

DELIVERING THE RIGHT TO HEALTH TO THE RURAL SECTOR

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One of the top medical schools in Karnataka offers a pocket pinching bond of Rs. 6,00,000 to the medical students if they refuse the compulsory rural service after their graduation. What is even more striking is students often opt for forfeiture of the bond than agree to a secondment in a village! The Ministry of Health, by considering the proposal of compulsory rural internships for students of medicine in 2007, has opened a can of worms. There has been a lack of consensus in the medical fraternity regarding the feasibility of the proposal. Students have constantly resisted the idea as it means extending their course to a term of six years. While on one hand, the State considers the compulsory internship as an instrument to fulfil obligations as a welfare state, medical students protest on, what they feel is a form of conscripted labour. Can the students argue that their rights under Art. 19(1)(g) stand violated by this compulsory form of service or can the State demand rural service in return for a subsidized medical education? This paper tries to present the debate between the medicos and the State against the larger outlay of public health as well as constitutional freedoms. An attempt has been made to evaluate the merits of arguments made on both sides and present an efficacious model reconciling their concerns, in light of the larger issues involved.

I. INTRODUCTION

The rural health sector in India, if not nonexistent, is still at the very least, in shambles. Originally conceived to be an integrated system of providing access to both traditional and modern means of medicine to individuals, it remains nearly sixty decades after independence a hollow promise.¹ Its urban counterpart on the other hand, though hardly in the pink of health, has fared relatively better. The urban-rural divide has been the main plank on which many of the policies of the Government to meet rural health needs have been built. Two new schemes, in different stages of development in this regard are: one, the Compulsory Rural Medical Service Scheme ('CRMS'), where medical students are expected to spend an extra year after their fifth year internship

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¹ P.S. Appu, *Eleventh Plan and Health Care*, THE HINDU (Chennai) November 24, 2009.

working in the rural health sector and two, the Bachelor of Rural Medicine and Surgery ('BRMS') where locals are trained in basic medicine for a three to four year period and are expected to meet the essential health needs of their rural area. Interestingly, the medical fraternity has been up in arms against both the schemes.

Regarding the first scheme, the medical students are the most vociferous in their opposition. They heatedly declaim it as being in violation of their rights. They assert that it not only makes an already arduous medical education process lengthier and more complicated, but also ends up giving them a raw deal in the form of temporary postings and not permanent jobs for rural doctors. Moreover, they claim that the scheme would not in any way alleviate the rural health services from its present ignominy, as there are structural deficiencies that needed to be sorted out. Thus, though various states such as Kerala and Maharashtra have passed laws in furtherance of the compulsory rural service system, the strikes and protests are not likely to die out any time soon and the scheme is likely to face judicial scrutiny.

The second scheme has on the other hand drawn harsh criticism from the upper echelons of the medical fraternity with the Indian Medical Association ('IMA') labelling it as a process of creating half baked doctors.² It would be, its critics argue, legalising quacks and encouraging them to dabble in allopathic treatment with dangerous consequences. It would also be a legal sanction to treat rural and urban patients in a different and discriminatory manner. Others, however, feel that keeping in mind the present scenario, barefoot doctors³ may be the saving grace of an otherwise hopeless situation.⁴ Giving them training and legalising their activities would not only provide for the basic medical needs of the rural people, but would also help to increase the accountability of these practitioners who would otherwise exist outside the ambit of the law. The scheme has been put into effect in states like West Bengal⁵ but here too the matter is up for challenge in court.

The judiciary is therefore likely to find its hands full as it tries to make sense of the different demands. On one hand there is the urgent need to provide the right to health to all which is a State duty under Art. 47 and which is furthermore a fundamental right under Art. 21. On the other hand, there is

² The Hindu, *Protest Against BRMS course*, THE HINDU (Thiruvananthapuram) January 28, 2010.

³ Szubha, *Barefoot Doctors for India*, available at <http://www.szubha.com/content/2010/mar/01/barefoot-doctors-for-india/> (Last visited on March 10, 2010). (Barefoot doctors in China are trained farmers who help healthcare reach villages where well qualified doctors will not like to settle down).

⁴ *Id.*

⁵ TargetPG, *West Bengal Passed the Controversial Rural Health Regulatory Authority Bill 2009*, available at http://www.targetpg.in/2010/03/02/courses/brhc_brhs_brms/wb-rural-health-regulatory-authority-bill-2009/1397 (Last visited on March 21, 2010).

the question of whether there is a proper or appropriate way of delivering this right. It is important when deciding on these issues that a holistic approach is undertaken regarding the same rather than studying the two schemes in isolation. Both the schemes are meant to address, after all, a common malaise and through this paper, we try to analyse the relative merits of the schemes and the line of reasoning that the court is likely to take.

II. RIGHT TO HEALTH

India's commitment to providing healthcare to its citizens stems not only from its constitutional mandate and progressive interpretation of the duty of the State, ascribed to it by various judicial pronouncements but also from its international commitments. In this part, both the State's duty to provide health as well as the nature of the right to health available to the people is sought to be highlighted.

A. RIGHT TO HEALTH IN AN INTERNATIONAL CONTEXT

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition.”⁶

It is of some academic interest to note that it was India's first prime minister Jawaharlal Nehru who put forward the proposal for the set up of the World Health Organization,⁷ the principle organ of the UN responsible for health issues, and which had come up with the definition of health in its inclusive form above. Even though the term ‘health’ was defined, the right to it was not clearly enunciated. The earliest mention of health comes in the United Nations Charter (‘the Charter’) which calls for under Art. 55(b) the promotion of solutions of international economic, social, health, and related problems for stability and well being in the world.⁸ Furthermore, under Art. 56, Member

⁶ Constitution of the World Health Organization, available at http://www.who.int/governance/eb/who_constitution_en.pdf (Last visited on Feb 25, 2010).

⁷ World Health Organisation, *Chronicle of the World Health Organization*, Volume-II 1948, 54, available at http://whqlibdoc.who.int/hist/chronicles/chronicle_1948.pdf (Last visited on February 27, 2010).

⁸ United Nations Charter, 1945, Art. 55(b): With a view to the creation of conditions of stability and well- being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

(a) Higher standards of living, full employment, and conditions of economic and social progress and development;

States pledge to jointly and separately cooperate with the UN to achieve the purposes set forth in Art. 55.⁹ It has been pointed out that the Charter does not talk of health in terms of rights but in terms of a problem which needs to be solved in order to achieve well being in the world.¹⁰

Again, in the Universal Declaration of Human Rights, 1948 ('UDHR') Art. 34 declared that everyone was entitled to adequate standards of living for the health and well being of self and family including among other essentials medical care.¹¹ The right to health, however, has not been directly mentioned. The State is not being asked to directly provide essential medical care; instead it talks of placing an individual in a position wherein he would be in a position to achieve the same.¹²

Thus though the Charter and the UDHR did talk of health it was not till the International Covenant on Economic, Social and Cultural Rights ('ICESCR') that there was any clear recognition of the right of an individual to health. Art. 12(1) provides that the individual has a right to the highest attainable standard of physical and mental health.¹³ Furthermore, Art. 12(2) included specific steps that the States would have to base their policy on in order to realize the right to the fullest extent possible which included ensuring of medical services, prevention of epidemics, endemics etc.¹⁴ Firstly, Art. 12(1) injects a degree of practicality to the nature of the right to health. It is the best possible level of health, both physical and mental, that is attainable- a standard which may not perhaps be ideal.¹⁵ The wording of Arts. 12(1) and 12(2) read together is again of interest. On one hand they may be read as being complementary to each other- Art. 12(1) highlighting the individual's right to health and Art. 12(2) fledging out the State's duty to provide the same.

