IMA WHITE PAPER ON PROMOTION OF FAMILY MEDICINE

Preamble

 70% Indians lives in villages.

 Basic Health care is lacking in villages.

 Certain states in India have well developed Rural Health work force. Eg: Andrapradesh, Tamil Nadu, Karnataka, Kerala, Gujarat etc

 Many States in India have large shortfall of Rural HWF Eg: Assam, Chhattisgarh, MP, UP, Orissa, WB etc Hence an alternate model of Rural Health care is needed for India

 MCI Act 1956 says MBBS is the Basic Medical qualification.

 Constitution Article 21 says Right to Health

 Article 14 says Equality

 80% of disease need Primary care

 China developed Barefoot Doctors.

 Mid level mobile Health workers are there in Sub-Saharan Africa.

 Even developed countries like UK, USA & Canada have developed Physician Assistants& Nurse Practitioners (NP) to meet the Health Challenges in remote areas.

Efforts by Govt of India to improve rural health care

1. BRMS → BRHC short term health workers course recommended
2.Posting AYUSH practitioners in PHC after undergoing bridge course.
Family Doctor or primary care physicians are the first rank in Health care delivery for the population. They play a vital role in Preventive health, early diagnosis and treatment of acute and chronic medical conditions with timely referral in addition to up keeping of health records of family members in the community and providing continuity of care.

Health workforce in India

Medical seats

The admission capacity in year 2013-2014 was about 50,078 students, at Undergraduate level and about 24,239 students, at Postgraduate level in India. (MCI Website, June 30, 2015)

According to the Medical Council of India (MCI), the total number of registered doctors in the country is 9,36,488 as on December 31, 2014 and that of auxiliary nurses midwives is 7,56,937 & registered nurses/midwives are 16,73,338 (Health Minister J P Nadda in Lok Sabha, March 13, 2015)

Six 'high HRH production' states (i.e. Andhra Pradesh, Karnataka, Kerala, Maharashtra, Pondicherry and Tamil Nadu) represent 31% of the Indian population, but have a disproportionately high share of MBBS seats (58%) and nursing colleges (63%) as compared to the eight 'low HRH production' states (i.e. Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttaranchal and Uttar Pradesh), which comprise 46% of India's population, but have far fewer MBBS seats (21%) and nursing colleges (20%).

India has 19 health workers (doctors – 6, nurses & midwives – 13) per 10,000 people. WHO norms provide for 25 per 10,000 people (Steering Committee on Health for the 12th Five Year Plan of the Planning Commission)

Though adequate number of MBBS qualified Doctors are in India, why there is a short fall of Doctors in primary care and rural India?
Key reason is today's medical graduates are trained and oriented towards Tertiary care with no exposure to primary care.

How to resurrect and strengthen primary care in our nation?

1. Department of Family Medicine

All medical colleges both Government and Private in India must have a department of Family Medicine. We have MCI approved post graduate qualification MD in India without department of family medicine.

This is the key Lacuna.

When new specialities are initiated barriers will be faced.

Like this in Family Medicine also issues will crop up. Unitil departments of Family Medicine are establishment in Medical colleges, this role could be played by dept of SPM

2. Faculty in Family Medicine:

a) Competent part of Family medicine DNB qualified specialities are available. They can be utilised as full time or part time Faculties.

b) Social and preventive Medicine specialities who have aptitude towards Family Medicine by Bridge course can be trained to be Faculty.

\c) Public Health Specialists can be utilised the same way

d) Internal medicine and other broad specialities within interest in Family Medicine must be trained and posted.

e) Community experience should be counted towards faculty eligibility.

Faculty cadre of Family Medicine as Assistant, Reader, Professors to be created with promotional opportunities and a distinctive space in field of Medical Education.

3. Training in Family Medicine:

UG training in Family Medicine department in the medical college with 6 months Community training in PHC, CHC to be done. During Internship also 3 months training to be given in PHC and CHC. Their posting in the Emergency room will help to be the first contact physicians in medical emergencies.

UG training in Family Medicine to be increased with atleast 6 months exposure in community settings. Community Based Education must be strengthened than tertiary care based system.

4. Curriculum in Family Medicine:

Like other Broad Specialties curriculum to be drawn and a separate paper in the pre final year to be included for Family Medicine.

