TIF - The National Medical Commission: A Renaming or Transformation?

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An elderly man walking to a Primary Health Centre in Tamil Nadu | Mohan Kumar (CDC Global) from Wikimedia (CC BY 2.0)

Medical education in India has been beset so far by scandal. In medical practice, professional bodies have been opposing plans for a mid-level professional. Can the new National Medical Commission reform education and regulation to enable better healthcare?

In a much awaited and what is certainly a major change in how medical education and practice will be regulated in India, Parliament in August enacted the National Medical Commission Act 2019.

We now have the new National Medical Commission (NMC) as the regulator because the Medical Council of India (MCI) that had been mired in corruption slowly imploded and self-destructed over the years. While the Government lauds itself on enacting the legislation establishing the NMC and others have critiqued its shortcomings, the fundamental issue really is the impact the NMC will have on the delivery of effective healthcare to our fellow citizens. In other words, is the new NMC a game changer, will it nudge medical reform in the right direction or is it just another symbolic move by the state with business as usual on the ground?

There are about 529 medical colleges in India, almost half of which are state run. These colleges churn out nearly 80,000 MBBS graduates every year. In a recent development, the Government has declared that it will be setting

up 75 new medical colleges in three phases, adding another 15,000 seats to the current number.

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In addition, there are about 30,000 new graduates trained in Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) every year, many of whom make up a potential workforce for delivering basic care. Whilst a poor doctor-patient ratio is a reality in India, the greater challenge is the rural-urban divide, and the poor training and quality of the new graduates.

Becoming a doctor at all costs is a huge aspiration as it not only guarantees income but also social status and upward mobility. The demand for a medical seat is therefore still very high in India. The conundrum for the state has been how to harness and channelise this intense demand through appropriate training to create doctors who will be sensitive to healthcare needs and who are capable of delivering care where it is needed.

Before we delve into the evolution of and issues related to the NMC, it must be noted that the promulgation of the NMC has rankled the largest association of India's allopathic doctors, the Indian Medical Association (IMA). Normally an influential body, the IMA has in the past been able to stall several reforms in the health sector. For the IMA and most allopathic doctors, the contentious issue in the NMC Act has been the provision for community health workers, who will be mid-level healthcare professionals. This time around, the Government has ignored the IMA's opposition and pushed the NMC Act through.

All in all, the NMC with minor modifications will now operate to provide the framework for medical education and the regulation of practice across India. Thus, its importance is far reaching for the health of our people, many of whom continue to be deprived of basic care.

Medical Education in India – A Brief History

What is history? An echo of the past in the future; a reflex from the future on the past – Victor Hugo

For centuries, healthcare in India was largely delivered by traditional providers and the AYUSH group of alternative systems, as they are now designated, continue to play a major role in providing care. Western medicine entered India along with the East India Company in the year 1600. The regulation of such services started in 1775 when the Commander-in-Chief of the British Army established the offices of the Surgeon General and Physician General. A decade later, medical departments were set up in the three British presidencies of Madras, Bengal and Bombay. Regulation of healthcare took a major turn with the Uprising of 1857, which led to the establishment of the British government in India. Along with it came services like the Indian Medical Service, Central and Provincial Medical Services, the public health commissioner, and the like. In 1869, medical departments in the presidencies were subsumed into the Indian Medical Service.

While all that was happening on the regulation front, allopathic medical education in India started with the setting up of the Native Medical Institution in Calcutta in 1822, which trained 20 Indian students in western medicine. The British also facilitated teaching of Unani in the Calcutta Madrasa and Ayurveda in the Sanskrit College, Calcutta, in 1826.

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However, aspersions were cast on teaching indigenous systems of medicine and Governor General William Bentinck set up a committee to look into how Indians could be trained in western medicine. The committee criticised the practices of the Native Medical Institution and suggested that the state set up medical schools that would teach all branches of medical science as in Europe. In 1835, the Native Medical Institution, Calcutta Madrasa and Sanskrit College folded up and in the same year the Calcutta Medical College was established.

Around the same time, events in Bombay Presidency led to plans for establishment of a medical college to address the healthcare needs of Indians who died in large numbers due to lack of medical care. The Grant Medical College was set up in 1843. There were two levels of instructions in the college. A longer one to become doctors and a shorter one to become medical subordinates for British government services. A medical school established in Madras in 1835 started by conducting different 2-year courses to train Indians.

By the 1850s, university affiliated medical schools had been opened in various provinces. However, by the end of 1877 less than 3% of medical practitioners were trained in western medicine. The rest practiced indigenous systems of medicine. In what can be termed as a clash of cultures and also owing to the Independence movement, traditional or indigenous systems of medicine were at loggerheads with western medicine. The latter received state patronage and the former was seen as of a second class. This historical evolution has a bearing on the current state of affairs and will help us frame the issues that have cropped up with the establishment of the NMC.

