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MAKING DOCTORS AVAILABLE FOR RURAL INDIA: REGULATORY UNDERPINNINGS

*A alocação de médicos para a Índia rural:
fundamentos regulatórios*

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ABSTRACT

In the backdrop of acute shortage of allopathic doctors in rural India, this paper looks at the interplay and tension between central and state regulatory measures aimed at improving the availability and retention of allopathic doctors in the rural areas, within the overarching framework of centre-state relations and division of legislative powers between them, with respect to regulation of medical education. While the Central Government has introduced certain provisions in the central law – Medical Council of India Act, 1956, to promote availability of doctors in rural areas, some States have implemented provisions with the same objective, that go beyond the stipulations of the Central Act. Several such measures taken by state governments; be it reservation of post graduate seats for doctors serving in government rural institutions or developing cadre of medical practitioners for rural area under certain conditionalities; have been challenged in courts and held to be violative of the central legislation which *inter alia*, regulates standards of medical education and registration of doctors. The measures introduced by the state governments for increasing availability of doctors in rural areas, even though struck down as invalid, were intended as instruments of equity and social justice, with far reaching implications for improving availability of health care services in underserved areas. Unless the Medical Council of India Act is amended or the subject matter of medical education is moved from Union list to State list, state interventions are likely to continue to be struck down if they are found to be affecting the standards of medical education.

Keywords:

Health Workforce; Medical Council of India Act; Post Graduation Reservation; Regulation; Rural Medical Practitioners.

RESUMO

Este trabalho examina a relação entre o Governo Central e os governos estaduais da Índia no que tange às medidas regulatórias direcionadas à melhoria da disponibilidade e à retenção de médicos alopáticos nas áreas rurais do país, considerando a escassez desses profissionais nessas regiões. A análise é feita à luz do marco legal e da divisão de competências legislativas relativas à regulação da formação dos profissionais médicos. O Governo Central tem introduzido certas disposições na Lei do Conselho Médico da Índia, de 1956, para promover a disponibilidade de médicos nas áreas rurais; concomitantemente, alguns estados também têm implementado disposições com o mesmo objetivo, disposições estas que vão além do que estipula a Lei do Conselho Médico da Índia. Várias dessas medidas tomadas pelos governos estaduais – seja a reserva de vagas de pós-graduação para médicos que trabalham em instituições rurais do governo, seja a formação de quadros de médicos para as áreas rurais sob certas condicionantes – têm sido contestadas nos tribunais e consideradas violadoras da legislação central a qual, *inter alia*, regula os padrões de formação e o registro dos médicos. A menos que a Lei do Conselho Médico da Índia seja emendada ou o tema da formação dos profissionais médicos seja transferido da competência do Governo Central para à dos estados, as intervenções dos governos estaduais continuarão a ser derrubadas, caso considere-se que elas afetam os padrões de formação dos profissionais médicos.

Palavras-Chave:

Força de Trabalho em Saúde; Lei do Conselho Médico da Índia; Pós-Graduação; Regulação; Médicos Rurais.

Background

Globally, the estimated needs-based shortage of health workforce is to the tune of 17.4 million healthcare workers¹. In the absence of adequate availability of skilled health professionals, health outcomes will be adversely impacted^{2,3}. The shortage of human resources is a cause of concern particularly in developing countries like India⁴. As per Census 2011, the health worker to population ratio in India is 3.80 and skewed towards urban areas (with a ratio of 6.60)⁵. The shortage of health workers stands at an estimate of 0.79 million if we apply the WHO norm of 4.45. The problem will become more acute if we take out the number of Accredited Social Health Activists (ASHAs) inducted by the National Health Mission between 2001 and 2011, which nearly counts to about two-thirds of this increment. Meanwhile, an estimate made on the basis of intake capacity of MBBS students predicts that India will achieve adequate allopathic doctors by 2024⁶.

India had 4.6 million health workers by 2011 with the ratio for doctors remaining the most acute. In addition to the shortage, its distribution across and within the States results in poor service delivery in many parts of the country⁷. Ironically, India remains the largest source of physicians in the USA and the UK, and the second and third largest in Australia and Canada⁸. So, while India has a reasonably good ratio in urban areas and even supplies its doctors to other countries, its rural area remains deprived of doctors⁹. Efforts taken by State Governments to attract and retain doctors in rural areas often gets challenged on the grounds of being contrary to existing regulatory framework on medical education.

Materials and methods

The objectives of the study were (i) to outline the regulatory framework on Allopathic Medical Education in India; (ii) to describe the State wise initiatives on rural postings including legal promulgations; and (iii) to discuss the Judgments of the apex courts of India relevant to rural postings and creation of cadre of Rural Medical Practitioners.

In order to meet this objective, a desk review was conducted using online legal resources like Manupatra using the following key words - regulatory framework, health policy, National Health Mission, Medical Council of India, Rural Medical Practitioners, High Court / Supreme Court (India). State experiences on a separate cadre of medical practitioners (other than MBBS) for rural areas have been discussed as a case study. The narration has followed a 'meta-analytic' approach to the extent that it 'does evidence synthesis while bringing contrasts in approaches by different agencies (State, Court, Professional bodies etc.) to the same problem.

The initiatives of the government (Maharashtra, Madhya Pradesh etc.) allowing practice of allopathic medicine by Ayurvedic or Homeopathic or Unani

Practitioners, in order to address the shortage of MBBS doctors have not been dealt with / discussed in this paper. The paper also does not cover general reforms undertaken/advocated in the area of medical education like revision of undergraduate medical curriculum, Family Medicine etc.

