White Paper
on
Rural Health India

Preample:

As the Father of our Nation said "India lives in villages".
Current Population of India is 1,349,841,263 (1.34 billion) as of January 23, 2018.
About 72.2% of the population lives in some 638,000 villages and the rest 27.8% in about 5,480 towns and urban agglomerations.
Today Hitech Health Care is available in Metros and Big cities but even Basic health care (Primary care) is not available to more than 70% people living in villages. **Hard Core Fact**

Many factors may contribute to this gap:

a. Failure to create Family Practice and Rural Health Practice oriented Doctors by the system in place today.
b. Paucity of Doctors. Doctor population Ratio is 0.62 per 1000 only.
Faulty Recruitment - majority
Less Production? less posts?
c. Doctors not serving and settling in Rural areas?
d. Lack of infrastructure facilities & safety

There are two dimensions that we should not lose sight when we critically analyse this issue. The first and foremost is that this **inequitable access** is not only due to Urban and Rural divide. There are social and economic factors which are the root cause of this discrimination. Levels of literacy and gender bias play a prominent part as well. **It is not by the geographical location alone that the rural Indian is denied access to healthcare. Poverty and social stratification take away his voice. The second dimension is that the consideration of patient safety is supreme and any relief should address it adequately.**

The gap that exists between Urban and Rural is both in infrastructure and in service delivery. ***Public sector spending accounts for less than a quarter of health spending.*** There has been a sharp reduction in capital investment in public hospitals and gross under funding of National Health Programmes. If one goes through the direction of health planning a clear shuffling is visible between primary health care and vertical programmes. This has confounded confusion right from policy level.

But planning to fill this Gap by "Compromised Health Workers" in the name of 'Crash Course to AYUSH' will be deterimental

Two standards of Health care for the citizen of India: This is against the fundamental right of the citizen of India. Blatant violation of Constitution against "Equality"

Alma Ata Declaration 1978 has said that Primary Health Care should include atleast: education concerning prevailing health problems, food supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health care, immunization and appropriate treatment of common disease.

- **MCI Act 1956 says MBBS is the Basic Modern Medical qualification.**
- **Constitution Article 21 says Right to Health**
  Article 14 says Equality
- **80% of diseases need Primary care & referral to other centres only.**

Doctor Indices

- Sixty years ago the total number of physicians was 47,524, with Doctor population ratio of 1 to 6300
- Minister of State for Health Anupriya Patel said as per information provided by the Medical Council of India, there were a total 10,22,859 Modern Medicine Doctors registered with the State Medical councils or Medical Council of India as on March 31, 2017.
  Assuming 80 per cent availability, it is estimated that around 8.18 lakh Doctors may actually be available for active service. It gives a Doctor-population ratio of 0.62:1000 **(1:1613**)as per current population which is estimated to be of around 1.33 billion," she said during Question Hour.
- **Urban–Rural disparities**
  Of all health workers
  59.2% were in **Urban** areas, where 27.8% of the population resides Doctor patient ratio around 1:500
  40.8% were in **Rural areas**, where 72.2% of the population resides Doctor patient ratio around 1:2000

Indian Medical Graduates : Medical council of India data on date says annually 67,218 Medical graduates are coming out of 479 Indian Medical Colleges. 40,479 Post Graduate seats are available in Medical Colleges.
Foreign medical graduates 7500 pass out every year out of which 25% get registration in the national medical registry / year by passing the Qualifying exam. That means 5600 x 7 years = 39200 graduates are jobless.
What this balance 27,000/Annum plus 39200 Doctors do?

