For many observers, the period of 2012 - 2013 is the year of global economic slowdown and political uncertainty. Several policies directions rolled out during these years are likely to impact the health status of the people of India in the decades to come. Providing healthcare for a billion plus population has always been considered an impossible task for a developing country like India. India has been spending just about 1.2% of her gross domestic product (GDP) on the health sector, perhaps the lowest in the world. In the 12th Five Year Plan (2012-17), the government has proposed a significant increase in the spending on healthcare. For the first time in the history of Republic of India, a basic framework of Universal Health Coverage (UHC) has been proposed. Although the exact modality delivery of the UHC is being discussed and debated on various forums, it is likely to take concrete shape over the next decade.

**12th National Plan (2012-17)**

The Planning Commission was set up in March 1950 in pursuance of declared objectives of the Government of India to promote a rapid rise in the standard of living of the people by efficient exploitation of the resources of the country, thereby increasing production and offering opportunities to all for employment in the service of the community. The Planning Commission plays an integrative role in the development of a holistic approach to the policy formulation in critical areas of human and economic development.

The 12th Five Year Plan has ambitious objectives for the health sector. In the near future, spending on health would increase from 1.2% at the current level to 2.5% of GDP over the five year period. The paper on the 12th Plan calls for a more comprehensive vision of healthcare, which includes service delivery for a much broader range of conditions, covering both preventive and curative services. The 12th Plan will prioritise convergence among all existing National Health Programs. It is within the ambit of the 12th national plan that the Universal Health Care (UHC) has been proposed.

**Universal Health Coverage**

In 2010, a High Level Expert Group (HLEG) was constituted by the Planning Commission to develop a framework for providing easily accessible and affordable healthcare to people of India.
The HLEG compiled a report in November 2011 with elaborate financial plan and framework for human resource development. The HLEG has defined UHC as

“Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative, and rehabilitative), as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services.”

High Level Expert Group (HLEG)

Some of the key recommendations of HLEG include (a) Developing a national health package offering essential services as part of citizen entitlement; (b) Charging no fee of any kind for healthcare services under UHC; (c) Ensuring availability of free essential medicines; (d) Using general taxation as the principal source of health financing; (e) Strengthening district hospital networks as care delivery and training network; and (f) Effective contracting in guidelines with checks and balances for care provision to the formal private sector. In addition, there is a clause for well-defined service delivery with government as purchaser and private sector as provider under strong regulation, accreditation, and supervisory framework.[9]

National Rural Health Mission (NRHM 2005): Moving towards National Health Mission (Proposed 2012)

National Rural Health Mission (NRHM 2005) was launched to strengthen the rural public health system. The mission sought to provide effective healthcare to the rural population throughout the country with special focus on the States and Union Territories (UTs). Despite setbacks and administrative leakages, NRHM has contributed significantly towards strengthening human resource and public infrastructure in focus states. NRHM is now proposed to be merged with National Urban Health Mission to form National Health Mission. The Prime Minister of India envisioned the formation of a National Health Mission in his Independence Day speech (15th August 2012).[4,5]

Benchmarking Healthcare: National Accreditation Board for Hospitals and Healthcare Providers Accreditation, Clinical Establishment Act, and Indian Public Health Standards 2012

Within the scheme of UHC, rational health care financing holds the key to success. Considering that large amounts of public funds would be available to purchase care from public and private providers, there is a need for standardization and regulation of the healthcare units. It is understood now that the right of patients to rational treatment of good quality at reasonable cost should be protected. Standard treatment guidelines and medical audits should become norms of practice. In India NABH, the IPHS, and the CEA define these standards.

National Accreditation Board for Hospitals and Healthcare Providers

NABH is a constituent of Quality Council of India (QCI), set up to establish and operate accreditation programme for healthcare organisations. The board has functional autonomy while being supported by all stakeholders including industry, consumers and government. Accreditation to a healthcare organisation is a continuous process of improvement, NABH accreditation reflects an organization’s commitment to quality care. It raises consumer and community confidence in the services offered and also provides opportunity to healthcare unit to benchmark with the best. Accreditation provides access to reliable and certified information on facilities, infrastructure, and level of care. Therefore, accreditation provides an objective system of empanelment by insurance and other third parties.[6]

The Clinical Establishment Act 2010 - Notified in 2012

The Clinical Establishments (Registration and Regulation) Act, 2010, is notified now and its provisions have come into force in a few states.

Trade unions of medical professionals have opposed the implementation of this act at large, as they consider it an infringement on the autonomy of their practices. Until now, a medical doctor could practice in his/her clinic only on the basis of the medical council registration. Now a standard set of infrastructure and clinical practices is mandatory.[7,8]

However in the emerging scenario of health system development, it is in the best interest of the health care professionals to gear up for quality care, accreditation, and standardization; which would define their compensation and incentive for the services they provide. Perhaps the best way forward towards greater acceptance of CEA by the medical professionals would be an incorporation of the concept of quality care into medical education curriculum.