Findings and discussion

The Indian Republic has a federal structure with a parliamentary system of government comprising 28 States and eight Union Territories (UTs). The Constitution of India distributes legislative powers between national parliament and state legislatures. In this arrangement, public health is a state subject. Healthcare services in India are available from multiple and often competing sources. These include a very large public sector, which has phenomenal reach as well as a large number of private providers who are mostly concentrated around urban areas and operate in a largely unregulated market. In addition to these, health services are also available for defined categories of people including the employees state insurance, central government health scheme, railways hospitals, armed forces medical services etc. On the far end of the spectrum are the informal providers some of whom are partially trained paramedics and some others who do not have any formal training in health at all¹⁰.

Since health manpower and infrastructure (as part of public health), is a state subject, its funding and management, is in the domain of respective state governments. The national government does however influence health policy through preferential budgetary allocations for specific centrally sponsored schemes. The implementation of these programmes uses management and implementation apparatus of state governments. The success of these programmes, therefore, really depends upon performance of state institutions. The states on the other hand have been facing critical problem of designing and maintaining sustainable health systems where fund allocation for healthcare can be increased and capacity for utilization of allocated resources augmented.

From around the time of independence, various government committees: Bhore¹¹, Mudaliar¹², Shrivastav¹³, Bajaj¹⁴ have made recommendations towards

¹⁰ ASIA-PACIFIC ACTION ALLIANCE ON HUMAN RESOURCES FOR HEALTH (AAA). *History*. Available at: <http://aaahrh.net/history/>. Accessed: 1 Apr. 2019.

¹¹ BHORE COMMITTEE, 1946. *National Health Portal of India*, 2015. Available at: https://www.nhp.gov.in/bhore-committee-1946_pg. Accessed: 29 Mar. 2019.

¹² MUDALIAR COMMITTEE, 1962. *National Health Portal of India*, 2015. Available at: https://www.nhp.gov.in/mudaliar-committee-1962_pg. Accessed: 29 Mar. 2019.

¹³ SHRIVASTAV COMMITTEE, 1975. *National Health Portal of India*, 2015. Available at: https://www.nhp.gov.in/shrivastav-committee-1975_pg. Accessed: 29 Mar. 2019.

¹⁴ BAJAJ COMMITTEE, 1986. *National Health Portal of India*, 2015. Available at: https://www.nhp.gov.in/bajaj-committee-1986_pg. Accessed: 29 Mar. 2019.

improving the system. The launch of the National Rural Health Mission in the 11th plan period (NRHM)¹⁵ and subsequent addition of Urban component¹⁶ have given a lot of impetus to strengthening health systems for better implementation of national/state Programmes.

In terms of physical infrastructure, the rural public health sector comprises Sub-health Centres (SCs) (for every 5000 population), Primary Health Centres (PHCs) (20,000 to 30,000 population), Community Health Centres (CHCs) (80,000 to 1,20,000 population) and District Hospitals (DH), which currently cater to nearly 20 lakh population. After the launch of Urban Health Mission, initiatives to strengthen urban health institutions are also underway. In addition to the urban PHCs and urban CHCs, the medical colleges are by and large located in the urban areas and taking a huge load of secondary and tertiary care. Majority of private practitioners prefer providing services in the urban areas.

The efforts undertaken by the governments in order to address the shortage of doctors in rural areas can be broadly categorized into two groups; (1) the reservation of all or part of Post Graduate seats in allopathy for MBBS graduates who have served a defined period of time in government rural postings; (2) creating a diploma course for building a separate cadre of rural health practitioners, who upon completion of the diploma course, would practice allopathy only in government health centres in rural areas to provide health services for a prescribed set of ailments. These efforts have been challenged in the courts and have been struck down as violative of the MCI Act and / or the Constitution. In order to understand the rationale for the judgements of the courts on validity of the state measures and laws, it is necessary to understand the constitutional framework on medical education and the extent of State's mandate to legislate on the same. Allowing medical colleges to be operated by private sector in India is not considered in the paper as a measure to improve availability of doctors in rural sector but to improve the doctor population ratio in the country.

I. Distribution of Legislative Powers between Centre and the States

India is a federation with division of powers, including legislative powers, between the Central (federal) government and the State Governments. Under the Constitution of India, there is a threefold distribution of legislative powers between

¹⁵NATIONAL RURAL HEALTH MISSION - NRHM. National Rural Health Mission Framework for Implementation - Government of India, 2005. Available at: <https://nhm.gov.in/WriteReadData/1892s/nrhm-framework-latest.pdf> Accessed: 29 Mar. 2019.

¹⁶NATIONAL URBAN HEALTH MISSION - NUHM. National Urban Health Mission Framework for Implementation - Government of India, 2015. Available at: <http://www.nhm.gov.in/nhm/nuhm/nuhm-framework-for-implementation.html>. Accessed: 29 Mar. 2019.

the Centre and State as defined by the three lists – Union, State and the Concurrent list, explained below:

- List I (Union List) includes subjects over which the Union Parliament shall have exclusive powers of legislation, such as: defense, port quarantine, foreign affairs, banks, currency and coinage, patents, citizenship etc.
- List II (State List) includes subjects over which the State Legislature shall have exclusive powers of legislation, such as: public order and police, local government, agriculture, forests and fisheries, public health, hospitals etc.
- List III (Concurrent List) includes subjects over which both the Union and the States have concurrent powers to legislate, such as marriage, contracts, torts, trusts, welfare of labour, medical education, social insurance, economic and social planning etc. However if the Centre makes a law on a subject in the concurrent list, then it will prevail over a state law. In case of repugnancy between a Central law and State law on a subject matter in the concurrent list, the former will prevail.

