LEGITIMACY OF COMMUNITY HEALTH PROVIDER: REVIEW OF NATIONAL MEDICAL COMMISSION ACT, 2019

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Abstract

National Medical Commission Act, 2019 is a central legislative enactment with twin objectives of increasing healthcare access for masses and for doing away with the colonially designed Medical Council of India. The new legislation is focused on 'public health' in all its disease prevention and health promotion aspects, lessening the emphasis on 'disease' and 'cure' which talks of individualism and promotes capitalism largely. Healthcare ecosystem globally is vying for attainment of sustainable health through universal health coverage. Social, economic and political justice, the vision of constitutional guarantees, is not to be realized in the absence of substantive state actions. Indian Judiciary too has read the right to life with dignity being inclusive of the right to medical care and access to healthcare facilities. Flagship scheme of Ayushman Bharat aims to establish 1.5 lakh health and wellness centers in India for delivering customized primary, curative as well as promotive healthcare to rural and remote millions at their doorstep. Community Health Providers (CHPs), as provided in the Act are fulcrum around which these services aim to be provided enroute to 'Right to health' for Indian citizens. The legislative comment checks the legitimacy of these proposed agents of the healthcare delivery system amidst a lot of resistance by doctors viewing this action as deregulation of their prescribing power.

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II. The Foundation of modern scientific Healthcare System in India
III. Disparity in Demand and Supply
IV. Legislative Provisions and Indian experience
V. International Experience
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I. Introduction

NATIONAL GUIDELINE for social consumption of 'health' are enumerated in National Health Policy 2017[1] which has focused on universalization of healthcare and ensuring

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[1] National Health Policy 2017, Ministry of Health and Family Welfare, Government of India, *available at*: http://vikaspedia.in/health/nrhm/national-health-policies/national-health-policy-2017#:~:targetText=The%20National%20Health%20Policy%2C%202017,to%20all%20at%20affordable%20cost. (last visited on Feb.24, 2020).

minimum basic health to all Indians. International instruments are working for attainment of Sustainable Development Goal-3,[2] to which India is obliged to work for and which has added significance for quality healthcare. Achievement of Universal Health Coverage[3] especially targets reduction of financial risks, to leave no one behind and to provide a state of physical, mental and social well-being to all. In view of the global shortage of 7.2 million[4] health workforce, provisioning of health guarantees to global citizens and working towards universal health coverage seems a daunting task. Policy makers are hard-pressed to see that patient safety is not compromised and at the same time public money is not wasted on ineffective and harmful treatments.[5] Professional self-regulatory systems are under assault for bias and alleged corruption issues. Under growing pressure, national governments are sought to provide an enabling environment through external control over the system of 'care' through legislative changes. Efforts are for making the public health system, robust, and right to health of subjects, implementable. The National Medical Commission Act, (NMC Act)[6] aims for quality healthcare and access to healthcare facilities to rural poor. Contentious issues of bureaucratic control, diluting the medical field of a standard of care and commercialization of medical education as well as healthcare systems are strongly resisted by 'Doctor' who has been synonymous to 'health' till date. These issues need an analysis in the current context of demand and supply of health economics and prevailing 'disconnect' of societal expectation, and social and legal 'duty to care' of physicians. A survey of national and international precedence and judicial decisions on the issue helps critically analyze and check the constitutionality of legislative provisions.

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[2]UNDP-SDG-3, *available at*: https://www.undp.org/content/undp/en/home/sustainable-development-goals/goal-3-good-health-and-well-being.html#targets (last visited on Feb.24, 2020).

[3]WHO defines Universal health coverage to mean that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

[4]WHO, "Global health workforce shortage to reach 12.9 million" (*WHO Media Centre*, Nov. 2013), *available at:* https://www.who.int/mediacentre/news/releases/2013/health-workforce-shortage/*en/* (last visited on Feb. 24, 2020).

[5]Angela Coulter and Helen Magee (eds.), *The European Patient of the Future* 8-9(Open University Press, McGraw-Hill Education, Berkshire, United Kingdom, 2004).

[6]The National Medical Commission Act, 2019 (Act no. 30 of 2019) provides for the National Medical Commission in place of erstwhile Medical Council of India. This is an Act to provide for a medical education system that improves access to quality and affordable medical education, ensures the availability of adequate and high quality medical professionals in all parts of the country that promotes equitable and universal healthcare and encourages community health perspective making services of medical professionals accessible to all the citizens; it promotes national health goals; it encourages medical professionals to adopt the latest medical research in their work and to contribute to research, it has an objective of periodic and transparent assessment of medical institutions and of facilitating maintenance of a medical register for India, it enforces high ethical standards in all aspects of medical services.

NMC Act[7] repeals Indian Medical Council Act 1956 and dissolves Medical Council of India (MCI) which was set up for medical education establishing medical institutes and maintaining their standards. The Parliamentary Standing Committee, Expert Committee under the Chairmanship of Professor Ranjit Roy Choudhary and the NITI Aayog together suggested overhaul of the functioning of the MCI through legislative changes.[8] The recommendations were brought to effect by providing for the constitution of a National Medical Commission as the apex supervisory body to guide and superintendent several autonomous boards for quality of medical education, ethics in medical practice, establishment and accreditation of medical colleges, maintenance of national medical register. The whole exercise is for increasing the access to healthcare which aids in achieving social justice, as envisioned in the Preamble to the Constitution read with Part IV directives, in Indianized terms. So what was so alien in earlier structure?

II. The Foundation of modern scientific Healthcare System in India

There is an interesting account of Medical History of India[9] documented by D G Crawford, himself a physician. As per his narration, once Jahan Ara, the daughter of the doting Emperor Shahjahan got severely burnt. Unable to get proper treatment from indigenous sources through *hakeems*, he sought help from Gabriel Boughton, the ship surgeon with HMS Hopewell stationed at Surat. In lieu of his charges for treatment offered to the princess either in monetary terms or wealth of some sort, the altruistic doctor asked nothing for himself. Instead, he helped the East India Company receive duty free access to all the Mughal controlled ports. This helped the Company establish Fort Williams in Calcutta and with that the expansive and colonial rule had begun. The modern scientific system of medicine has been founded on such alien terms which lacks harmony or synchrony with the Indian society and many tricks of the trade are still to be imbibed by people of the soil. Echoing the same sentiments of feudal and colonial policy of expansion and exploitation, which believes in information asymmetry[10] and concentration

[7]*Ibid*.

