Case study of the Regulatory Measures for Attraction and Retention of Doctors into Rural Health Services in India & Causative Analysis for better dispersion of Skilled Health Professionals in Rural and Remote Areas

Draft Report

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&

Causative Analysis for better dispersion of Skilled Health Professionals in Rural and Remote Areas

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1.1 Introduction

The shortages and inadequate distribution of appropriately trained and motivated health workers, and inefficiencies in the ways in which the health workforce is managed and utilized has remained the major impediments to the effective functioning of health systems and constitute one of the main bottlenecks to achieve the health-related Millennium Development Goals (MDG). India has been facing acute shortage and uneven distribution of skilled health workforce, in rural areas, where 72% of the country‘s population. It has 100 skilled service providers (doctors, nurses and midwives) per 100,000 population as against the international norm of 228 per 100,000 population in order to achieve a minimum 80% coverage rate of deliveries by skilled birth attendants or for measles immunization.

A slew of measures were introduced under NRHM to address the problem of attraction of doctors and nurses to rural postings and to retain them. These measures could be categorized as (a) Incentives- financial and non-financial; (b) Regulatory – Insisting of rural service as pre-qualification to be considered for admission to post-graduation courses or bonds which insists on doing rural service after the course; (c) Workforce management- Transfer policies that Which work as motivational force to retain in service (d) Educational Strategies- Measuresfor career development of doctors who are in service to preferentially admit only those students who are likely to serve in under-serviced areas and mold education to retain this commitment; (e) Multi-skilling existing staff to provide larger range of services and alternative service provider strategies: introduction of three year course to train rural medical assistants, posting of AYUSH doctors.
In India, under regulatory measures for rural retention; there are two common strategies in use (a) post- graduation rural service bonds and (b) pre-post-graduation mandatory rural service.

Whereas, 72% of the 1.2 billion population of India resides in the rural areas (census 2011), the availability of the sufficient skilled health workers in the rural and remote areas is a big impediment towards provision of effective health care and improving health indicators. While the current ratios of Doctor-Population in India stands at 1:1507 and Nurse-Population at 1:1207. It however fails to reflect the true picture of distribution of these health workers, as reflected by the fact that 60% of the health workers are present in the urban areas where only 28 % of the population resides, meaning thereby that access to health care services and providers is limited in the rural areas.

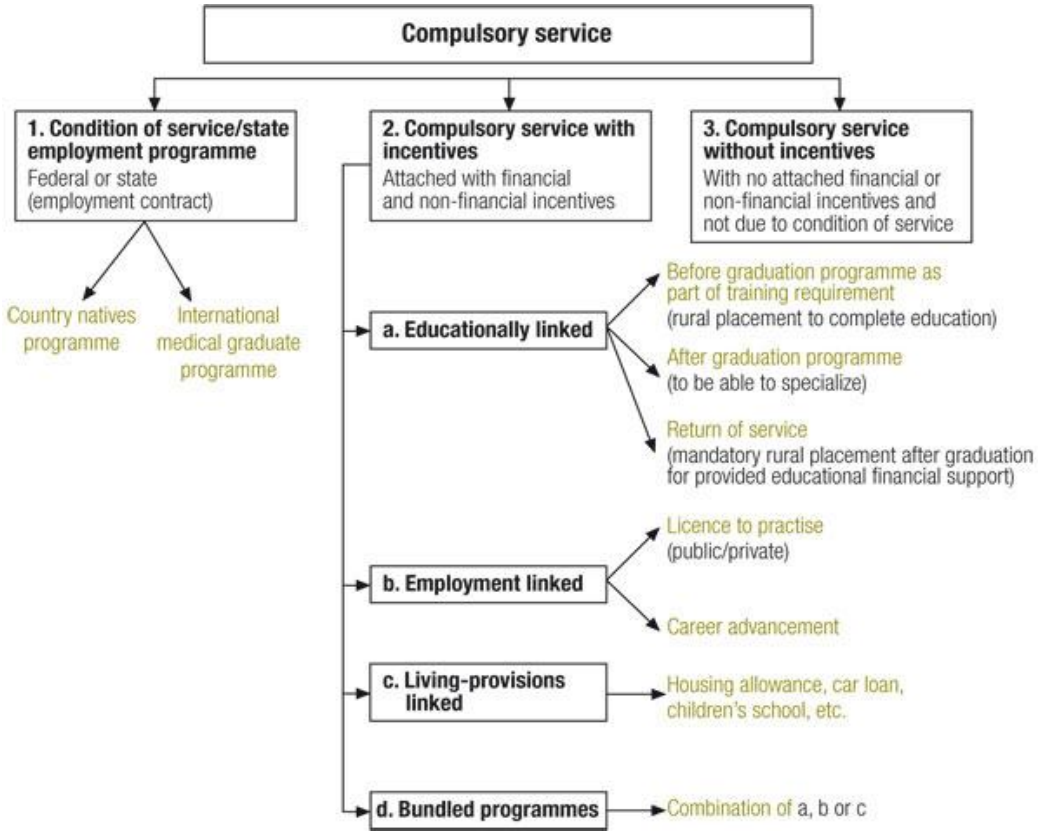
To improve attraction, recruitment and retention of health workers in remote and rural areas, the interventions fall under four categories: education, regulation, financial incentives, and personal & professional support. The interventions vary from state to state and its implementation too. Hence it is decided to study these measures.

