Making Doctors Serve In Underserved Areas

Findings From A Review Of Regulatory Measures Across Five Indian States

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The Problem

Urban Vs Rural distribution of doctors - 70:30**

Doctor density per 10,000 populations is 2.42 and 9.12 in rural and urban area respectively**

*Rural Health Statistics 2016
*Rao et al 2007, NSSO 2004-05
## Attracting and Retaining Health Workforce in Remote Rural Areas*

<table>
<thead>
<tr>
<th>Category of Intervention</th>
<th>Examples</th>
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</table>
| **A. Education**         | A1. Students from Rural Backgrounds  
|                          | A2. Health professional schools outside major cities  
|                          | A3. Clinical rotations in rural areas during studies  
|                          | A4. Curricula that reflect rural health issues  
|                          | A5. Continuous professional development for rural health workers |
| **B. Regulatory**        | B1. Enhanced scope of practice  
|                          | B2. Different types of health workers  
|                          | B3. Compulsory service  
|                          | B4. Subsidized education for return of service |
| **C. Financial Incentives** | C1. Appropriate financial incentives |
| **D. Professional & Personal support** | D1. Better living conditions  
|                          | D2. Safe and supportive working environment  
|                          | D3. Outreach support  
|                          | D4. Career development programs  
|                          | D5. Professional networks  
|                          | D6. Public recognition measures |

*Increasing access to health workers in remote and rural areas through improved retention, Geneva: WHO 2009*
The Study -1

The Objectives

- Review the salient features of regulatory measures for compulsory service programs for doctors
- Evaluate the degree of implementation of these strategies
- Explore the views and perspectives of doctors in-and eligible for-compulsory rural service
- Explore the views and perspectives of key informants and stakeholders
- Capture emerging themes following a review of the information collected
- Provide recommendations for improving the effectiveness of current regulatory measures

The Design

- Mixed method approach
  1) Quantitative - secondary data collection
  2) Qualitative - primary data (semi-structured interviews with doctors and stakeholders/key informants)
The Study - 2

The Sample

No. of Doctors and Stakeholders interviewed

<table>
<thead>
<tr>
<th>States</th>
<th>Doctors</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assam*</td>
<td>96</td>
<td>0</td>
</tr>
<tr>
<td>Chattisgarh</td>
<td>85</td>
<td>6</td>
</tr>
<tr>
<td>MP</td>
<td>104</td>
<td>16</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>201</td>
<td>4</td>
</tr>
<tr>
<td>Karnataka</td>
<td>78</td>
<td>36</td>
</tr>
</tbody>
</table>

*Only informal discussions were held with stakeholders in Assam

Categories of Doctors Interviewed

- UGs undertaking rural service: 37%
- PGs undertaking rural service: 19%
- Defaulting doctors; paid penalty: 16%
- Defaulting doctor; NOT paid penalty: 15%
- Doctors serving even after expiry of bond: 10%
- Doctors in training; eligible for rural service: 3%

n=564
Salient Features of Regulatory Measures

- Involves a bond making it mandatory for UG & PG doctors to complete a pre-agreed tenure in government service.
- Period usually varies from 1-2 years for UGs, but could be longer for PGs.
- Non-compliance incurs a financial penalty ranging from $4,500 to $36,000.
- Conditions are periodically revised in few states.
- Very few states have a separate Bond Enforcement Cell (BEC) to monitor compliance with bond requirements.
Complimentary Measures

- Financial incentives mainly involving an incremental payment for serving in difficult areas.
- Educational incentives of
  a) extra/grace marks in PG entrance examinations for UG doctors undertaking compulsory rural service
  b) reserved post-graduate (PG) seats in medical colleges for doctors serving in the public sector
- Accommodation facilities, various forms of insurance and the ability to choose the next posting after a certain number of years in rural service.
Results & Findings - 3

Implementation of Regulatory Measures

- Well developed policies but weak implementation
- Inefficient flow of information among stakeholders
- Lack of systematic mechanism to track and monitor doctors under the bond; and issue notices to defaulters
- Bond not seriously by many doctors - majority choose to forego compulsory service; only a small proportion pay the penalty fee
Doctors’ Perspective (n=564)

Professional barriers to rural service:
- Pursuing PG: 41%
- inadequate infrastructure: 36%
- job insecurity: 6%
- inadequate remuneration: 6%
- others: 11%

Personal barriers to rural service:
- lack of accommodation: 24%
- lack of opportunities for children's education: 16%
- inadequate security: 20%
- others: 40%
Stakeholders’ Perspective (n=62)

- Resonated the concerns of doctors
- Issue of absenteeism
- Issues with the Bond Enforcement Cell (BEC)
To Conclude

- Limited impact of compulsory rural service as a regulatory measure to address the shortage of doctors in remote, rural and underserved areas
- Doctors enrolling for rural service is minimal - and even amongst them, there are high levels of absenteeism and drop-outs.
- Ensuring robust implementation practices is critical to improving compliance
- This strategy alone is neither desirable nor sufficient to address the human resource shortage
- A mix of strategies - both financial and non-financial is important to provide an enabling professional environment for health workers.