Enter the Medical Council of India

We are now certain that the MCI is a den of corruption — Supreme Court of India (2001)

The formal establishment of a medical education regulator in India took place when the MCI was set up in 1934 under the Indian Medical Council Act, 1933. Modelled around the British General Medical Council (GMC), the MCI with its own constitution was a classic model of self-regulation that had been globally accepted. Many bodies like the GMC in the United Kingdom (UK) continue to play this role effectively. But, alas, the MCI soon became an unchallenged entity regulating a scarce resource like medical seats and was involved in one scandal after another.

Simultaneously from the mid 1970s, India saw the introduction and growth of the private medical college sector. Many of these private colleges lacked the necessary infrastructure but had money and political connections. Soon this became a gravy train for those running the MCI.

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Things came to a head in 2010 when the then President of MCI, Dr Ketan Desai, was arrested and jailed on charges of receiving a bribe of Rs. 2 crore for granting permission to a particular medical college. That the

Supreme Court of India labelled the MCI a "den of corruption" was just another nail in its coffin. While inspections of MCI had become a dreaded experience for private medical colleges, government medical colleges wallowed in mediocrity. With the curriculum unchanged for decades and no focus on outcomes, the large number of MBBS graduates that the system churned out lacked basic competency.

Beginning from 2010, through various Bills and Ordinances, the government of the day toyed with reviving and refreshing the MCI, including by setting up a Board of Governors to oversee the working of the MCI until a new regulator emerged.

After the Ranjit Roy Chaudhury committee of 2014 suggested reforms of medical education, one of the first things that the new National Democratic Alliance (NDA) government, which took charge in May 2014, did, was to examine overhauling of the MCI. In September 2015, the Parliamentary Standing Committee on Health and Family Welfare while endorsing the Ranjit Roy Chaudhury committee's recommendations gave a damning report on the failure of the MCI in all its mandates. Later, in May 2016, the Supreme Court of India ordered the establishment of an Oversight Committee, which officiated MCI activities.

The NITI Aayog's role in shaping the replacement of MCI was crucial. In a report submitted in August 2016, the planning body, taking into account mainly the reports of the Parliamentary Standing Committee and the Ranjit Roy Chaudhury committee, proposed for the first time, the establishment of a new regulator, the NMC.

MCI to NMC – Nomenclature or More?

The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking. — Albert Einstein

With the MCI dissolved and the NMC with a new member structure taking its place, we need to examine how the new structure and workforce will make regulation efficient, transparent and yet avoid harassment.

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As a departure from the MCI power structure, the NMC will comprise a chairperson and 10 ex officio members. It will, however, have greater union government representation and 22 part-time members, most of whom will represent state medical councils. As a welcome step, the Act makes it compulsory for all members to declare their assets and liabilities before and after their tenure in the NMC, as also their professional or commercial engagement. While the Act states that the chairperson and members would be barred from holding posts in a private medical institution after their tenure in the NMC, there is also a caveat that such an appointment may be permitted by the central government.

Though the NMC proposes "no harassment"during the multitude of "inspections" of private medical colleges, it will have to spell out how it will assess medical colleges on their training capacity, rather than nitpicking on infrastructure that was the norm earlier.

There is no question that on the face of it, the new structure is both less democratic and less federal. This is because of the nomination structure where the Government has a bigger say and because the turn for representation of each state will come only once in three years. Of course, it needs to be noted that though the previous MCI had more elected members from various states, it was a collective disaster with no evidence of the members trying to change its direction. Whether this leaner avatar of the MCI in the form of the NMC will be

transparent, impartial, free of corruption and improve efficiency remains to be seen.

The Case for a Mid-Level Healthcare Professional

Keep your face to the sunshine and you cannot see a shadow. - Helen Keller

The idea of a mid-level healthcare provider to augment the current workforce and, more importantly, improve access in underserved areas is not new and has been implemented globally with success. In 2012, the MCI gave permission to the Chhattisgarh government to deliver a three-and-half year medical course, called the BSc in Community Health. This move gained significance since it undid what the Bhore Committee of 1952 did – abolishing the Licentiate in Medical Practice (LMP), the holder of which was a mid-level healthcare worker. It was only after a national consultation of medical education experts in February 2010 that the MCI gave assent to the Ministry of Health's plan for rolling out a Bachelor of Rural Medicine and Surgery (BRMS) programme. With a career progression plan suggested by the then Planning Commission (albeit eventually with a name change), this programme was approved for Chhattisgarh.

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As part of the regulations of this cadre, these healthcare workers were not to use the prefix 'Dr', the recruitment was to be strictly local, the career progression was limited to the district level, there was to be a service bond that tied the graduate to government service, and the scope of practice of the mid-level health worker was clarified. Despite the IMA dragging the Government of Chhattisgarh to court, the state introduced a Rural Medical Assistant (RMAs) cadre and with the first batch graduating in May 2006, successfully recruited them to man Primary Health Centres (PHCs) and health sub centres. While nearly 400 PHCs in the state did not have MBBS doctors in August 2008, they all had RMAs.