1.2 Review of Literature

I. **International Experiences**: The Compulsory Service Programmes have existed since the early 20th century as documented in the Soviet Union in 1920, in Mexico in 1936 and in Norway in 1954. The last decade had witnessed an overall increase in attention paid to inequities in health provision as well as increased worldwide interest in socialist ideologies, especially the belief in national service and pride. Over the years, different countries had created and implemented compulsory service programmes, one of the most recent ones was started in Ghana in 2009.

Classification of Compulsory Rural Service: Based on the evidences from many countries, a tripartite classification system for compulsory service programmes was developed (Fig. 1). The types are: (a) condition of service/state employment programme; (b) compulsory service with incentives and (c) compulsory service without incentives.[8]

Figure 1: Classification of Compulsory Service Programmes [8]



As per the **"*condition of service*";** the health professionals are required to work for the government with little or no opportunity for private or non-governmental practice. The employment contracts framed by the Federal and State Ministries of Health provided the

employer with the authority to assign health employees in any part of the country, based on need for a specified number of years.

Under the "***compulsory service with Incentives";*** the compulsory service is associated with incentives to serve in designated areas for specified time periods. Four categories of compulsory service with incentives were identified as ***(a) Educational measure*** with 3 types of education-incentive-linked compulsory service. In the first type, students are required to complete rural placement during training course to complete their education.In the second type, the graduate is required to serve as a prerequisite for entering a postgraduate/specialization programme as in Mongolia, Viet Nam and parts of India. In the third type, there is a return of service programme where service is required after graduation, often for particular period for which financial support is provided. (***b) Employment measure:*** Two employment-linked models exists; the first, as a requirement for attaining a license to practice (publicly or privately) and the second, as a prerequisite for career advancement; ***(c) Living provisions-linked*** – family and resource linked incentives as in Kenya and Mozambique ***(d) Bundled*** as in Ecuador and Thailand which have programmes that combine incentives for education, employment and living provisions; Under ***"compulsory service without incentives"***; the graduates are required to work in an underserved setting with no attached incentive, usually for one year as practiced in Kerala and Assam.

Outcome of Programme: There is paucity of information regarding the measurement of outcomes and results of such programmes. The number of health professionals who stay in rural areas after their compulsory service was over was not clear for most countries. The Norway's administrator's measure a variety of factors such as rural/urban upbringing, age, family composition and gender related to the types of individuals who stay in rural areas after the requirement is complete. It was estimated that 20% stay in rural areas after completion of the compulsory rural service contract. In Puerto Rico before compulsory service, 16 of 78 municipalities had no physician. After implementation of programme, all 78 municipalities had at least one doctor.[9] The Incentive-linked compulsory service in Indonesia increased new doctors' willingness to work in remote areas.In South Africa, better staffing levels in rural hospitals have resulted in shorter waiting times for patients.More frequent visits to outlying clinics by health workers are reported for better utilisation.[10]

Challenges from professional groups: Many health professionals had objected to compulsory service programmes for reasons cited due to cost, utility and sustainability of programmes, poor rural facilities, lack of transportation and inadequate clean water, electricity, equipment and medications. In Kerala (India), there was a strike and protests against a three-year compulsory service requirement which led the Government to reduce the service period to one year.[11] Professionals' opposition can be minimized if programmes are planned in consultation with health professionals.[12] Several authors advise that compulsory service should be supplemented by a support system and incentives.[11,13] Programmes that provide reasonable benefits and support may be more costly than compulsory service without incentives, but the likelihood of effective service will be maximized.

