2016

Views & Suggestions on "Medical reforms in The Country"

Submitted

To

Committee on Petitions(Lok Sabha) under the Chairmanship of Shri Bhagat Singh Koshyari, MP

By
Indian Association of Preventive & Social Medicine (IAPSM)

Indian Association of Preventive & Social Medicine

Estd. 1974

National President
Dr. Ashok Mishra

Secretary General
Dr. A. M. Kadri

Date : 10/6/2016

To,
Additional Director (Q & P).,
Lok Sabha Secretariat,
Room No. 155, Parliament House Annexes,
New Delhi- 110001,
Telephone No. 2303528

Sub : Submitting Views and Suggestion on Medical Reforms in Country.

Dear Sir,

Let me take an opportunity to introduce Indian Association of Preventive & Social Medicine (IAPSM) first. IAPSM is a National Professional Body consisting with 4200+ who are specialists in the field of Community Medicine/Preventive & Social Medicine/Public Health from all over of India. IAPSM is an important stakeholder in Health care services, Medical Education and Public Health/Community Medicine.

In response to advertisement published in various news papers for inviting views/suggestion on Medical reforms in country by Committee on Petition (Lok Sabha) under the Chairmanship of Shri Bhagat Singh Koshyari, M.P. IAPSM had invited views/suggestions from its members representing from different parts of India for same. They are senior experts and experienced faculties in Medical Colleges.

Herewith please find the complied views/suggestions by the members of Indian Association of Preventive & Social Medicine. I am sure views and suggestions from committee will be useful.

As a national level Professional Body on Public Health/Community Medicine; we feel that it is our moral duty to support this endeavour. **We are requesting a personal meeting for discussion and share our views/suggestions as well.**

President
IAPSM

Secretary General
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Introduction

Indian Association of Preventive & Social Medicine (IAPSM) :

IAPSM is a National level Professional Body consisting with 4200+ who are specialists in the field of Community Medicine/Preventive & Social Medicine/Public Health from all over of India.

The Indian Association of Preventive and Social Medicine (IAPSM) has State Chapters in almost all states, is dedicated to promote the concepts and practice of Community Health, to facilitate quality implementation of Health Policies and Programs in India. The members of this organization comprise of Public Health and Community Medicine Experts playing a wide spectrum of roles such as Academicians, Researchers, Trainers, Health Managers/Administrators, Public Health Consultants, Disease Surveillance Officers and Medical Faculty in the Department of Community Medicine in Medical Colleges and in the State Directorate of Health Services.

It is working with…

Vision :

Contributing to the overall development of County by improving the health of people through collective wisdom of its members.

Mission

Enhancing teaching, training, services and research in field of Community Medicine / Preventive & Social Medicine/ Public health/Health system to strengthen Health system and public health.

Expertise of the its members are in :

1. Assessment of health conditions and needs of community;
2. Identifying the direct and indirect determinates of health conditions.
3. Planning of services to meet needs;
4. Promotion of health, including health education;
5. Measuring the effectiveness of health care services and promoting improvements;
6. Promotion of research and development into health care services;
7. integration of health services and their co-ordination with other services, particularly the relevant services provided by local government; and
8. Provision of medical advice and services to other bodies, including local government authorities responsible for environmental hygiene and the control of communicable disease.

These professionals are broadly Planners, Co-coordinators, Implementers, Human Resource Managers and Evaluators. Hence the IAPSM is a rich resource of Public Health Experts who can meaningfully contribute in ensuring Quality Medical Education, Equitable Health Development, Promotion of Universal Primary Health Care and as Epidemic Intelligence Officers for prevention/control of Epidemics aligning Health Policy and Multi-sectoral Development in India.

IAPSM is an important stakeholder in Health care services, Medical Education and Public Health/Community Medicine. The participation of IAPSM as an organization must therefore, be mainstreamed in all policy decisions and Health program initiatives. The IAPSM can effectively facilitate creation of evidence based opinions for decision-making by the Administrators and Public Representatives. In fact, IAPSM should be a part of the "**Think Tank"** of the Ministry of Health at State and Central level.