(b) Solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and

(c) Universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.

⁹ *Id.*, Art. 56: All Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Art. 55.

¹⁰ Steven D. Jamar, *The International Human Right To Health*, 22 S.U. L. REV. 1, 20.

¹¹ See Universal Declaration of Human Rights, G.A. Res. 217A, U.N. Doc. A/810 (December 12, 1948) §34. Preamble, 71-72. (It also provides that vulnerable health populations, such as pregnant women and children, are entitled to special protection).

¹² Jamar, *supra* note 10, 21. (The author provides the example of the individual being provided with a job with enough salary to achieve the objectives of this declaration).

¹³ See International Covenant on Economic Social and Cultural Rights, 1966, Art. 12(1).

¹⁴ *Id.*, Art. 12(2): The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;(b) The improvement of all aspects of environmental and industrial hygiene;(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

¹⁵ Jamar, *supra* note 10, 24.

On the other hand, it can be said, that the wording of Art. 12(2) is more in the nature of a checklist consisting of steps that the State would have to tick off as and when it decides to achieve the full realization of the right. Thus it is up to the State as to when it wishes to recognize this right and to decide as to what extent it wishes to recognize it.¹⁶ This again has to do with the understanding that it may not be possible to immediately achieve the right to health to its fullest potential firstly perhaps because of the inadequacies of a State's resources and also perhaps because this standard is subject to change over time.¹⁷ The Council for Economic and Social Rights has, however, made it clear in its comment that the State has to provide at least essential primary healthcare, in the absence of which it would be *prime facie* failing to discharge its obligations under the ICESCR.¹⁸

Apart from these generic international commitments, India was also part of the important Alma Ata conference of 1978¹⁹ which had declared as its goal 'Health for All by 2000 A.D.'²⁰ It had specifically talked of the State's responsibility to ensure the availability of essential primary healthcare.²¹ The Alma Ata Conference is important for our discussion because it explicitly stated that the attainment of health is a fundamental human right. Again it sets as the goal of attainment of the highest possible standard of health, though instead of focussing just on the State, it talks of the need for cooperation between various economic and social sectors and not just the health sector.²² This seemed to come from an understanding that for the attainment of health, there were various overlapping economic and social conditions necessary.²³

Thus on the international forum, although it seems to be now commonly agreed that there exists a right to health, the nature and extent of it that is promised to the individual varies and is left largely to the State's discretion.

¹⁶ Jamar, *supra* note 10, 23.

¹⁷ Jamar, *supra* note 10, 26, 34, 35.

¹⁸ Jamar, *supra* note 10, 42.

¹⁹ Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 1978 available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf (Last visited on February 25, 2010).

²⁰ Anand Phadke, *Right to Health Care Towards an Agenda*, Vol. 38 No. 4 ECONOMIC AND POLITICAL WEEKLY 4308 (2003).

²¹ NHRC, *Regional Consultation on Public Health & Human Rights Report and Recommendations* available at <http://nhrc.nic.in/publications/publichealthtext.pdf> (Last visited on September 18, 2011).

²² Declaration of Alma-Ata, *supra* note 19: The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

²³ David A. Tejada de Rivero, *Alma-Ata Revisited*, available at http://www.paho.org/english/DD/PIN/Number17_article1_4.htm (Last visited on March 1, 2010).

B. RIGHT TO HEALTH IN INDIA

In India, the judiciary has interpreted the constitutional provisions in a manner as to empower the people with the fundamental right to health. Public health had been bundled up as part of other State duties such as providing standards of living, nutrition etc. under Art. 47 of the Directive Principles of State Policy ('DPSPs'). It is noteworthy that Art. 47 counts improving public health as one of State's primary duties, however, the right to health could only be substantially fleshed out when the court began reading Art. 21 progressively. Ever since the landmark judgment of the Supreme Court in the *Maneka Gandhi v. Union of India*, Art. 21 has come a long way from being interpreted in a narrow manner by which only procedural irregularities could be combated, to its present broad and expansive ambit which has been evoked to protect the life and liberty of the individual time and again.²⁴ Courts have progressively interpreted the right to life under Art. 21 as being a right to live with human dignity and not a state of mere animal existence.²⁵

In cases such as *Paschim Bangal Khet Mazdoor Society v. State of West Bengal*²⁶ there is a straightforward understanding that denial of treatment facilities would lead to the denial of life under Art. 21. The court therefore held:

“Article 21 imposes an obligation on the State to safeguard the right to life of every person. Preservation of human life is thus of paramount importance. The government hospitals run by the State and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of the government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21.”

Furthermore, courts have also stressed on the State's welfare duties as being complementary with the individual's fundamental rights. In

²⁴ *Maneka Gandhi v. Union of India*, (1978) 1 SCC 248; AIR 1978 SC 597. See Francis Coralie Mullin v. Administrator, Union Territory of Delhi, (1981) 1 SCC 608; 1981 SCC (Cri) 212; AIR 1981 SC 746 (In fact the court opines that Art. 21 has developed a highly activist magnitude).

²⁵ K. Mathiharan, *The Fundamental Right To Health Care*, available at <http://www.issuesin-medicaethics.org/114hl123.html> (Last visited on March 11, 2010); See also Kharak Singh v. State of Uttar Pradesh, AIR 1963 SC 1295; (1963) 2 Cri LJ 329; [1964] 1 SCR 332. (Subba Rao J. in *Kharak Singh* had quoted the following passage from the judgment of Field J. in *Munn v. Illinois*, 94 US 113 (1876) to emphasize the quality of life covered by Art. 21: “By the term ‘life’ as here used something more is meant than mere animal existence”. This famous quotation has become a staple ingredient when interpreting right to life under Art. 21).

²⁶ *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, (1996) 4 SCC 37; AIR 1996 SC 2426.

Bandhua Mukti Morcha v. Union of India,²⁷ the Court opined that Art. 21 derives its life breath from the DPSPs and in the narrow issue of worker rights held that at least it must include the protection of health of the workers and the children.²⁸ Thus understanding that the individuals are entitled to live with dignity and the State, as a welfare state, has a duty to provide the conditions necessary for such a life has played an important role in moulding of a right to health in India.²⁹

The reading together of Arts. 47 and 21, has led to further development of right to health. The Court thus held in *Vincet Panikurlangara v. Union of India*³⁰ that “attending to public health, ... is of high priority- perhaps the one at the top.” Furthermore, in *State of Punjab v. Ram Lubhaya Bagga*,³¹ it has been held that:

“... to secure protection of one’s life is one of the foremost obligation of the State, it is not merely a right enshrined under Article 21 but an obligation cast on the State to provide this both under Article 21 and under Article 47 of the Constitution. The obligation includes improvement of public health as its primary duty.”

The Court has also crucially highlighted that lack of resources will not be an excuse for providing adequate healthcare. In *Paschim Bangal Khet Mazdoor Society v. State of West Bengal*,³² while detailing the facilities that should be made available at primary and district health levels, it was pointed out that:

“It is no doubt true that financial resources are needed for providing these facilities. But at the same time it cannot be ignored that it is the Constitutional obligation of the State to provide adequate medical services to the people. Whatever is necessary for this purpose has to be done.”