[8]Niti Aayog, *The Committee on the Reform of the Indian Medical Council Act, 1956*, (Government of India, Aug., 2016), *available at*: https://niti.gov.in/writereaddata/files/document_publication/MCI%20Report%20.pdf (last visited on Mar. 17, 2020).

[9]D G Crawford, The Legend of Gabriel Boughton, 1-7 *The Indian Medical Gazette* (Jan 1909).

[10]Amartya Sen, "Learning from others" 377 *The Lancet* 200-201 (2011). --health is also a typical case of "asymmetric information", with the patients knowing very little about what the doctors (or "supposed doctors") are giving them, the possibility of fraud and deceit is very large. There is very definitive evidence of a combination of quackery and crockery in the premature privatization of basic health care in India. This nastiness is the result not only of shameful exploitation and rudderless medical ethics, but ultimately of the sheer unavailability of public health care in many localities around India, *available at:*

of power in few hands, the *Chattisgarh* case: HNP Discussion Paper;[11] opined:

From early 2001, when discussions within the government on the three-year course began, opposition from the Medical Council of India (MCI), the professional body regulating medical education, was anticipated. Ever since the Indian Medical Council Act, 1956 stipulated the functions of the MCI, it has always opposed any dilution to the status of doctors trained in western allopathic medicine and registered by the MCI. Therefore, MCI has consistently opposed both the induction of doctors trained in traditional Indian medicine and the prospect of three-year courses training physicians entitled to doctor status. Consequently, to avoid this likely rejection, the Administration Departments in Chhattisgarh agreed that the powers of recognizing and approving the three-year course should be given to a new body specifically created for this very purpose through an act passed in the state legislative assembly. It was through this mechanism that the state intended to bypass the MCI.

III. Disparity in Demand and Supply

In backdrop of colonial control, persisting information asymmetry and prevailing exploitation of masses, NMC Act[12] is more in line with the global strategy of providing human resources for health and increasing healthcare access. SDG-3 recognizes universal health coverage as a key agenda which seeks to recruit, develop, train and retain the health workforce in the developing region of the developing country itself.[13] The Act has amalgamated different issues of medicine and public health which in fact have different goals to achieve. Field of medicine has focused on 'cure', working on individual patients, diagnosing his sickness and treating to make him disease free. On the other hand, public health works on population, is preventive and promotive in nature, and seeks to keep the population in a state of health. The cadre of Community Health Provider (CHPs) as provided in section 32 of NMC Act, is to bridge this

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https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60035-4/fulltext (last visited on May 17, 2020).

[11] Shomikho Raha and Thomas Bossert, *Political Economy of Health Workforce Policy: The Chattisgarh Experience with a Three-Year Course for Rural Healthcare Practitioners* 6 (HNP Discussion Paper, World Bank Human Development Network, Mar. 2010).

[12] *Supra* note 6.

[13] WHO and its partners developed the Global Strategy on Human Resources for Health: Workforce 2030 (GSRH) to accelerate progress towards UHC and the SDGs by ensuring equitable access to health workers within strengthened health systems. Resolution (WHA69.19) urges Member States to consolidate a core set of HRH data with annual reporting to the Global Health Observatory, as well as progressive implementation of National Health Workforce Accounts to support national policy and planning and the GSHRH's monitoring and accountability, *available at*: https://www.who.int/hrh/statistics/hwfstats/en/ (last visited on Mar.27, 2020).

gap. He is to prescribe in primary care setting curing the ailments and also, he works more on the aspect of screening the diseases, nip the bud at its inception working in close proximity of masses, advising for prevention of disease and promotion of health, thereby strengthening the public health system.

Mid-Level Health Worker (MLHW)

Community Health Provider (CHP) as referred in section 32 of the NMC Act, has not been defined in the Act in concrete terms as to their qualifications and their duties and responsibilities. Their regulatory frameworks and area of working too has been left for secondary legislation in the form of rules and regulations to be drafted by executives. This creates vagueness and is one of the contentious issues among the medical fraternity for taking it as diluting the medical profession and decreasing the standards of care involved therein because *prima facie* it looks to institutionalize the non-licensed practitioner as prescriber of medicine.

Section 32, which is the main provision dealing powers and scope of CHPs, reads as:

32. (1) The Commission may grant limited license to practice medicine at mid-level as Community Health Provider to such person connected with modern scientific medical profession who qualify such criteria as may be specified by the regulations:

Provided that the number of limited licenses to be granted under this subsection shall not exceed one-third of the total number of licensed medical practitioners registered under sub-section (*1*) of section 31.

(*2*) The Community Health Provider who is granted limited licenses under sub-section (*1*), may practice medicine to such extent, in such circumstances and for such period, as may be specified by the regulations.

(*3*) The Community Health Provider may prescribe specified medicine independently, only in primary and preventive healthcare, but in cases other than primary and preventive healthcare, he may prescribe medicine only under the supervision of medical practitioners registered under sub-section (1) of section 34.

What we gather from the provision is:

i. CHPs are not doctors.

ii. They are to function at mid-level, only where the deficiency of service has been noticed and service of qualified doctors are not available because of reach, cost and other factors.
iii. Number of CHPs is not to exceed one third of the number of licensed doctors in medical practice in India.
iv. This is a temporary arrangement to tide over a shortfall of the health workforce.
v. They are only to work in the domain of primary and preventive healthcare and other than that, their work will be supervised by doctors.
vi. Their prescription will be of limited number of medicines, they will carry out a limited number of procedures, in limited designated areas of work (and after getting adequately trained?).

These deductions also raise questions for which we need to find answers either in provisions of enactment itself or laws which have been laid down earlier; the enquiries are;

(1) What is the universe from which candidates working as CHPs will be selected?

(2) What is the curriculum or course module in which they will be imparted training in?