In response to the appeal made by the committee on the petitions, Loksabha Secretariat, Parliament of India to submit views and suggestions on Medical reforms, the IAPSM desires to represent itself as a National Professional Advocacy Organization of Community Medicine Experts to express its views / suggestion/ recommendations on the issue of medical reforms in the country.

The IAPSM recognizes the need for the Health System of the country be balanced congruently as two divisions i.e. one division being the curative health care division and the second being the preventive health care division. It is an established fact that the focus of Health care Policy should be more inclined towards strengthening preventive, promotive, primary Health Care services. The medical education reforms and the subsequent reforms in Health services be always formulated considering the ultimate objective of equitable Health care, promotion of self reliance in Health matters, facilitating holistic human development in the country. The Medical graduate and the post graduate therefore must be sensitive to social, cultural, demographic realities of India. Thus appropriate reforms are inevitable especially focusing on Community Medicine / Public Health while adopting modern technological applications in Health Care. It is of utmost importance to understand the difference between " Doctors of Disease" and "Doctors of Health". Health sector should be meaningfully utilized as a medium of Socio- economic development.

The IAPSM proposes to represent itself with the following views / suggestions/ recommendations in the interest of quality medical education and promotion of quality healthcare as follows:

Views & Suggestions
on
“Medical reforms in The Country”

1. Reforming Medical Education :

The First World Medical Education Conference that met in London in August 1953 reviewed the requirements of entry into medical schools, the aim and content of the medical curriculum, the technique and method of education, and the importance of preventive and social medicine in the training of physicians. The southeast Asia Regional Office of the W.H.O., in their analytical study of Medical Education, recommended the reorientation of medical teaching from the predominantly individual and curative approach to a more community minded and a preventive one.

A . Failure of medical education in achieving its goal:

Curriculum of Medical education especially for graduation should be as per the need of country and relevant to contemporary period. The overall goal and objectives of the curriculum for MBBS course are well drafted with overall goal of producing basic doctors. As per the Graduate Medical Education Regulation, 1997, of Medical Council is that medical curriculum is to be oriented towards training students to undertake the responsibilities of a physician of first contact who is capable of looking after the preventive, promotive, curative & rehabilitative aspect of medicine. Also all other objectives of medical curriculum is directed toward making basic doctor, with well understanding & skill about common health problems, health programs, community etc. This has resulted shifting of focus of Medical care from basic care/ general practice to specialization/super-specialization has derailed the goal, leading to the situation where students hardly develop insight as well competences as a basic doctor. Practically every report evaluating Medical education has declared that current medical education system has failed to produce basic doctor. Reason is that vision and roadmap prepared are completely diverging in both important strategy of medical education i.e. at curriculum level and teaching setting level. The current situation for medical graduation teaching is described as below.

i. Dissociated Curriculum:

MBBS course fragmented in different subjects and Medical college hospital in various specialization departments. These two important central structure arrangements takes medical graduate from habits (integrated) understanding to the fragmented vision.

Broad objectives for MBBS curriculum and individual subjects are developed, but syllabus and curriculum for individual subjects are not fixed. It has created situation like vision without roadmap. Over the period this has resulted in to overloading of knowledge and skills in each subject, which exceeds the expected requirement for MBBS graduates i.e. over teaching in each subject/in different topics in each subject at the cost of basic knowledge and skills.

ii. Curriculum dilemma : Basic Vs. Advanced teaching

Currently, an undergraduates students study total around 20 subjects and attend 14 examinations. Every subject is learnt in isolation, leading to the condition where each subject tries to teach as much as specialist. In the particular topic is supposed to know. This situation at one end leads to overburden (thus stress) on students, at another end the

focus from basic is lost. Undergraduate students are stressed to learn as much as in each subject at a specialist in particular subjects needed to learn.

iii. Well conceived vision but ill defined role of Community Medicine/Preventive & Social Medicine in Medical Education :

