EDITORIAL

PHYSICIAN SHORTAGE: BOTTLENECKS IN FINANCING, MANAGING, TRAINING AND A RUSH FOR SPECIALIZATION

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Healthcare in India:

As described by the WHO, of the six building blocks of the health systems (service delivery, health workforce, health information system, medical products vaccines and technologies, health systems financing, and leadership and governance), the human resources for health are pivotal. In today's complex health systems, physicians are an integral and important component, which unfortunately, are routinely missing in our system.

This paper attempts a brief discussion and summary of various issues underlying this problem by moving forward from the Lancet paper describing the human resource situation in India. The total number of allopathic doctors, nurses, and midwives are about a quarter of the WHO benchmark of 25.4 workers per 10000 population. These averages hide more unnerving details. After within country geographical imbalance; a remarkable rural urban discrepancy is a defining feature of this health worker distribution. Though not so severe for nurses and other health workers it is quite prominent for doctors and especially so among specialists.

Various studies have brought out that the shortage of health workers in rural areas is because of both the disinclination of qualified health providers (especially physicians) to work there and the inability of the public sector to attract and provide adequate amenities in these rural health facilities. Studies have also explored the reasons for stay of medical officers in rural and remote areas and emphasize on the need of a broad agenda of social development including strengthening of public service systems.

The previous decades' structural adjustment inspired policies from the World Bank leading to low resources for the public sector goods have promoted a *laissez faire* healthcare system. The public healthcare system shackled to such policies has withered to providing barely skeletal services supported by vertical programs.Consequently, a flourishing private healthcare industry has come into being. While the urban areas at least have variety of providers specializing from expensive In Vitro Fertilization (IVF) and medical tourism to the cheaper slum quack; the predominantly rural India is devoid of any skilled providers and is completely at the mercy of unlicensed providers, quacks and faith healers. The

health “consumer”, left to the market for long, faces an expenditure on health care now as the single largest cause of falling into poverty.

This *laissez faire* health system had been the case in most of the developing countries, though recently there has been a strong (and often successful) push for a universal (public) health care system. Similarly in India, the steering committee of planning commission has also accepted a report of the High Level Expert Group suggesting a universal health care system in India under the 12th plan period.

Human resources for health:

India has roughly 270 medical schools, from which 28,158 doctors graduate every year. While these numbers translate into an average of 500 doctors per district per year, at the same time the specialist training opportunities are few. Also as described above, there is a great rural urban disparity in the distribution of these providers. *So there is a shortage of physicians, a severe shortage of specialist physicians and an extreme shortage in rural areas*.

Specialists

There is a bottleneck between the number of graduate MBBS and post graduate MD/MS seats. Due to a pressure of getting specialized training; considerable time (sometimes many years) is spent by graduate doctors in preparing for the few precious post graduate specialty seats. Interestingly, Postgraduate degree and diploma courses - MD / MS are considered “courses” in India while they are understood as training positions in other countries. This implies that to run courses permissions from academic bodies are needed coupled with more focus on “academic” facilities. In reality, less teaching takes place in lecture theatres or in demonstration rooms in these “courses”, majority of learning is in the ward rounds and clinical / surgical duties under supervision of consultants and most of the time is spent is on patient care. The implications are that though we have potentially numerous training facilities – many public and even quality private sector hospitals, we are unable to use these to train our specialists. Other countries have had reforms in medical education but we still continue with the way things have been in the past. The Medical Council of India (MCI) did initiate consultations but there hasn’t been progress. There is a lack of mainstreaming of Diplomate of National Board (DNB) trainings and courses like family medicine compounding the problem of availability of adequate number of specialists.

The implications of current training are apparent in the loss of clinical skills taught in medical schools, where students spend majority of their time preparing for the post graduate “PG” entrance examinations. This practicing of Multiple Choice Questions (MCQs) starts early on in medical schools and takes precedence over acquisition of clinical skills. Anecdotal evidence suggests that while graduate physicians in previous generations were quite capable of performing minor unassisted surgeries, a high proportion of the present medical graduates may never have put a suture in their 5 years of training.

EDITORIAL

Rural areas

As has been pointed out by various researchers, current medical training in India is a long process and is geared towards development of specialists. Specialists, whose needs and aspirations are far removed from the needs of the health system in the country. This may also be a reflection of changing societal norms which emphasize more on material possessions at the cost of values. This mismatch in aspirations and system needs lead to many sad outcomes including physician migration and attrition of doctors towards management and other careers which do not fully utilize the expensive medical training.