One study conducted by the Public Health Foundation of India, National Health Systems Resource Centre, New Delhi, along with the State Health Resource Centre, Chhattisgarh, showed that the competence of RMAs in treating the five commonest ailments encountered in a PHC was either at par or better than that of the MBBS doctors.

India is not unique in trying to attempt to build a mid-level cadre. The history of Physician Assistants (PA) in the United States (US) takes us to World War II, after which there was a severe shortage of doctors and such a cadre was therefore raised. The PA course, usually taken by paramedics and nurses, has flexibility in learning and as of 2017 there were more than 100,000 PAs in the US. In the UK there is a two-year bridge course in adult medicine and general practice. In New Zealand there is the Rural Health Development Programme, graduates of which work under a senior doctor and complement nursing and medicine. The Sub Assistant Community Medical Officer (SACMO) in Bangladesh and the Assistant Doctors in China are all examples of successful programmes of building amid-level practitioner.

> *In thus what is essentially a turf war, there lies a tremendous opportunity to change healthcare delivery.*

It was this provision for creation of a cadre of Community Health Workers in the NMC Act that pushed the IMA to take to the streets. This has been a major bone of contention for some time since the provision for a bridge course for AYUSH professionals was mooted in the original NMC Bill. The medical fraternity portrays this as legitimising quackery. But the reality is that the typical allopathic doctor who is today largely a specialist in training, aspires to work in the lucrative private sector in urban areas and is therefore not willing or likely to work in under-served areas. The IMA has no workable solution for this problem.

In thus what is essentially a turf war, there lies a tremendous opportunity to change healthcare delivery, especially in the vast swathes of hinterland India. A WHO report of 2016 stated that 60% of India's healthcare force catered to urban India where 30% of Indians live, while 40% takes care of the remaining 70%, who are rural dwellers. According to the Ministry of Health and Family Welfare (MoHFW), the urban to rural doctor ratio stands at 3.8:1. If the NMC can bring together bodies like the MoHFW, the Ministry of AYUSH and the Central Council of Indian Medicine, (CCIM), and plan a robust bridge programme that improves the availability of providers in under-served areas, it would both provide a competent mid-level healthcare professional as well as help weed out the large population of quacks.

Nowhere NEXT

`Uncertainty always creates doubt, and doubt creates fear — Oscar Munoz`

The case for an exit exam as made out in the NMC Act is curious. While usually an exit exam is meant to ensure a minimum level of quality, the proposed National Exit Test (NEXT) aims to achieve much more than that. There is a general consensus that the quality of a MBBS graduate churned out by a majority of Indian medical schools is below par and also extremely uneven. With many private medical colleges running with ghost faculty members and non-existent infrastructure and many government medical colleges operating with a severe shortage of faculty and dilapidated infrastructure, it is only natural that the quality of graduates varies sharply from one college to another.

When the first version of the NMC Bill was tabled, it had a provision for a National Licensure Examination or NLE which would be an all-India exam, qualifying in which would be mandatory to get a licence. This proposal met with resistance from the expected quarters, including the IMA, all of whom derided the proposal for yet another exam that an MBBS graduate would have to face. Even the Parliamentary Standing Committee on Health and Family Welfare expressed its reservations on this provision in its 109th report on the NMC. Facing opposition, the Union Cabinet in March 2018 dropped the plan and instead stated that the final year MBBS examination would serve as a licensure exam.

> *[T]he idea of making the current final year MBBS examination in India a licensure examination is steeped in confusion.*

A licensure examination is found in many countries, most notably in the US, which has been conducting the United States Medical Licensure Examination (USMLE) since 1992. However, the idea of making the current final year MBBS examination in India a licensure examination is confusing. For if it were to aim at a uniform standard of MBBS graduates, the examination needs to be uniform in nature, which is currently infeasible. The final year MBBS examination has both theory and practical components in four broad subjects (medicine, surgery, obstetrics-gynecology and pediatrics). How such an exam can be made uniform for all the 529 medical colleges in the country is not known.

Not just that, but in a surprising move this proposed NEXT will also serve as the entrance exam for the post-

graduate course in India. The logic of subsuming the current NEET-PG under the new exit exam is perhaps to save the MBBS graduate from having to take yet another gruelling examination. But here the framers have perhaps missed taking into account the purpose of the different tests. As the fundamental tenet goes, a test is as good as its intended objective. The objective of an entrance exam is to act as a differentiator. Selection for the post-graduate course is to filter tens of thousands of MBBS graduates for the 40,000 odd post-graduate seats that are currently available.

