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Doctors' strike in Bengal intensifies, but Mamata remains defiant

Doctors on st

HEALTH CARE

Skewed vision

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Students of PSG Institute of Medical Sciences and Research in Coimbatore, in February 2017. There is an almost exclusive reliance on NEET at every stage of education as the single most important strategy of all educational governance. Photo: M. Periasamy

At the Military Nursing School make BSc the only nursing ent

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The policy fails to address concerns of equity in access to health care or access to health care education and will pave the way for an unhealthy commercialisation of education in this domain.

Health care education finds place in the draft National Education Policy (NEP) as one of the subtopics in the chapter on Professional Education in Part II, which deals with Higher Education. Health care education is also addressed in the National Health Policy, but clearly the concerns that this policy has are different.

Any policy on health care education will have to address three important challenges.

The first and most important of these is the serious maldistribution of health care professionals across the nation. The national commitments to achieving universal access to health care can be achieved only if there is a minimum density of doctors, nurses and allied health care professionals in every block and district. Such distribution of health care professionals is closely linked to policies concerning entry into educational institutions, the context and content of the curriculum, and the subsequent policies of public financing and organisation of public health services.

The second important challenge is ensuring quality education so that the young men and women who pass out of these institutions have the knowledge and skills to make the right decisions and provide the right care. Health care is a service sector where, owing to information asymmetry and uncertainties in outcome, the service user's ability to make the choice of provider, or even to judge whether the care received was appropriate and adequate, is limited. Further, in most contexts of private practice, the provider's own monetary incentives may not be aligned with the best interests of the patient. All this calls for a high degree of trust, and the state must ensure that health care professionals have the skills to deserve such trust.

The third challenge is also a dimension of the quality of education; it is not just technical competence in terms of knowledge and skills that is required but an attitude of caring. These are caring positions where the majority of practitioners will have to feel fulfilled and creative through acts of preventing illness, of taking care of the sick and even in supporting the dying. No doubt, at all levels of care some technical skills are essential, but what is equally important is the empathy that care providers have for those they care for and the close bonding that is required between providers and the communities that are served and the ethical values care providers have imbibed during professional education and practice.

The draft NEP not only fails to address these challenges but can actively worsen them.

Table 1 shows the highly skewed distribution of undergraduate and postgraduate seats per one lakh population across States. Those States that have the largest shortfall of doctors are also the States where the number of seats per one lakh population is lower than the national average. The distribution within States is also similarly skewed. A similar skew in availability of seats and professionals can be demonstrated for nurses and for many of the allied health professionals too.

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Given the fact that upwardly mobile urban youths from more privileged sections of society are the most successful in gaining entry into health care educational institutions, the increase in the number of seats in States with relative surplus is only going to lead to unhealthy competition and lowered remuneration for doctors within a few of the larger urban areas. It does not lead to surplus doctors and nurses shifting to under-serviced areas. Bonds or other forms of compulsion for working in rural areas seldom work, and even to the extent they do, such professionals will not have the same level of empathy and bonding with communities as a doctor who would actively choose to work in such areas. In many nations across the world, preferential admissions for students from under-serviced communities and regions along with commitments and incentives to go back to these areas after graduation are what has helped most in closing such service gaps.

The draft NEP is silent on how these huge human resource gaps by region, by State, by gender, or by more marginalised castes and communities would be addressed. The silence is not surprising since equity in access to health care education and access to health care can be achieved only through public educational institutions based on public financing and affirmative actions such as free or highly subsidised education to bring in suitable candidates from these regions and communities. The silence would, however, be consistent with an approach that prioritises opportunities for private profit in health care education and the demand of the more privileged sections to send their children to medical schools over the public needs for health care . Over the last two decades, commercialisation of health care education has been increasing rapidly, and now the majority of the institutions are in the private sector. Further, the majority of medical and nursing seats need such high payments that much of the population is actively excluded from such education. The draft NEP exacerbates this problem. It gives permission to educational institutions to charge any level of fees and commits them only to providing scholarships for a proportion of the students—a commitment that in practice would be almost impossible to enforce.The terms of such market-driven expansion of health care education have led to great loss of quality in the output—a fact that is almost universally noted and lamented. The policy quite correctly states that regulatory regimes under professional councils were inadequate to the task and had serious conflicts of interest. But the solutions proposed are worse than the problem. The draft NEP calls for dispensing with the role of councils as regulator and instead proposes one huge centralised structure that will command all of higher education across the nation. It is unclear whether any single Central institution can ever command such a capacity or needs to. (Constitutional provisions put educational standard setting in the Union List but explicitly leave regulation of higher education to the States.)