The Constitution however provides for certain exceptional situations, when the Union Parliament can legislate on a subject that is in the State List. These exceptions are covered under four articles¹⁷:

- (i) Article 249** – Power of Parliament to legislate with respect to a matter in the State List in national interest. This article empowers the Union Parliament to legislate on any matter listed in the State List (List II), whenever the council of states resolves by a 2/3rd majority, that such legislation is ‘necessary or expedient in the national interest’¹⁸. In such scenario, Art 246(3) ceases to be a fetter on the power of the Union Parliament, to the extent that the resolution goes. National interest is wide enough to cover any matter, which has incidence over the country as a whole as distinguished from a particular locality or section of people¹⁹.
- (ii) Article 250** – Parliament has power to legislate with respect to any matter in the State List, if a Proclamation of Emergency is in operation. Such a law passed by parliament on items of state list shall be in force for the period of emergency and 6 months beyond that period.
- (iii) Article 252** – Power of Parliament to legislate for 2 or more States by consent and adoption of such legislation by any other state. If it appears to

¹⁷ INDIA. *Constitution of India*. National Portal of India, 2017. Available at: <https://www.india.gov.in/my-government/constitution-india/constitution-india>. Accessed: 29 Mar. 2019.

¹⁸ State of Karnataka v. UOI A. 1978 SC 68 (paras 72, 76, 79, 104).

¹⁹ DESHPAN, V. S. *Comparative Federalism* (1987). By Durga Das Basu. Prentice-Hall of India Pvt. Ltd., New Delhi. Pp. xxv+642. Price Rs. 200. [Book Reviews] Available at: [http://14.139.60.114:8080/jspui/bitstream/123456789/17177/1/050_Comparative Federalism %281987%29 %28254-257%29.pdf](http://14.139.60.114:8080/jspui/bitstream/123456789/17177/1/050_Comparative%20Federalism%201987%29%2028254-257%29.pdf). Accessed: 29 Mar. 2019.

the legislature of 2 or more states, that any matter with respect to which the Parliament has no power to legislate, should be regulated in those states by the Parliament by law, they shall pass a resolution to that effect, in both houses. Passing of the resolution is a condition precedent for vesting the power in the Parliament.

- (iv) **Article 253** – Power of Parliament to make law for implementing any treaty, agreements, conventions etc. Parliament has power to make any law for the whole or any part of the Territory of India for implementing any treaty, agreement or convention with any other country or countries or any decision made at any International Conference, Association or Other body. The limitations imposed by Articles 245 and 246 (division of subject matters in 3 lists) are removed and the total field of legislation is open to the Union Parliament^{20, 21}.

II. Overlapping Powers of Central and State Governments to regulate ‘Medical Education’

Entry 66 List I (Union list) covers coordination and determination of standards in institutions for higher education and scientific and technical institutions.

Entry 25 List III (Concurrent list) covers education including medical education and universities, subject to the provisions of entries 63 - 66 of List I.

Education is a divided area between the Centre and the States. The subject of “education” has been moved from List II (State List) to List III (Concurrent list).²² This was done, among other reasons, so that the Parliament can secure uniformity in standard and syllabi of education in the country.

The use of the expression “subject to” in entry 25 List III, means that out of the general heading “Education”, the matters contained in entries 63-66 in List I have been carved out. It means that if a matter is covered in entries 63-66 in List I, the power to legislate on that matter lies exclusively with the Parliament, even though that matter may otherwise fall within the broader field of “Education”. This means that entry 66 List I and Entry 25 List III have to be read together. On reading them together, it is evident that while both the Union and State Governments have the power to pass legislations in relation to education (including medical education), the power of State Government is subject to the application of ‘doctrine of occupied

²⁰Krishna v. Land Tribunal A. 1993 SC 883 (para 3).

²¹Venkaiah v. St. of A.P., A. 1980 SC 1568 (para 6) C.B.

²²The 42nd Amendment Act of 1976 transferred five subjects to Concurrent List from State List, that is, (i) education, (ii) forests, (iii) weights and measures, (iv) protection of wild animals and birds, and (v) administration of justice; constitution and organisation of all courts except the Supreme Court and the high courts.

field'²³. Accordingly, the validity of a state law under entry 25, List III, would therefore depend on whether it prejudicially affects 'coordination' and 'determination' of standards in medical education. If there is a central law in respect of that matter, it would have paramountcy over the state law.

The Parliament has enacted several central laws to regulate various fields of medical profession:

- Medical: The Indian Medical Council Act, 1956 provides for the constitution of the Medical Council of India (MCI) and state councils. The MCI regulates standards of medical education, permission to start colleges, courses or increase the number of seats, registration of doctors, standards of professional conduct of medical practitioners etc.
- Nursing: The Indian Nursing Council Act, 1947 provides for the constitution of Nursing Council of India (NCI). The NCI regulates standards of nursing education, permission to start colleges or schools, decide on the number of seats, registration of nurses and midwives, standards of professional conduct etc.
- Dentistry: The Dentists Act, 1948 provides for the constitution of the Dental Council of India (DCI). The DCI regulates: permission to start colleges, courses or increase the number of seats; registration of dentists; and standards of professional conduct of dentists, among others.
- Pharmacy: The Pharmacy Act, 1948 establishes the Pharmacy Council of India (PCI) and the state pharmacy councils. PCI has powers to lay down standards of education for qualification as pharmacists, approve courses of study and examination, maintenance of registers of pharmacists, regulate practice of pharmacy etc.