²⁷ *Bandhua Mukti Morcha v. Union of India*, (1984) 3 SCC 161: 1984 SCC (L&S) 389: AIR 1984 SC 802, 811.

²⁸ *Id.* (“This right to live with human dignity enshrined in Art. 21 derives its life breath from the Directive Principles of State Policy and particularly clauses (e) and (f) of Arts. 39, 41 and 42 and at the least, therefore, it must include protection of the health and strength of workers men and women, and of the tender age of children against abuse, opportunities and facilities for children to develop in a healthy manner...”).

²⁹ Sheetal B. Shah, *Illuminating the Possible in the Developing World: Guaranteeing the Human Right to Health in India*, 32 VAND. J. TRANSNAT’L L. 435.

³⁰ *Vincet Panikurlangara v. Union of India*, (1987) 2 SCC 165: 1987 SCC (Cri) 329.

³¹ *State of Punjab v. Ram Lubhaya Bagga*, (1998) 4 SCC 117: 1998 SCC (L&S) 1021: AIR 1998 SC 1703.

³² *Supra* note 26.

Though the judiciary has thus accepted the fundamental right of the individual to health and has called upon the State to do all that is necessary to ensure this right, the ground reality of healthcare facilities in India, especially the rural sector leaves much to be desired.

C. RIGHT TO HEALTH IN REALITY WITH REFERENCE TO THE RURAL SECTOR

Western medicine was introduced in the country largely to cater to the colonial settlers and their sepoys in the army.³³ While elite India had the options of availing benefits of western medicine, the Indian masses were left to be catered to by the indigenous system and its practitioners. The vast majority of the rural population had no opportunity of coming into daily or even an occasional contact with ‘qualified’ medical practitioners.³⁴ For the same, the British Government introduced the licentiate form of medical practice in the country. This Licentiate Medical Practitioner (‘LMP’) course was for three to four years, often in the vernacular and geared to general practice in small towns and rural areas,³⁵ so as to ensure that the rural population had an access to the minimum standard of healthcare services.

Even before independence, the issue of the dilapidated status of rural healthcare system in the country was tabled at national forums. The Committee for National Health, chaired by Col. Santok Singh was constituted by the National Planning Committee of the Indian National Congress in 1938.³⁶ The Santok Committee submitted a report reflecting the pathetic status of medical facilities and infrastructure in large parts of the country, and recommended the constitution of a single State agency to ensure the availability of health facilities and medical services to all.

In 1946, the Committee constituted under the chairmanship of Sir Joseph Bore (the Bore Committee) published a report that transformed the healthcare system of the country. The report laid emphasis on integration of remedial and precautionary medicine at all levels and presented constructive proposals for restructuring of health services in India.³⁷ One of the recommendations in the report was the decentralization of health services with a three-tier system: keeping district as the coordinating unit, the sub-division as the unit of specialization and the primary level (the village) serving as the nucleus

³³ SONYA GILL, *HEALTH STATUS OF THE INDIAN PEOPLE* (1987).

³⁴ *Id.*

³⁵ Meenakshi Gautham, *Merit versus Social Responsibility*, *THE HINDU* (New Delhi) July 23, 2006.

³⁶ GILL, note 33, 4.

³⁷ National Institute of Health and Family Welfare, *Committee & Commission*, available at http://nihfw.org/NDC/DocumentationServices/Committe_and_commission.html (Last visited on March 10, 2010).

for efforts of integration of preventive and curative health services. It also suggested the participation of community in ensuring the availability of health services to all. This was to be done by training voluntary workers, who would be known as the Community Health Workers ('CHW') selected by the medical officer and approved by the people of the region. The practice, however, could not survive the lack of organization in the system and gradually faded away.³⁸ One of the much critiqued recommendations of the Bhole Committee was the call for abolishing the LMP degree. The committee based the recommendation on the popular European traditional belief in the need for uniformity in education and therefore recommended standardization of medical education by a rigorous degree of five-and-a half years. This was an attempt to dissolve the divide between medical practitioners and do away with the indigenous systems of medicine as the indigenous system was then considered to be "static in conception and practice."³⁹

The Government's first organized endeavour of restructuring the rural health system in the country was reflected in the first five year plan (1951-56). Although, for want of monetary resources, it could not elevate the standard of rural health services to laudable heights, it did contribute significantly by establishing public health centres ('PHC') ensuring community participation in rural healthcare. In the subsequent five-year plans, the focus shifted from rural health to broad-based health objectives of family planning, epidemic-prevention and vaccination and the peripheral objectives regarding improvement of infrastructure in rural healthcare services were theoretical and not reflected in reality.

The last decade witnessed a renaissance, when the Government efforts saw a shift from hollow utopian objectives to a pragmatic approach of ensuring minimum standard of health services to rural India. The comparison between urban and rural areas show that urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 100,000 urban population in sharp contrast to rural areas which have 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 100,000 rural population.⁴⁰ The National Health Policy introduced by the UPA Government in 2002, unlike its unsuccessful predecessor of 1983, had as its principal objective, the removal of this disparity and "evolving a policy structure that allowed the disadvantaged sections of society a fairer access to public health services"⁴¹

³⁸ GILL, *supra* note 33, 5.

³⁹ Meenakshi Gautham & K.M. Shyamprasad, *Needed: 'Basic' Doctors of Modern Medicine*, THE HINDU (Chennai) November 5, 2009 available at <http://www.thehindu.com/2009/11/05/stories/2009110554760800.htm> (Last visited on March 10, 2010).

⁴⁰ Shambhu Ghatak, *Health Situation in India: Related Issues and Policy Concerns*, available at <http://zunia.org/uploads/media/knowledge/Health%20Situation%20in%20India.pdf> (Last visited on March 10, 2010).

⁴¹ Ministry of Health and Family Welfare, *National Health Policy Document 2002*, available at <http://www.mohfw.nic.in/np2002.htm> (Last visited on March 13, 2010).

One of the significant objectives of the NHP was to increase the national expenditure on public health to 2 percent of the GDP.⁴² The NHP, 2002 and subsequently the flagship programme of the Government in the form of the National Rural Health Mission ('NRHM') in 2005 reflected the intentions of the Government to implement the bottom-top approach⁴³ to ensure that the primary health sector was equipped with minimum facilities and achieve an acceptable standard of good health among the general population of the country.⁴⁴

The NRHM aimed at bridging the gaping disparity between facilities available in rural and urban areas. It asserted the role of the PHCs as the pivotal centres of distribution and regulation of medical services for attainment of the broader objective of decentralized planning, with close participation by the community.⁴⁵ The mission aimed to enhance and encourage community participation through Accredited Social Health Activists ('ASHA').⁴⁶ ASHA were women from the village with a minimum educational qualification of standard VIII, selected by the Gram Sabha and approved by the community. ASHAs were to be accountable to the Panchayat and the villagers at all times and their presence was aimed to ensure the much-required linkage between the residents and providers of the medical services in rural areas.⁴⁷

ASHA envisaged by the NRHM gives a sense of déjà vu, taking one back to the late forties, when the Bhore Committee report was published.⁴⁸ As mentioned earlier, the Bhore report recommended participation by community through the training of volunteer workers from the region. The idea failed then for want of an efficient organization and accountability mechanism.⁴⁹ The ASHA scheme too, though projected as the poster boy of the mission has been bogged down by red-tape and inefficiency. In some states ASHAs have also been over-burdened with work. The demand for permanent employment, lack of monetary incentives and delay in payments are other issues that are likely to derail this scheme.⁵⁰ The NRHM in its mission statement envisaged ensuring and improving "the availability of and access to quality healthcare by people,

⁴² Indlaw, *Highlights of National Health Policy 2002*, May 4, 2002, available at <http://www.indlaw.com/guest/DisplayNews.aspx?F7D48DDC-37A2-4BB3-8F0F-A33AD8B4020D> (Last visited on March 07, 2010).