More central to the mere presence of a physician in the public system is the motivation of the said physician. Since their specialist colleagues enjoy comparatively higher salaries and better working conditions including staying in urban areas, the few non-specialists available in rural areas are demotivated. This reflects in the quality of care offered in the otherwise skeletal rural public facilities.

The nation's leaders when jolted with these realities of physician shortages, intuitively and as a knee jerk reaction, move towards a "stick" approach.The suggested measures include compulsory bonds for working in rural areas among others. What is not recognized here is the need of motivation in the workforce deputed to these underserved areas. The doctors working in the government sector are under paid. MBBS doctors working in a village under the state / Provincial Medical Service get a low salary of around 40,000 INR in Uttar Pradesh. This apart from causing low motivation in the first place, makes their prescription practices vulnerable to commercial interests (from pharmaceutical companies) and suggests them to start a prohibited private practice.

There has been an increase in number of medical beds and medical seats through proliferation of for profit private medical education. These private medical colleges often run by politicians are primarily focused on making profits and frequently do so by providing the bare minimum training facilities and charging exorbitantly high fees. So much so, that the going rate of MD/MS seats in sought after specialties could be in multiple crores of rupees.Indebted graduates from these colleges are surely not in a position to work for the public sector if they plan to pay back their fees. Thus, the current privatized and for profit medical education is not geared towards generating rural physicians.

Suggested Solutions

Even if the government recognizes the existence of a problem and looks for the measures to address it, it would take a while to correct this shortage. Due to prolonged nature of medical training it would take almost a decade to correct the imbalance in this supply of physicians. Health being a state subject it is feared that some of these suggestions would be implemented through multiple state governments at the risk of patchy, fragmented and piecemeal execution.

Some suggested measures include:

- Massive increase in healthcare funding for both medical education and medical care. Many new medical colleges have to be setup across the country to provide human resources to the massive number of new health facilities to be set up. The government through National Rural Health Mission (NRHM) has already embarked on its promised increase in spending to align it to around 3% of GDP. This still far below what developed countries spend (17% for US) and even the WHO recommendations (≈6%).
- MD/MS should be reclassified as training position (not a course), after working under supervision for a specified period of time the candidates can attempt specialty board exams for accreditation. Similar existing measures like the DNB need to be mainstreamed. Besides having an effect on miserly "stipends", this would increase the number of specialty training positions and would be in line with the number of medical graduates passing out in the country each year. This is the case in developed countries like the US where there are around 22,000 specialty positions for 16,000 medical school seats.
- De-stressing the role of specialization in medical education can happen when defined incentives, career choices and plans are in place for existing non-specialists. Existing practices of ad-hoc / contractual appointments and absence of promotions have to be stopped. Family medicine has to be popularized as a medical specialty with same career growth trajectory. This can provide an attractive alternative to existing specialties, as is the case in countries like UK.
- Wage reforms should be initiated to put the government salaries at par with the prevailing specialists' market rates in urban areas (at least for the short term). Additionally, staff working in difficult and hard to reach areas should be provided with a supplementary hardship / difficulty allowance which is a considerable portion of their salary. Projected (and promised) dramatically increased government funding would lead to salary expenses reduced to being a small portion of overall expenditures. Instances where lack of specialists to read CT scans and absent technicians to operate the expensive machines can thus be avoided.
- Amid staunch opposition from the Indian Medical Association, there have been attempts to start shorter Rural MB & BS type courses in states like Chhattisgarh. Recently MCI has

recognized a bachelor of community health course. While these attempts are a start more evidence is needed to ensure that these graduates stay in the areas where they are needed the most. Another aspect to it is that a supply of undertrained physicians may lead to the public losing hope in the quality of care offered in public facilities leading to a dip in the otherwise low attendances in rural public health facilities.

A unified national council of health which subsumes the functions of MCI and Ayurveda, Yoga, Unani, Siddha & Homeopathy (AYUSH) councils would help in issues related to accreditation of medical education, training and job responsibilities. This would also help in sorting out the current grey areas pertaining to permissibility of cross practice by AYUSH providers in light of its current need. Though the current medical council regulations recognize the specialty trainings received in selected western countries, defined career choices and plans for returning physicians from other countries would also be needed from the new unified health council.

This country has a shortage of doctors being trained; it takes half a decade for medical training; training which in itself is expensive. Then we have tens of thousands of these fresh medical graduates sitting at home for years and preparing for a "pg" entrance exam. This translates into millions of wasted physician hours every year in an under-served country. This state of affairs is unacceptable.

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