IMA's View Point on BRMS / BRHC

- Government of India has decided to introduce a short 3 years course in modern medicine called BRHC(Bachelor of Rural Health and Care) exclusively to serve the villages. Originally it was named BRMS (Bachelor of Rural Medicine and Surgery)

- This decision is under the pretext that doctors are not available in villages and with the full connivance of MCI (Medical Council of India), purportedly follows a questionable Delhi High Court directive.

- IMA strongly opposes this ill advised move.IMA questions the bonafides of such a decision.

- The full 5 ½ years M.B.B.S course equips the medical graduates to function as competent practitioners of modern medicine. Any deviation from the exacting standards and schedules will certainly pose danger to the society.

- It is understood that for this purpose medical schools will be started in District Hospitals. The recruitment of the students will be from rural areas and on completion of the course they will be obliged to serve in the native rural areas for five years. It is also proposed to give license to practice for one year which is liable to be renewed every year for a period of five years. At the end of the fifth year of service in the rural area, the graduate will be given permanent license to practice. Such graduates will also be given an option to undergo a bridge course so as to enable them to obtain the regular M.B.B.S degree.

- The value of human life in all areas is one and the same. Life of persons living in rural areas is as important as the life of persons living in the urban areas .There is no disease confined exclusively to the rural or the urban area either.

- There are better ways to overcome the shortage of modern medicine professionals in the rural area. Lowering the standard of medical education and producing low quality professionals is not the solution.

- In the process of introducing separate set of medical professionals exclusively for the rural India, the Government is infact resorting to discrimination against rural citizens treating them as second-class citizens. The same will be in flagrant violation of the fundamental right of the rural citizens of India to have quality health care. The discrimination could sow the seeds of discontent.

- Instead of rendering medical service to the rural population in a manner equivalent to that is available to the urban population, the Government itself is bringing out an inequality and irrational discrimination. This is violative of Article 14 of the Constitution of India.

- Since the matter relates to the life and healthy living of a human being, this infraction of the basic feature is also bringing about a violation of Art 21 of the Constitution of India.

- Any legislation in this regard which will be brought by the Union of India will be a colorable exercise of power and will be vitiated by lack of legislative competence. Any such course will be against the mandate of Sec 15(2) (b) of the Indian Medical Council Act.

- Any legislation that may be brought will not be in consonance with the directive principles of State policy enshrined under Art 38(2) and 47 of the Constitution of India.

- Public health being a state subject under Entry 6 List II of the Constitution of India, Government of India have no right to take any such policy decision to employ the BRHC professionals in the sub-centers, PHCs and District Hospitals situated in the rural part of India. It is for the state Governments to take decision in this regard. The decision taken by the Govt of India to introduce the course named Bachelor of Rural Health Care, which will enable the graduates of the said course to practice modern medicine in the rural areas is beyond the competence of Govt of India. It is unconstitutional, illegal and unenforceable.

- New medical colleges can be started with the same effort of establishing medical schools for introducing BRHC course.The existing medical colleges are hamstrung due to paucity of qualified faculty. Certainly it will be a difficult task to find trained faculty for the new course in medicine attached to the District Hospitals.

- It will dissuade regular doctors from serving in rural areas. If the service of qualified doctors is denied to the rural population, early detection of complicated diseases and providing appropriate treatment will be impacted.

- Suboptimal impact on disease burden in rural areas is not due to shortage in human resources alone. Vacillation of policy makers and their inability to choose between primary health care and vertical programmes is a serious flaw. More over inadequate strengthening of referral mechanism has resulted in a system failure.

- The Bhore Committee way back in 1946 recommended the abolition of LMP, to lay the foundation for the present day health care delivery system. The objective was to ensure same standard of health care to all citizens of India. The move to start three year short term BRHC course puts the clock back by sixty years.

- The responsibility of district health authorities is preventive and curative health care. Burdening them with training and teaching programme will lead to collapse of the existing system.

- The notion that over 20-30% of PHCs do not have a MBBS qualified doctor is not supported by statistics provided by Government of India. Only 5.3 percent of PHCs went without a qualified doctor. Even this is due to administrative inefficiency and exigencies. Efficient administrative practices by concerned Health department should suffice.