(3) What is the adequacy of duration of such training looking for a holistic approach of the act amalgamating modern (allopathic) and Indian (AYUSH) system of medicine?

(4) Should the existing institutions of medical education or newer systems need to be in place for the training of CHPs?

(5) Is it going to be a private initiative regulated by the government based on the Chhattisgarh model or such training may need involvement of public funds?

(6) What infrastructure facilities and academic faculty are needed for such effort?

vii. Which body will have supervisory power over the training facilities for uniformity of approach and desired outcome?
viii. Who is certifying and licensing authority for CHPs to regulate their practice?
ix. Is there any grievance redressal system in place for professional misconduct cases of such CHPs?

The present paper seeks to find answers to relevant questions which authenticates the working of these agents of healthcare.

Universe of selection

World Health Organization (WHO) defines[14] such Mid-level health workers (MLHWs) as those who have received shorter training than physicians (between 2-4 years) but will perform some of the same tasks as physicians. Therefore, a mid-level health worker is not a medical doctor, but provides clinical care (may diagnose, manage and treat illness, disease and impairments) or engage in preventive care and health promotion.[15] There are wide variations across countries regarding their title, job description, content, duration and quality of training and the framework within which they work.[16] They are addressed as nurse practitioners, clinical practice nurse, non-physician clinician, medical assistant, physician assistant and surgical technician. Thus, different types of mid-level health workers providing care in different kinds of settings can be seen, be it community care, in primary health centers, or in hospitals and health centers. Cadres of such workers are available in developed nations too, where nurses no longer are happy working as doctors' assistants.[17] Their role is more complementary in nature rather than being subordinate. Many of the nurses are well qualified professionals and are confident of taking extended responsibilities. They increasingly are seeking their role as prescribers of medicines. Their role of working as sources of information and as support in critical and life-threatening diseases has been exemplary. In a similar category is the role of pharmacists, who often have more knowledge than doctors about how drugs work and their side effects and contra-indications. Many of them think that their skills are underutilized in patient care. Are we happy to consult nurses and pharmacists instead of doctors for our medical problems? What is the evidence of efficacy and safety of such roles?

Eight country case studies in Asia, Africa and Latin America by Global Health Workforce Alliance reviewed the effectiveness of MLHWs in provisioning of essential health services.

Key paper of a 2013 systematic review regarding quality of care of mid-level health workers concluded having found no difference between the effectiveness of care delivered by the MLHWs[18] in the Reproductive and Child Health (RCH) facilities and in the areas of communicable and non-communicable diseases treatment settings, in comparison to those

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[14]WHO-UHC Technical Brief, *Mid-level health workers: a review of the evidence* (Health Systems Department ,WHO Regional Office for South-East Asia and the WHO Country office, India, 2017).
[15]Z. S. Lassi, Cometo G. *et.al.*, *Quality of care provided by mid-level health workers systematic review and meta-analysis* (Bull World Health Organisation 2013).
[16]World Health Organization, *Mid-level health providers- a promising source to achieve the health millennium development goals*, 100 (WHO-Geneva-2010).
[17]*Supra* note 5.
[18]*Supra* note 13.

provided by higher level health workers. UHC technical brief on mid-level health workers conveys[19] that seven other relevant reviews affirm the same conclusion. This also tells about 'task shifting' or 'optimizing skill mix' with lesser tasks done by less trained workers. This provides a policy option for alleviating problems due to shortages of human resources for health. Cochrane review 2016 of non-medical versus medical prescribers in acute and chronic care settings concluded both to be equally effective. In low and mid-level economies, the MLHWs are increasingly employed to serve independently in rural and remote areas to fill the gaps. Kampala Declaration and Agenda for Global Action[20] adopted in 2008 advocate the same. The evidence based results and international obligations provide the foundation for the inclusion of a cadre of 3 lakhs CHPs as prescriber in primary and preventive care settings. To fulfill this goal, section 10 of the Act[21] provides for powers and functions of the Commission which includes assessment of the requirements in healthcare, including human resources for health and healthcare infrastructure and developing a roadmap for meeting such requirements and further section 57(2)(zn) empowers the Commission to make regulations consistent with this Act and rules there under to specify the criteria for granting limited license to practice medicine under section 32(1).

Talking of requirements, India needs to wait till 2030 for fulfilling 'One doctor per 800 population',[22] according to the WHO norms. Indian nation has one doctor per 1674 persons and the shortage is more pronounced in rural areas. There is a global challenge in healthcare delivery system of nations because of shortages[23] of the health workforce in terms of availability, mal-distribution and uneven performance. Medical brain drain further accentuates the crisis in the developing world due to international emigration. Trained health workers end up concentrating in urban areas. WHO survey in 2016 found 57 percent of allopathic practitioners without medical qualification.[24] In rural areas this problem is more acute, figure reading 80 percent plus of non-qualified persons pursuing the art of medicine endangering the life of a common man. IMA figures of quacks in the country is somewhere around one

[19]*Supra* note 10.
[20]WHO, *Health workers for all and all for health workers* (Kampala Declaration and Agenda for Global Action, Global Health Workforce Alliance, 2008).
[21]NMC Act *Supra* note 6, s.10(c)
[22] Vinod Paul, Niti Ayog member at PGIMER, Chandigarh, cited in Shimona Kanwar, "By 2030, India will have one doctor to every 800 patients" *The Times of India*, Feb. 27, 2020.
[23]WHO, *Working Together For Health* (The World Health Report, 2006) puts this figure at 4.3 million global shortage, *available at:* https://www.who.int/whr/2006/en/ (last visited on Mar. 27, 2020).
[24]Sudhir Anand and Victoria Fan, "The Health Workforce in India: Human Resources for Health Observer Series No. 16" *The World Health Organization* 19-20 (2016).

million.[25] Government tried other measures to fill this gap, by giving extra money to doctors serving in rural areas, extra marks in post graduate entrance to those who served in such areas, forcing doctors to sign bonds for working in rural setting for a few years, but nothing has resulted in increasing the access and uniformity of healthcare services available to people. The step to create a cadre of paramedics at a time when the country faces shortages of qualified doctors sounds logical and laudatory. Dispelling fears concerning institutionalized quackery, as raised by the opposition, the Union Executive assured the decision of finalization regarding the universe of selection will be taken only after extensive public consultation and debate. Rather than legalizing quackery, the punishment for the same has been enhanced upto one year imprisonment and upto Rs 5 lakhs. Law is a powerful tool for advancing global health, though it still remains underutilized and not so clearly understood in the globalized era.[26]