Turnover of health workers: Doctors' unwillingness to continue in their assigned posts negatively impacts continuity of care and may mean that many workers in underserved areas are inexperienced. Managers in South Africa believe the inexperience of doctors sent to rural areas resulted in slower, poorer care for some patients. 30% of compulsory service doctors intended to leave South Africa after completing their obligation, and an additional 13% planned to go into private practice.[14]

II. **India's Experiences on Regulatory measures:** Two common strategies are used i.e. post-graduation rural service bonds and pre-post-graduation mandatory rural service. The rural service bond is the oldest strategy, which involves a student signing a bond at the time of education into medical school assuring that he would work for a specified number of years later or pay a huge penalty. It was given up in many states because it was difficult to implement- either due to legal wrangles or due to the difficulty of follow up and mechanisms to enforce it. However in some states this does persist and plays a useful role. In Meghalaya which has no medical school, students who have completed 3 years rural service are sponsored to study in different colleges all over the country and on completion most return to do another 3 years rural service or pay Rs 10 lakhs. Mechanisms to enforce non-compliance are weak, but it is the easy access to a secure milieu that attracts the student back- and the bond becomes more of an entitlement to a job than a restriction on them. Gujarat has a 3 years' service bond with a penalty of Rs 1.5 lakhs, Jharkhand a 1 year service bond with a penalty of Rs 5 lakhs but not implemented. In Tamil Nadu, currently there is a bond for post graduates committing them to put in 5 years of service after certification from a government medical college and 3 years if they graduate from a private medical college, with a penalty clause of Rs 10 lakhs. Assam has introduced a 5 years' service bond in 2009 for rural service after MBBS with a penalty clause of Rs 7 lakhs.[7]

To attract doctors to government service and rural posts, at least 11 states in India have reserved post-graduate (PG) seats in medical colleges for doctors serving in the public sector which took advantage of the strong desire among medical graduates to become specialists and the considerably few PG seats available compared with the number of medical graduates.[16] Table 1 shows the states which are implementing the regulatory measures.

Table 1: Regulatory approaches and linkage between post graduate admission and rural service[7] adopted in Indian states

State	Years of rural Service	Forfeit penalty fees	Other Additional Features
Andhra Pradesh	3	20	30% seats in clinical specialty course & 50% in non-clinical specialty reserved for in-service doctors with 5 years of service with either 2 years of service in tribal areas or 3 years in rural areas. For regular staff like MOs, they have compulsory rural bonding for 2 years in tribal region and 3 years in plain area to take admission in PG. Even during the completion of PG, salary for that duration is paid by the government along with the fees of that institute.
Assam	5	7 lakh	In Case of Medical Officer- MBBS, compulsory 1 year rural service is mandatory for doing PG Studies
Chhattisgarh	2	Open candidates for state PG seats: Bond amount for Degree course is 10 lakh (General) And 5 lakh (for SC/ST/OBC In-service candidates: Bond amount for Degree course is 5 lakh (General) And 2.5 lakh (SC/ST/OBC)	30% seats reserved for MOs with 2 years in rural areas, started in 2004 as a pre PG compulsion of 2 years rural service, the government lost the case to students for right of education & it was then changed to 30% reservation with other seats open to all.
Gujarat	2 yrs (for GMO doctors) 10 years (for PG candidates)	Rs.75,000/ for MBBS doctors (govt) and 5 lakh for PG holders	10% seats in 5 specialties reserved in rotation for MOs Other seats open to all.
Haryana	3		Proposed – As an eligibility criteria for PG
Jammu & Kashmir	2		10% seats in the states' seats reserved for those with over 5 years services, marks in PG entrance according to number of years of rural service.
Jharkhand	1	5 lakh	Proposed - Plus one point in the entrance examination for each year up-to maximum of 5 points
Kerala	1		Additional marks for PG entrance