⁴³ Bebabar Banerjee, *Politics of Rural Health In India*, Vol. 4 No. 30 ECONOMIC AND POLITICAL WEEKLY 3257 (2005).

⁴⁴ WHO Regional Office for South-East Asia, *Country Health System Profile-India*, available at http://www.searo.who.int/en/section313/section1519_10849.htm (Last visited on March 10, 2010).

⁴⁵ Bibek Debroy, *Choice in Health*, available at <http://www.indicus.net/media/index.php/2008/1228-choice-in-health> (Last visited on March 12, 2010).

⁴⁶ *Id.*

⁴⁷ AK Sharma, *National Rural Health Mission: Time to Take Stock*, available at <http://www.ijcm.org.in/text.asp?2009/34/3/175/55268> (Last visited on March 12, 2010).

⁴⁸ Debroy, *supra* note 45.

⁴⁹ Gill, *supra* note 33.

⁵⁰ Debroy, *supra* note 45.

especially for those residing in rural areas, the poor, women and children” by 2012.⁵¹ The Government in its effort to keep up with the NRHM mission statement, allocated in the 2010-2011 budget a whopping Rs. 22,300 crores to rural healthcare sector from Rs. 19,534 crores during the previous fiscal year⁵² ensuring that the flagship mission does not suffer from want of monetary support.

This flow of funds, however, cannot veil the shortcomings of the mission. Despite the laudable contribution of NRHM in terms of ensuring grassroot-level participation in regulating and imparting healthcare services in rural areas, the fact that rural health problems are not confined to maternity and childcare, cannot be ignored.⁵³ The absence of resident doctors in villages increases the vulnerability of rural India to diseases and ailments which need expert medical care.⁵⁴

Sixty years of organized Government efforts have not contributed much in terms of reducing the gap between the standard of health services provided in rural and urban India.⁵⁵ What cannot be ignored is the fact that any discussion about the quality and standard of medical services in rural parts of India seems hyperbolic as quality cannot be assessed or expected in the absence of the very minimum health facilities.

Recently, discussions over the Government proposing a one year compulsory rural medical internship for medical graduates to secure eligibility for enrolment into the post-graduate programme have gained momentum in political and academic circles. The next section of this paper traces the history of this compulsory medical internship and illuminates the arguments raised by the Government as well as the medicos, critiquing the former’s lack of foresight and the latter’s ambivalent stance on rural internships.

III. COMPULSORY RURAL MEDICAL SERVICE

The Government in the 11th five year plan (2007-12) affirmed the critical shortage of doctors, poor working conditions, inadequate incentives available to doctors and health personals and the low utilization of the already meager facilities available in Government hospitals as potential causes

⁵¹ NRHM, *NRHM Mission Statement*, available at <http://www.nrhmorissa.gov.in/pdf/NRHM%20Mission%20Document.pdf> (Last visited on March 6, 2010).

⁵² Sreeraman, *Union Budget 2010-11: Impact on Health Care*, available at <http://www.medindia.net/news/indiaspecial/Union-Budget-201011-Impact-on-Health-Care-65647-1.htm> (Last visited on March 11, 2010).

⁵³ Ashok Vikhe Patil, *Current Health Scenario In Rural India*, available at <http://www.sas.upenn.edu/~dludden/WaterborneDisease3.pdf> (Last visited on March 11, 2010).

⁵⁴ C. J. Punnathara, *Ills in Health Management: Prescription for the Malaise*, *THE FRONTLINE* May 23, 2008, available at <http://www.thehindubusinessline.com/2008/05/23/stories/2008052350150900.htm> (Last visited on March 11, 2010).

⁵⁵ GILL, *supra* note 33.

of failure of NRHM.⁵⁶ The problem of shortage of doctors was aggravated by the absenteeism of doctors commissioned at PHCs in rural areas.⁵⁷ Urgent measures had to be taken to ensure the minimum health services to these rural citizens. It was for this purpose that the Ministry of Health, under the umbrella of NRHM, approved in July, 2007 the proposal of compulsory rural medical internship for medical graduates from government as well as private colleges.⁵⁸ The internship was a prerequisite for obtaining their MBBS degrees and medical practitioner licenses.⁵⁹

The acceptance of this proposal by the Ministry of Health has, however, been met with much resistance. Medical students across the country participated in organized resistance campaigns and blanket boycott of classes⁶⁰ in protest of the idea. Fast unto deaths were undertaken⁶¹ and rallies and demonstrations⁶² by students were carried out opposing it. The students denounced the scheme as they felt that the idea of compulsory internship was politically motivated and the Government had launched this stop gap arrangement of compulsory internship for medical students in order to save face in front of its vote bank as it was no where even close to giving them what was promised at the launch of NRHM in 2005.⁶³ The then Minister of Health, Dr. Anbumani Ramadoss vehemently denied the allegations and constituted the Sambasiva Rao Committee to look into feasibility of the proposal in the light of grievances of the students and suggest plausible modifications if any.⁶⁴ This committee was, however, considered to be a “mere eyewash”⁶⁵ by medical students as allegedly even before the committee could finish surveying the target-group and formulate recommendations, the Minister announced that the bill was to be presented in the next session of the Parliament.⁶⁶

⁵⁶ Appu, *supra* note 1.

⁵⁷ Planning Commission, *Chap 7 Planning Commission Delivery Report*, available at http://planningcommission.nic.in/reports/sereport/ser/bihinter/st_bihch7.pdf (Last visited in Feb 26, 2010).

⁵⁸ SP Kalantri, *Getting Doctors to the Villages: Will Compulsion Work?*, available at <http://www.issuesinmedicalethics.org/154ed152.html> (Last visited on March 7, 2010).

⁵⁹ *Id.*

⁶⁰ The Hindu, *Rural Service will Hit Medicos' Higher Education Plans*, THE HINDU (Tirunelveli) November 16, 2007, available at <http://www.hindu.com/2007/11/16/stories/2007111658640300.htm> (Last visited on March 2, 2010).

⁶¹ Zee News, *18 Medicos on Fast unto Death in Coimbatore*, December 3, 2007, available at <http://www.zeenews.com/printstory.aspx?id=411056> (Last visited on March 2, 2010).

⁶² The Hindu, *supra* note 60.

⁶³ NRHM, *supra* note 51.

⁶⁴ Vijay, *Say No To Medical Conscripton*, available at <http://www.catscanman.net/blog/2007/11/say-no-to-medical-conscripton/> (Last visited on March 12, 2010).

⁶⁵ The Hindu, *supra* note 60.

⁶⁶ Dilip Thakore, *Should Medical Students Protest Compulsory Rural Service?*, available at <http://www.educationworldonline.net/index.php/page-article-choice-more-id-1044> (Last visited on March 11, 2010).

Despite the fact that the central bill was not presented in the Parliament due to substantial resistance from the medical community,⁶⁷ many states *suo motu* took up the proposal and enacted legislations implementing the same. While some states like Kerala accepted the proposal with minor modifications,⁶⁸ states like Tamil Nadu introduced it with substantial amendments such as the fact that it provided for an incentive of extra marks in the post-graduate entrance examination to students who had completed such one-year rural medical internship.⁶⁹

The proposal has been widely debated both in political and academic forums and there are essentially two perspectives to this scheme. These have been discussed in detail below.