Training module

Having understood the need for CHPs in the current context of human resource for health scarcity and global consensus for employing such mid-level health workers independently as prescriber in primary care setting, it is important to decide what sort of training they need to undergo serving healthcare fields effectively. The legislation doesn't talk of any test specifically for this purpose. The already trained workforce of nursing staff, pharmacist, dentist, laboratory technicians and likes may not need very exhaustive training. A refresher course in holistic medicine emphasizing on primary and secondary prevention agenda and integrating elements of Indian system of medicine will serve the purpose. Though, diverting these workforce may create scarcity in other areas which may require increased enrollment in such areas. This still is a cost-effective approach and such workforce are likely to be retained for a longer duration in the specified area of service. Alternatively, fresh recruits which may include unqualified practitioners (already serving in their locality) can be trained after getting them recommended through local panchayats. A three-year diploma course under The Chhattisgarh Chikitsa Mandal Adhiniyam, 2001,[27] serves as a model course. Assam, Maharashtra, Karnataka, West Bengal also have their mooted course curricula which can serve

[25] Ishita Mishra "The Spin Doctors: India's quacks imperil lives, but are 'god' to their patients" *The Hindu*, Mar. 31, 2018, *available at:* https://www.thehindu.com/sci-tech/health/the-spin-doctors-indias-quacks-imperil-lives-but-are-god-to-their-patients/article23398980.ece(last visited on Mar. 20, 2020).

[26] Lawrence O Gostin, John T Manahan, *et al*., "The Legal Determinants of Health: harnessing the power of law for global health and sustainable development" 393 *The Lancet* 1857 (2019).

[27] The Chhattisgarh Chikitsa Mandal Adhiniyam, 2001 (Act 7 of 2001).

as a foundation and a fresh look can be given to devise a uniform syllabus for CHPs with room for additions as per local needs.

32 (1) The Commission may grant limited license to practice medicine at mid-level as Community Health Provider to such person connected with modern scientific medical profession who qualify such criteria as may be specified by the regulations:

The Commission (NMC), reserves the right to grant the limited license to practice medicine to any person connected with the modern scientific medical profession based on some criteria to be devised by regulation. Literal interpretation says that such persons are already trained in allopathic systems of medicine and based on criteria to be specified by regulators, they can be employed as CHPs after granting them limited license. Alternatively, the criteria specified may be a training module or diploma course undergoing which such persons get connected with the modern scientific medical profession and henceforth they qualify to get the grant of limited license from the Commission employing them as CHP. Any clarity on this aspect will be obtained by regulation which comes in force vide section 57(2)(zo) read with 32(2) as to what extent and in which circumstances and for what period the CHP needs to be deployed in healthcare service.

Duration of training

Section 10(1)(a) provides for laying down of policies by the Commission consisting of the majority of team as learned and competent medical professionals and collectively they carry loads of experience in the field. Section 10(1) (a) read with section 10(1)(c), emphasizes the requirement to be assessed of human resource for health and a roadmap for meeting such requirement is to be made. Section 11 provides for a Medical Advisory Council which has representatives of each state and union territories, one member from each state medical council and the other member being the vice -chancellor of a health university in each of said state or union territory. Council also has all NMC members as *ex-officio* members. Directors of IIT, IIM and IISc to be part of the Council. *Vide* section 12(1), the council being the primary platform to which states and Union Territories put forth their views and agenda relating to medical education and training. The council in turn as per section 12(2) advises the Commission in all matters of coordination and maintaining standards of medical education,

training and research. Further, section 51 empowers every state for promoting primary healthcare in rural areas and for the same taking necessary measures for enhancing the capacity of healthcare professionals. Thus, we assess the legislative intent is not to fit one size for all, rather it uses abstract terms to accommodate all need based demands and accordingly fix the duration of a course for a particular area and for a particular group of candidates. Hence we conclude for this enquiry that the enactment has not prescribed the duration in so many words but has provided the necessary guidelines and section 57(2)(zo) read with 32(2) which makes regulations as to what extent and in which circumstances and for what period the CHP needs to be deployed in healthcare service will fix the duration of such training necessary for such actions.

Certifying and licensing authority and grievance redressal mechanism

The Act has provisions for the medical assessment and rating board in section 26 and for the ethics and medical registration board in section 27. Reading the terms as to how terms 'medical institution' and 'medicine' have been defined in the Act brings clarity if they are inclusive of CHPs and their qualifying training. A look of letters of law:

Section 2(*i*) "medical institution" means any institution within or outside India which grants degrees, diplomas or licenses in medicine and include affiliated colleges and deemed to be Universities;

(*j*) "medicine" means modern scientific medicine in all its branches and includes surgery and obstetrics, but does not include veterinary medicine and surgery;

26 (1) The Medical Assessment and Rating Board shall perform the following functions, namely:

(*b*) grant permission for establishment of a new medical institution, or to start any postgraduate course or to increase the number of seats, in accordance with the provisions of section 28;

(*c*) carry out inspections of medical institutions for assessing and rating such institutions in accordance with the regulations made under this Act:

27(1) The Ethics and Medical Registration Board shall perform the following functions, namely:

(*a*) maintain National Registers of all licensed medical practitioners in accordance with the provisions of section 31;

(*b*) regulate professional conduct and promote medical ethics in accordance with the regulations made under this Act:

Analyzing the provisions makes it clear that any training course which may be a diploma designed for CHPs and started within an existing medical institution or in a newly established one, comes under the purview of the act and the medical assessment and rating board will be instrumental in maintaining the quality and standards of such training. Also 27(1)(a) read with 31(8) the Ethics and Medical Registration Board is to maintain a separate national register of CHPs with all relevant details. The names will be added or removed as per criteria specified by regulations. Thus, this will have powers of grievance redressal as well as disciplinary actions.