III. Provisions in Central Law to promote availability of doctors in rural India - The Medical Council of India Post Graduate Medical Education Regulations, 2000 (MCI Regulations)

The Medical Council of India Act is a central law, which falls within entry 66 of List III. The Act provides for the constitution of the Medical Council of India (MCI). The MCI regulates standards of medical education, permission to start colleges, permission to start courses or increase the number of seats, registration of doctors and standards of professional conduct of medical practitioners.

Under Section 33 of the Act, the MCI has the power to make regulations to carry out the purpose of the Act. Under section 33 read with section 20 of the Act, the MCI framed The Medical Council of India Post Graduate Medical Education

²³ Doctrine of Occupied Field refers to those legislative entries of State List, which are expressly made 'subject' to a corresponding Entry in either the Union List or the Concurrent List.

Regulations, 2000 (MCI Regulations), that governs the determination of admission criteria and other related aspects for all post graduate medical courses in India (diploma as well as degree).

Regulation 9 of the MCI Regulations (amended in 2012 and operative from year 2013-14), lays down procedure for selection of candidates for postgraduate courses. It states that admission shall be on the basis of merit through the single eligibility cum entrance examination, namely, 'National Eligibility-cum-Entrance Test' (NEET). However, in public interest in improving availability of doctors in rural, remote and difficult to access areas, the Regulation directs that determination of merit may include incentives and reservation of seats for service rendered in rural and remote areas:

- (i) The proviso to Regulation 9 Clause (IV) states that in determining the merit of candidates who are in-service of Government/public authority, weightage in marks may be given as an incentive at the rate of 10% of the marks obtained for each year of service in remote and/or difficult areas up to the maximum of 30% of the marks obtained in NEET. This would be applicable to degree courses as well as diploma courses.
- (ii) Clause VII of Regulation 9 specifies that 50% of the seats in postgraduate diploma courses shall be reserved for medical officers in the government service, who have served for at least three years in remote and/or difficult areas. After acquiring the PG Diploma, the medical officers shall serve for 2 more years in remote and/or difficult areas as defined by State Government from time to time. This provision is applicable only for admission to postgraduate diploma courses.

The regulations have been held by the Supreme Court of India (SC) to be a complete code in relation to such admissions and to hence be binding and mandatory on all states. Therefore, any law made or orders / rules passed by State legislatures under Entry 25 List III, must be in consonance with the MCI Regulations (which is a Central Legislation). State rules or laws, to the extent that they are contrary to the scheme of the MCI Regulations, or otherwise exceed its' scope, would be *ultra-vires* and hence, liable to be struck down.

IV. Efforts of State Governments to Increase Rural Postings – going beyond the mandate of the central law

In order to address the problem of acute shortage of doctors in rural and remote areas, several states have, over a period of time, introduced measures that provide incentives for doctors to practice in rural areas. These include – incentive marks for admission in diploma as well as degree courses; reservation of seats for in-service candidates in both PG diploma and degree courses (while the central law only allows it for diploma courses), who worked in rural areas for a prescribed

number of years and; service in rural area for a specified number of years as a mandatory criterion for admission in PG courses. In several states, a practice has been followed; that for about 100 seats in the pool of eligible candidates, 50 are attributed to the All-India category and 50 to the state quota. Of the latter, 25 seats are allocated to the open market and 25 are reserved for the in-service candidates²⁴.

Some of these measures pertaining to admission in the PG courses go beyond the provisions stipulated in the MCI Regulations discussed above. As a result, their legal validity has been challenged as being violative of the MCI Regulations. Legal challenges to some of these measures have been discussed below:

1. Rural practice as mandatory requirement for admission in PG courses

State of Chhattisgarh, passed the “Chhattisgarh Snatakottar Pravesh Pariksha Niyam 2002” in short, “PG Rules, 2002”. Rule 6.3 of PG Rules, mandated completion of two years’ service in a rural PHC under the State Government as mandatory for appearing in the Pre-PG Examination. A Writ Petition was filed challenging the validity of the Rule as the immediate effect of it was that even candidates who had an outstanding academic career could not take up the Pre-PG Examination, in case they had not rendered service under a rural PHC for a period of two years, though they may have otherwise been practicing in a rural area. It was alleged that the Rule violated Clause 9 of the MCI Regulation.

It was contended by the State that though the State could not dilute the standard laid down by the MCI, it was perfectly within its right to provide something in addition to the standard laid down by the MCI. It was also submitted that Rule 6.3 in no way offended Clause 9 of the MCI Regulations, for it had nothing to do with the selection criteria, but was in fact an eligibility criteria laid down by the State Government and it could not be construed as providing for 100% reservation for in-service candidates.

Putting forth the public health rationale, the State averred that out of 1792 sanctioned posts, 588 posts were lying vacant, of which 438 were in the rural areas. It was submitted that the action was deemed necessary because it was felt by the State that the doctors did not co-operate with the State Government to fulfill the constitutional obligation of the State as enshrined in Article 47 of the Constitution of India, which enjoins the Government to provide medical facilities to the citizens. According to the State, the students who obtain their degree course from the State funded medical colleges have a social obligation to serve the State and specially the remote and underserved areas, which lack medical facilities.