A. GOVERNMENT'S PERSPECTIVE

Access to basic health is an integral part of right to live with human dignity and hence this is secured for all citizens by the Constitution.⁷⁰ Also, Art. 47 of the Constitution lays on the Government the duty of improving health of all in the country. The Government, to fulfill these obligations as well as to achieve the targets of NRHM, introduced the compulsory rural internship aiming to ensure the presence of doctors in the PHCs for providing rural India the basic standard of healthcare.

The Government justified this action on the ground that crores were being spent subsidizing education for students of medicine in government colleges.⁷¹ For students availing the subsidized education, serving the poor rural areas was a way to give back to the nation as well as the society their due.⁷² This argument was supplemented with the idea that such internships would provide students the opportunity to understand the socio-clinical nuances of medicine.⁷³ As far as the increase in the duration of the education term from five and a half years to six and a half years after the introduction of this internship was

⁶⁷ Times News Network, *Rural postings bill not in coming Parliament session: Ramadoss*, THE TIMES OF INDIA(Chennai) November 17, 2007.

⁶⁸ Government of Kerala, Health & Family Welfare Department Order (GO (MS) No.263/04/H&FWD,/dated 04-10-2004); Government of Kerala, Health & Family Welfare, *Medical Education Service- Establishment- Compulsory Rural Service of Doctors*, available at http://www.kerala.gov.in/dept_health/health&fly.pdf (Last visited on March 6, 2010).

⁶⁹ The Hindu, *Do not make Service in Rural Areas Compulsory*, THE HINDU (Madurai) November 18, 2007.

⁷⁰ Mathiwaran , *supra* note 25.

⁷¹ Thakore, *supra* note 66.

⁷² S. Shivakumar , *Why Medicos Balk at Rural Service?*, available at <http://www.merineews.com/article/why-medicos-balk-at-rural-service/128310.shtml> (Last visited on March 7, 2010).

⁷³ Interview of Dr. Abhijit Das, Director of Centre For Health and Social Justice, by Sagarika Ghose on Face the Nation, IBN-CNN (December 4, 2007), available at <http://ibnlive.in.com/news/rural-stint-for-docs-is-it-forced-philanthropy/53549-3-single.html> (Last visited on March 7, 2010).

concerned, the government contended that this additional year would only add to their practical experience which was an integral requirement of the course.

Thus, the Ministry of Health considered it to be an efficient means of answering the need of the hour by ensuring presence of resident interns in PHCs which were ignored by senior doctors for their private practice.⁷⁴

B. STUDENTS' PERSPECTIVE

As mentioned earlier, the proposal was tabled in the Ministry of Health with the idea of ensuring the availability of nearly 30,000 doctors to rural areas every year.⁷⁵ Even though the purpose behind the idea seems genuine, the students found it unrealistic and inefficient.

As the very root of the issue was absenteeism of senior doctors commissioned in rural areas from their PHCs; medicos contended that being fresh out of college, they were not experienced enough to utilize the extremely limited resources available in the PHCs in the best efficient ways or deal with unexpected medical emergency without supervision of a senior doctor.⁷⁶ This would result in putting the life of villagers in jeopardy by entrusting them in the hands of unsupervised novices besides resulting in inefficient use of the available resources- both human and infrastructural as the senior doctors who were paid to do the same would escape with their absenteeism.⁷⁷ Besides that, unsatisfactory working conditions in PHCs, lack of adequate staff and equipment, and living environment in rural areas would add to the students' woes.⁷⁸

They argued that such a mandate would increase their already lengthy education term to six and a half years which would subsequently defer the possibility of pursuing higher education and establishing their careers.⁷⁹ They supported their resistance to this proposal by highlighting the fact that firstly, the incentives in these compulsory postings were negligible⁸⁰ as the students were to be considered temporary employees entitled to stipends and not salaries. This meant that the interns were to receive much less remuneration than doctors for the same amount of work. Secondly, while they were subjected

⁷⁴ Planning Commission, *supra* note 57.

⁷⁵ Press Release, Ministry of Health and Family Welfare, *Shortage of doctors and nurses*, August 30, 2007, available at <http://pib.nic.in/release/release.asp?relid=30771> (Last visited on March 10, 2010).

⁷⁶ India Edunews, *One Year Rural Posting Must Before PG Course*, July 23, 2009, available at http://www.indiaedunews.net/Maharashtra/One_year_rural_posting_must_before_PG_course_8835/ (Last visited on March 4, 2010).

⁷⁷ K.S. Jacob, *Rural Health: To Tinker or Transform*, THE HINDU (Chennai) March 11, 2010.

⁷⁸ SP Kalantri, *Getting Doctors to the Villages: Will Compulsion Work?*, available at <http://www.issuesinmedicalethics.org/154ed152.html> (Last visited on March 7, 2010).

⁷⁹ The Hindu, *supra* note 60.

⁸⁰ The Hindu, *supra* note 69.

to such a mandate in lieu of subsidized education in government colleges, their counterparts in other government colleges for engineering, management etc. did not have to face any such situation. Even medical students in private institutes, receiving subsidized education under government reservation-quota policies were excluded from the proposal. The students raised the contention that such a practice was discriminatory and hence violative of their right to equality. They also argued that this mandatory internship was an infringement of their right to freedom of trade and profession as they were being compelled to work without adequate incentives.

C. ANALYSIS OF THE SCHEME

The students found the idea of mandating this service in conflict with the idea of ethical responsibility as in a way, they were being compelled by the Government to be driven by their ethics and serve the society. As pointed out by former Health Minister Dr. Anbumani Ramadoss, however, Malaysia and Singapore had a similar scheme to meet the shortage of doctors in rural areas.⁸¹ Although drawing parallels between those countries and India does not justify the Government's action, it does support the fact that it is every State's responsibility to cater to the health needs of the citizens and mandating internships to ensure the availability of workforce is an instance of the same effort. The students may be right in considering this as an impediment to their careers as private practitioners but the scheme meant for increasing access to health services in rural India cannot be discarded simply for private gain. Another question that arises is whether this proposal was merely meant to be a politically motivated makeshift arrangement- to superficially cog the gaping holes in the institution of dispensing fundamental health services or is it a genuine attempt to ensure at least a phantom presence of doctors in PHCs by mandating the service of interns. If one considers the expert opinion on the subject, the odds tip in favour of the students as inexperienced students are hardly capable of handling the responsibility of taking care of the lives of thousands of people in such rural areas, who are dependent on PHCs as their primary sources for healthcare.⁸² Critics of this stance, however, connote this as the students' attempt to evade their social responsibility towards citizens in order to complete their post-graduation and thereafter indulge in a lucrative private practice.⁸³

The introduction of mandatory rural internships for medicos was spurred by the absenteeism of senior doctors commissioned in the PHCs. The reality was that senior professionals stayed away from PHCs as more often than not they were lured by the chance of a cushiony private practice in a city where they could avail the luxuries of life.⁸⁴ The dilapidated infrastructure of

⁸¹ Jacob, *supra* note 77.

⁸² India Edunews, *supra* note 76.

⁸³ *Supra* note 73.