Reliance on NEET

The bigger problem is an almost exclusive reliance on the common National Eligibility-cum-Entrance Tests (NEET) at every stage as the single most important strategy of all educational governance. The proposal assumes that common examinations for entry at the undergraduate level and the postgraduate level are effective and seeks to transform the latter to also serve as

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a common exit examination for licensing purposes. Presumably, the two NEETs would be utmost fair and transparent and purely merit-based measurements of quality that would cut across the divides of public and private, community and region. If the proposal to allow all professional students to do a common first-year foundational course followed by a merit-based sorting into medicine, nursing or dentistry streams is taken seriously, that would probably add a third NEET to the pool. But the challenges of implementing such streaming are so ridiculously high that we need not get distracted into discussing them.

The NEET itself has been a basis of considerable criticism and it is now clear that it is a tool that exacerbates inequities and undermines the federal nature of educational governance. Protest is maximal in precisely those States, such as Tamil Nadu, where after a long process of discussion with different sections a working balance had been struck between the needs of different regions to access health care and the needs of different sections of the population to access the opportunities of health care education. Then, as now, 15 per cent of the undergraduate seats and 50 per cent of the postgraduate seats were under the all-India quota. But for filling up 85 per cent of the seats, another merit-based, fair and transparent system was devised by States, which was perceived as giving students from government schools and the more marginalised communities following the State language as a medium of instruction and those who are unable to afford costly coaching sessions a reasonable chance of getting selected. Even this had problems. But post-NEET, students who are from schools following Central, all-India examination boards and those going to costly coaching schools which have cracked the subtext of these examinations have an advantage over others.

Similarly, at the postgraduation level, Tamil Nadu had a system in place where graduates would work in rural areas, confident of the extent of advantage it would give them for accessing postgraduation courses, and the government worked out how to fill specialist posts in all its district hospitals. The State had also chosen to invest in expanding postgraduate and super-specialisation courses using its own budget and made public service after qualification mandatory to those getting government education. But with a nation-level centralisation of the examination process and surrender of 50 per cent of the postgraduate seats and 100 per cent of the super-specialisation seats to the central pool, the ability of the State government to find the necessary candidates has been seriously compromised.

Further, private educational institutions are allowed to keep fairly high levels of seats in the management quota. Thus any student seeking admission in a private medical institution who is able to pay high fees and with enough influence to get selected would qualify with a lower NEET cut-off score. This system not only continues but is also encouraged within the language of the policy.

All of this emphasis on nationwide common examinations is presumably in pursuit of measuring merit in a manner that is blind to social and educational backgrounds—a sort of huge educational level playing field that encourages competition among students where the only currency is objectively measured merit. But then in a bizarre Freudian slip, the text of the draft policy has this gem: “This exit examination will be administered at the end of the fourth year of the MBBS so that students are

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relieved of the burden of studying for a separate, competitive entrance examination at the end of their residency period. *With the entrance examination out of the way, they can spend their residency period acquiring valuable skills and competence*" (paragraph 16.8.3, page 305). The true import of this is that the proposed measure of testing will not measure valuable skills or competence, even those that are learnt in the most crucial part of the medical curriculum, that is in the final year of clinical training. *De jure*, NEETs are the only basis for measuring learning. But *de facto*, the national common examination is accepted as a barrier to learning. The only use that NEET then has is as a device for ranking and sorting students into an apparent hierarchy of merit with all its attendant privileges and to exclude the rest and justify the exclusion.

Close to 1.47 lakh medical graduates appeared for the PG-NEET examination last year, of whom only about half are considered to have passed and only about 27,000 would get seats anywhere; of this, a much smaller proportion would be affordable seats. The majority of those who "fail" NEET would face frustration and guilt—all the more so because to get so far they might have had excellent academic careers and would be much better by temperament, attitude, experience and skill and even knowledge than those who made it. There are other unfortunate collaterals of this NEET-defined hierarchy of merit. One, for example, is that students who qualify with lower thresholds because of reservation quotas face discrimination which could get justified on this basis, although their work performance may be no less than that of the others. The recent tragic suicide of Dr Payal Tadvi was an example of this. The rich student in the management quota is, however, unlikely to face such a disadvantage.This hierarchy of merit takes other forms. There is, for example, the proposal to phase out all diploma education in nursing and make BSc the only nursing entry. Persons working in field situations would testify that not only is it impossible to close gaps in nursing cadre with only BSc nurses, but there are many field situations that diploma nursing students are better suited for. Similarly, a community health worker or a mid-level care provider is not an apology for not having a doctor. Rather, they are the most appropriate care providers in that given context.

One curious inconsistency in the draft is a proposal for periodic renewal of licences for nurses through some testing procedures, while there is no such clause for any other category of service providers—specialists, doctors or other allied health care professionals who may need such periodic skill upgradation and re-certification even more.