Training in public domain or by private players

The *Chhattisgarh* case, provides that the institutes for such training may be run by private players who will charge candidates as per guidelines laid down by criteria as well as such private players can pay fees to the Commission also for its activities. That will require strict regulations for uniformity of services to be provided and standards of training to be maintained. These CHPs can be trained in existing medical colleges and healthcare institutes too, where they get trained by doctors and have more practical training with patients admitted therein. Some concrete methodologies need to be designed to see both ends meet.

IV. Legislative Provisions and Indian experience

The Preamble to the Constitution which gives a broad direction for the Indian Republic, refers to social, economic and political justice and also to equality of status and of opportunity. Under the term 'Social Justice', one can bring in the question of access to health care facilities and the principle of justice involved in the equality of access to these facilities. In the same way, equality of status and of opportunity may be taken to refer to the equality of practice of the medical profession, access to medical educational institutions, *etc*. In order to improve the citizens' socio-economic and health status all three levels of government have been vested with different powers and responsibilities. Duty has been cast upon citizens too for the promotion of their own health and collectively that of the entire society.

Legislative intent behind enactment of the NMC Act has been to end inspector raj in the medical education sector and to bring uniformity in the system with all MBBS students of the

country appearing in the same final examination (NEXT) which becomes the basis for; (i) licensing and practice of medicine, (ii) admission to post graduate courses and (iii) certifying foreign graduates to practice in India. In a way, the legislation focuses on the outcome of medical education rather than the process of frequently inspecting the infrastructure and academic facilities of institutes of higher learning. The outcome has to be a guarantee of equitable access to healthcare facilities to all Indians and equal opportunity for keeping in health.

The Parliament is empowered to enact the NMC Act by the Entry 66 of List I of the Seventh schedule read with article 246 of the Constitution. Entry 66 reads as:

> Coordination and determination of standards in institutions for higher education or research and scientific and technical institutions.

Entry 25 of List III reads further:

25. Education, including technical education, medical education and universities, subject to the provisions of Entries 63, 64, 65 and 66 of List I; vocational and technical training of labor

Entry 6 of List II: [28]

Public Health and sanitation; hospitals and dispensaries.

Eleventh Schedule read with article 243-G empowers Panchayats for providing health related facilities in its territory:

"Entry 18. Technical training and vocational education"

"Entry 23. Health and sanitation, including hospitals, primary health centers and dispensaries."

"Entry 29. Maintenance of community assets."

Twelfth schedule read with 243-W empowers municipalities similarly.

"Entry 6. Public health, sanitation conservancy and solid waste management."

Thus, we have detailed provisions for health-related enactments in our constitution and the role of CHPs' is likely to be regulated and supervised by all three levels of governance. This is unlike the earlier law where central law was dominant and many state laws could not pass the

[28] *Ins*. by the Constitution (Forty-second Amendment) Act, 1976, s. 57 (*w.e.f.* 3.1.1977).

test of constitutionality because of that. The erstwhile MCI allowed for mushrooming growth of medical institutions flouting rules and standards, thus the quality of medical care becoming a serious threat to effective healthcare. The Supreme Court also put reliance on the Medical Council adversely criticizing the government of acting without MCI recommendations.[29] Over the years clinical establishments, big, small, corporate entities and partnership firms at micro levels run by doctors could not exude much confidence in patients. While at macro level government facilities have been overcrowded and delay in them has been unending. All this was affecting the quality of service and raised a need for addressing the issues with serious concerns. There have been legislative attempts to regulate the private practices of doctors working in clinics or hospitals.[30] West Bengal allowed unqualified persons getting mainstreamed (by Liver Foundation) with training on the pre-conditions that they would not prefix 'Dr.' to their name and will not prescribe medicines labeled for restricted use. The State of Chhattisgarh employed training for three years for this public health cadre syncing their work with doctors at higher level centers. This model worked decently as it drew people from the local rural population which were not likely to migrate to urban centers. Providing health care is a human resource–intensive activity and in Chhattisgarh the shortage of trained health care providers was among the most acute in the entire country. Overcoming the crisis situation, the newly built state responded with some novel mechanisms and today it is one of the better states in terms of health care indicators in India.

V. International Experience

Philip Lee[31] writes about barefoot doctors of China wherefrom the concept of mid-level health gained momentum:[32]

> Prior to the founding of the People's Republic of China in 1949, epidemics, infectious disease and poor sanitation were widespread. "The picture today is dramatically different … there has been a pronounced decline in the death rate, particularly infant mortality. Major epidemic diseases have been controlled …

[29] *P C Kesavan Kutty Nair* v. *Harish Bhalla* (2003) 8 SCC 490.

[30] The Clinical Establishments (Registration and Regulation) Act 2010 (Act 23 of 2010) aimed at streamlining private sector healthcare services in India, *see also*, "11 states and UTs except Delhi have adopted CEA-2010" *The Times of India*, Dec. 28, 2018, *available at*). : https://timesofindia.indiatimes.com/business/india-business/11-states-all-uts-except-delhi-have-adopted-clinical-establishment-act-govt/articleshow/67286073.cms(last visited on Mar. 20, 2018).

[31] Philip Lee, "China's primary health care system" *Western Journal of Medicine* (1973).

[32] Cui Weiyuan , China's village doctors take great strides, *WHO Bulletin*, *available at*: https://www.who.int/bulletin/volumes/86/12/08-021208/en/ (last visited on Mar.27, 2020).

> nutritional status has been improved [and] massive campaigns of health education and environmental sanitation have been carried out. Large numbers of health workers have been trained, and a system has been developed that provides some health service for the great majority of the people".

Marshall Islands health assistants - empowered by an eighteen-month training program - are stationed at remote outer island health centers and are expected to provide a broad array of primary healthcare services.[33] The role of non-clinical physicians has been very important in delivering healthcare services to the African continent.