The Medical Education Conference organized by the Government of India in 1955 after the World Medical Education Conference recommended major reforms in medical education in India. This Conference made several suggestions in this regards including Community Medicine/(preventive and social Medicine subject) is key subject to and put stress its role in medical education so that the goal and objective of medical curriculums for producing basic doctor who can practice preventive, promotive health practices keeping culture-socio milieu in mind is lost. can be supported But because of ill designing of medical curriculum and non-clarity about Preventive & Social Medicine/Community medicine practice models in hospitals/college the entire purpose of including this subject is lost.

iv. A paradox in Medical education : Learning in basics at tertiary (specialist and super specialist hospital of Medical college)

Currently, specialists OPDs are running and during clinical posting students are directly posted into specialist departments. Thus they never exposed to the basic medical care unit. This can be considered as a situation where goal is set to teach trainees floor gymnasium but their practices are scheduled on equipment gymnasium. Thus "goal" of MBBS and "teaching arrangements" are not matching; here they completely opposite i.e. making basic doctors by posting in specialist departments.

Recommendations:

When it is well established fact that medical education for MBBS has failed to produce basic doctors, the remedy should be some big reforms/restricting at curriculum level and teaching setting level. They are suggested as below…

1. A detail curriculum with **"HOW MUCH"** and "**WHAT MUCH**" to learn in each subject Curriculum reform with clear cut list of basic topics and skills in each subject.
    a. One central Curriculum committee with sub-committees in each subject.
    b. Revising curriculum every five years keeping recent changes and contemporary requirement.
    c. The subject of Community Medicine at under graduate level is evaluated at the beginning of 3rd Year MBBS. This should be evaluated at the end of 3rd year along with other clinical subjects.
2. Hospital care restructuring wherein in tertiary care center there should be rearranged in two levels of medical care i.e. Basic Medical care and Specialist Medical Care unit.
    a. Basic Health & Medical Care : It is a first level care unit providing, preventive, promotive & basic curative care.

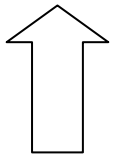
i. It should consists of Basic Health & Medical care units like General OPD (male, female), health preventive service centre like Immunization Clinic, Obstetric Clinic, Family Planning Clinic Under Five Clinic, Geriatric clinic, emergency OPD, Screening centre for Hypertensions, diabetes, cancer etc.

ii. These units can be manned by medical officers, one specialist/ junior or senior residents of specialist department. Specialist from Preventive and Social Medicine should be made in charge of the basic medical care units which are providing Preventive & Promotive services.

b. Specialist Medical Care : All other specialist OPDs and wards should be put to one level higher as a specialist Medical Care units where in patients are referred from the basic health and medical care unit and patient who are old cases of specialist clinics.

The schematic diagram for the same is shown below for better idea.

Specialist care									
Medicine Clinic	Gynecology Clinic	Pediatric Clinic	Surgery Clinic	Ortho Clinic	Skin Clinic	Psychiatric Clinic	ENT Clinic	Ophthalmology Clinic	Super specialty Clinics



Basic care (First level Contact)							
Immunization clinic	Under five clinic	Obstetric Clinic	General Clinic (Female)	General Clinic (male)	Screening Clinic	Geriatric Clinic	Emergency Clinic

3. The restructuring of the medical care should be complemented by restructuring of the curriculum wherein MBBS student will be devoting 70% of posting time in Basic health and medical care unit, and that of 30% in specialist medical care unit.

These restructuring will have three advantages:

1. Orientation and learning of MBBS students will be changed towards Basic care, thus very much goal of MBBS will be attained.
2. In current situation large number of general patient and patients with common disease are reaching directly to specialist taking away the major chunk of their time. This time will be saved. Specialist will deal patients who are requiring specialist care.

3. Time saved of specialists in examining general patients will be effectively utilized in undergraduate and post graduate teaching as well as in research.

