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Viewpoint

Synergizing medical education & health services in India: A 'boon-to-be' with constitutional amendment

The Indian Constitution was adopted by the Constituent Assembly and came into effect on January 26, 1950, marking the Republic Day. As per the seventh schedule under articles 245 and 246 of the Indian Constitution, the States and the Union Government enjoy independent legislative powers under 'State' and 'Union' Lists, respectively, in addition to the 'Concurrent List'. Power to regulate 'health' and 'medical education' was under the State initially[1]. However, during the 42nd Amendment Act of 1976, five subjects from the State list were transferred to the concurrent list which includes medical education. The health services remained in the State list[1].

Being under the concurrent list, various medical education institutions have excelled over the past decades; providing state-of-the-art learning experiences for students across the country. This further extends to other sectors of education such as information technology, management studies, *etc*., which function on par excellence with the above-mentioned.

On the other hand, legislative powers related to health services behold with the respective State Governments. However, not all States function the same way. The majority of the States have health services under 'Health Ministry' headed by the Health Ministers whereas medical education is headed by their counterparts from Education Ministry. It is understood that these two ministries have an overlay in their goals, which include producing doctors, nurses and paramedical personnel and providing healthcare services; employing them under the State, respectively. Thus the authors have attempted to argue the need for unified governance for both health services as well as medical education by urging to shift health services to the current list alongside medical education.

Call for unified governance

The 15th Finance Commission Report by the Government of India 2021-26 had laid down major recommendations for the health sector in the country by reviewing the functioning of the Union of India and the States[2]. It had recommended various strategies that were in line with synergizing medical education and health services in the country. One of the observations of this commission was the disparity among States' health services with regards to availability of adequate human resource and infrastructure. Health being a State subject, major expenditure is handled by the respective States. Yet significant impact had still been powered by Centrally Sponsored Schemes (CSS) with only certain States being proactive in formulating unique initiatives; creating non-uniformity in the country's growth. One such example is the improvement of healthcare system in the North-East Region (NER) following the National Rural Health Mission and *Ayushman Bharat* initiative[3]. Furthermore, the report proposed that the States may adopt existing schemes from the Centre wherever possible. Thus, a unified governance can promote more CSS funding while the States can adapt with necessary local modifications. With regards to human resources, the public health system lacks uniformity across States in effectively implementing national health programmes, infrastructure, care providers and coordination between various departments. This also included varied availability of medical colleges with rural-urban divide. Due to such disparities, the Commission recommended the Union of India to constitute an All India Medical and Health Service (like a recruitment committee or a board) under the All India Services Act 1951 in collaboration with the States, again reflecting the need for unified governance which shall aid feasibility[2]. It also included utilizing district hospital for starting DNB (Diplomate National Board) courses. The above-mentioned steps can not only increase human resource but also reduce the asymmetric distribution of medical colleges across geographical diversity.

Secondly, the Commission put forth the need for increasing expenditure budget for strengthening primary

care[2]. Premier institutes ensuring effective infrastructure, policy and funding, seem to be frontrunners in advance research projects/initiatives that aid in development of the country's healthcare system[4]. For these reasons, citizens are compelled to travel to States with better services or with centre run hospitals. This, in a way violates the Article 21 Right to life and liberty under the Constitution of India. Supporting these observations, the Commission recommended the Union to fuel primary, community health centres and subcentres with newer initiatives and schemes. The *Ayushmann Bharat* initiative of revamping Community Health Centres to Health and Wellness Centres is one such example. The authors question the effective integration and contribution of medical colleges towards all national health programmes as well. For example, training aspects of undergraduate medical students (who are the future health service providers) on how a public health service administration is run is often overlooked. This had previously necessitated induction training programmes for recruits under Health Services which is based on specific training modules and manuals that are not part of their regular medical education syllabus[5]. Thus a need for a predominant community based or primary health care based medical training/curriculum is recommended[6]. Furthermore, when referrals of patients between these two systems (Medical Education/ Colleges and Health Services which includes PHCs, *etc*.) are done to avail certain medical services (*e*.g. referral of patients evaluated at medical colleges to PHCs to avail ATT or ART kits) it is found to be cumbersome for the service utilizer. This shows a lack of continuity in care, accountability, poor utilization of the national and local programme allowances including social schemes benefits. This scenario gets even complicated in cases of medical tourism while attempting to avail these benefits beyond their native States. With the country moving away from institutional care to primary and community-based approaches, it is high time that medical training is incorporated and integrated into more lower levels of care than at higher centres. This move shall not only strengthen the primary care system but can also reduce the need for capacity building while reorienting medical graduates for health services. Thus unified governance aids in a lot of positive aspects moving forward in improving the healthcare system in the country. Moreover, the Medical Council of India was criticized for a disintegrated approach for health planning[7]. Thus the Government of India passed the National Medical Commission (NMC) Act 2019[8] that came into force to promote 'equitable and universal healthcare that encourages community health perspective and makes services of medical professionals accessible to all the citizens.

Potential limitations

One potential limitation in merging Health Services and Medical Education would be the utilization of funds at the State level. With the State continuing to be a federal structure, it is bestowed with the powers to modify the fund allocation and renumeration as per their norms and requirements. With existing low par infrastructure, the fear of allocating greater proportion of funds to improve may be possible leaving education at stake. To add to this, a few States like Tamil Nadu having different Directorates as administration (namely Health Services, Medial Education and Public Health) yet under the same Ministry (Health) had demonstrated a compatible designation/pay scale policy between medical college faculty (designated as Professors) and non-academic hospitals (designated as Civil Surgeons). This has ensured equal opportunities and effective administration, demonstrating a better healthcare delivery system[9]. However, other States like Karnataka and Madhya Pradesh failed to demonstrate success while merging the administrations at the State level. The merger did not last long as there were conflicts and disputes over designation compatibility (teaching *vs*. non-teaching in academic *vs*. non-academic hospitals), pay scale, *etc*., during transfers/ deputes. Thus, the attraction to employment in central institutes and opportunities abroad may still continue. It is entirely up to the States to amend their policies with a long-term vision so that the national disproportion in performance and growth can be decreased[10].

Conclusions

This aberration of health services being in State subject and medical education in the concurrent list has contributed to non-uniform State health policies, poor public health financing, concentration of health resources in urban areas, poor inter- and intra-sectorial coordination[11].To draw global comparisons, developing countries like Bangladesh had demonstrated effective healthcare administration with health services and medical education under unified governance despite being a low resource setting[12,13]. Thus, in order to achieve excellence and uniformity in providing healthcare services across the country, there is a need for constitutional amendment with a unified governance approach that can enhance healthcare delivery and education hand-in-hand.

Recommendations

Firstly, shifting health services to the concurrent list of the constitution of India so as to improve governance, resource utilization and building capacity[14]. Secondly, amalgamation of health services and medical education portfolio under one ministry and focusing on building a comprehensive health model can take a step towards the much awaited 'Right to Health' for all citizens and achieving the Sustainable Developmental Goals. This shall aid in integration of policy and plan of action so that the community is not only ensured with quality medical professionals but also receiving effective healthcare services from them. In this way, there shall be a continuity of care from treatment till availing social benefits under health services itself for the same reasons mentioned above. Thus, the authors recommend that the health education, health services including medico-social rehabilitation which falls within the same spectrum would function effectively on par excellence with state-of-the-art facilities if the administrative body is solitary. It is high time that research focuses on highlighting these needs and call for a unified central healthcare system.

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