A relevant text by V De Silva says:[34]

The history of Assistant Medical Officers (AMOs) in Sri Lanka can be traced back to the 1860s. Their training from the beginning followed an allopathic, 'evidence based' model. AMOs have played a key role in rural and peripheral health care through staffing of government central dispensaries and maternity homes, and may have contributed to Sri Lanka's favorable health outcomes. While there are currently approximately 2000 AMOs, their training course was discontinued in 1995. It was argued that the quality of care provided by the AMOs is substandard relative to that of physicians, and also since enough physicians are there to render services in rural areas. The success, rapid expansion and integration of physician assistant programs into the United States healthcare system have recently spurred other countries to introduce similar programs. This paper reviews Sri Lanka's move in the opposite direction, phasing out the AMO profession, without any research into their contributions to access to inter professional primary health care and positive health outcomes.

The Sri Lankan model is particularly for genealogical emulation in India. Getting free from colonial clutches around the same time, Sri Lanka continued its focus on *ayurveda* and developed its healthcare system with a holistic approach since the beginning. It believes in free healthcare services for people and over the years has developed a model which compares with India in per capita health expenditure but health indicators closely match with those of developed society such as the United States and United Kingdom. Private interests are dictating terms globally in the era of deregulation of economies. Exclusive emphasis on the allopathic

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[33] Balachandra H Keni, "Training Competent and Effective Primary Health Care Workers to fill a void in the outer islands health service delivery of the Marshal Islands of Micronesia" 4 *Human Resources for Health* 27 (2006).

[34] V De Silva, "The assistant medical officer in Sri Lanka: mid-level health worker in decline" 27 *Journal of Inter professional Care* 432-3 (Sep. 2013).

model to deliver healthcare services in India has increased the inequality of access and has skewed development. Time is ripe to gain from international experience, and balance and harmonize Indian indigenous system for delivering care which has more socio-cultural connection with the modern scientific medical system which is more technologically advanced with a range of services. CHPs in the Act has been envisaged to provide care in community drawing from both the systems.

VI. Judicial Decisions in the Context

There have been many pronouncements of the apex court which are binding precedents as of now, but will need a review in the light of the NMC Act. The apex court in *Poonam Varma*[35] held that a person can practice only that system of medicine in which he has acquired a degree or qualification, practicing any other system amounts to negligence per se and is actionable. In *Martin d Souza,*[36] The apex court held that prescription should not be ordinarily given without actual examination. Also, it forbade the tendency of prescription based on telephonic advice unless in emergency situations. A study[37] has found prevalence of cross-pathy with data of 12 percent prescription in tertiary care allopathy hospital of ayurvedic drugs and 58 percent of drugs being prescribed in tertiary care ayurvedic institutes belonging to allopathy. The court in *Mukhtiyar Chand* case[38] held that modern medicine practiced by Indian System of Medicine (ISM) practitioners is only possible when they are enrolled in the state medical register maintained by the state medical council. The respective state government needs to notify the recognized qualification eligible for registration in the state medical register. The concerned ministry in the wake of the court ruling requested all state governments to amend their laws and add an enabling provision for registration of ISM practitioners.

Assam legislature enacted 'The Assam Rural Health Regulatory Authority Act' (ARHRA),[39] in 2004. A diploma course in rural healthcare and medicine in an institute established at Jorhat had trained five batches of students and had given employment provided by the state. Indian Medical Association challenged the constitutionality of the legislation.[40] The High Court of

[35]*Poonam Verma* v. *Ashwin Patel* (1996) 4 SCC 332.
[36]*Martin D'Souza* v. *Mohd. Ishfaq* (2009) 3 SCC 1.
[37]U. Verma and R. Sharma *et al.,* "Allopathic versus Ayurvedic practices in tertiary care institutes of Urban North India" 39 *Indian Journal of Pharmacology* 52-54 (2007).
[38]*Mukhtiyar Chand* v. *State of Punjab* (1998) 7 SCC 579.
[39]The Assam Rural Health Regulatory Authority Act (Act 19 of 2004).
[40]*Indian Medical Association* v. *State of Assam* (2015) 1 Gau LR 321.

Guwahati struck down the ARHRA holding it unconstitutional in a 2014 judgement. The court said:[41]

> ...There is no check and balance for the rural health practitioners...As a court we cannot say whether the so-called diploma-holders would be competent to function as doctors unless they are declared and certified by the Indian Medical Council... To allow the diploma-holders to function as rural health practitioner in the field of allopathy without judging their competency by the competent authority would have disastrous consequences in the rural healthcare, and to permit such diploma-holders to practice in the field of allopathy in rural areas without a proper certification by the Indian Medical Council, would not only be bad in law but would have a deleterious consequence in the matter of rural health...

ARHRA Act, was found to be in conflict with section 10A(b)(i) of Indian Medical Council Act, which was enacted by virtue of Entry 66 of List I which by non-obstante clause declares that "notwithstanding anything contained in this Act or any other law for the time being in force, no medical college shall open a new or higher course of study or training." The words "open a new course" taking in its sweep the diploma course contemplated under the ARRA Act. For opening a diploma course a prior permission of the Central Government was required which was not obtained. The State had ventured to introduce a new diploma course in medicine and rural health care in the field of allopathy - without the necessary permission as contemplated under the IMC Act.

The Supreme Court is yet to deliver judgement in this appellate matter.

Test of constitutionality

The NMC Act in this respect is likely to pass the test of constitutionality as per following analysis:

Indian Medical Council Act 1956, has been repealed by the NMC Act 2019, the bar of section 10A(b)(i) of IMC Act no longer exists. Section 51 of NMC Act empowers the state government to enhance the capacity of healthcare professionals (inclusive of CHPs) and to promote primary healthcare in rural areas. States are also empowered by entry 25 of concurrent list and can provide for training of CHPs by way of rural medicine courses, now with the NMC Act

[41] *Ibid*.

facilitating rather than obstructing. The regulation needs to provide for a course of adequate duration, due certification and proper supervision of such practice.