Indian Public Health Standards 2012

The IPHS for Sub-centers, Primary Health Centers (PHCs), Community Health Centers (CHCs), and Sub-District and District Hospitals were first published in January/February, 2007, and have been used as the reference point for public healthcare infrastructure planning and upgradation in the states and Union Territories. The IPHS 2007 has been revised and the latest version has been released, which is known as IPHS 2012. IPHS 2012 offers regional flexibility and is built upon the experience of the NRHM in the past.[9]
One of the major concerns towards implementation of IPHS 2012 is the lack of availability of human resources capable of providing clinical care and guarantee an effective clinical governance in the community setting. For a country which graduates more than 40,000 doctors in a year, only 27,000 doctors are available in rural areas at any given time. Keeping services functional round the clock, maintaining quality emergency services, provision of advance obstetrical care, care for neonates and children; management of chronic diseases; early diagnosis of cancer; introduction of adolescent health services; comprehensive care for elderly etc., need attention towards practical implementation of IPHS 2012.

Pradhan Mantri Swasthya Suraksha Yojana: Six new AIIMS institutions

Six additional AIIMS (All India Institute of Medical Sciences) institutions are being established by the Ministry of Health & Family Welfare, Government of India under the Pradhan Mantri Swasthya Suraksha Yojna (PMSSY) by an act of parliament. The aim of this initiative is to correct regional imbalances in quality tertiary level healthcare in the country and attaining self-sufficiency in graduate and postgraduate medical education. These institutes are being established in the under served areas of the country. These new AIIMS have already have admitted their first batch of the MBBS students.

Twenty six medical colleges have also been supported under Pradhan Mantri Swasthya Suraksha Yojna (PMSSY) and 46 State Government owned medical colleges have been given assistance for the strengthening and up-gradation of facilities needed to start new post graduate departments. It is proposed that nearly 90% of all government medical institutions would be upgraded during 12th five year plan.

A Medical College in each District of the Country (reported 2012)

According to a recent report, the government is all set to provide financial help to State Governments to start a medical college in each of 626 districts of India. The vacancies are likely to further rise in future in rural India under the NRHM. Sixty percentage of specialist posts are still vacant at community health centers. This shortage is expected to rise to about 50% in the next four years. With recent rationalization infrastructure and faculty requirement for medical colleges, the number of MBBS and post graduate seats are likely to double soon.

India is one of the few countries in the world that continues to invest heavily in undergraduate medical education. With majority of medical colleges operating in the private sector, India can boast the largest number of medical schools in the world. It is a matter of immense importance that the fresh medical graduates are appropriately engaged with the health care delivery system with a viable career progression.

International experience has shown that the students from rural background are more likely to opt for rural practice in future. Therefore, the local students should be given preference for admission in district medical colleges, maintaining at least 25% of students from the local district population.

Uniform Code of Pharmaceutical Marketing Practices – Positioned to become Mandatory Code (2012)

The Department of Pharmaceuticals (DoP) had introduced, in 2011, a draft Uniform Code of Pharmaceutical Marketing Practices (UCPMP), which is to be adopted voluntarily in the first instance. Under existing regulations, companies cannot, directly or indirectly, sponsor travel entertainment, hospitality for medical practitioners and their families. Unregulated marketing practices are also responsible for promotion of irrational use of medicines in the country. There is a rightful growing demand for promotion of generic drugs.

Code of ethics for doctors has existed since the establishment of medical council of India (MCI). Amendments have been introduced in 2002 and 2009. It is worth noting that while the code of ethics has been made mandatory for the medical professionals for a long time, a similar code on industry has been brought only now and only to be left out for voluntary implementation by the pharmaceutical companies. In other words, while the MCI regulations are binding on the medical practitioners, the Uniform Code is not yet binding on industry.

Reinforcement of medical ethics within the medical curriculum along with introduction of penal provision for violations of UCPMP by companies will strengthen the drive for rational usage of drugs and promotion of generic medicines.

Medical Education Reforms: NHSRC Bill & NEET

NHSRC Bill 2011

The National Commission for Human Resources for Health (NCHRH) was proposed to be an overcharging regulatory body for medical education and allied health sciences with a dual purpose of reforming the current regulatory framework and enhancing the supply of skilled manpower in the health sector.

NCHRH was supposed to prescribe, monitor, and promote standards of health professional education. Establishment of NCHRH may help in breaking out of the existing fallacies of the medical education regulatory mechanism.