But we do not have Doctors to serve in Rural or Urban areas. Why? Paradox

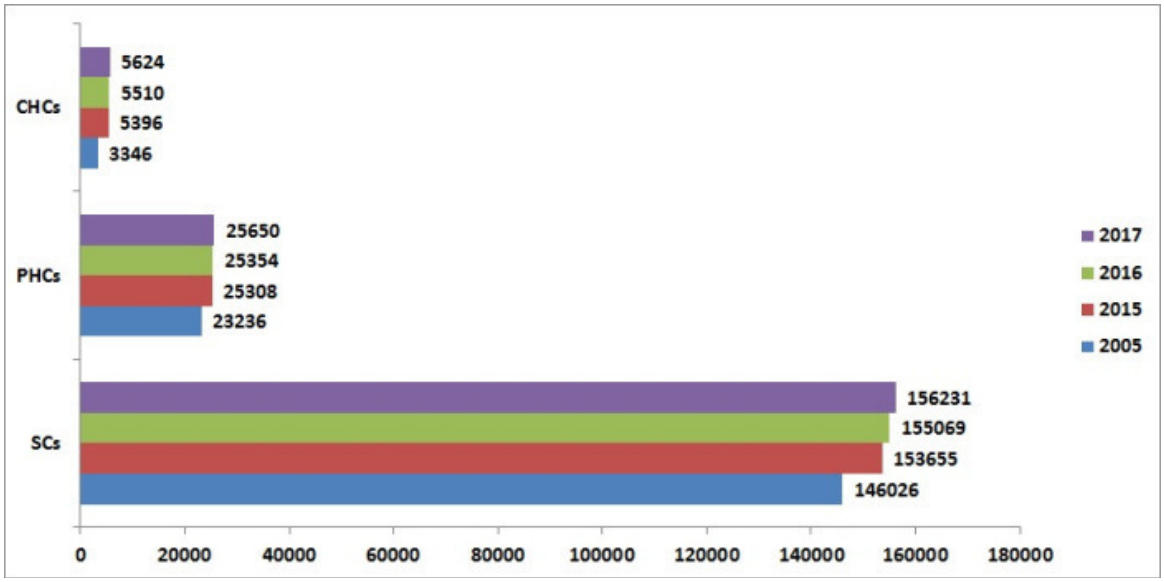
Rural Health Infrastructure:

- VILLAGE LEVEL-Managed by Village Health Guides, Local Dais Anagwadi Worker

- SUB CENTRE (1,38,000)- 5000-3000 Population-Managed by Multipurpose Health Worker
- PRIMARY HEALTH CENTRE (23,730)- 30,000 Population-Doctor
- COMMUNITY HEALTH CENTRE (3,276)- 80,000- 1,20,000 Population-Specialist Doctor

Rural Health Statistics 2017

- There has been a consistent increase in the number of sub centers (SCs), primary health centers (PHCs) and community health centers (CHCs) over the years but the current numbers are not sufficient to meet the population needs.



- Since the 6th plan for the years 1981-85 till the present 12th plan for 2012-2017, the health infrastructure has increased, but so is the population. Since 2005 to 2016 the number of SCs has increased by 6%, number of PHCs has increased by 9% and the number of CHCs has increased by 65%. **https://nrhm-mis.nic.in**
- **The population coverage status of the public health facilities in 2017:**

Health facility	Norm	Status (2017)
Sub Center	3000-5000	5337
Primary Health Center	20000-30000	32505
Community Health Center	80000-120000	148248

Rural Health

- As compared to their pre-independence levels, all health parameters have shown remarkable progressive improvement even in Rural India.

- States like Maharashtra are now producing surplus MBBS Doctors. The Government of Maharashtra has, therefore, decided to scrap the service bond to serve Rural
- Primary Health Centres (PHCs) are the cornerstone of Rural health delivery system. The number of PHCs has increased from 77 in the first plan (1955) to 23,887 in 2011, a 300 fold increase.
- 30 per cent PHCs have two or more Doctors and equal number provides 24 × 7 h services. The number of doctors at the PHCs has increased from 20308 to 26329 (addition of 1,200 doctors per year) in the period 2006-2011

Myth: The shortage of Doctors in Rural is a misplaced argument:

According the **Rural Health Statistics released by government of India**. As per 2016 there was a shortfall of Doctors at PHCs is only 3244 where India has currently capacity to produce 67,000 MBBS doctors per year.