Chhattisgarh as the state was carved out from the State of Madhya Pradesh in 2001, it immediately faced the lack of health-workforce to work in rural, remote and the Naxalite hit areas. Seeing no scope of upper level of health workers providing services in such areas, the state passed the Chhattisgarh Chikitsa Mandal (CCM) Act. The Act bypassed the authority of Medical Council of India *vide* section 10A(1)(b) of IMC Act as approving and certifying body of the course. It created another authority of Chhattisgarh Chikitsa Mandal (CCM) which was to approve and regulate a 3 (three)-year course. The course offered was called 'Practitioner in Modern Medicine and Surgery' and this became a bone of contention with the medical regulator. The IMA raised concern that such misleading titles to diploma holders will give them overarching powers and will in turn result in the dilution of medical practice in the state. The name of the course was changed to 'Rural Medical Assistants' (RMAs), who were to work under the supervision of doctors under government employment. The RMAs were trained in six newly created institutes in the first phase which were in the private domain, regulated by government executives. Thus the created workforce of 1397 RMAs were to serve all PHCs in the state at a much lower cost than that which was needed to deploy doctors in the same positions. These RMAs belonged to local communities and got government employment which helped retain this workforce in the area for which they were trained. The act[42] as amended in 2007 to define medicine as 'modern and holistic medicine and all its branches' and practitioner in alternative medicine as 'practitioner in modern and holistic medicine'. Thus, the NMC has a *Chhattisgarh* experience of having seen the healthcare picture holistically and pilot already successfully done. The second phase begins with NMC facilitating the model in the whole of India. The elaborate list of dos and don'ts, the list of prescription medicines by RMAs, the procedure they are likely to conduct, these all come handy for further elaboration. Three-year diploma course prepared skilled force to work in underserved areas, location of six institutes purposely were rural areas. Internship training of RMAs were more focused in the primary care setting than MBBS who are trained for tertiary care. The course module was patterned to have RMAs aspire to be the best of the lot working in PHCs unlike the MBBS whose aspiration is to postgraduate and specialize. Many of the MBBS graduates migrate looking for greener pastures.

[42]The Chhattisgarh Chikitsa Mandal (Sanshodhan) Adhiniyam, 2007 (Act 9 of 2007).

Apart from RMAs, the state also trained quacks to make them more useful. On the recommendations of panchayats, such candidates were sent for six months training. Upon completion of the training they were to serve the same area which had sent them. Chhattisgarh has been a response to the crisis situation and the state deserves kudos to have shed the 'BIMARU'[43] tag and embraced technology and innovations to take health and healthcare to the doorstep of the people.

The challenge raised was for the identity of the qualifying candidates, their selection criteria, syllabus and curriculum, the teaching faculty, certification and maintenance of standards of such workers. With nurses, pharmacists, dentists, homeopaths and other 'people connected with modern scientific medical profession' coming in the category of community health providers, surveying of provisions in the wake of judicial decisions is desired.

Relevant sections of NMC Act read as:

> "30. (*1*) The State Government shall, within three years of commencement of this Act, take necessary steps to establish a State Medical Council if no such Council exists in that State.
>
> 31. (*1*) The Ethics and Medical Registration Board shall maintain a National Register containing the name, address, all recognized qualifications possessed by a licensed medical practitioner and such other particulars as may be specified by the regulations.
>
> (*2*) The National Register shall be maintained in such form, including electronic form, in such manner, as may be specified by the regulations.
>
> (*3*) The manner in which a name or qualification may be added to, or removed from, the National Register and the grounds for removal thereof, shall be such as may be specified by the regulations.
>
> (*4*) The National Register shall be a public document within the meaning of section 74 of the Indian Evidence Act, 1872.

[43]Acronym for four Indian states which lag behind in social indicators (Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh).

(*5*) The National Register shall be made available to the public by placing it on the website of the Ethics and Medical Registration Board.

(*6*) Every State Medical Council shall maintain and regularly update the State Register in the specified electronic format and supply a physical copy of the same to the Ethics and Medical Registration Board within three months of the commencement of this Act.

(*7*) The Ethics and Medical Registration Board shall ensure electronic synchronization of the National Register and the State Register in such a manner that any change in one register is automatically reflected in the other register.

(*8*) The Ethics and Medical Registration Board shall maintain a separate National Register in such form, containing such particulars, including the name, address and all recognized qualifications possessed by a Community Health Provider referred to in section 32 in such manner as may be specified by the regulations."

Reading sections 30, 31 and 32 together, following deductions can be arrived at:

That the concerned state, where a CHP will be functional, will recognize his qualification post training, will admit him in a separate register other than that for doctors, and will license him to practice independently in a defined setting with a limited therapeutic armamentarium of medicines and procedures, and where he is to practice in a tertiary care center, it has to be under supervision of doctor concerned. So, primary care with prevention of disease and promotion of health and treatment of common ailments will be the domain of working of CHPs, which really is the need of a large population.

Further, sections 50 and 51 provide for medical pluralism which accommodates all the systems of medicine and does away with the bar put by earlier court decisions. The training module is to be all encompassing, drawing from all the systems of medicine and should be able to offer a basket choice of treatment to patients. There needs to be complementarity and not exclusivity of treatment protocol. Present prevalence of colonial division should be done away with in this age, and a harmonious approach of treating a patient is required instead of curing the organ and tissue.

Sections 50 and 51 read as follows:

> "50. (*1*) There shall be a joint sitting of the Commission, the Central Council of Homoeopathy and the Central Council of Indian Medicine at least once a year, at such time and place as they mutually appoint, to enhance the interface between Homoeopathy, Indian Systems of Medicine and modern systems of medicine.
>
> (*2*) The agenda for the joint sitting may be prepared with mutual agreement between the Chairpersons of the Commission, the Central Council of Homoeopathy and the Central Council of Indian Medicine or be prepared separately by each of them.
>
> (*3*)The joint sitting referred to in sub-section (*1*) may, by an affirmative vote of all members present and voting, decide on approving specific educational modules or programs that may be introduced in the undergraduate course and the postgraduate course across medical systems and promote medical pluralism.
>
> 51Every State Government may, for the purposes of addressing or promoting primary healthcare in rural areas, take necessary measures to enhance the capacity of the healthcare professionals."

As cited, there have been earlier examples of implementation of CHP concept in Indian states to meet the shortfall of health workforce in Chhattisgarh, Assam, West Bengal, Maharashtra and Karnataka. The most notable and recent of those are the Rural Medical Assistant (RMA) in Chhattisgarh and Rural Health Practitioners (RHP) in Assam. The question of NMC Act provisions passing the test of constitutionality in the wake of earlier decisions of the Court has been analyzed and it is held that the whole exercise of the Act is a guided power and legislative enactment matches with judicial thought process.

