National Medical Commission Bill, 2019 – Good intent but unmet expectations

Indian modern medical education is deep-rooted in the strong structures and systems thoughtfully established by the British in the pre-independence era and effortlessly inherited by us. Although generally robust and effective, it has been a victim of several serial populistic decisions and predatory actions by the governments in power over the decades and has been grossly exploited for commercial intent. Glaring deficiencies currently are the nonuniform standards of admission, training, regulation, and certification, thus resulting in variable professional standards ranging from suboptimal to sublime.

The Medical Council of India (MCI), established in 1933, was modeled on the General Medical Council (GMC) of the United Kingdom and was expected to foster professional self-regulation with critical internal checks and balances. MCI, similar to GMC, was to set the standards of good medical practice; standardize, accredit, and thus assure the quality of undergraduate and postgraduate medical education; administer systems for the registration and licensing of doctors to control their entry to, and continuation in, medical practice; and deal firmly and fairly with doctors whose fitness to practice was questioned. In 1956, the 1933 MCI Act was repealed and a new act was established. MCI blemished and undermined itself over the years because of its allegedly opaque and arbitrary decisions, questionable composition, biased regulatory role, allegations of corruption, and lack of accountability and was finally dissolved and superseded by a Board of Governors.[1]

The intention of reforming the MCI took root in the 2009 Independence Day speech of the then Prime Minister. The Yashpal Committee and the National Knowledge Commission recommended separating the regulation of medical education and medical practice.[2] The vision was to replace the MCI with an overarching National Commission for Human Resources for Health with four verticals – undergraduate and postgraduate education, accreditation and licensing and ethical practice.[2] In 2013, the Parliamentary Standing Committee (PSC) returned the Bill with observations that it potentially violates the federal principles and has excessive bureaucratization and centralization with scope for abuse. The PSC, Expert Committees under the Chairmanship of Ranjit Roy Choudhary, and the NITI Aayog in 2016 suggested legislative changes to overhaul the functioning of the MCI.[2] The NITI Aayog recommended the creation of several autonomous Boards to address different functions, such as medical education and qualifying examinations, medical ethics and practice, and accreditation of medical colleges.[3] The National Medical Commission (NMC) Bill, 2017 was introduced in Lok Sabha on December 29, 2017 and was set to repeal the MCI Act of 1956.[2] The highlights of the NMC Bill, 2017 were as follows:

1. NMC with 25 members to regulate medical education and practice
2. Four autonomous Boards under the NMC to focus on undergraduate and postgraduate medical education, assessment and rating, and ethical conduct. The proposed boards were Undergraduate Medical Education Board (UGMEB) and the Post-Graduate Medical Education Board (PGMEB) to formulate standards, curriculum, guidelines, and grant recognition to medical qualifications; the Medical Assessment and Rating Board (MARB), a regulatory body with punitive teeth; and the Ethics and Medical Registration Board (EMRB) to maintain a National Register of licensed medical practitioners and regulate professional conduct
3. Medical Advisory Council, a primary federal platform to provide representation to the States to express their views and concerns before the NMC and to advise the NMC on measures to ensure equitable access to medical education
4. National Eligibility-cum-Entrance Test (NEET) for admission to undergraduate medical education
5. National Licentiate Examination (NLE) to provide a license to practice after graduation and be the basis for admission to postgraduate medical courses
6. To determine fees for up to 40% of seats in private medical institutions and deemed Universities
7. State Medical Councils to receive complaints relating to professional or ethical misconduct and act as a platform for the aggrieved to appeal to successively higher levels of authority.

While the MCI members were elected from within the medical community, the members of the NMCwere to be appointed by the government. NMC was thus prone to politicization of its very governing structure. It also summarily eroded the medical fraternity's privilege of self-regulation. The Bill included the contentious provision of a Bridge Course to allow practitioners of alternative medicines to pursue allopathy. The fear that mixing up diverse health systems based on radically different founding principles and understanding of the diseases could imperil healthcare was not unfounded. After its introduction in the Lower House in 2017, the Bill was referred to a PSC following vehement protests from the medical fraternity. The PSC submitted its report on March 20, 2018.[4] The key recommendations of the Committee were as follows:

1. The strength of the NMC to be increased from 25 to 29 members to include 9 elected registered medical practitioners and 10 nominated members from the States
2. The composition of the four Autonomous Boards under the NMC to be enhanced to five instead of three members
3. The EMRB to be independent of the NMC to avoid any conflict of interest
4. Constitution of a Medical Appellate Tribunal to have appellate jurisdiction over the decisions taken by the NMC
5. Fee regulation for at least 50% of seats in private medical colleges, the deemed Universities not regulated under any existing mechanism and continuation of existing fee regulatory mechanisms
6. NLE to be integrated with the final year MBBS examination, conducted at the State level, and made mandatory for all medical graduates prospectively
7. Bridge Course should not be made a mandatory provision in the Bill.

