

Implementation of Diplomate of National Board (DNB) Programme Adopted Strategies to Target Shortages of Medical Specialists and Transforming Health Education Gujarat Scenario

Snehal Parmar*

Department of Public Health, Sardar Vallabhbhai National Institute of Technology Surat, Gujarat, India

Abstract

Medical specialists are scarce in India, and the numbers are disproportionately lower in the public sector, at the Community Health Centre (CHC) level and above. Even district hospitals in several states have an acute shortage of medical specialists. There is a huge potential for starting DNB courses in State Government District and Sub-district Hospitals to overcome shortages of Medical Specialists at these levels. NHM provides monetary support under the resource envelopes of the states to start DNB courses in district hospitals. Gujarat has a gap of 1200 specialists in public sector hospitals, when compared to sanctioned posts, wherein only 50% are filled. After various internal assessments state had identified 18 DHs and 28 SDHs to apply for DNB programme during 2019 accreditation cycle to overcome shortages of medical specialists. Applications for total 46 districts and sub-district hospitals have been done for seeking approval of 224 seats. Gujarat has lodged highest number of application during 2019 cycle across the country. These applications are in process and results are yet to be declared by NBE.

Keywords: Community health centre • Hospitals • Medical specialists • Public health

Introduction

The health workforce is critical to achieve health and wider development objectives in the next decades. Health systems can only function with health workers. The mere availability of health workers is not sufficient; health workers need to be equitably distributed and accessible, possess the required competency, and are motivated and empowered to deliver quality care translating into effective service coverage [1]. An analysis conducted by the Global Health Workforce Alliance and World Health Organization estimated a gap of 7.2 million professional health workers in 2012, which is set to rise to 12.9 million over the next decades. Countries at all levels of socio-economic development face the challenge of how to sustain the human capital for guaranteeing universal access and universal health coverage [2].

Along with the shortage of other human resources, there is a marked misdistribution of doctors and medical specialists across the states in India. An imbalance between the urban and the rural distribution of doctors is also evident with 74% of the trained doctors practicing in the urban areas whereas 72% of the Indian population resides in the rural and remote areas [2].

Medical specialists are scarce in India, and the numbers are disproportionately lower in the public sector, at the Community Health Centre (CHC) level and above. Even district hospitals in several states have an acute shortage of medical specialists. At the country level, we continue to face a shortage of specialists even when we consider the total number of specialists in the country.

In Adequacy of Specialists and its Importance

An extreme shortage of specialists is another major roadblock in ensuring accessibility of treatment to all people. Take any specialty, shortage is the story. Be it, pulmonologists, neurologists, nephrologists or general surgeons, India has a perpetual short supply of specialists. In a country which is increasingly being referred to as the heart disease capital of the world, there are a paltry 4,000 cardiologists, when what we require is 88,000. For a nation where more than 25% of all deaths occur due to cardiovascular disease, this is an unforgivable situation. Even as child mortality remains a major concern, we have an estimated 23,000 paediatricians only when the number should ideally be 2,30,000. India has only 650 specialists in Endocrinology at a time when over 70 million of its people have diabetes.

*Address for Correspondence: Dr Snehal Parmar, Department of Public Health, Sardar Vallabhbhai National Institute of Technology Surat, Gujarat, India; Tel: 8320509667; E-mail: dr.snehalparmar@gmail.com

Copyright: © 2022 Parmar S. This is an open-access article distributed under the terms of the creative commons attribution license which permits unrestricted use, distribution and reproduction in any medium, provided the original author and source are credited.

Received: 14-Nov-2019, Manuscript No. M-4600; **Editor assigned:** 18-Nov-2019, PreQC No. P-4600; **Reviewed:** 02-Dec-2019, QC No. Q-4600; **Revised:** 28-June-2022, QI No: Q-4600; Manuscript No. R-4600; **Published:** 26-July-2022, DOI: 10.4172/2380-5439.100011

More worrisomely, most of the existing specialists are concentrated in urban areas, leaving a vast majority of the Indian population deprived of treatment for preventable diseases.

Since we have a large shortage of specialists at the country level, we need cost efficient and easily scalable models that can be produce specialists through existing facilities and in the clinical specialists of urgent need within state.