B. Internship posting:

Internship is the most crucial period for clinical skills building. But currently all post graduate admissions are taking place as entrance examination. Hence; the focus of all fresh medical graduates remains now on preparation of entrance examination during internship period. This is adversely affecting learning during internship. Further entrance exam for post graduate admission is completely knowledge based; hence medical graduates who are preparing for Post Graduate entrance are completely ignoring skill based learning during undergraduate learning including internship periods.

The post graduate Entrance Competitive Exams may be held immediately after commencement of Internship. This will enable students to focus on skills based learning during their Internship postings. The duration of internship posting in Community Medicine be changed to 12 weeks instead of 8 weeks as of now.

C. **Reforms in Medical Council of India:**

MCI may formulate 4 permanent committees with 2 years tenure posts

1. Curriculum reforms: trimming of irrelevant portions, making curriculum vibrant with catering to present day needs.

2. Assessment and evaluation: objectivity, timeline, use of technology, conduct common entrance tests, declaring results

3. Monitoring, certification and accreditation: train all associate and professors for uniform planned online transparent process.

4. Research and training committee: provide additional monetary incentives for motivated faculty to indulge in this activity. This committee shall also have complaint redressal as a part of it. This committee identified local, state and national level faculty for nomination into other committees on a tenure basis.

Medical Council of India should revamp & amend the provisions and norms with reference to teaching and training of all faculty departments in view of the advances globally and nationally. These reviews must be periodically constituted every 10 years. With reference to the Community Medicine Department it is necessary to modify the eligibility for establishing Rural and Urban Health Centres especially the emphasis on the distance and ownership in view of rapid strides in development and reduction of Urban Rural proportions coupled with changing demographic and cultural characteristics.

Recommendations:

For improving the quality of internship learning following reforms are suggested.

1. All India Post Graduate Entrance examination (National Eligibility Entrance Test-NEET) for knowledge assessment should be taken at the beginning of internship examination.
2. Skill assessment to be included in NEET. It can be taken after internship at regional/state level arrangement.

C. Reforms in Post Graduate Teaching :

During post graduation teaching, along with deeper understanding about specialized subject it is expected that the PG students must get orientation about research methodologies; acquire basic understanding as well as skills about it. Dissertation (thesis) is the most important part of PG learning and is mandatory for qualifying in appearing PG examination. But dissertation preparation has become a ritual as unwanted non significant task to be performed. This has defeated the very much objective of imbibing research insight and basic research skills in post graduates. Current Post Graduates are gaining very good knowledge and skill in their particular subject of specialization but they are completely poor in basic understanding and skills of research. This is a big loss to country and medical science. In spite of huge medical/clinical materials and intelligent experts in the field they could not convert their experiences in to quality research which can contribute in advancement of medical science and help in medical care scenario over the period.

Recommendations :

To get benefit of experiences and intelligence of specialist doctors for Medical Science and country following reforms are suggested.

1. There should be a separate question paper in theory examination on research methodologies in medical sciences.

2. A special Viva-Defending the Dissertation (Thesis) to be given due weighage with examination with specialist in Research/Biostatistics

3. The criteria of Rural Health Training Centre affiliated to Community Medicine Department, being not more than 30 KM from Medical College & being under ownership of the Medical College must be suitably amended. In view of rapid urbanization and promotion of "Smart City Developments" projects, the distance between urban and rural localities is widening. Hence the distance criteria be discarded especially if it does not compromise with the travelling convenience and availability of appropriate physical facilities for faculty and students and Interns.
The concept to of ownership must be flexible as the training in primary health care and hands on skills based training in Public Health cannot be imparted unless the Rural Health Training Centre / Urban Health Training Centre of the Medical College essentially

collaborates with government managed Primary Health centre or Urban Health Centre. In fact working in isolation from the established government Primary Health Centres will fail to orient the students in understating the primary health care system of the country, indirectly leading to inadequate understating of the Health Policy implications & the Role of Community Medicine Experts in Medical Care. The Department of Community Medicine if develops collaborative partnerships with District Health Office with appropriate terms of references, as such may be recognized as Rural Health Centre of the Medical College