⁸⁴ Debroy, *supra* note 45.

the PHCs and the absence of the bare necessities of life like electricity and water supply let alone the presence of intellectual dialogue resulted into a discouraging environment for the professionals. The situation is likely to be worse for graduates fresh out of college after five and a half years of rigorous professional training. The idea that they would be paid a monthly stipend of approximately Rs. 8,000⁸⁵ is hardly an incentive for quitting the prospect of a post-graduation or private practice for or even for merely leaving their comfortable lives in cities. Quoting *Meenakshi Gautam v. Union of India*, a recent PIL filed before the Delhi High Court, which seeks directions to improve the rural healthcare:⁸⁶

“Socially, a rural posting can be excruciatingly isolating and working conditions quite challenging for someone who has spent long years acquiring knowledge and skills in an urban medical institution. In the words of a medical intern- Doctors are extremely reluctant to be posted at PHCs for it is literally a professional dead end. There is a fear of sophisticated skills becoming rusty. Also a fear of an academic fade-out due to absence of the stimulating atmosphere that one finds in city hospitals and urban practice.”

Certain state governments, however, consider these internships to be an efficient means to meet the immediate demands of healthcare and hence have introduced it either as mandatory service for obtaining the MBBS degree or as an incentive for extra weightage in post-graduate exams.⁸⁷ The student community, however, felt that the scheme was introduced when the Government realized it could not exercise its power over senior practitioners. It thereafter exercised its authority over the students.

In states where such internships were made mandatory, students have resorted to filling the coffers of middle-men to wriggle out from them. Power exhibits and the pull of money therefore have already crept into the system much to its detriment. As far as compulsory service for extra marks in the post-graduation exam are concerned, more often than not the PHCs are graced by half-hearted interns buried in their books in preparation for the PG exams, demonstrating minimal signs of concern for the people.⁸⁸

Despite all this, the Government insists on carrying on with the proposal. The Government's arguments of such service being a return for the heavily subsidized medical education in government colleges as well as of

⁸⁵ The Hindu, *Extended Internship in MBBS Opposed*, THE HINDU (Mysore) November 21, 2007, available at <http://www.thehindu.com/2007/11/21/stories/2007112154410400.htm> (Last visited on March 6, 2010).

⁸⁶ *Meenakshi Gautham (Dr.) v. Union of India*, Writ Petition (Civil) No. 13208 of 2009 decided on 10-11-2010 (Del).

⁸⁷ *Supra* note 76.

⁸⁸ *Supra* note 60.

social responsibility compels us to examine them by subjecting them to the test of equality. As per the various state enactments on the proposal, private colleges are excluded from such compulsory internships as their inclusion cannot be justified by the subsidized education argument. This fact can be treated as a possible ground of violation of the right to equality by raising the question of students in the reservation category in private institutions. After the 93rd Amendment Act,⁸⁹ up to 50 percent of seats in these private institutions could be encroached upon by the Government mandate of providing reservation for upliftment of socially and educationally backward classes.⁹⁰ Such students by virtue of being in private institutes do not have to undergo this compulsory internship like their counterparts in government colleges even though they pay a subsidized fee. This is a violation of right to being treated equally in relation to students of government colleges.

Also, excluding private institutes raises reservations over and above the social responsibility and medical ethics of the students making us reflect upon the question as to whether such social responsibility has a direct nexus with the amount of fee paid by the student as only students from government colleges are being subjected to it, unlike their equivalents in private medical institutions.

Nevertheless, the Government insists on continuing such internships, even while pressing issues of providing infrastructure or incentives for permanent doctors remains waylaid. One wonders if this stance of the State can be attributed to the fact that the burden on the State coffers will multiply with the commissioning of permanent resident doctors in rural areas who would be paid nearly seven times more than an intern with a monthly stipend less than Rs. 8,000. Also, since interns are temporary employees, such an arrangement can save the Government the hassle of endowing permanent service benefits to the doctors to be commissioned in the PHCs. Unfortunately, there exists little academic proof to supplement this argument as it is voiced by disgruntled medicos who consider this exercise futile- a burden on them as well as state resources.

Despite nearly two years of debates on the issue, there are unanswered questions which linger, attacking the fundamentals on which the proposal has been shaped.

⁸⁹ The 93rd Amendment Act, 2005 added to the Constitution Art. 15(5) which read: "Nothing in this article or in sub-clause (g) of Clause (1) of Article 19 shall prevent the state from making any special provision, by law, for the advancement of any socially and educationally backward classes of citizens or for the Scheduled Castes or the Scheduled Tribes insofar as such special provisions relate to their admission to educational institutions including private educational institutions, whether aided or unaided by the state, other than the minority educational institutions referred to in clause (1) of Article 30."

⁹⁰ *Supra* note 33.

The compulsory medical rural internship seems to be a stop gap arrangement to ensure the presence of some semblance of medical practitioners in the public health centres.⁹¹ One has to realize that posting interns and expecting them to double-up as qualified experienced doctors, merely driven by pious ethics of serving the society is both unreasonable and utopian. The end result will be a hollow obligation which will be discharged by students for the sheer want of their practitioners' licenses or extra marks in post-graduate exams, defeating the very purpose of the exercise which was to ensure the minimum standards of healthcare in rural areas.⁹²

Considering the deplorable state of healthcare in rural areas, however, the Government cannot turn a blind eye to the issue and sit back with the status quo. Lately the political and academic scenes have witnessed strenuous efforts to seek the long-term solution of this problem in the new proposed BRMS scheme. The next section of the paper attempts to examine the feasibility of the BRMS, by bringing out the pros and cons associated with the same.

IV. BRMS: ARE RURAL DOCTORS THE ANSWER?

Even as the CRMS scheme continues to fill newsreels, a new scheme which is in pipeline and creating equal furore is the 3-4 year medical course geared for the rural sector, which would confer on its successful graduates a Bachelor of Rural Medicine and Surgery (BRMS). According to the proposal put forward by the MCI, the course will be conducted in district hospitals and Community Health Centres ('CHCs') for students from the rural areas, and after the completion of this short term course (which will stretch to 4 years at best) they will be eligible to serve only in the rural areas of their states.⁹³

The scheme seems at the first instance a throwback to the LMP scheme which existed in pre-independence India and which the Bhoré Committee recommended be abolished. And yet, almost 60 years after it was abolished, the scheme is being revived in its new avatar. Understanding the reasons for this and the protest against it might go a long way in addressing the question of what we mean by right to health in India especially in regard to its large rural populace.

⁹¹ Shivakumar, *supra* note 72.

⁹² The Hindu, *supra* note 60.

⁹³ The Hindu, *supra* note 2.