Empathy and values

On the challenge of creating health care professionals with empathy—scientifically competent, but also ethical, humane, caring, communicative, sensitive to concerns of equity, and socially accountable—the section on health care policy is a non-starter. This is surprising considering the almost poetic eloquence with which the importance of liberal education is set out in the introductory chapters of the higher education section. The introductory chapters posits liberal, broad-based multidisciplinary education as essential for developing "critical 21st century capacities" and defines this as including not only exposure to humanities and social sciences but also an ethic of social engagement (para 11.3.1, pages 234-235). It calls for

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professional education to be "cognizant of larger social concerns, and develop a mindset of public service and cultural awareness" and promises that professional and technical education will not remain narrowly focussed on technical expertise alone (Chapter 9, page 202). On the specific strategy to achieve this, it is proposed that "the practice of setting up stand-alone universities for professional education will be discontinued" as "the practice of setting up separate technical universities, health sciences universities, legal and agriculture universities in each State to affiliate colleges offering professional education in their respective disciplines has resulted in deepening the isolation further. All institutions offering either professional or general education must organically evolve into institutions offering both seamlessly by 2030" (page 301). It particularly condemns how in health care , education is offered largely in silos of individual subjects and separate from general higher education. Although the effort in professional education has been focussed mainly on making students ready for "jobs", the outcomes, in terms of employability, leave a lot to be desired (Chapter 16, page 293).

None of these laudable values seem to inform or animate the authors of the health care education section. Nowhere in the text of this section is any attention given to how we produce health care professionals who care, who feel for the individual and society. And whatever space emerges for such character-building locally or spontaneously would be swallowed up by the waves of MCQ (multiple choice questions)-based national examinations that the student would have to face. The proposals in this section are all examples of what is declared as wrong with professional education in the earlier section.

Allied health care providers

The paragraph on allied health care providers states that a "syllabus will be standardised pan-India, drawn up in conjunction with Health Universities and State Allied Health Sciences Boards.... These training programmes will be hospital-based, at those hospitals that have adequate facilities, including state-of-the-art simulation facilities, and adequate student-patient ratio". In this policy statement, the health university is retained, and the vision of the educational institution has given way to a description of a corporate hospital. Further, some of the jobs mentioned as priorities are very narrowly based on current corporate health care industry requirements (for example, general duty assistant), and more broad-based skills such as pharmacists and counsellors find no mention. Almost none of the essential public health skills merit mention.

As a concession to the imperative of regional equity in the creation of new health education institutions, the policy puts forth a proposal "to upgrade the nation's 600 district hospitals to become teaching hospitals, to train doctors, nurses and allied health care professionals". But is it so easy to transform district hospitals into educational institutions? Whatever happened to all those brave words about liberal education and multidisciplinary university? It is one thing to ask for district hospitals to be upgraded to tertiary care hospitals and linked to university-based medical colleges. It is quite another to talk of upgrading district hospitals into teaching hospitals "by investing in infrastructure" and "stationing adequately qualified teaching faculty". A proposal to identify districts with major human resource shortages and link these with medical colleges and health care

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institutions that are part of public universities providing subsidised or free education with affirmative policies to bring in more candidates who relate to local communities would have been welcome. What is stated now (*all* district hospitals are to be so upgraded), read in conjunction with repeated announcements and efforts to outsource district hospitals to corporate agencies, gives rise to fears that even this proposal may be a justification for providing private medical colleges an access to the clinical exposure that public hospitals provide.

The answers to any of the three challenges that a health care education policy faces are not easy, but they are available, and across the world many nations have learnt to address them. Even for the most difficult challenge of the three, providing health care professionals with empathy and ethics, there are many innovative efforts to learn from. Even within India, there are many good examples. Institutions such as the Christian Medical College, Vellore, have for over a century been identifying and training students from very remote and underprivileged communities and returning them successfully as sensitised, caring individuals to serve these communities for a number of years, while maintaining standards of excellence far above the average. (Far from learning from them, NEET has so comprehensively undermined these policies so much so that CMC Vellore has had to petition the Supreme Court to try and safeguard its mission—as yet unsuccessfully.) If select universities and regions did have the powers and flexibility and there was a suitable policy framework that ensured that such flexibility was only exercised in favour of the health care needs of the population and not for private profits, much could be improved.

But as it stands, the policy has not seriously engaged with these questions. It is contradictory to its own stated objectives of liberal education, fails to address concerns of equity in access to health care or access to health care education, and paves the way for an unhealthy commercialisation of education in this domain. There is a need for a rethink with more broad-based consultations, taking care to exclude conflicts of interest in the process of decision-making.

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