4. Clinical Orientation Training/Field postings for PG students (M.D. Community Medicine)

No.	Field Posting and work	Duration
01	Posting at Sub centers & PHCs Under & at RHTC and UHTC attached to Dept of Community Medicine as per MCI norm	Total period of ONE year during the 3 year period of PG course. Posting at RHTC should be residential.
02	Posting in the teaching hospital for exposure to clinical departments namely Pediatrics, OBGY & General medicine to acquire clinical skills for diagnosis and management of CDs and NCDs	Total One month General Medicine-2 wks Pediatrics-1 wk OBGY-1 wk Time of posting shall be at discretion of local feasibility
03	Work attachment to get hands on training in public health department & orientation in Health Administration and Management of various national health programmes and aspects of public health management at DHO/DHS/THO/DTO/DMO/CDPO/MOH of Local Civic Body etc.	Total One month Place & time of 2 posting of 2 wks each shall be at discretion of local feasibility.
04	Short duration posting in various camps, melas, public health emergencies, investigation of epidemics, implementation of NHP, linen dept of hospital, Hospital kitchen, Hospital record section, central drug store, Medical Supdt. Office, blood bank, casualty dept., CCL, Hospital waste management, ART-VCTC, Matron Office(HRD) ,HMIS etc.	Total One month Minimum Four postings of 1wk duration shall be done subject to local feasibility.
05	Visits to various institutions of Public Health Importance	Subject to local feasibility

Note- The duration of postings for Diploma course shall be 2/3 duration of MD degree course as mentioned above. (Duration of course is MD- 3 yrs and Diploma- 2 yrs)

D. Enhanced Role of Medical Colleges:

Medical colleges are expected to play three roles

a) Educational institution
b) Medical care providers
c) Research institutes

Out of the three it plays first two roles in varying proportions. But by and large medical colleges have failed to play its role as a research institute across the India. Every day when thousands of patients are attending hospitals, millions of laboratory test are carried out, and thousands of cases are admitted in hospitals. Every year we miss the opportunity to generate evidence to guide and further develop knowledge in medical science. Ultimately it is a loss to country.

Additionally medical college hospitals are catering huge numbers of the patients. Various medical activities, right from the Outdoor patient examination to final discharge/death event are occurring. These all events general lost of data. It is treasure and by methodological analysis we can extract valuable of information for health conditions, its trends and its overall impact. Current this opportunity is lost due to devoid of priority and lack of arrangement. Current entire arrangement is focused as per the requirement of Medical Education under Medical Council of India regulation.

Recommendations:

Role of medical college as research institutes and their additional roles in generating evidences for supporting Health System of country can be realized by following reforms in medical colleges/hospitals.

1. A well quipped and staffed Medical Research Unit must be made mandatory with well laid down criteria and guidelines in each medical college.
2. Selected medical college hospital should be created for general surveillance, specific diseases related surveillance/registry etc.
3. All clinical as well as non- clinical departments must fully equipped with Information Technology support.

2. Realignment of Public Health:

Health is basic right of citizen of India and public health is the most important duty of Government. Public health has been transformed to primary health care. However it needs to be realigned with the national health need, which in itself needs to be aligned with epidemiological situation of the country.

Criticism about current Government health system of India are..

1. Rural centric

2. Infectious disease oriented
3. Preventive and protective approach
4. Mother and child health focused.

It needs to be realigned with

1. Urban population
2. Non, infectious disease
3. Health promotion.
4. Other vulnerable group e.g. adolescent, mental health, geriatric health etc,

Recommendations:

1. The Department of Community Medicine in the Medical Colleges be recognized and placed on records as an organization for collaborative partnerships for Health Projects, Quality Services, Training, Evaluation and Research.

2. The Urban and Rural Health Training Centers of the Community Medicine Depts. in the Medical Colleges must be reflected as additional Health Unit in the spectrum of Government Primary Health Care System. Thus, the Urban and Rural Health Centers must be provided a separate Health Budget as is sanctioned for Primary Health Centers and Rural Hospital by the State Governments.