A. REASONS FOR THE INTRODUCTION OF BRMS

1. The Urban-Rural Divide

As already discussed, there exists a wide disparity in the health facilities available in the urban and rural areas. While there are 62.5 qualified doctors per 1,00,000 of the population in India, in the rural areas the figure is only 5 per 1, 00,000 of the population.⁹⁴ In the CHCs, about 59.4 percent of surgeons, 45 percent of gynaecologists, 61.1 percent of physicians and 53.8 percent of paediatrician posts are found to be vacant.⁹⁵ Again only 31.9 percent of all government hospital beds are available in rural areas as compared to 68.1 percent for urban population.⁹⁶ This lack of manpower was one of the main grounds on which the Bhore Committee's recommendation to abolish the licentiate system has been critiqued. Even among the committee members, there was dissent against this recommendation as it was felt that in the face of the shortage, India should try to provide for healthcare by any means possible.⁹⁷ The Basic Doctor of the Bhore Committee would not be available for a large section of the Indian population and they felt that "public health over the remaining four-fifths to one-half of the country... will atrophy. There will be no personnel like the licentiates even to help the regions and institutions which will come under neglect." This warning could not have proved more potent with the increasing burgeoning population of India and the widening chasm between rural and urban healthcare.⁹⁸ It is this urban-rural disparity that is sought to be addressed by the BRMS schemes as former MCI President Ketan Desai said: "The idea of BRMS is to get students from rural areas willing to work in their hometowns rather than try getting doctors who don't want to live or work in villages."⁹⁹

2. The Shortage of Practical Healthcare

In *Dr. Meenakshi Gautham v. Union of India*¹⁰⁰ an interesting observation is made about the nature of the medical education that is provided today. According to the PIL the long and expensive MBBS degree "does not

⁹⁴ Thakore, *supra* note 66.

⁹⁵ Piyush Diwan, *Government Launches a Four Year Medical Course*, available at <http://www.topnews.in/government-launches-four-year-medical-course-2253058> (Last visited on March 7, 2010).

⁹⁶ Yadav, Jarhyan *et al.*, *Revitalizing Rural Health Care Delivery: Can Rural Health Practitioners be the Answer?*, available at <http://medind.nic.in/iaj/t09/i1/iajt09i1p3.pdf> (Last visited on March 24, 2010).

⁹⁷ GILL, *supra* note 33.

⁹⁸ Gautham & Shyamaprasad, *supra* note 39.

⁹⁹ Times of India, *Experts in favour of starting 4-yr rural medicine degree*, available at <http://timesofindia.indiatimes.com/india/Experts-in-favour-of-starting-4-yr-rural-medicine-degree/articleshow/5540315.cms#ixzz0y1fZzKW9>.

¹⁰⁰ *Supra* note 86.

even equip them [the doctors] to treat common medical problems or perform common basic tasks like finding a vein to draw blood, diagnosing common diseases or preventive care such as immunization, but provides them with academic information at the cost of clinical skills.¹⁰¹ This is because the MBBS degree is geared towards providing advanced medical care which is dependent on technology and tests while 80 percent of healthcare needs require primary healthcare which involve hands on skills. These needs therefore do not require (and as the PIL argues they cannot be met by) the highly qualified practitioners churned out by the MBBS course. It is therefore possible to have a 3-4 year course specifically geared to meet the primary needs of rural healthcare.

3. Embracing Locals & Eliminating Quacks

Even though according to §15(2)(b) of the Indian Medical Council Act, 1956 no person other than a medical practitioner enrolled in a State Medical Register, can practice medicine in any State¹⁰² which means that only medical graduates of the 5 year medical course can practice allopathic medicine, the ground reality differs greatly. In a study conducted in rural Uttar Pradesh in 1995 only 3 percent of medical practitioners were MBBS graduates while 68 percent of them had no training in any form of medicine.¹⁰³ It has, however, been found that over 75 percent practiced modern medicine.¹⁰⁴ These are the 'quack' doctors that have flourished due to the in built deficiencies of India's health and planning programs.

It is important to remember, however, that it is not just the lack of health practitioners or quality healthcare that the Government has failed to provide but also the fact that these quack doctors have one key advantage in the rural sector, because they are usually local individuals a part of the village etc., they are not only more accessible, usually more affordable but also more acceptable to the local people. Thus in providing primary healthcare they have some basic qualifications that are indigenous due to their place of origin.¹⁰⁵ This is the very resource that the BRMS scheme would seek to tap in. By providing trained local practitioners, the quacks reach would be lessened.¹⁰⁶ Essentially it would use the understanding that a local health provider would have a better reach, and to ensure that healthcare provided is on par, they would be given the essential training.

¹⁰¹ *Id.*

¹⁰² Indian Medical Council Act, 1956, §15(2)(b).

¹⁰³ *Supra* note 96.

¹⁰⁴ *Supra* note 89.

¹⁰⁵ Yadav, Jarhyan *et al.*, *supra* note 96.

¹⁰⁶ Times of India, *supra* note 99. (Health Minister Ghulam Nabi Azad said, "We have to reduce dependency on quacks by increasing availability of trained doctors).

The PIL filed before the Delhi High Court highlights these points even as it asks the Court to give directions for upholding the fundamental right to health, guaranteed under Art. 21 of the Constitution of India (and supplemented by the duty ascribed to the state under Art. 47 to maintain health) and which has been denied to large swathes of the Indian population. This denial, it argues, is stark when one considers the healthcare facilities available in rural and remote areas vis-à-vis urban areas, which is a violation of the right to equality under Art. 14. The PIL calls for the amendment of §15(2)(b) of the IMC and concurrent introduction of the 3 year course as a viable solution for meeting healthcare needs in rural India. In its own words it feels that the BRMS would be most effective as:

“The irony is that for rendering primary medical care it is not necessary to go through this long and expensive medical course for six years. In fact, an intermediate duration course for three years can easily be devised which can adequately train and equip a person to render primary medical care. Such a course would enable the training and licensing of a much larger number of medical professionals who would be able to take care of the vast majority of the medical needs of the common people of the country.”

B. ANALYSIS OF THIS SCHEME

This scheme, however, has been met with some criticism and many have denounced the scheme as a stop gap measure which is likely to push back healthcare reforms. According to Ashok Adhav, national president of the IMA “Factors like paucity of doctors, low doctor-population ratio (1.62 per 10,000 only), absence of doctors, lack of infrastructure facilities contribute to the absence of proper healthcare in rural areas. But this situation cannot be corrected by compromised health workers in the name of BRMS.”¹⁰⁷

Much of the criticism has been based on the argument that the scheme is likely to create half baked doctors. In the intervention, filed by an NGO named People for Better Treatment, it is argued, based on the Supreme Court’s words in *Medical Council of India v. State of Karnataka*¹⁰⁸ that a medical student has to be trained in such a manner that when he graduates, he is perfectly capable to handle the medical practice.¹⁰⁹ The BRMS course is unlikely

¹⁰⁷ Umesh Isalkar, *Meeting to Discuss Planned Shorter Medical Degree*, THE TIMES OF INDIA (Pune) January 31, 2010.

¹⁰⁸ *Medical Council of India v. State of Karnataka*, (1998) 6 SCC 131.

¹⁰⁹ *Id.* (“A medical student requires gruelling study and that can be done only if proper facilities are available in a medical college and hospital attached to it has to be well equipped and teaching faculty and doctors have to be competent enough that when a medical student comes out

to produce this desired effect as it is felt that the sharply truncated proposed medical course of three or four years could never fully impart such capability unto a person.¹¹⁰ This in turn would lead to two cadres of health professionals—the better qualified serving the urban sectors, while the lesser qualified being reserved for the rural areas.¹¹¹ It was argued that this would be in violation of the Right to Equality envisaged under Art. 14 of the Constitution as the rural population will not have access to the same medical services as their urban counterparts. Furthermore, this being a short term measure, it would be ineffective to treat the deficiencies in the rural health sector. Such measures as the LMP had been abolished for the reason that it was felt that only by the 5-6 year course could the necessary expertise be obtained by a doctor so as to provide adequate healthcare. It would increase the incidents of quackery and would in essence be a denial of right to health under Art. 21 of the rural people.