²⁴MEHAL, Jain. Can States Provide reservation for in-service candidates for PG medical courses? SC constitution bench reserves interim order [read order]. *Live Law.in*, 18 Apr. 2018. Available at: <https://www.livelaw.in/can-states-provide-reservation-service-candidates-pg-medical-courses-sc-constitution-bench-reserves-interim-order/>. Accessed: 29 Mar. 2019.

The issue was whether the prescription of two years rural service relates to “standard of education” and, therefore, beyond the legislative competence of the State Government. The court did not accept this contention of the petitioners that the measure was beyond the legislative competence of the State. However, regarding the issue whether the mandated rural service could otherwise be sustained, the court held

there is no getting away from the fact that the effect of Rule 6.3 is that there is cent percent reservation for in-service candidates--because only those who have served under the Government, whether in a temporary, permanent or an ad-hoc/contractual capacity can hope to do post-graduation in the State of Chhattisgarh. Even one who had devoted his service in a rural area as a private practitioner is debarred from taking up the Pre-P.G. test, as he is not eligible under the said Rule. In practice only “in-service candidates”, i.e., those who have rendered service in a Primary Rural Health Centre under the Government in any capacity whatsoever will alone be entitled to take up the Pre-PG test to the exclusion of all others howsoever brilliant they may be. It, therefore, follows that by incorporating Rule 6.3 the Government has tried to achieve or provide for cent percent reservation for in-service candidates--something, which it could not do directly, has been done indirectly.

Hence the provision contained in Rule 6.3 was annulled.

2. Reservation of seats in PG “degree” courses

The State of Uttar Pradesh (UP), by way of a Government Order dated 28 February 2014, created reservation of 30% for in-service candidates for admission to post-graduate medical courses in 6 State medical colleges. Such reservation could be availed by those persons who had passed the common entrance examination, if they had served in health centres or PHCs or CHCs in difficult, remote and backward areas, for a period of 3 years or more²⁵.

The UP Government Order was challenged by in-service candidates in urban areas before the Allahabad High Court (HC) seeking, *inter alia*, the inclusion of the areas they had been serving in and questioning the arbitrary application of the 3 year criteria retrospectively, which had effectively deprived them of the opportunity of opting for rural areas, as they were unaware of the added advantage of doing so at the time of making such choice. The Allahabad HC, in the matter of “Dr. Dinesh Singh Chauhan v. State of U.P. & Ors.”, struck down the Government Order on the basis

²⁵BHARGAVA, Vanita; CHATURVEDI, Aseem; ANAND, Meherunnisa. India: Supreme Court strikes down practice of grant of reservation for in-service candidates in post graduate medical degree courses. *Food, Drugs, Healthcare, Life Sciences - India*. Aug. 23 2016. Available at: <https://vlex.in/vid/supreme-court-strikes-down-647491929>. Accessed: 29 Mar. 2019.

that the MCI Regulations, being a complete binding code in itself, did not provide for any reservation for admission to post graduate degree courses (as opposed to diploma courses), to which selection was to be based purely on merit.

In Appeal before the SC, the State argued that the MCI Regulation did not explicitly bar the State government from providing reservation for in-service candidates in the 'degree' courses and that there were precedents of SC suggesting that such arrangement is permissible as a separate channel of admission for in-service candidates. Supreme Court (SC) in "State of U.P. & Ors. V. Dinesh Singh Chauhan"²⁶ upheld the order and judgement of the Allahabad HC and held that the State Government order was contrary to Regulation 9 of the MCI Regulations by providing reservation for admission in degree courses, which is not envisaged in the MCI Regulations. The SC held:

- By now it is well established that Regulation 9 is a self contained code regarding the procedure to be followed for admission to medical courses. It is also well established that the State has no authority to enact any law much less by executive instructions that may undermine the procedure for admission to Post Graduate Medical Courses enunciated by the central legislation and regulations framed thereunder, being a subject falling within the Entry 66 of List I. The procedure for selection of candidates for the Post Graduate Degree Courses is one such area on which the Central Legislation and Regulations must prevail.
- The precedents had considered provisions regarding admission process governed by Regulations in force at the relevant time. The admission process in the case under dispute is governed by the Regulation that came into force from Academic Year 2013-14. And the MCI Regulations do not provide for reservation for in-service candidates in Post Graduate "Degree" Courses. If it were intended, it would have been provided for in the same manner as it was done for 'Diploma' Courses.

3. Separate source of entry for in-service candidates in PG degree courses

Since 1989, the State of Tamil Nadu has had a policy of providing a separate source of entry to in-service candidates to the extent of 50 per cent of the state's seats in degree courses. Further, since 2007 the State of Tamil Nadu has, by a government order, provided a preferential weightage to those in-service candidates who have served in rural, hilly and difficult areas. Tamil Nadu Medical Officers' Association and others²⁷ filed a writ petition before the SC, seeking the following declarations: (i) that Regulation 9 of the MCI Regulation, does not take away the power of the States under Entry 25, List III to provide

²⁶State of U.P. & Ors. V. Dinesh Singh Chauhan (2016) 9 SCC 749.

²⁷Tamil Nadu Medical Officers' Association & Ors. V. UOI & Ors. Writ petition (civil) no. 196 of 2018.

for a separate source of entry for in-service candidates seeking admission to Degree Courses; and (ii) Alternatively, that Regulation 9 [more particularly, Regulations 9 (iv) and 9 (vii)] as being arbitrary, discriminatory and violative of Article 14 and Article 19(1)(g) of the Constitution and also ultra vires the provisions of the Indian Medical Council Act.