Strategies adopted by NBE for expansion of DNB programme

There is a huge potential for starting DNB courses in state government district and sub-district hospitals. So far only a fraction of this existing infrastructure has been utilized for the purpose of post graduate teaching and training. The strengthening of district hospitals is in priority of the central government.

NHM provides monetary support under the resource envelopes of the states to start DNB courses in district hospitals.

NBE has taken a number of measures to facilitate the accreditation process. The applications seeking accreditation with NBE shall now be invited bi-annually instead of only once in a year. The application submission process has been made online with less documentation. The time taken in processing of applications has also been reduced from around 10 months to 6-7 months. New medical colleges running MBBS courses can apply for DNB programme till such time they become eligible/choose to start MD/MS courses in the same specialization.

In case the district hospitals do not have requisite facilities for training of DNB students, they may collaborate with a teaching hospital attached with a medical college or accredited with NBE as "Secondary node" where the DNB students could be sent for rotatory training. There is no distance criterion to form "Secondary node". To elicit cooperation from medical colleges with regard to serving as secondary nodes under district DNB programme and also for starting of DNB courses in medical colleges, ED, NBE is thinking of forming Coordination Group with MCI to issue appropriate guidelines to medical colleges.

As per NBE guidelines for DNB the states would have to arrange specialist doctors with 8 and 5 years clinical experience in district hospitals to work as DNB faculty. The training of DNB students would be supervised by their guides in district hospitals. NBE conducts a regular review of its training programme through Specialty Boards.

The matter of allowing access to ERMED Consortium of National Medical Library to district hospitals for the purpose of DNB training is still in discussion phase. NBE along with NHSRC is in process of revising Indian Public Health Standards for district hospitals to run district DNB Programme.

Implementation experience of DNB in Gujarat State

The Gujarat health system is organized on the principle of dynamic concentration of medical facilities round about the teaching hospitals having all medical specialties and facilities for having serious patients referred from lower tier hospitals and the radical downward flow of active services from the teaching hospitals to peripheral levels

through mobile teams of specialists, are the essence of the well-organized regionalization [3].

Medical relief is provided to the rural and urban people through 56 District and Taluka General Hospitals, 4 Mental Hospitals, 3 speciality Hospitals (2 Ophthalmic Hospitals and 1 Infectious Disease) and 60 Dispensaries. A total 6,648 beds are available in these Hospitals. All Districts and Sub-District Hospitals are equipped with Operation Theatre, Intensive Care Units, X-Ray, Ultrasound and Laboratory facilities, E.C.G and blood Transfusion services [3].

Although medical specialist gap in community health centres/sub district hospitals/district hospitals is a big challenge for the State. Gujarat has a gap of 1200 specialists in public sector hospitals, when compared to sanctioned posts, wherein only 50% are filled. To reduce this gap, Government of Gujarat has decided to start DNB courses in District and Sub-district Hospitals of the State [3].

MOU with public health foundation of India

Government has decided to affiliate eligible district and sub-district hospitals with national board of examination after feasibility assessment of the government hospital [4]. Government of Gujarat has done MOU with Public health foundation of India to develop implementation framework of the DNB model for the state of Gujarat. For the technical assistance PHFI has appointed Project Officer to the State Government.

- The state government will identify a list of facilities/district hospitals, sub-district hospitals where this model can be implemented in state.
- The state government will undertake the infrastructure strengthening of facilities/district hospitals, Sub district hospitals to offer the program to address gap.
- The state government will evolve an admission plan for the students at identified DH/SDH.
- A steering committee and a technical advisory group shall be established to oversee the programme development and implementation.

Formation of steering committee

State has formed State level Steering committee for the design and implementation of the activities in the state of Gujarat. State health officials have been included as members of steering committee.

Steering committee provides oversight to the efforts directed towards scaling up implementation of DNB. They guide representatives of district and sub-district hospitals in introducing DNB program as outlined in national health policy 2017.

Evaluation of programme in state owned district/sub-district hospitals

The first step was to identify district and sub-district hospitals which can match guidelines for affiliation of hospitals to run DNB courses.