While a licensure examination cannot test only the knowledge domain, an entrance test to the post-graduate course can do so. Testing all essential domains as part of the post-graduate entrance examination involves huge logistical challenges. And it is this logistical nightmare that makes one wonder how the NEXT will be conducted. The three-year implementation period can actually be used to build a system that will enhance the quality of medical education in the country.

Regulating fees

Virtue is more to be feared than vice, because its excesses are not subject to the regulation of conscience. — Adam Smith

Since the opening of the medical education sector to private players, the act of securing a MBBS seat by paying large sums of money has been mainstreamed. This has dented the “merit” argument against reservations in admissions.

In recent years, based on the Supreme Court of India guidelines and with the entrance examination for entry to the MBBS subsumed into a nationwide test called NEET, the “management quota” seats, as they were called, for which astronomical sums were charged, have been done away with. This has led to private medical schools increasing fees, often leading to meritorious students from economically weaker sections being unable to study medicine despite securing higher ranks in the entrance exam. All this leads to several perverse practices and is a major driver of corrupt practices, a glaring example of which was the Vyapam scandal in Madhya Pradesh.

The NMC Act proposes a departure from the current system: 50% of all seats will now have a fee cap in private colleges and deemed-to-be private universities, while admission to the other 50% would be decided by the NMC and/or the state governments, depending on under whose aegis they function. The Government claims that by this arrangement, with almost half the MBBS seats in the government sector, a total of 75% of the seats would have nominal fees, thus encouraging merit.

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The central government also claims that since the NEXT results and a rating of medical colleges (through the Medical Assessment and Rating Board set up under the NMC) will cause market forces to apply, institutions will regulate fees accordingly and not charge exorbitantly for the 50% of the seats under their control. However, confusion seems to writ large with Health Minister Dr Harsh Vardhan recently commenting that the “cap” or upper limit of fees would not be mandatory and that only “guidelines” will be issued to institutions regarding fee fixation. Only after the rules are finally inked by NMC will there be clarity on this matter.

One needs to look at the medical education landscape to understand the nuances of the issue. In an ideal world, the state should have been the provider of all medical education with a transparent board, optimal entrance exam, good quality teachers, top class infrastructure, etc. However, if this is not the case, the gap will inevitably be filled by the private sector. The private sector in India, however, has had a poor record owing to the deep

political affiliations of a vast majority of medical colleges, substandard facilities, abysmal teaching standards and outright corruption. The regulators are to share a large part of the blame. Since the goods (MBBS and post-graduate seats) are in short supply and the regulator corrupt, the market forces did not apply in a natural environment and the medical education ecosystem veered towards dysfunctionality.

One will have to see if the fee capping provision in NMC will set things right. We may not be able to wish away the private sector, where there are a few good institutions. Running a medical college is a capital-intensive process and private players will naturally seek profit from such an endeavour. We may need a cultural shift to accepting profit-making in the higher medical education sector in a tightly regulated form. Discouraging the private sector from earning profits may result in further deterioration of teaching standards, facilities and thereby the quality of doctors. One way the NMC plans to intervene is through the mechanism of the NEXT exam. Only time will tell whether this kind of tweaking of the examination pattern will result in substantive change on the ground.

Opportunity in Change

With the enactment of the NMC Act, healthcare in India is perhaps witnessing one of its biggest changes since Independence. The dissolution of the MCI was long pending. Its position and existence had become untenable. While there are plenty of questions that remain unanswered, a few of which have been deliberated in this essay, there are opportunities and possibilities that this move for a new regulator has opened up.

For example, in crafting a well-designed exit exam, the NMC can ensure that a minimum standard of quality is maintained, and medical graduates are sensitised to our health needs. There are sound international practices vis-à-vis licensing exams that the NMC can borrow from. There are plenty of medical education experts rooted in this country’s reality who could be taken on board to deliberate and decide on what is best.

In designing a robust bridge course and regulating the functioning of mid-level health practitioners, the NMC can help bridge a glaring gap in Indian healthcare delivery. The community health provider as envisaged in the NMC Act can function to provide succour to the under-served in India as well as address problems like the emerging epidemic of non-communicable diseases (NCDs). There are good in-house examples in Chhattisgarh and Assam, as well as multiple practices in other countries to follow and implement nationally.

By bringing transparency to the fee structure, the NMC can crackdown on corruption in this area to a large extent. Medical education India has been associated with substandard colleges, high capitation fees, deceit in allocation of management quota seats and in general a sense of fraud and scandal. The NMC has quite a task at hand to end these practices.

The NMC has the potential and opportunity to usher in a new era in medical education and practice, and, in turn, in healthcare delivery in India. But a regulatory body can only act and deliver within a facilitatory and congenial ecosystem that for healthcare involves the state, providers and even ordinary citizens. After all our health and well-being is too important an issue to be left to a single institution.

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