Although the Union contended that the issue has been settled in “Dinesh Singh Chauhan” case (discussed above), the petitioners argued in the said case, the Court had not considered the relevant legislative entries and had also not referred to precedents of the SC, which was passed by a bench of the same strength as in “Dinesh Singh Chauhan” case. The SC agreed with the petitioners and referred the matter for consideration by a larger constitution bench.

A 5-judge constitution bench of the SC heard the matter and held that

the decision in “Dinesh Singh Chauhan” holds the field as it is based on a construction of Regulation 9 (IV), which at least at the present stage, could not be brushed aside. The principle that had been adopted in the decision of “Dinesh Singh Chauhan” is consistent with the primacy that is attributed by the Constitution to Entry 66 of List I. This is the clear intendment of the words “subject to” in Entry 25 of List III. MCI has, as an expert body, proceeded on a principled basis. Any attempt at this stage to read into Regulation 9(IV), a separate source of entry or a reservation for in-service candidates in degree courses would impinge upon Entry 66 List I and the exercise of regulatory powers under the central statute.

4. Separate cadre of Rural Medical Practitioners

States of Chhattisgarh and Assam introduced a course for development of a cadre of Rural Medical Assistants. The candidates who underwent this course got a diploma, not a degree, even though the course was similar in content to the MBBS program. The programme went into problems due to a variety of reasons including a legal battle. A brief case study on them is given in Case Study 1 (Chhattisgarh) and Case Study 2 (Assam).

Case Study 1: RMAs – The Chhattisgarh experience²⁸

²⁸Based on a work by Public Health Foundation of India (PHFI), National Health Systems Resource Centre (NHSRC) and State Health System Resource Center (SHSRC), Chhattisgarh; the details of which was published as a report in June, 2010. Excerpts quoted from the report RAO, K.D. *et al.* *Which doctor is for primary health care? An assessment of primary health care providers in Chhattisgarh, India.* PHFI, New Delhi & NHSRC, New Delhi, and SHRC, Chhattisgarh, June 2010.

In 2001, Chhattisgarh introduced a three-and-a-half-year course to create a cadre of Rural Medical Assistants. The graduates were awarded a diploma, not a degree, in modern and holistic medicine, even though the course was similar in content to the MBBS program. The states of Maharashtra, Karnataka and West Bengal also had similar courses in place.

Chhattisgarh introduced this course by passing the Chhattisgarh Chikitsa Mandal (CCM) Act, 2001. The course underwent a change in its title, from the original name of 'Practitioner in Modern Medicine & Surgery' to 'Diploma in Alternate Medicine' when it got into a legal battle with the MCI. The second change was when the government tried to affiliate it under the paramedical council, as "Diploma in Holistic Medicine and Paramedical Course" in March 2003. The state had the rationale that affiliation under the paramedical council would be less likely to be legally challenged than would the CCM as it would be clearly outside the purview of medical councils and associations.

The name change, however, struck a problem from another quarter. This time the students agitated that the term "paramedical" was a dilution of the status of the course from the "medical" profession to which they desired affiliation. The name of the course instead was revised again following the July 2003 student strike to "Diploma in Modern and Holistic Medicine". The legal and political issues, rather than any dialogue over the aims and purposes of the course, governed the decisions to change the name of the course several times and with it, its stated curriculum.

Two Inspection committees in 2004 and 2005 examined the syllabus and recommended changes in syllabus to make it more appropriate for the epidemiological needs of the rural and tribal population- but these were not carried out. The change in the state government after the November 2003 elections brought the issues of course objectives and identity of the graduates into a fresh review.

The new political regime dropped officer in-charge of the 3-year course (the OSD) as a political and irregular appointment, and the health secretary was brought back to re-formulate policy on the course after a gap of almost two years. By then there were around 809 dropouts from the six institutes out of total 2200 admissions made. On 1st September 2008, the course officially ended.

Attention now shifted to the question of what should be done with these 1391 students. The government therefore had to define what they could be allowed to practice, which did not fall under the MCI Act but yet would be medical enough to manage this situation. With the clarity that no legal independent practice in allopathic medicine was possible for these students, a bipartisan high powered committee was tasked to find a viable employment for the students.

One suggestion that the committee considered was to revive the post of Assistant Medical Officer (AMO), an earlier post which had been abolished in 1976.

The post had been occupied by the three year Licensed Medical Practitioner (LMP) of West Bengal and the Registered Medical Practitioner (RMP) of Maharashtra. The proposal in Chhattisgarh was to create a third post of AMO in addition to the 2 MOs that had been already sanctioned per PHC.

This proposal however was rejected by the Finance Department on grounds that such an increase in health personnel expenditure was not justifiable. The next option considered was to post them as Block Extension Educators (BEE). This was not acceptable to the students since the words 'Medical' was found missing from the title of the course.

Then it was decided to appoint Rural Medical Assistants in lieu of the second MO post which was kept in abeyance. The government thus saves half the salary of the second MO-Rs 8,000/- against Rs.15,000/- to MBBS doctor by this measure. The RMAs were sanctioned selectively in the PHCs classified as remote or tribal in districts with the most acute shortage of doctors. By the letter of the law they are not to be posted where there is no medical officer, for they are only assistants, and therefore they would not contravene the law. However in practice medical officers would not join in many PHCs and these RMAs may have to function independently. Government employment with medical functions thus becomes possible, but private independent practice by these graduates is still not permissible. The IMA finds this truce acceptable and so do the students who have got the title of 'medical' in their designation and government job- two key demands of theirs. The funds are from the central government through the NRHM mechanism and therefore the state finance department finds it easier to accept- though in the long run it would have to take this over. Thereafter the vacant posts were filled except the 95 posts of RMAs since they fall under the SC/ST (Scheduled castes and Scheduled Tribes) category. They remained vacant, not because of a dearth of interested applicants, but due to the absence of adequate numbers of SC/ST students ever trained in these institutes. The reservation rules at the time of admissions were either insufficient or poorly implemented. The female RMAs are posted at far-flung CHCs that lacked lady doctors.