3. Rejuvenating Primary Health care:

Government of India is a signatory to the "health for all" declared during World Health Assembly in year 1977, held at Alma Ata. The approach adopted to attain the goal of "health for all" was "Primary Health Care. India has also adopted concept of Primary Health Care as being a signatory to it. But the concept of primary health care could not be implemented in its letter and spirits. Primary Health Care is a three tire systems. Primary health Centre, Community Health Centre and District/Medical College hospitals are three tires under it. Under Primary Health care it is envisaged that these three tires should be linked with other. But in reality they are working in isolation. Linkage between Primary Health Centre and Community Health Center is weakest. Community Health Center has to play role as a first referral unit with specialist medical backup support to preventive, promotive & curative care being provided by the Primary Health Centers in the areas it is covering. Field reality is that Community Health Centers are working as isolated small Medical hospitals, rather than a Health Centre. The most important reason behind failure of the concept is it was never manned by Community Physician/Public Health Specialist who is a specialist and trained as a link between Primary Health Care / Public Health services and clinical care services.

Various units are functioning/health services are provided under various health programs, but they are never in priority of the Superintendents and specialists from curative branches. This has resulted poor performances of such units and thus overall performance of health programs. This

is has happened because focused has remained to employ specialists from the curative branches as medical care as priority over preventive & promotive care.

It is irony or lack understanding on the part of planner that the name of institute is Community Health Centre but there is no provision of Community Medicine experts in our health system. This resulted that Community Health Centre has turn to Medical hospital, breaking the link between primary and tertiary centres in other wise well conceived three tires Health Care System in India and this is the key reason in failure of Primary Health care.

Recommendations:

1. Guidelines under Indian Public Health Standard for Community Health Centre have emphatically mentioned inclusion of the Public health specialist at centre. Also various experts have suggested to employ Community Medicine/Preventive & Social Medicine/Public Health experts at Community Health Centre.

2. It is recommended that Community Medicine/Preventive & Social Medicine/Public Health experts must be made available at Community Health Centre. This will rejuvenate Community Health Centre and thus concept of Primary Health Care to attain health for all as a whole.

3. The criteria of Rural Health Training Centre affiliated to Community Medicine Department, being not more than 30 KM from Medical College & being under ownership of the Medical College must be suitably amended. In view of rapid urbanization and promotion of "Smart City Developments" projects, the distance between urban and rural localities is widening. Hence the distance criteria be discarded especially if it does not compromise with the travelling convenience and availability of appropriate physical facilities for faculty and students and Interns.

The concept to of ownership must be flexible as the training in primary health care and hands on skills based training in Public Health cannot be imparted unless the Rural Health Training Centre / Urban Health Training Centre of the Medical College essentially collaborates with government managed Primary Health centre or Urban Health Centre. In fact working in isolation from the established government Primary Health Centres will fail to orient the students in understating the primary health care system of the country, indirectly leading to inadequate understating of the Health Policy implications & the Role of Community Medicine Experts in Medical Care. The Department of Community Medicine if develops collaborative partnerships with District Health Office with appropriate terms of references, as such may be recognised as Rural Health Centre of the Medical College

4. Reforming stewardship of Government Health System

Running a health system managing and public health interventions are specialist jobs like treating cancer or malaria or carrying out surgery. Community Medicine Department is the specialist branch which is especially developed consciously by the government and experts in the medical education to facilitate the achievement of goal of MBBS curriculum i.e. who can use

principles of preventive, promotive, curative and rehabilitative care to practice as a basic doctors. However; vision to create specialist failed due to lack of blue print to realize the vision. There is complete absence of creation of the structure and mechanism where specialized can be roped in to fulfil goal of Government Health care.

Correcting Mismanagement: Putting square pegs in round holes:

This has not only pushed the community medicine (PSM) as a specialist in corner, but has adversely affected public health / government health system.