- To say that none of the 1,46,000 sub centers have a qualified MBBS doctor is a misrepresentation of fact to create a false case. The sub centers have been programmed to be staffed with one ANM and one male health worker only.

- For whatever small shortfall that exists compulsory rural health posting of MBBS graduates for one year after internship as practiced in Kerala would make available 30,000 MBBS graduates every year.

- It may be noted that none of the health documents of the country have asked for or planned a short term medical undergraduate course(Health policy 2002,Report of the national commission

on macroeconomics and health 2005,National Rural Health Mission document 2005).

- One has to have a holistic view of the situation rather than making scape goat of MBBS doctors. Poverty, Illiteracy, demography and good governance play a crucial role in the disparity and inequity in health care between urban and rural areas.

- In National Family Health survey-3, 84.5% of women in rural areas said institutional delivery was not necessary or customary or the family did not permit and only 1.1% complained about lack of female attendant in facility. This points to lack of health awareness rather than lack of MBBS doctors.

- National Human Rights commission has come out strongly against such a course and has termed it as discrimination.

- IMA strongly contends that there is any credible shortage of MBBS doctors to serve in PHCs. This has not been substantiated by data. There is no rationale need for creation of a short term course in modern medicine. This will only lead onto dilution of medical standards and will endanger patient safety.

- A qualified and practicing doctor is not the only person responsible for health care delivery. The role of the nursing staff,paramedical staff,health workers,laboratory technicians,pharmacists and other catagories of health workers is equally important. Producing substandard doctors in large numbers will only create mismatch of human resources. It is not the panacea for large shortfall in health workers, paramedics and laboratory technicians.

- Safe drinking water, sanitary toilets, environmental cleanliness, shelter, nutrition, personal hygiene, basic educational status of the public, social customs and habits and disease preventive measures are also major factors in improving the health conditions of the citizens of rural India.

- 15 (2) (b) of the Indian Medical Council Act, 1956 is the most decisive clause as far as setting standards for the practice of modern medicine. It is also pertinent to mention here that the requirement under Section 15(2) (b) of the IMC Act is similar to the requirement of medical qualification world over. Section 15(2) (b) of the IMC Act actually protects the fundamental rights of every citizen by ensuring adequate access to quality health care.

- Registered practitioners under other systems of medicine and the modern medical practitioners in the private sector have not been taken into consideration.

- 50% of the seats in postgraduates diploma courses are being reserved for medical officers in the Government Health services in all the states, who have served for at least three years in remote and difficult areas. After acquiring the PG diploma of two years duration, the medical officers shall serve for two more years in remote and or difficult areas.

- In determining the merit and the entrance test for postgraduate admissions, weightage in the marks may be given as an incentive at the rate of 10% of the marks obtained for each year in service in remote or difficult areas upto the maximum of 30% of the marks obtained.

- MCI has already approved the decision of its postgraduate committee with regard to reservation of 25% of the seats in postgraduate degree courses being filled through all India examination for doctors who have served for at least 3 years in remote and difficult areas with a rider that after acquiring the postgraduate qualification they shall serve for 3 more years in remote and difficult areas.

- Adequate allowances and facilities like rural service allowances, proper free accommodation, education allowances for children, vehicle or vehicle allowances, appropriate reservation for education and employment for their children, sabbatical leave for academic enhancement of Doctors, allowances for attending academic conferences for updating their knowledge, facility for interest free personal loans should be provided to doctors serving in rural areas.

- Full utilization of the private medical sector including out sourcing of investigative/ Diagnostic facilities and part time service in Primary/ Rural Health Centers.

- Encourage private participation in Rural Health care by offering free land, interest free loan, preference in water, electricity and other support facilities at concessional rates.

- Increasing the number of seats for MBBS and Post Graduate Courses in the existing Medical Colleges is also an option.

- Enhance budgetary allotment for Health care from the present 2.1% to 12% of GDP. If the funds are adequately allotted and effectively utilized manpower deficiency can be overcome and better health care can be provided. Wherever NRHM is working efficiently there is no dearth of manpower even now and health care delivery in the rural area has improved remarkably.

- Say no to BHRC and save our villagers.