The total number of posts sanctioned at PHC in India only 34068 about half of the current number of MBBS seats. **Apparently there is over supply of MBBS Doctor for whom there is no jobs in Government Sector. Create more posts for Doctors to work in Rural areas.**

Doctors at PHC India Rural Health Statistics Government of India	2005	2016
Doctors at PHCs Required	23236	25354
Doctors at PHCs Sanctioned	24476	34068
Doctors at PHCs In Position	20308	26464
Doctors at PHCs Vacant	4282	8774
Doctors at PHCs Shortfall	1004	3244

Fact: There are very less sanctioned positions of Doctors at PHC given the Indian population and hence high morbidity levels.

https://nrhm-mis.nic.in

The current reasons for non availability of Doctors in Rural areas are following:

Privatization of PHC in many states

Gazetted regular services of Doctors converted into low paid contractual services by Central and State agencies

No housing and other facilities for Doctors in Rural areas

Challenges in Rural Health

- 8% of the PHC centers do not have Doctors or medical staff
- 39% do not have lab technicians
- 18% PHCs do not even have a pharmacist.

- 66% of rural Indians do not have the access to the critical medicines
- 31% of the population travels more than 30 kms to seek healthcare in Rural India
- Half of all residents of Rural areas live below the poverty line struggling for better and easy access to health care and services & safe drinking water
- **Health issues confronted by Rural people are many and diverse** –
  -Malnutrition
  -from severe malaria to uncontrolled diabetes
  -from a badly infected wound to cancer
  -Postpartum maternal illness and contributes to maternal mortality,
  -Majority of people die due to preventable and curable diseases like diarrhea, measles and typhoid

Rural Health need public health worker and Primary care qualified Physician

The non-availability of modern medical Doctors in Rural areas in sufficient numbers is due to multiple reasons:

1. There is less number of medical colleges in states where there is shortage of Doctors
2. The syllabi and curriculum of MBBS do not give exposure to a Medical student regarding Rural heath scenario
3. The entrance examination system NEET for MBBS itself promotes city-based candidates to get admission
4. **The Doctor population ratio is not the only criteria for better health parameters**, e.g. Sri Lanka. It is the doctor, nurse, midwife, health worker population ratio which is more important. India has better doctor population ratio, the nurse, midwife, health worker population ratio is worst.
5. The Government instead of addressing all the issues related to Public Health, is trying to solve it by a single intervention of empowering AYUSH Doctors, which is going to have a disastrous effect on Public Health

Projected availability of Allopathic Doctors and Nurses by 2022

	2011	**2017**	**2022**
Allopathic Doctors, nurses and midwives per 1000 population	1.29	1.93	2.53
Population served per allopathic Doctor	1953	1731	1451
Ratio of nurses and midwives to an allopathic Doctor	1.53	2.33	2.94
Ratio of nurses to an allopathic Doctor	1.05	1.81	2.22

http://www.planningcommission.gov.in/

The overall picture of the health manpower.

India has 19 health workers per 10,000 people (Doctors – 6, nurses & midwives – 13). WHO norms calls for 25 per 10,000 people.

Among the 57 countries facing HRH crisis India is ranked 52.

Why professional do not prefer Villages

Studies have identified various reasons for so called shortage of Doctors in villages.

- Feeling of professional isolation
-Disparity in the living conditions e.g. railway colonies
- Low salary
- Safety
-Poor working condition

- "Estimates from studies indicate that there are about four times as many allopathic Doctors per 10,000 population in urban areas as compared to the Rural areas.

The seven **'high Human Resources for Health (HRH) production'** states (i.e. Andhra Pradesh, Telangana, Karnataka, Kerala, Maharashtra, Pondicherry and Tamil Nadu) with 31% of the Indian population, have a disproportionately high share of MBBS seats (58%) and nursing colleges (63%).