State	Years of rural Service	Forfeit penalty fees	Other Additional Features
			examination for in-service doctors since 2009
Karnataka	1	1-10 lakh for MBBS doctors; 5-25 lakh for PG holders; 3-15 lakh for diploma holders	From 2012 onwards, the penalty fee has been increased for non-compliance to the bond; Bond Enforcement Cell (BEC) deals with the regulatory measures, their compliance and review of outcome etc. Under BEC, 109 MBBS doctors and 20 specialists had signed the bond
Maharashtra	5		Preference for PG after serving 5years in tribal / difficult area since 15 years, Preference given at the time of interview ***More information is presented in the section 3.1 below as a part of tasks of the assignment.***
Madhya Pradesh	2		The MBBS students, who have passed recently from government hospitals, have to serve 1 year in rural areas as a compulsion and 2 years in rural areas to do post-graduation.
Meghalaya	3	10 lakhs	Students who have completed 3 years rural service are sponsored to study in different colleges all over the country and on completion most return to do another 3 years rural service or pay Rs 10 lakhs
Manipur	1		Tenure of service reduced to 1 year from 3 years to qualify for PG course
Orissa	3 (for PG Diploma) 5 (for PG Degree)		50% of total seats reserved for in service candidates after completion of 5 years of service or 3 years of rural service
Tamil Nadu	3	10 lakh	1 mark is given on completion of 1 year of service. Additional 2 marks in entrance examination for every 2-years' service in tribal area
Uttarakhand	3		Additional marks for PG admission and some seats are reserved as in-service quota

In the state of Andhra Pradesh, fifty percent of the PG seats in pre- and para-clinical specialties (Anatomy, Physiology, Biochemistry, Pathology, Pharmacology, Microbiology and Forensic Medicine) and 30% of the seats in clinical specialties (such as Internal Medicine, Surgery, Gynecology, Pediatrics, ENT and Ophthalmology) in government medical colleges

in the state are reserved for in-service candidates. In private medical colleges, reservation for in-service candidates applies to the approximately 50% of PG seats that are filled through the PG entrance examination; the in-service quota does not apply to the other half of seats that are filled by the management of these private colleges. In-service candidates pay the regular fees for private colleges as prescribed by the state government. Students using the quota have to sign a bond of Rs. 20 lakhs and are required to serve the state government for 5 years after completing their PG education. If they leave government service within the bond period, they are obliged to pay the bond amount and refund the salary received after starting their PG course. It was found that officials in the Medical, Health and Family Welfare Department reported that Medical Officers and specialists who are brought to rural posts through the PG reservation scheme may not be performing their job well though the scheme has managed to place doctors in rural posts who might otherwise be disinterested in serving there. Placing a doctor in a rural health facility is a necessary but not sufficient condition for strengthening rural health services.[15]

Very recently in 2012, the Ministry of Health & Family Welfare, Government of India had proposed that doctors will be attached with NRHM during the year-long rural posting which will help to improve the health care services in villages and steps are being processed to ensure that it becomes part of MBBS curriculum. A medical student, after completing 4.5 years of study and thereafter the hospital internship, will have to undergo a mandatory year-long house job in the form of a rural posting before getting the MBBS degree. Till then, the degree would be provisional.[15] 2012 is the launching year of year-long mandatory rural stint in certain states of India for PG graduating doctors, aimed at improving health care services in rural area. A bipartite agreement had been signed between the Government and junior doctors in February 2012 and the State government ought to appoint a committee to look into the feasibility of mandatory rural service. The Government of India assures to post the Post Graduate medical professionals in the specialties of their study in Post Graduate Diploma and Post Graduate Degree.[16]

1.1 Rationale of Study:

Some states in India had started the regulatory measures even before the launch of NRHM but with NRHM there were similar efforts in all states. There has been no evidence to ensure how effective these strategies are and how much they contribute to closing gaps though anecdotally they helped to attract doctors to rural service- but by themselves, whether they are adequate to ensure that doctors actually reside at the place of posting and deliver services as expected has yet to be established.