The proponents of this policy, however, are quick to point out that the BRMS scheme is not meant to replace the MBBS doctors in the villages.¹¹² As Gulam Nabi Azad, while defending the BRMS scheme had to say: “It is not our case to shirk away from our responsibility of having trained doctors but idealism needs to be tempered with reality... the existing situation prevailing in rural areas is compelling us to look beyond current solutions.”¹¹³

Furthermore, the Supreme Court’s comments in the *Medical Council of India v. State of Karnataka* case must be taken in their context which had to do with increasing the number of seats in the medical course against regulations.¹¹⁴

Furthermore as has been suggested by the Task Force on Medical Education for the NRHM, medical services should be operated on three levels: firstly primary healthcare services should be provided by short course health practitioners, secondly graduate MBBS doctors should deal with balance of the medical conditions as well as the more complicated cases of the first category, and thirdly specialist with post graduation qualifications should engage with

he is perfect in the science of treatment of human being and is not found wanting in any way. Country does not want half-baked medical professionals coming out of medical colleges when they did not have full facilities of teaching and were not exposed to the patients and their ailments during the course of their study”).

¹¹⁰ Times News Network, *Half-Trained Docs For Rural Bengal? Rights Body Files Pil On Rural Health Bill*, TIMES OF INDIA (Kolkata) December 21, 2009.

¹¹¹ *Medical Degree for Rural Doctors in 3 Years to Serve the Rural Population?*, available at <http://www.stopbrms.com/ima-ksb-write-up.php> (Last visited on March 11, 2010).

¹¹² Mathrubhumi Education News, *BRMS would give us trained HR for Health Sector*, available at http://www.mb4education.com/php/news_events_details.php?nid=15601&slinkid=2 (Last visited on March 3, 2010).

¹¹³ Szubha, *supra* note 3.

¹¹⁴ *Supra* note 108.

cases requiring expertise.¹¹⁵ The BRMS scheme is also already under consideration with a subcommittee of the MCI and is to be formulated in a manner so that its graduates are quite capable of handle primary healthcare needs and there is adequate supervision and monitoring. For instance, with a view to increase their training period it has already been decided to increase their training period from 3 to 4 years. Further, for supervision and monitoring states are likely to pass special laws such as the proposed bill in West Bengal- The West Bengal Rural Health Regulatory Authority Bill, 2009.¹¹⁶ Thus, the operation of a three level health system with the requisite regulatory controls would not result in a twin track health system wherein the urban and rural population are subjected to unequal standard of medical services.¹¹⁷ Thus as the scheme is not meant to replace the MBBS doctors in the villages and instead is aimed at giving the rural population better healthcare it cannot be held to be in violation of Arts. 14 and 21.

This is not to project the BRMS as the panacea to rural health problems. When compared with the CRMS scheme, however, the BRMS scheme seems to have several advantages. Firstly it would be easier to find local youth who would be interested in working in their own villages rather than importing the MBBS graduates who are clearly unwilling to work in the villages. It is of course open to debate as to how devoted the enlisted doctors in the former scheme are likely to be considering they view it as a form of compulsory medical conscription. Furthermore the BRMS scheme may prove more beneficial to the rural society than the CRMS. Both schemes are essentially seen as temporary solutions but the BRMS scheme is likely to provide more regularity and gain more acceptance with the rural people. A doctor under the CRMS is likely to serve in a scheme of rotation for barely a year at best. Patients therefore will be treated by a different set of these medical graduates every time and the doctor-patient relationship is unlikely to develop. The concept of the 'family doctor' is more likely to be met by a rural health practitioner who would be a more or less permanent fixture in the area he serves. It is possible for such a health practitioner to gain experience and further training over time, while the

¹¹⁵ Ministry of Health & Family Welfare, *Task Force on Medical Education for the National Rural Health Mission*, available at http://mohfw.nic.in/NRHM/Documents/Task_Group_Medical_Education.pdf (Last Visited on August 30,2010).

¹¹⁶ The West Bengal Rural Health Regulatory Authority Bill, 2009, available at http://www.wb-health.gov.in/notice/let_to_aso.pdf (Last visited on March 12, 2010) (The Bill provides for setting up a Rural Health Regulatory Authority which would be responsible for: “ (b) to maintain State Register of Rural Health Practitioners; (e) to reprimand a Rural Health Practitioner, to suspend or remove the name from the State Register of Rural Health Practitioner or to take such other disciplinary actions against him as may in the opinion of the Authority be necessary or expedient..” Further the rural health practitioner area of practice and her limitations have been laid down: Every person whose name has been enrolled in the State Register of Rural Health Practitioners ... shall be eligible to practice medicine and Rural Health Care in rural areas of the State of West Bengal. Provided that no Rural Health Practitioner shall use the word 'Doctor' or 'Dr.' before and after his name”).

¹¹⁷ Ministry of Health & Family Welfare, *supra* note 115.

CRMS scheme is only likely to provide a fledgling set of graduates to the rural people every time.

Finally it is quite interesting that the scheme's main protestors have been doctors and their organisations such as the IMA.¹¹⁸ Though these protests seem to have been driven by concern for the health of the rural people, it is important to question whether the real concerns were not closer to home.¹¹⁹ Sociologists have questioned many of the regulations and the supposed expertise surrounding professions like medicine and have argued that regulations such as registration not only set out the qualifications for registration but also restrict entry to the profession, thus giving the registered doctors a legally sanctioned monopoly over the profession.¹²⁰ This is not to say that the doctors' concerns are not genuine, but it is necessary to study schemes such as the BRMS keeping in mind the rural sector's health needs.

V. CONCLUSION

The right to health is a fundamental right of each and every citizen of India and yet there exists a clear disparity in the availability of health facilities for rural and urban areas. While some feel that the health policies of the Government must be geared towards correcting this disparity, others are clearer on the fact that the rural population must have access to medical resources, even if they are not at least initially at par with the urban areas. The two schemes - one, to have a compulsory internship for medical students and two, to have rural health practitioners - are directed towards this end. As these are essentially short term measures it is necessary to evaluate them not on the basis of whether they correct the urban-rural imbalance but as to which is likely to serve better health needs of rural people in isolation. In this regard, we feel that the scheme for rural health practitioners may be the more efficient for building a bottom up approach to healthcare. It is possible also to supplement these kinds of arrangements with other schemes. One such scheme is that of the twice-a-week health camps in the rural areas where people are notified in advance of the doctors visiting. Such a pattern has been successfully followed in reproductive and child care camps¹²¹ in various rural regions of the country. Such camps take place on designated days where senior professionals visit the PHCs to examine the patients. This seems a plausible answer to the key problems of infrastructure as well as lack of interests of senior professionals to be resident doctors in PHCs. Introducing short terms measures

¹¹⁸ Isalkar, *supra* note 107.

¹¹⁹ Gautham & Shyamaprasad, *supra* note 39.

¹²⁰ TONY BILTON *et al.*, *INTRODUCTORY SOCIOLOGY*, 426- 430 (1981) ("the professional rhetoric relating to community service and altruism may be in many cases a significant factor in moulding the practices of individual professionals, but it also clearly functions as a legitimating of professional privilege").

¹²¹ RCH Newsletter, Vol. 1 No. 1-2 Nov. 2000, available at <http://mohfw.nic.in/rchnews.html> (Last visited on March 10, 2010).

whether it be compulsory rural internships or rural health practitioners must be supplemented by building up side by side infrastructure and human capital in rural areas. Only then will there be a permanent answer to the endemic issue of want of resident doctors in rural areas as envisaged by the NRHM.

