to the 2001 Census, there is a tenfold difference in the availability of qualified doctors between urban and rural areas i.e. one qualified doctor per 8,333 (885) people in rural (urban) areas of India. Addressing this rural scarcity is fundamental to efforts for achieving universal health care in India.

There are several notable reasons why doctors are reluctant to serve in rural areas. Fundamentally, the professional and personal expectation of medical graduates is not compatible with the life of a rural doctor. Their ambition lies in becoming medical specialists. Once they specialise, the professional, income, lifestyle, and family life opportunities in cities make rural jobs unattractive. Moreover, with private medical schools and their high fees dominating medical education, it makes little sense for medical graduates to take up jobs that don’t offer them the opportunity to recover their investment.

The scarcity of rural doctors places an important responsibility on the government. However, its efforts to place government doctors in rural posts have been largely unsuccessful. For the hardship that rural doctors have to endure, government service offers relatively little in terms of remuneration, quality schooling for their children and a chance at a decent family life. Human resources in the State health services are also poorly managed.
For instance, there is little transparency about transfers and postings because they are a source of both corruption and political patronage in the health system. Absenteeism is another issue. Indeed, most of the court cases facing State health departments have to do with human resource issues. However, given the professional and personal expectations of doctors, it appears unlikely that large increases in salaries and management changes will attract adequate numbers to government jobs and rural posts.

**Situation abroad**

Interestingly, many high, middle, and low-income countries also face a scarcity of rural doctors. Many of them have ameliorated this problem by using non-physician clinicians to deliver basic health services. In the United States, the United Kingdom, many countries in Africa, and even in South Asia, individuals such as nurse-practitioners or medical assistants, who have some years of basic clinical training, perform many of the clinical functions normally expected of fully qualified doctors. In sub-Saharan Africa and many parts of Asia, clinical services in rural areas are possible only because of these non-physician clinicians. They provide a range of clinical functions, including basic clinical services, manage deliveries, caesarean sections and abortions. Importantly, assessments from a variety of settings have shown that they perform as well as doctors.

**Clinician cadre**

India, however, has had an uneasy relationship with mid-level clinical cadres. At the time of India’s independence, licentiate medical practitioner (LMP)s, who underwent three years training, comprised nearly two-thirds of the qualified medical practitioners (the other one-third being doctors) and they mostly served in rural areas. LMPs were abolished after Independence but doctors never really occupied the space that LMPs vacated. Now, the shortage of rural doctors has forced some States to look towards non-physician clinicians for relief. Clinicians with around three years of clinical training currently serve at government rural health clinics in Chhattisgarh and Assam. Importantly, assessments of their performance in Chhattisgarh have shown them to be as competent as doctors for delivering basic clinical care. And because their training focuses on serving as rural clinicians and their career ambition is to have a government job, these clinicians, as the Chhattisgarh experience shows, have a greater likelihood of staying and serving in rural areas. The Central Health Ministry has proposed to expand this clinician cadre nationally through the Bachelors of Rural Health Care (BRHC) course. Unfortunately, expanding this cadre has met with considerable opposition and a former health minister even labelled them as “qualified quacks.”

The road to universal health care in India necessarily requires a serious assessment of basic problems that afflict the health system like the lack of human resources in rural areas. While this piece has focused on doctors, the rural scarcity of other health worker cadres such as nurses, lab technicians and pharmacists is equally acute and equally deserving of serious attention.
Higher government spending on health or how health services are purchased will do little to ensure that all Indians have health care if there are inadequate numbers of trained health workers with the right skill mix. The experience of other countries and two States in India show that non-physician clinicians, whether they are three-year trained clinicians or nurse-practitioners, can be part of the solution.

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