Right to health

Judgments of the Supreme Court in *Mohinder Singh Chawla*[44] and *Paschim Banga Khet Mazdoor Samity*[45] have held the right to health as integral to the right to life which obliges the

[44]*State of Punjab* v. *Mohinder Singh Chawla* (1997) 2 SCC 83.
[45]*Paschim Banga Khet Mazdoor Samity* v. *State of West Bengal* (1996) 4 SCC 37.

state under article 21 of the Constitution to have adequate medical facilities for the people. Government hospitals and medical officers are duty bound to provide medical assistance to the needy for saving human life. Provisions read together emphasize that people have the right to health and to fulfill that obligation States need the presence of CHPs on the Indian healthcare map. How effective this legislative roadmap can be, is to be decided by the implementation role of the executive.

VII. Conclusion

Three key messages which can be drawn from the paper is, *Firstly* prescription dilution is meant for increasing access to healthcare, keeping the population healthy. The logical explanation given for this intended prescription deregulation is the inadequacy in the number of upper level health workforce in rural and remote areas and non-uniformity of healthcare service available to the masses. The aim of this public health approach in the wake of universal health coverage is to improve the health status of the poor and the vulnerable and gradually increase the quality of healthcare services. A prescription, apart from being an advice for patient's recovery, is also a legitimate order for sale of pharmaceutical products.[46] This may include controlled drugs too. Creating a cadre of 3.5 lakhs CHPs for manning the Health and Wellness Centers under Ayushman Bharat scheme for primary, preventive and promotive healthcare is an approach in the right direction. The intended beneficiaries must be the people of India and this should be clear in all minds. If it starts benefitting the pharma industry at the cost of care, the whole purpose of this exercise will be defeated. The erstwhile colonial influence of keeping the medical field away from common domain with a deliberate effort of creating information asymmetry[47] needs to go. The judicial limb of governance needs to see the Act in this light. The focus is on making public health robust through the agency of CHPs who are addressed as MLHWs globally. Their services have been cost effective, within reach of the community and with efficacy at par with those delivered by upper level health workers, as evidence cited above has proved. So, the introduction of CHPs in Indian healthcare ecosystem is a laudatory legislative job. *Secondly* the Act through health universities is roping in all stakeholders to keep focus on 'health' especially with primary care at the fore. Instead of creating an emphasis on 'disease' and 'cure' which serves more private interests and creates more inequalities in society by creating hierarchies, CHPs main role is the prevention of disease and promotion of health.

[46]Raman Kumar and Pritam Roy, "Deregulation of allopathic prescription and medical practice in India: Benefits and pitfalls" 5 *Journal of Family Medicine and Primary Care* 215-219 (2016).
[47]*Supra* note 10.

For this aim, a common platform is being created by the legislation with both, the Allopathic system of modern medicine and AYUSH, the traditional system of Indian medicine. This common platform with modern science in allopathy and culture and tradition in indigenous AYUSH system, devises and suggests strategies for making 'health' being connected with prevalent socio-cultural milieu and thus is generally more acceptable to the masses. Citing an example, when we say a person has to eat carbohydrates, proteins, fat, minerals and vitamins daily as part of daily diet, this is not in common knowledge of the population what to eat and what not. Same is said in traditional cultural language that we need to eat six tastes in our daily diet in food tasting sweet, sour, salty, bitter, pungent and astringent to taste-buds, and this gives all the necessary ingredients of a healthy diet. *Finally,* the enactment is a conscious effort to do away with the earlier hurdles which the judiciary saw as arbitrary and unconstitutional. The erstwhile central legislation, the Indian MCI Act forbade opening of new institutions and starting new courses without its permission. Since the MCI served the allopathic interests only and it had a duty cast upon it to maintain the standards of medical education, it never thought of sharing these responsibilities with professionals of other indigenous systems for providing holistic health to masses. NMC Act creates an enabling environment for developing healthcare as an amalgamation of all systems with leading experts in their respective fields guiding it. It accommodates and facilitates state government actions too as public health in Entry 6 of list II remains in states' domain to work upon. This strengthens federalism and advocates a need-based approach at the ground level looking to the local realities rather than one size fits all.

A recent apex court decision upheld the compulsory bonds executed by states as constitutional which allows states to keep original certificates of doctors till the time they serve in the rural areas as mandated in the bond. Actions of all three limbs of governance seem to be in sync as far as improving the health ecosystem is concerned. Fear of the medical fraternity of diluting the discipline of medicine with creation of insufficiently qualified practitioners and prescribing power to them, in a way legalizing quackery, is an initial resistance. Making the medical ecosystem bi-layered will invite more human rights concerns in the form of the rural population getting treatment with the classification which is in violation of the equality code of constitution. People living in rural and remote areas are less than equal and do not deserve treatment by qualified physicians can be one view. At the same time the state has witnessed

that since the recommendations of BHORE committee[48] At the dawn of independence regarding medical infrastructure in the country, there has been inability to meet the then requirement till date. India as a developing nation is fighting the menace of both infectious and non-communicable diseases together. With increasing population, it keeps us in no position of providing doctors and medicines and hospitals to all ailing Indians. Connecting the dots, Modi 2.0 is likely to face an uphill task regarding regulatory mechanisms of the NMC Act in the growing scenario that LAWs are practicing outside of their licensed scope of practice[49] in many jurisdictions thereby compromising patient safety and exposing providers to legal liabilities. The WHO has called upon countries to review their medical licensure laws ensuring proper definition of scope and autonomy as well as training and supervisory requirements of such practice. This emphasizes on the need to have an extra cautious approach going forward.

[48]The Health Survey and Development Committee, also known as BHORE Committee (1947) The preamble of the BHORE committee report began with the opening line: "No individual should fail to secure adequate medical care because of inability to pay for it."
[49]WHO, *Mid-level and Nurse Practitioners in the Pacific: Models and Issues* 16 21 (Manila 2001).