Short term training programmes say 4-6 weeks, which can be developed by IMA-CGP and offered to inservice doctors posted at PHC/CHC as an immediate measure. These programmes can provide credits which a doctor can accumulate and get counted when undergoing PG Diploma / Degree in FM & S.

5. Positions in Health System:

After completion of MBBS their placement in the Health system will attract young Doctors. TO be posted in PHC, CHC, District Hospital NRHM & NHM with large funding can utilise the MBBS doctors in the rural posting with highremuneration package.

Recruitment rules for MO/CMO position in state cadre to include special incentives for Family Medicine Specialities.

PHC (primary health centre) should be re designated as "Family Health Unit" which should provide comprehensive primary health care instead of diseased focused public health intervention.

Family physicians should be placed at front line as team leaders of the "Primary Care Teams"

Finance and position are the key to attract Doctors in Primary care

6. Post Graduation:

In today's demanding Health scenario every young medical graduate is compelled to do Post graduation. Now MCI approved three year institutional MD Family medicine is existing but taken by vary few because of placements. When Department of Family medicine with positions are in place youth would prefer Family medicine. Remuneration must be compensatory for the rural working depending on hours of working

Engaging MCI/GOI for approval of revised Family Medicine & Surgery course (recommended by NCFM – national consultation on family medicine, 2013) which provides the Family Medicine doctor with LSAS, EmOC, Child Care and Skills to manage emergency.

Compulsory Rural Posting Vs Residency training in family medicine:

Most of the developed countries have adopted the strategy of large number of residency positions in family medicine in order to strengthen the human recourse in rural and remote locations.

By academic institutionalization of community health services (district hospitals, sub divisional hospitals, CHC, PHC etc) through appropriate regulatory reforms large number of family medicine programs can be initiated.

In future sub speciality course in Family medicine can also be introduced to create status for Family Physicians.

7. On line Post graduate Qualification in Family Medicine:

E learning in the order of the day in Education globally

When our Prime minister is promoting Digital India, Digital PG courses must be a reality in India.
Theory (Knowledge) component will be online. Skills (Clinical) Component will be by month end clinical training in Medical colleges or Accredited Private Medical Institutions- Blended Learning.

The curriculum and syllabus will be vetted and approved by Government of India.

This approved Digital PG course of Family Medicine will attract Young Medical graduates to undertake Family medicine post graduation while continuing their self-practice or Institutional both Government and private assignments .

This will solve the non availability of Medical Doctors in primary care in cities and rural areas.

Accessible and Affordable healthcare will reach for Indians.

Will also offer equitable healthcare to Indians both rural and urban as per constitution of India.

8. Engagement / Advocacy at State level for ensuring creation of FM positions at secondary care level

9. At this juncture IMA has taken serious cognisance of the move by GOI to post AYUSH doctors in PHC after crash course training programme as it will violate the article 21 and 14 of Indian constitution by not offering

Right to health and equality.
In addition this move of MOH will destroy the Primary Care Doctor system itself in India.

HLEG report:

To achieve required doctors, nurses and midwives per 1000 population, our requirement of medical colleges, nursing colleges & schools are as above. The fact that this statistics have been worked out taking into consideration that one doctor sees 25 patients per day where as in India, when a doctor sees 200 and above patients per day, this theoretical number is not immediately necessary.

What we need in more of nurses and midwives rather than medical doctors

So there is no need for a short term plan of training AYUSH Doctors for prescribing modern medicine drugs and posting them in PHCs.

Building Partnership:

Indian Medical Association is the Global largest NGO representing 2.5 Lakh of Qualified Modern Medical Doctors in India. Realising the value of Family Doctor in India, IMA formed an Academic wing as IMA College of General Practioners in the year 1963 and educations Primary Care Physicians to be scientifically strong to serve the Community.

IMACGP Courses in Family Medicine are very popular and so far thousands of Qualified Family Doctors pool has been created.

IMA & IMACGP are willing to partner with Government of India in this crucial decision and offer all the needed support.

Indian Medical Association has widely discussed the issue of "Strengthening Primary Care in India",

in the International Congress of Family Medicine held at Delhi on 25th and 26th July 2015 with experts in Family Medicine in India and South Asia region with representatives of Medical Councils of India and National Board of Examinations of India and request the Government of India and Ministry of Health to **adopt and strengthen Family Medicine in India** to **offer Equitable Affordable Accessible health care in India.**