Community medicine specialty is developed and promoted in India keeping the specific / government health system, where government health care is involved in preventive, promotive and curative services are mixed model of public plus private. However, traditional concept of doctor means curative care providers has superseded and involved managing public health system ignoring the specialists who are qualified and equipped to deal public health problems and working in community. Training in Community Medicine (PSM) is completely in alignment with goals and objective of Government Health system.

In fact current policy of putting specialists from varied medical branches in Public health system offices is like putting Ear, Nose & Throat specialist in Gynec clinic, Orthopedic in Psychiatric and Cardiologist in Skin. It is the perfect example of mismanagement by putting "square pegs in round holes".

We must not hesitate to accept that this single structure anomaly in Health system has cost very much to the people's health.

Recommendations:

Government must rectify mistake of "Square Peg" as early as possible by putting right persons on right jobs.

1. Specialist from PSM/Community Medicine/Public health should be placed and promoted at Community Health Centres, appropriate at district health units, state and central health teams and institutes working in public health.
2. Government, state and central as a main beneficiary or employer must increase minimum 25% of total post graduate seats in Community Medicine/PSM/PH, as suggested in national health policy 2002 and in various reports.

5. Reform in Civil Services: Creating Indian Health Services:

Numerous reports, studies and experts have given the opinion that we have the best of design health programs but they have failed due to bad management.

The first health committee, just before the independence has recommended creating Indian medical (health services) but it was never accepted due various reasons. The most important reason is that Country is shortage of doctors and more needed for curative care then

administration. In fact, still recent past, medical doctor were not allowed to apply for Indian services, IAS/ IPS/ IRS due to sole this reasons. But in change in the situation of availability of doctors policy has changed. Many doctors have cleared civil services exams and proved successful in administration as IAS. We have experimented the model of leading health services and health programs by General Managers i.e. IAS. But this model has failed, and required to rethink. Though there are extraordinary IAS officers who are having exemplary record as health leaders but these are exceptions rather than rule. Most of the IAS cannot connect themselves easily with this specific sector which is complex in nature. Further short tenure of IAS, frequent change of guard is adversely effecting the direction and progress made in it.

Recommendations:

It is the time that government should accept that health is a specialist Sector. It requires to be lead by specialists in the field. It is recommended that Government should establish Indian Health Services, in the line of Indian Engineering Services, Indian Statistical Services etc. This will mainstream the Health department perfectly aligned with other developmental sectors and will promote effective intersectoral coordination, thereby ensuring Quality Health Services

6. Reform to Reduce Out of Pocket Expenditures:

Out of pocket expenditures on health care is in India is exorbitant. It is estimated at it lead to catastrophic effect on around 6.3 people, pushing them down below the poverty line. Health is a basic a right of Indian citizen, but two major development in health care system has created the situation where the catastrophic effect of health care will going to be from worse to worsen.

- Private doctors/hospitals have outnumbered government hospitals very significantly
- Cost of medical consultation, diagnosis and hospitalization has escalating at a greater pace than overall income growth.

Further, health insurance are currently covering expenses related with hospitalization only but expenses of consultation, diagnosis and treatment on outpatient basics are not covered under it.

Also, policy of government to shifting the burden of running the medical college and promoting prevent college to run on very high tuition fees has fueled this situation further. Currently number of Private Medical Colleges has crossed that of Government Medical Colleges and days are not for when it will be doubled than Government College.

Medical doctors who have acquired the qualification after spending such huge amount on teaching will be going to recover their expenses from people only. Thus it will worsen situation of out of the pocket expenses.

Government hospitals and dispensaries are inadequate number to cater neo middle class group, which has increased substantially in India. This large group of India does not prefer government hospitals due to various reasons and could not afford private health care services leading to mismatch the types of medical care and its demand.