The eight '**low HRH production' states** (i.e. Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttaranchal and Uttar Pradesh), with 46% of India's population, have only 21% of MBBS seats and 20% nursing colleges.
In 2006, only 26% of Doctors resided in Rural areas, serving 72% of India's population and **density of nurses is three times higher in urban areas than Rural areas.**
The above facts clearly shows that there is less number of medical colleges in states where there are already shortage of Doctors (skewed distribution) The syllabi and curriculum of MBBS do not give exposure to a medical student regarding Rural heath scenario.The entrance examination system for MBBS itself promotes city-based candidates to get admission

Where do Medical Profession stand?
In the meantime, **Times of India**, NewDelhi has come out with a message dated 8th March 2010 "**Docs ready to work in Villages for PG Quota**". This outcome is following a world Bank sponsored collaborative study conducted in 10 Medical & Nursing Colleges of UP. This reveals the mindset of the young Medical Graduates of India; their willingness to work in Rural India.
The cat is out of the Bag. Solution is ready.
Around 1,00,000 young graduates are available in India in this pool. They will solve the issue of "Rural Health Crisis" today itself.

Alternate solution suggested by Public Health Activists is to reserve 25% seats in Medical Colleges to Rural students with a guarantee to serve in Rural areas for 5 years.

The 25% Reservation system will give MBBS Doctors after 5 ½ years.

The AYUSH promoted by GOI will offer poorly qualified Myxopathy Team

But the offer by young Medical Graduates will solve the crisis today itself. Thanks to the youth Medics.

Solutions to address Rural health issues.

A.Immediate Solutions:

- ***Budgetary provision*** for health should be increased from 1.1 of GDP to 5. Allotment for Rural health should be more.
- **Weightage for PG admissions. Utilising the unemployed pool of Doctors:**

The immediate answer to the "Rural Health Crisis" is to create a Reservation of 25% PG seats at Government Medical Colleges, of India to Doctors served in Rural areas for atleast 1-3 years depending upon the need of the State.

- Special package should be introduced to attract young Doctors.
- Offer attractive salaries, accommodation, nurseries, day care centers, and facilities for education of children.
- Transport facility
- Facility for academic activities like internet connection, e medical journals, library, allowance for attending CME's.
- Rural service by young Doctors should be given weightage either by seat reservation or 20% grace marks
- Preference to be given for these graduates in permanent appointment
    - Safety and Security by establishing Health Workers Colonies on the lines of Railway colonies.
    - Adequate paramedical staff, facilities for investigations and provision for necessary medicines in the PHC's.
    - Over the last 7 years there are about 39200 **foreign qualified Doctors** who are jobless. This category of medical personnel can be utilized in sub centres instead of AYUSH or Nurse practitioners. As and when they pass qualifying examination they can be promoted as medical officers in PHCs. **Immediate results yielding solution.**

    - In Digital India **Digital Health** can definitely compensate the deficiency of HealthWork Force in Rural Areas.
      Bluetooth enabled stethoscope, BP apparatus, Glucometer, Thermometer, ECG etc can be handled by Nurses / Health Assistants to be transferred to the nearest CHC / District Head quarters or Medical College Hospital for interpretation. Tele Consultation can be done with specialist**. This will be another immediate solution.**
- **Mobile Health**. Mobile vans with Health workers can reach to unreached areas to offer Primary Care. If necessary can transport patients for Secondary & Tertiary Care.

- **Mobile Telemedicine**: Mobile vans with Telemedicine equipments can reach to Rural India & offer Primary care & monitor NCD & other Chronic Diseases can link to Base Hospitals in CHC or District Headquarters. Proven benefit to NCD, Secondary & Tertiary Care
- **Rural IMA Clinics**
  Indian Medical Association is the largest Global Professional NGOs with 3Lakh Members located upto Rural India
  Rural IMA Clinics can be adopted villages by local IMA Branches. Retired Doctors can be used to run these clinics in fixed hours Logistics has to be worked up.
- As you know, in countries like UK, where they have a National Health Service comparable to India's Primary Care system, GPs enjoy special status- often higher than a specialist. We speak of Universal Health Care now. Our neighbour Srilanka is a good example. To quote, " *Sri Lanka's model of primary health care, available free through a government health system with island wide availability, forms a sound basis for providing universal health coverage. ... Also known as MOH areas, they are managed by a medical doctor, supported by public health field staff.* "
  Streamline immediately Indian Healthcare into Primary, Secondary & Tertiary with great emphasis on Family Doctor System
- **Compulsory Rural posting of 1 year after internship may be considered in select needed states**

B.Long Term Solutions:

- Create "**Rural Medical Colleges/ Schools**" by strengthening District Head Qs Hospitals where there are no Medical Colleges. In India there are roughly 600 Districts but only around 300 Medical colleges are available Hence 300 more Medical Colleges at Districts Head Quarters is possible. With an annual intake of 50/100 students annually, 15,000/30,000 more Doctors will be available in another 5 ½ years. The Rural Health issue will be sorted out permanently. This can be tailor made as per the local need.