On March 28, 2019, the Union Cabinet approved the amendments to the NMC Bill and included the common undergraduate National Exit Test (NEXT), composite fee regulation for 50% of seats in private sector, increase in federal representation in NMC to 6, assurance that 21 of 25 members of NMC will be from the medical profession, stringent punishment for unqualified medical practitioners, and removed the provision of Bridge Course.[5] The Bill, however, lapsed with the dissolution of the sixteenth Lok Sabha.

The NMC Bill 2019 is up for reintroduction in the current session of the parliament. The Cabinet meeting on July 17, 2019 has approved that the common final year MBBS examination will

now be known as NEXT and will be the criteria to start medical practice, seek admissions to postgraduate medical courses, and work as a screening test for foreign medical graduates; NEET, common counseling, and NEXT will be applicable to all the medical institutes to ensure uniform standards; NMC will regulate fees and all other charges for 50% seats in private medical colleges and deemed Universities; MARB will assess medical colleges and develop a system for ranking; UBMEB, PGMEB, and EMRB will ensure a dynamic and modern educational environment, decreasing the emphasis on physical infrastructure, achieving the norms in global standards, and set up an effective grievance redressal mechanism; MARB will grant permission for new medical colleges, starting postgraduate courses and increasing seats based on the standards set by the UGMEB and PGMEB, with elimination of the need for annual inspection and renewal; and Medical Advisory Council will be a federal platform to address the concerns of the States and shape the overall agenda in medical education and training.

While the intention of the government seems to be holy and the change is always welcome, it remains to be seen whether this will mark a new era in healthcare in India. Healthcare policy in India is grossly flawed by urban–rural disparity, decisions based on poor quality data, abysmally low per capita government expenditure, reliance on underregulated private players to deliver healthcare to the masses, suboptimal and illogical reimbursements for care provided under the ambitious, but seemingly hurriedly designed Ayushman Bharat national health insurance scheme, and commercialization of medical education, with fees for 50% of seats unregulated and still set by the private medical colleges. The differences between the proposed NMC and erstwhile MCI should not be merely cosmetic and organizational.[6] Replacing the MCI with NMC does not guarantee the end of corruption.[6] Having several nominated members does not guarantee excellence.[6]

The NMC Bill is unlikely to harbinger a fundamental change in the way medical education is provided in India or effectively address the rural–urban imbalance.[6] Some of the irritating ills in the current system continue to thrive. The issue of variable duration of "bonds" arbitrarily enforced by the States and medical institutes needs to be redressed on a priority and logically standardized. It is unfair on a young doctor to have grossly different policies in different States under the garb of federalism or institutional immunity. Emoluments to interns, residents, and fellows also vary severely and need to be made more uniform.

The Bill does not address the ills of postgraduate education at all. Standard national curriculum and uniform teaching, surgical training and infrastructure standards for residency training, and a postgraduate board examination or a national exit examination to ensure uniform standards can be governed by the empowered subspecialty boards. The abolishment of 2-year postgraduate diploma and awarding of a uniform 3-year postgraduate degree is a crying need.

Several public and private hospitals that are not attached to medical colleges have excellent infrastructure, talent pool, and an immense potential to train specialists. Postgraduate trainees in these hospitals are currently awarded the Diplomate of the National Board (DNB), which undeservingly gets a step-motherly treatment. The ideal would be to constitute a National Medical University, under whose umbrella all the DNB institutes could be organized and regulated and a uniform postgraduate degree (MD/MS) could be awarded. Providing the status of a recognized postgraduate teacher to the faculty of DNB institutes will help bring in a pool of good teachers into the mainstream, enable cross-migration of some of these experts into predominantly teaching-academic environment, and bolster the trainer: trainee ratio.

Postgraduate fellowship programs are very diverse, unregulated, and are mainly run by private organizations. Fellowship training is vital to provide cutting-edge expertise in focus areas. These programs need a formal sanctity, need to be curriculum-based, standardized, certified and accredited, and brought under the purview of subspecialty boards or medical Universities, as done by the Rajiv Gandhi University of Health Sciences in Karnataka.

We hope and believe that the collective wisdom of the parliamentarians, medical professionals among them, governments, and professional medical organizations will prevail and the deficiencies in the current form of NMC Bill will be addressed sufficiently to help provide standardized and high-quality medical education at all levels. This may prove to be one of the effective and vital cogs in the wheel to help neutralize the healthcare paradox in India.

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