During accreditation cycle 2017-2018 total 7 district/sub-district hospitals identified as per NBE's guidelines of minimum required bed strength and faculty availability [5]. Applications were done for 26

seats among these 7 DHs/SDHs out of which 14 seats have been approved by NBE. It has been found that few hospitals were failed to full fill minimum required departmental beds or minimum eligible criteria of faculty in terms of years of experience.

Before applying in accreditation cycle 2018-2019 State has decided to conduct a state level workshop to give a brief description about DNB courses and its guidelines to all the RDDs and CDMOs.

After discussion few major decisions have been taken which are as following:

- To increase hospital and departmental bed strength of DHs and SDHs.
- To appoint required faculties as per NBE guidelines.
- Encourage all DHs/SDHs to apply for DNB.
- Provide additional fund for DNB.
- To provide necessary documents or undertakings from State to district authority within time period.

After various internal assessments state had identified 18 DHs and 28 SDHs to apply for DNB programme during 2019 accreditation cycle but important thing was to make them eligible for affiliation. State has utilized its own resources to make this possible [6]. It is difficult for DHs and SDHs to produce all kind of teaching and educational facilities at their facility like library, basic science teaching and training, research support, Hands on training, adjunct faculty, rotatory postings etc. So for that medical colleges are the best institutes from which these facilities can be utilized. As per NBE guidelines a hospital can tie up with medical colleges as their "Secondary node" from which they can utilize these services. In services state DHs and SDHs comes under the medical services department whereas medical colleges comes under medical education department. State has done a wise move of dividing DHs and SDHs based on zone wise distribution. There is minimum a medical college present in every zone of state and available DHs and SDHs were allocated to concern medical college where medical college acts as a "Secondary node". It was possible due to collaborative approach of state medical services and medical education department WHO.

After these all efforts 46 applications has been done for seeking approval of 224 seats. Gujarat has lodged highest number of application during 2019 cycle across the country. These applications are in process and results are yet to be declared by NBE.

Conclusion

The supply side of medical specialists (current models) in India is facing several impediments, involving limited number of post graduate

medical seats, high ratio of under graduate to post-graduate seats and a limited number of medical colleges and specialty faculty. In spite of a recent increase in the number of specialist seats, the shortfall of specialists at the CHC level is evident for all four specialist categories (medicine, surgery, gynecology and pediatrics) at the country level and is showing no signs of correction.

Health services need specialists, but do not have sufficient numbers to deliver quality services. There is additionally a wide inter-state variation and an urban-rural divide among the specialists who are in-position within the public system. Increasing the supply of post graduate seats through the existing medical colleges is quite challenging. Even creation of new medical colleges is an expensive and time-consuming proposition. The time interval between the establishment of medical college to producing the first batch of post graduate doctors can take anywhere between 8-10 years at minimum. In terms of time and resource intensive DNB is much better choice to produce medical specialists. NBE should increase its outreach to states and to hand hold those states which are applying for the first time. NBE should further simplify the application process and consider for time extension in the next cycle.

References

1. World Health Organisation. "Towards a global strategy on human resources for health background". Synthesis paper of the thematic working groups (DRAFT for consultation) health workforce 2030: WHO 2020
2. National Health Mission "Health Pyramid of Gujarat", Citizen's Corner. NHM 2018.
3. Leape, Lucian, Berwick Daniele, Clancy Cheri and Conway Jacqueline, et al. "Transforming Healthcare: A Safety Imperative". *BMJ Quality Safety* 18(2009); 424-428.
4. Zimmerman, Brenda. "How Complexity Science is Transforming Healthcare". *SAGE handbook compl Manag* 2011: 617-635.
5. Hillestad, Richard, Bigelow James, Bower Anthony and Girosi Federico, et al. "Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs". *Health Aff* 24(2005);1103-1117.
6. Witz, Steven M. "The Regenstrief center for Healthcare engineering: Designing, Implementing, and Sustaining Interdisciplinary Solutions to Transform Healthcare Delivery systems". *Int J Healthcare Technol Manag* 8(2007); 399-416.

How to cite this article: Parmar, Snehal. "Implementation of Diplomate of National Board (DNB) Programme Adopted Strategies to Target Shortages of Medical Specialists and Transforming Health Education Gujarat Scenario ". *J Health Edu Res Dev* 10 (2022): 011