  MCI will debate on Infrastructure and Faculties.

Already District Head Hospitals are available with 200 Beds.

NRHM is offering crore 50 per "Rural Health School". The average cost of a Medical college in India is only Cr 100/. With NRHM contribution these colleges can be created & sustained. In Tribal & Remote areas always relaxation of norms by MCI is available.

Next issue debatable in Faculties for Rural Medical Colleges.

We are ready to accept the services of Retired Teachers. The same can be offered here too.

More over, private health care is 70% in our country. Lots of teachers are available in **Private sector.** These Rural Medical Colleges can avail these services on fixed hours by fixed payment. Faculties solved.

These "Rural Medical Colleges" will select students in the villages with a guarantee to serve in the birth villages for 5 years. Later they can go for PG. This restors the Independent Rights of the citizen of India too.

- **A simple workable solution is Reservations in NEET for Rural Candidates with bond for Rural Service for atleast 3 years in needed States.**

Next is the issue of Specialists in CHCs:

The shortage of staff is chronic in case of CHCs. The CHCs in Rural India are suffering from '**missing Doctors syndrome'.** Nearly 82% of the posts of specialists in the CHCs are vacant.

- With the relaxation on norms for Teachers in Post graduate medical education, from one Student per Teacher to 2 Students per Teachers the PG Medical seats are going to doubled in the country. This will produce adequate number of specialists to man the CHCs. Only issue is their salary & service conditions and Rural access have to be improved. CHC issue is over.
- **As in Developed Nations Undergraduates, Postgraduates seats in country must equal. This will close most of the gaps.**
- One approach to solve lack of specialists in CHC's may be to post Postgraduate Medical Students at the CHCs, which are expected to provide minimum specialist services to villagers, as part of rotating posting of MD/MS courses.

Next is the issue of manning sub centers: Adequate Para Medicals are not available. True.

The Rural Medical Colleges can create "Rural Health Nurses, Pharmacists, Nursing Assistants" with 3 ½ years of teaching & training to work in sub centers. They will be given adequate exposure on Disease Prevention, Common ailments prevalent in Rural areas, National Health Programmes and Referral. This needs only 3 ½ year period of training for Nurses, Pharmacists & 1½ year period of training for ANM

Reshaping Medical Education in India

–Strengthening Primary Care in India UHC has to be built on Primary Care not on Tertiary Care

- Todays Medical Education has exempted Family Medicine / Primary care out of curriculum of UG Medical Education but PG in Family Medicine is available. Paradox. Todays Doctors don't have any feel or exposure to Primary Care but only trained in Hi Tech Tertiary Care. This is the basic defect in Indian Medical Education & Healthcare. Hence todays Doctors are reluctant & afraid of going to Rural India & offer Primary Care.

- **The moorings of our Rural HealthCare Problem lie in the System lapse that has penetrated deep into the very nature of Medical Training India has fostered over the years.**

The right solutions for Rural Health will be:

a) Create Department of Family Medicine in all Medical Colleges both Public & Private. Immediately the Community Health care department be converted to Family Medicine. Faculties can be chosen from MD Internal Medicine, MD Family Medicine, DNB Family Medicine & MD Community Medicine. Later MD Family Medicine alone can handle this Department.
b) Posting of UG Students in Family Medicine Department. 6 months in every year of Medical Training in Rural areas.
c) There must be a Prescribed Text Book of Family Medicine with Syllabus & Curriculum. This will reshape today's Medical Education.
d) There should be a paper in Final year examination like Medical, Surgery, O & G, etc
e) Internship Posting must be in PHCs for 3 months. Then the outcoming MBBS Doctors will develop interest to work in Rural India.