An assessment of primary health care providers in Chhattisgarh—on parameters of knowledge, attitude, behavior, and practice, including community perception— found RMAs and Medical Officers to be equally competent in managing conditions usually seen in primary care settings.(National Health Mission,2019)

Case Study 2: The Assam Rural Medical Practitioners experience

In order to respond to the human resource shortage in the rural areas, and based on the experience of other states, Assam promulgated the Assam Rural Health Regulatory Authority (ARHRA) Act, 2004. The act gave recognition to 'Diploma

in Medicine and Rural Health Care' and allowed the diploma holders to practice medicine and rural health care subject to the following conditions:

- (i) To treat only those diseases, carry out those procedures and prescribe only those drugs, which shall be outlined in the rules under the Act;
- (ii) Not to carry out any surgical procedure, invasive investigation or treatment, medical termination of pregnancy, etc., but to remain confined to such medical treatment and perform such minor surgery as prescribed under the rules;
- (iii) To issue illness certificates and death certificates;
- (iv) To maintain name/address, age, sex, diagnosis and treatment records of all patients treated;
- (v) To practice only in rural areas and not be eligible for employment in hospitals, nursing homes and health establishments located in urban areas as General Duty Physicians involved in patient care in OPD, Emergency and Indoor Services”.

The Indian Medical Association (IMA), filed a writ petition challenging the constitutional validity of the ARHRA Act, on the following grounds:

- (i) The ARHRA Act is repugnant to the provisions of the IMC Act. The required permission to teach the diploma course in medicine is not obtained as contemplated under section 10a of the IMC Act, which was enacted by virtue of entry 66 of list I of the Constitution of India (Constitution of India | National Portal of India, 2017).
- (ii) The ARHRA Act, enacted on the basis of entry 25 of list III, is repugnant to the provisions of the IMC Act and that no Presidential assent was obtained as required under article 254 of the Constitution of India.
- (iii) The students who pass the course and are issued with the diploma certificates would be ill equipped (as doctors) to treat patients and there would be a risk to patients who require quality medical assistance and treatment.
- (iv) The **provisions of section 24 of the ARHRA Act** impose illusory and unworkable restrictions on the practitioners who pass the course. The restrictions that they should not practice in urban areas and at nursing homes are illusory and such restrictions cannot be effectively implemented. Besides, to make a distinction between the medical services for urban areas and rural areas amounts to a hostile and irrational discrimination, and the standard and quality of medical services required for persons in urban areas and in rural areas cannot be different and the standard has to be uniform for the health and welfare of the society.

Since stay was not granted by the Court on the implementation of the ARHRA Act, by the time the matter came up for final hearing, about 5 batches had passed out and around 500 students had been awarded with the diploma by the ARHR Authority and they were under the employment of the state agencies in different rural areas in Assam.

The State contended that the courses approved by the Indian IMC (under IMC Act) are degrees in medicine and other higher degrees, whereas the ARHRA Act envisages a diploma course with certain restrictions on the medical practitioners who obtain a diploma, mainly with an intention to create a cadre of practitioners with competence to treat common diseases that afflict rural people. The practitioners under the ARHRA Act are not entitled to operate major surgeries and they are permitted only to treat certain types of diseases and prescribe certain types of medicines. Therefore, the persons who pass diploma course are not full-fledged doctors; they are in a sense, paramedics. In that view it is argued that the ARHRA Act does not suffer from any infirmity or illegality so as to be struck down.

The Court concluded that, it is evident that the ARHRA Act is in conflict with the IMC Act more particularly section 10(a) of the IMC Act, which is enacted by virtue of entry 66 of list I which categorically declares by non-obstante clause that “notwithstanding anything contained in this Act or any other law for the time being in force, no person shall establish a medical college and no medical college shall open a new or higher course of study or training except with the previous permission of the Central government obtained in accordance with Sec 10(a) of the IMC Act. The Court did not agree with the arguments of the State to declare these rural health practitioners as community health worker or paramedic because the ARHRA Act does not say anything like that and the Court could not re-legislate and declare the diploma-holders as paramedic. Therefore, keeping in view the larger interest of the health and welfare of the society and in view of the serious lapses committed by the state in enacting a legislation without proper approval from the Central Government and which is evidently in conflict with the **provisions of the IMC Act, the High court held the ARHRA Act, 2004** unconstitutional and struck it down. However, IMA kept pointing out that the diploma holders continued to work in the government facilities despite the judgement of the High Court and vowed to file contempt petition against the State Government if it did not put the diploma holders out of work.

Meanwhile in 2014, under directions of the Delhi High court, the Central Government approved introduction of a course namely, Bachelor of Science (Community Health). The main objective of the proposed course is to create mid-level health professionals who would possess the necessary public health and ambulatory care competencies to serve the rural population and will primarily be deployed at Sub Centres. The curriculum of the course has been prepared after taking into

consideration the views of various stakeholders, including the Medical Council of India. The degree for the course will be awarded by the respective State Universities and it will be accredited by the National Board of Examinations (NBE) to ensure uniformity in the content and delivery of the course. This course intends to create a cadre of health workers who can provide basic health services in rural or remote areas, backed by statutory validity.