One of the major concerns and biggest challenges for effective assured health care delivery in the rural and remote parts of the country is the issue of workforce availability in the Government Health Centers. A concentration of available human resource distribution results in lack of staff in the peripheral health centers. Since 2007, many states have proposed policies regarding compensation packages in terms of monetary incentives for attracting workforce and rewarding good performance in the rural and remote underserved

areas. However there is lack of substantive information in terms of degree of implementation of these incentive schemes or their effectiveness in retaining health workers in these areas. In spite of adopting incentive schemes, the RHS data in the states may be reviewed for shortfall of human resources in the health facilities (source: RHS-2012).

The dispersion of these resources in terms of remote and rural facilities and the gaps mitigated by contractual appointments needs further analysis. There is a need to understand both what is the desirable minimum set of workforce policies as well as the constraints and the ways different states are coping with such constraints. This study aims at analyzing the factors, which make healthcare staff work in rural and remote areas as well as the financial and various non-financial packages being provided to health workers in these areas and the effectiveness of these incentives in their retention.

SECTION II

2.1 Research Objectives

2.2. Study Design

2.3 Methodology

2.1 Objectives:

a) To document the various measures (financial, non-financial and regulatory) existing in the state to attract and retain doctors and specialists in rural areas.

b) To document the specific outcomes with respect to regulatory measures in terms of doctors bonded and improvement in vacancies position in districts.

c) To document the perspectives and views of bonded doctors (MBBS, PG students, Specialists), who signed the bond in the last 6 years period from March, 2007 to March, 2013.

d) To document the perspectives and insights of the key informants i.e. policy makers and administrators, programme managers, financial officials under the Directorate of Health Services, Medical Education and Bond Enforcement Cell (BEC) about the programme, status of implementation, challenges, bottlenecks and way forward.

e) To analyze the effectiveness of the regulatory measures in attracting doctors and specialists to rural postings and retaining them.

f) To provide recommendations for further improvement in the current regulatory system (compulsory rural services/bond) with regard to attracting and retaining doctors in rural areas.

2.2 Study Design

The study has primarily adopted a qualitative case study design, but also has quantitative aspects to complement the study by means of secondary data.

Review of secondary data about the available state government policies/guidelines, laws/act and relevant orders on regulatory measures for attracting and retaining doctors was conducted. It was very difficult to get the data and till date, data is not received despite follow ups.

Database on posting details of doctors (MBBS students, PG students and specialists) currently serving on signing of bond, doctors who had opted out of bond, doctors who had left the system with or without paying penalty fees etc. was collated and reviewed.

Sr. No.	Study Objective	Primary Data	Secondary Data	Data source/Method of data collection
1.	To document the various measures (financial, non-financial and regulatory) existing in the state to attract and retain doctors and specialists in rural areas.	NA	Review of state PIPs on financial and non-financial incentives for working in rural areas for doctors, Bond documents, rules/regulations on compulsory rural services, types of bond, changes in bond conditions, scope, coverage of bond, penalty etc (revisions made)	Various state planning documents/ reports, records, PG admission brochure, bond rules/guidelines
2.	To document the specific outcomes with respect to regulatory measures in terms of doctors bonded and improvement in vacancies position in the districts	District case studies: To ascertain decrease in vacancies in rural areas Posting Attachment and deputation to other facilities not located in rural areas Issues of absenteeism	Lists of doctors who had signed the bond (in-service candidates), pursuing PG/diploma courses Lists of bonded doctors who are currently serving Lists of doctors who opted out/defaulters Sanction/vacancy lists of doctors (district-wise)	Data to be collected from DHS, DME, facilities/informal places In-depth Interviews using semi-structured questionnaire to understand the HR/doctors availability, issues of deputation of doctors to other facilities and on absenteeism etc.