This will only be the definite long term solution for Rural Health & UHC.

<u>Other Solutions</u>

- Formation of NATIONAL MEDICAL CADRE where by young Modern Medical Doctors pool is created and they can be posted in PHC's where local doctors are not available on a special package as mentioned above.
- Public Private Partnership- for starting hospitals or medical colleges in Rural areas.
- Posting Undergraduates MBBS Students during Internship 4 months in PHCs. It is included in training but not practiced.
- In needed areas compulsory 1 year Rural posting for PG application.

- Each postgraduate student should spend a fixed time (*e.g.* six months) at a CHC in the second year of his/her training
- Strategic outsourcing of specialist care from the private sector.
- **Health Insurance for Primary Care:**

None of the Government Scheme & Insurance address Primary Care which is the cause for high (OOPE) out of Pocket expenses

The current well appreciated Globally vast National Health Protection Scheme is also silent on Primary Care. When 50Crore of the population are going to be beneficiaries it must include Primary Care too. Then Rural Health will spontaneously improve

In a Nutshell the needs of Rural Health are solved as below:

1. **PHC - Doctors** – Carrot of PG Reservation Quota for Rural service and Rural Medical Colleges creating more doctors. Quota in NEET for Rural services utilize Foreign Medical graduates' services.
2. **CHC - Specialists** – Equate PG & UG seats . PGs to be posted. Improve salary & service Conditions
3. **Sub centres:** ParaMedical - Rural Health Assistants.

All the PHCs are ill equipped, poorly maintained & have poor supportive staffs.

Improving the Infrastructure & Manpower in PHC is another key to attract Young Doctors

Hope the above is the realistic remedy to the "Rural Heath crisis" in India.

Why not AYUSH

Is alternate streams cheaper?

The country has 7.37 lakh practitioners of alternative medicine streams like Ayurveda, Siddha, Homeopathy and Unani registered with the AYUSH Ministry and over 3,600 AYUSH hospitals, the Rajya Sabha was informed. Among them, Ayurveda practitioners' number is 3.99 lakh, while Homeopathy practitioners amount to 2.8 lakh

Average medical expense per child birth, national average in Rupees

MODERN MEDICINE			OTHER STREAMS		
Public	Private	ALL	Public	Private	ALL
1589	14761	5547	1235	26771	4603

In some of the states, even within public system, modern medicine is cheaper than alternate systems

Limited resources and inequity in allocation

AYUSH allocation and utilization of central fund in CRORES

Budgetary allocation for health – the key to improving public health

- In 2015 budget, total health allocation decreased by 5.7 %
- **But out of 33,152 crore AYUSH gets 1,214 crore (3.7%)**
- **Whereas 0.5% of population use AYUSH for health care**
- The approved allocation of the AYUSH department has been increasing progressively over the years.
- The allocation of the 12th Five Year Plan of Rs.10,044 crore amounts to an increase of 235 per cent over the actual expenditure of 11th plan

Failed Experiment.

- Under NRHM, services of AYUSH practitioners are utilized for managing common childhood illness, counselling on family planning methods and as Skilled Birth Attendants (SBA).
- Even allowing AYUSH practitioners as SBA will definitely result in mismanagement of new born.
- **The infant mortality rate has not decreased in the states where this has been done.**

Supreme court Judgement

- Supreme Court Judgments that AYUSH Doctors cannot prescribe allopathic drugs are very clear in **Poonam Verma Vs. Ashwin Patel and Others (1996) 4 SCC 332**
- CROSSPATHY, has been held ILLEGAL, as per the landmark judgement of the Hon.Supreme of India (Poonam Verma versus Ashwin Patel, 1996AIR 2111). "A person who does not have knowledge of a particular System of Medicine but practices in that System is a Quack and a mere pretender to medical knowledge or skill" , said the honourable court.
- Bridge courses would mean ; legalising the QUACKERY by backdoor entry.