Following the approval of the course by the Central government, the State of Assam promulgated; **The Assam Community Health Professionals (Registration and Competency) Act, 2015** recognising the central government approved course of BSc. (Community Health) and providing for registration and practice of degree holders etc. Interestingly, through the new Act, the government has equated the earlier 'Diploma in Medicine and Rural Health Care' with the new BSc. (Community Health) course, thereby giving legitimacy to the diploma holders under the ARHRA Act that was struck down as unconstitutional. It remains to be seen, whether equation of the new course with the older course, is challenged by professional medical bodies like the IMA.

From 2016, the Central Government has approved a 6-month bridge programme, which is offered by IGNOU (Indira Gandhi National Open University). The course is offered to nurses or AYUSH doctors, who upon completion of the course, are posted as 'Mid Level Health Providers' (MLHPs) in the Health and Wellness Centres (HWC) set up under the AYUSHMAN Bharat programme. Delivery of health services by MLHPs through HWCs, is a crucial component for providing comprehensive primary health care. Though the course has been approved by the central government, it has not been notified under the MCI Act and the professional bodies of allopathic doctors have criticized the move as promoting quackery. As creation of this cadre and the bridge course is not yet backed by law, it is open to being legally challenged.

Conclusions

The government has, through NHM, made considerable efforts to place doctors and other health workers in rural areas. However, primary care facilities continue to report shortfalls and vacancies due to the overall shortage of skilled health workers and reluctance of health personnel to work in rural areas, reflected in the appointed health workers not taking up posts, absenteeism and dual practice^{29, 30}.

²⁹ MURALIDHARAN, Karthik; CHAUDHURY, Nazmul; HAMMER, Jeffrey; KREMER, Michael; ROGERS, F. Halsey. Is there a doctor in the house? medical worker absence in India, p. 1-19, Apr. 2011. Available at: https://scholar.harvard.edu/files/kremer/files/is_there_a_doctor_in_the_house_-_12_april_2011.pdf.

³⁰ WORLD HEALTH ORGANIZATION - WHO. Regional Office for the Western Pacific, 2013. Dual practice by health workers in South and East Asia: impact and policy options. Manila: WHO Regional Office for the Western Pacific, 2013. (Series/Report n. Policy brief, v. 2, n. 1, 2013). Available at: <https://apps.who.int/iris/handle/10665/206912>. Accessed in: 21 Feb. 2020.

Absenteeism among primary health care workers in India has been reported by one of the studies at a shocking 40%—the highest in the world³¹.

Regulatory measures are only one of the tools that State can use to manage work force. A look at the State Program Implementation Plans of the States reveal a range of mechanisms that States have employed like monetary compensation, public private partnerships, multi-skilling and task shifting, among others, to manage work forces. These did meet with various amounts of success, the details of which are available at the NHM portal where the Innovations have been documented³².

However, any measures that include task shifting, multi skilling, or creation of new cadres, raise issues of competency and quality. Therefore such measures should be backed by legal recognition, a defined scope of practice and quality assurance, to avoid being challenged in a court of law, as well as to successfully meet its objectives of augmenting shortage of doctors in rural India and providing quality health services to the poor and marginalised.

The State efforts on workforce management, even though struck down as invalid, have been instruments of equity and social justice, which would have far reaching impact on availability of health care in underserved areas³³. Unless the MCI Act is amended or the subject matter of 'medical education' is moved from Union list to State list, state interventions are likely to be struck down if they are found to be affecting the 'Standards of Medical Education' under the MCI Act³⁴.

The Medical Council of India Act, 1956, is now repealed and replaced by the National Medical Commission Act, 2019. However, the educational standards, requirements and other provisions of the Indian Medical Council Act, 1956 and the rules and regulations made there-under shall continue to be in force and operative till new standards or requirements are specified under the National Medical Commission Act, 2019.

The central government initiatives like BSc. Community Health and six months Bridge Programme for Nurses and AYUSH doctors is picking up and is expected to plug the gap in providing medical service to the difficult and inaccessible rural areas of India.

³¹THE WORLD BANK. (2008) Global Monitoring Report 2008. *MDGs and the Environment: Agenda for Inclusive and Sustainable Development*. Washington, DC, 2008. Available at: <http://documents.worldbank.org/curated/pt/998391468333899567/pdf/454030PUB097801E00ONLY10Apr014102008.pdf>. Accessed in: 21 Feb. 2020.

³²NATIONAL HEALTH MISSION - NHM. NATIONAL HEALTH SYSTEMS RESOURCE CENTRE - NHSRC. *National Health Care Innovation Portal*, 2019. Available at: <http://nhinp.org/index.php>. Accessed: 29 Mar. 2019.

³³FREHYWOT, S.; MULLAN, F.; PAYNE, P. W.; ROSS, H. Compulsory service programmes for recruiting health workers in remote and rural areas: do they work? *Bull World Health Organ.*, v. 66, n. 5, p. 364-370, May 2010. <https://doi.org/10.2471/BLT.09.071605>.

³⁴The Medical Council of India Act, 1956 is repealed and replaced by the 'National Medical Commission Act, 2019'. However, the educational standards, requirements and other provisions of the Indian Medical Council Act, 1956 and the rules and regulations made there-under shall continue to be in force and operative till new standards or requirements are specified under the National Medical Commission Act, 2019.

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