Recommendations

1. Government should promote outpatient consultation; diagnosis and pharmacy in proportion of different economical segments i.e. middle class as sole provider or public Private partnership with regulated rates of medical care.
2. Government should remain main producers of medical graduates and in no case the number of private medical colleges should increase over half of the total medical colleges.
3. Promotion of Rational use of Medicine, Generic Medicine and Government supported Medical Insurance & Community based medical Insurance policies

Recognition and inclusion of Medical Professional bodies in Policy framework:

The participation of Medical Profession bodies in formulating Health Policies and programs has been skewed so far. In fact the professional body such as Indian Association of Preventive and Social Medicine which can serve directly as advocacy organizations in the Health care systems have been inadequately represented in the various Government Health Committee at National and State level. It is necessary to include one representative of The Community Medicine specialty in all key Health Committees of the state and national levels.

Recommendations:

1. A committee for 'Enhancing Integration of Public Health and Medical Education' be established in all States with mandatory inclusion of IAPSM representatives and Faculty of Community Medicine of Medical Colleges
2. The President/Secretary of IAPSM and Senior Faculty of Community Medicine be inducted on the Technical Committees and Task Force Committees of the State and Central Health Ministries and Directorates of Health Services.
3. The ICMR may be directed to allocate Research Projects of Public Health importance to IAPSM and Depts. of Community Medicine in the Medical Colleges.
4. The IAPSM and Dept. of Community Medicine in Medical Colleges be recognized as a Training Institutes for imparting Training to Health Officials and Para-medical Staff at State and Central level.
5. Adequate support and opportunities for faculty development and special skills training be promoted in collaboration with Foreign Universities and Institutions.

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PARLIAMENT OF INDIA
LOK SABHA SECRETARIAT
NEW DELHI

COMMITTEE ON PETITIONS (LOK SABHA) INVITES VIEWS/SUGGESTIONS ON THE PETITION "MEDICAL REFORMS IN THE COUNTRY"

The Committee on Petitions (Lok Sabha) under the Chairpersonship of **Shri Bhagat Singh Koshyari, M.P.,** have taken up a Petition presented by **Shri Om Prakash Yadav, M.P.,** to Lok Sabha on 9 March, 2016 regarding 'Medical Reforms in the Country' for examination and report.

With a view to having wider consultations on the Petition, the Committee have decided to invite Memoranda containing views and suggestions of experts, individuals, institutions, organisations and other stakeholders interested in the subject matter. The issues, *inter alia,* cover systemic failures in the existing system to address contemporary requirements of medical education in the country so as to bring it at par with the global standards, besides synergizing it with country- specific requirements; to review the role/relevance of Medical Council of India (MCI); to sensitize stakeholders to the urgent necessity of reforms in various components of the medical education, recommended in various policy documents - either published by the Government or renowned experts in the field, but which mostly remained unaddressed; to assess the long felt need for an independent comprehensive 'ranking survey' of medical colleges in the country - be it government controlled medical colleges or private medical colleges; realignment of approach to public health; move away from top-down programmes, policies, monitoring mechanism to respond to the demands of the people; encouraging innovation in medical techniques, providing an impetus to 'Make in India' in the medical devices sector to provide for an affordable health care; shaping new policies and initiatives for enhanced funding and delivery in the medical services sector, etc.

Those desirous of submitting Memorandum may send two copies thereof, either in Hindi or English, to the **Additional Director (Q&P), Lok Sabha Secretariat, Room No. 155, Parliament House Annexe, New Delhi -110001, Telephone No. 23035283, Fax No. 23019660, E-mail: comm-petitions-lss@sansad.nic.in** - within three weeks from the date of publication of this Communique. The Committee would, thereafter, take oral evidence on the subject. Those who wish to appear before the Committee, besides submitting Memorandum, are requested to specially indicate so. However, the Committee's decision in this regard shall be final.

The Memorandum submitted to the Committee will form part of the records of the Committee and will be treated as strictly. 'Confidential' and not circulated to anyone, because such an act will constitute a breach of privilege of the Committee.

davp 31201/11/0004/1617

IAPSM Committee for sharing views and suggestions on
"Medical Reform in Country"

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And Many IAPSM Members who had shared their views & suggestions through online discussions.			