National consumer disputes redressal commission

- Original petition no 214 of 1997
- As laid down by Apex Court in the Jacob Mathew case, we feel it is high time that hospital authorities realize that the practice of employing non-medical practitioners such as Doctors specialized in Unani system and who do not possess the required skill and competence to give allopathic treatment and to let an emergency patient be treated in their hands is a gross negligence.

So taking into consideration of the Supreme Court and consumer court judgments- constitutionally and legally AYUSH practitioners should not be allowed to practice or prescribe Modern Medicine.

AYUSH Bridge Course

Posting of AYUSH Doctors after Bridge course in PHC's and SC's is not a solution for improving Rural Health.

The role of Doctor at the PHC is 20% curative and 80% preventive including immunization and improving S**ocial Determinants of Health.**

More over there are more than 7.5 lakhs of AYUSH practitioners. **When we need hardly 5000 Doctors more to fill vacant posts in PHC's what is the criteria to choose 5000 AYUSH Doctors out of 7.5lakhs.**
AYUSH is a pride of Indigenous origin. Let us not degrade it. Let us grow it parallel with evidence base. Many AYUSH organizations have expressed their non acceptance of the Bridge course.
It would be a death blow, to the Alternative system of medicine and degradation of Allopathic modern system. Thus , effectively 'killing' the proverbial , **'two birds' with 'one stone'**(the NMC Bill section 49 being the proverbial culprit).
Allowing AYUSH graduates to practice modern medicine is just like trying to fit in a square plug in to a round hole

Typical example is "Chhattisgarh Model" which is lying idle without takers.

The backbone of health care in any country is the **Family Doctor system**. By posting AYUSH practitioners in PHC, **Government is destroying the Family Doctor system.** Family Doctors are the first link in health care delivery for the population. They play a pivotal role in preventive health, early diagnosis and timely referral, up keeping of health details of Family members. Instead of destroying the Family Doctor system, the service of the Family Doctors in the respective PHC area particularly where Government doctors are not available, can be used on a retainership basis.

If AYUSH are to be posted in PHCs they can be put on their system not on Modern Medical System.

- **Many Drug companies are promoting Modern Medical training to AYUSH Doctors to push their drugs. This too has to be banned.**
- **Compulsory bonded service or AYUSH will not solve Rural Heath problem. May be of little temporary benefit. The New Cadre of AYUSH Doctors will create chaos in the Health System. How long they will continue services in Rural India. Will be attracted by urban comfort & come out from Villages.**

Conclusion:

- Budgetory Health allocation should be minimum of 5%GDP with more share to Rural health
- To achieve required Doctors, nurses and midwives per 1000 population, our requirement of Medical colleges, nursing colleges & schools are huge & not realistic. Not needed too.

- The fact that this WHO statistics have been worked out taking into consideration that one Doctor sees 25 patients per day as in western countries, where as in India, a doctor sees 200 and above patients per day. **So this theoretical number is not an immediately necessity.**
- **Shortfall of MBBS Doctors is a Myth.**
- **Doctors not going to Rural Area is a procedural lapse by GOVT**.
- **Create more posts for Doctors to work in Rural areas.**
- Immediate solution is utilizing the services of unemployed MBBS Doctors & Foreign Qualified Doctors for PHCs. Postgraduate students for CHCs.
- **NHM** to be empowered as an Autonomous institution.
- Doctors' recruitment to be kept in phase with the increasing population but it needs adequate Financial allocations.
- What we need is more of nurses, midwives and health workers rather than medical Doctors alone to achieve better health parameters.
- When developed countries and even emerging economies are utilizing post graduates in Family Medicine as primary health providers, India cannot afford to dilute our standards by leaving health care of the Rural population to under qualified personnel.
- AYUSH Crash course & posting will also cost Public money spending. While spending Public money let us proactively spend it.
- Bridge course will encourage craze commercialization of Medical education & would prove disastrous to the People's Heath.
- Addressing **Social Determinants of Health** and **increasing budgetary allocation** are the need of the hour.
- **Linking Clinical Medicine with Public Health is the way forwad towards UHC which can happen only through Primary Care.**

Health to all without public spending will continue to be a nightmare.

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