The Commission was to subsume the existing councils, viz. MCI, Dental Council of India, Nursing Council of India, and Pharmacy Council of India, which were to be replaced by corresponding new councils. The NCHRH Bill has already been
introduced in the house on December 22, 2011, however it was later rejected by the parliamentary standing committee.[16]

It is important at this juncture for the policy makers to come to an understanding that a guiding document is required in the form of “National Medical Education Policy” or “National Policy on Human Resource in Health”, which deals with not only numerical proportions but also addresses the long pending curriculum reforms.

NEET (National Eligibility con Entrance Test)
NEET was notified by the medical council of India in response to a public interest litigation filed by prospective medical student demanding a single entrance test. This was also seen an opportunity to curb the illegal capitation fee as well as bring uniformity in medical education across India. However this notification was quashed recently in supreme court of India on the ground that it violated the rights of state and private institutions to administer such institutions. A review petition has been filed. The outcome of this decision is likely to impact the institutions to administer such institutions. An opportunity to curb the illegal capitation fee as well as bring uniformity in medical education across India. However this notification was quashed recently in supreme court of India on the ground that it violated the rights of state and private institutions to administer such institutions. A review petition has been filed. The outcome of this decision is likely to impact the medical professionals and their practices for the coming decades.

Curriculum Reforms: Lagging Behind

“We also need to take a serious look at the curriculum for medical education so that doctors are trained to look at health in a truly holistic manner, and that it goes beyond a narrow clinical and technology-driven approach. Students training to be doctors have to be prepared to work with local communities and in our villages. They should be sensitised to the social determinants of health and be as willing to contribute to preventive healthcare and its management as the more lucrative curative systems.”

Prime Minister Dr. Manmohan Singh.

(June 30th 2012 at Convocation address at JIPMER Puducherry)

In the convocation address at Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER), Puducherry, Prime Minister Dr. Mamohan Singh has called for reforms of medical education. This reflects awareness at the highest level of governance about the malaise in medical education. However, it remains to observed, how this commitment is translated at the implementation level by the policy makers.

Few Positive Developments Primary Care Physicians

The Steering Committee on Health of Planning Commission has recommended that the discipline of Family Medicine should be introduced in all medical colleges. Such recommendations have also been made earlier by the Mehta Committee, National Health Policy 2002, and Prime Minister’s national knowledge commission. The MCI notified the curriculum of MD in Family Medicine this year. Calicut Medical College in Kerala became the first institute to start the MD family medicine program in India. Earlier, DNB Family Medicine training was available in institutions affiliated to National Board of Examination. All recently established new AIIMS institutions have commissioned a new Department - "Community and Family Medicine", which is a welcome change.

“As both medical knowledge and specialism increase, I believe that the need for a special kind of generalist who will need a special kind of training will more and more emerge. He must be an astute diagnostician, particularly if he is to recognize and intelligently control the significant beginnings of disease. The management of chronic illness and its rehabilitation will be among his most important activities. His function will be to maintain and promote health as well as to prevent disease... One of the fundamental responsibilities of this physician will be to guide his patients through the growing complexities of medical care. He will be keenly aware of the importance of utilising those community resources having something to offer in the management of his patients. In essence, then, I am proposing a new specialty.

Dr. John Millis, Citizen’s Commission on Graduate Medical Education (1966) USA

However, unless family medicine concept is compulsorily introduced at the MBBS level, medical education will remain fragmented into specialities and sub-specialties, and therefore negatively impact delivery of medical care. Undergraduate medical education should be anchored to a generalist, competent, comprehensive, psychosocial, and scientifically based frame. Curriculum reforms, which should be an area of high priority in medical education are lagging behind.

Concluding remarks

World over medical educationalists and policy makers are taking deliberate efforts to strengthen generalist component in medical education in order to maintain comprehensive, continued, and personalized care with the health care delivery system. In India, discussions are still largely centered on compulsory service by medical graduates (unprepared and unwilling) as medical officers in rural and underserved areas. Considerable thought is also been given to relax medical practice licensure, allowing larger groups of service providers to be able to legally prescribe modern pharmacy and practice allopathic medicine. With the quantum of financial resources available, it is important to maintain an effective gatekeeping through implementation of standard clinical practice guidelines, which would further evolve through continuous academic processes. To implement this gatekeeping, a clinically competent team is mandatory. Mere procurement and availability of generic drugs from a “common list” may not ensure best health outcome for a given population. Lessons must be learnt from the past experience of NRHM where large proportions of funds were lost as a result of dependence on
unprepared and inefficient administrative framework rather than competent clinical governance.\textsuperscript{19,20}

**Author’s Note**
The findings and conclusions in this article are those of the author and do not necessarily represent the official position of ILBS, New Delhi, India.

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