Sr. No.	Study Objective	Primary Data	Secondary Data	Data source/Method of data collection
3.	To document the perspectives and views of bonded doctors (MBBS, PG students, specialists) of various categories (as listed above) in the last 6 years from March, 2007 to March, 2013	Perspective of doctors (various categories) on bond conditions, bond tenure/penalty fees , issues with adherence, continuation of service in rural area, organizational practices, cultural factors and other facilitating and inhibiting factors for serving in rural areas	Lists of in-service candidates currently under bond Lists of bonded doctors who are placed in facilities across states Lists of doctors who continue to be in service though the bond period has lapsed Lists of doctors who are defaulters and paid penalty fees Lists of doctors who are defaulters but did not pay the penalty fees Lists of doctors who have signed the bond but are awaiting appointment letters, including interns	Data to be collected from DHS, DME, facilities/informal places where sample will be drawn In-depth Interviews using semi-structured questionnaire
4.	To document the perspectives and insights of the key informants i.e. policy makers and administrators, programme managers, financial officials under the Directorate of Health Services, Medical Education and Bond Enforcement Cell (BEC) about the bond scheme, status of implementation, challenges, bottlenecks and way forward	Perspective of key informants on bond condition, types/nature of bond, framework of implementation, organizational practices, cultural factors, penalty fees, compliance to bond, gaps/constraints in implementation/monitoring, suggestions etc	Reports (if any) available on compulsory rural postings	Visit to DHS, DME, district office to interact with officials/faculty etc In-depth Interviews using semi-structured questionnaire
5.	To analyze the effectiveness of the regulatory measures in attracting doctors and specialists to rural postings and retaining them	Collected data/information to be analyzed about the effectiveness and role of the regulatory bond scheme in terms of attracting and retaining doctors/specialists to rural postings		
6.	To provide recommendations for further improvement in	Based on the descriptive analysis, report will highlight key suggestions and recommendations for attraction and retention of doctors in rural areas		

Sr. No.	Study Objective	Primary Data	Secondary Data	Data source/Method of data collection
	the current regulatory system (compulsory rural services/bond) with regard to attracting and retaining doctors in rural areas			

2.3 Study Methodology and Tools

Purposive sampling method was used for selection of 2 districts the state for the case studies based on the availability of data where doctors are placed (considering the doctors sanctioned/in-position/vacancy status). Thus, Pune and Aurangabad were selected.

Selection of sample subjects: State government officials, programme managers and medical doctors under various categories were selected based on convenience sampling and snowballing method. In-service doctors who have signed the bond, including MBBS and specialist doctors were interviewed.

Categories of sample subjects: On the basis of database obtained on posting details of doctors (MBBS students, PG students and specialists); the categories of sample subjects are:

- Doctors who are currently serving the bond – MBBS, PG and awaiting posting
- Doctors who continue to be in service though the bond period has lapsed
- Doctors who are defaulters and paid penalty fees
- Doctors who are defaulters but did not pay the penalty fees
- Doctors who have signed the bond but are awaiting appointment letters, including interns

Sample Size: The total number of doctors/specialists interviewed was 201 distributed within various categories.

The distribution is as below:

Category	Number planned	Number Achieved
MBBS serving the bond	30	32
PG serving the bond	40	43
Interns awaiting posting	20	21
PG students	40	39
Bond completed but contd. in service	40	37

Defaulters who paid penalty	20	19
Defaulters who did not pay penalty	10	10
Total	200	201

Phase-wise Activities Undertaken:

Phase of study	**Activities**
Authorization / Identification of secondary data sources; designing, pre-testing and finalization of study tools*	Issue of necessary letters for collection of relevant government orders, rules/guidelines, and support from government officials of both Directorate of Health Services, Medical Education
	Designing study tools – semi structured questionnaire for interview of government officials, doctors etc
	Pilot testing and finalization of tools
Secondary and Primary Data collection	Database regarding number of different categories of doctors as listed in **Annexure table 1**
	Field visits to interview different categories of doctors
Report writing and finalization	Report prepared with various chapters including Executive Summary and chapters having charts, tables, graphs etc

* tools are attached as annexure 1

SECTION III

SECONDARY DATA

3.1 REVIEW OF GOVERNMENT POLICY/PLAN ON INCENTIVES & REGULATORY MEASURES

3.2 SERVING OF BOND (STATE WISE)/ IN FACILIITES FOR DIFFERENT CATEGORIES OF DOCTORS (2007-2013)

3.1 REVIEW OF GOVERNMENT POLICY/PLAN ON INCENTIVES & REGULATORY MEASURES

Documents reviewed:

1. GR Graduate and Post Graduate
2. GR naxallite allowance
3. Difficult areas PHC
4. Penalty order 2
5. Penalty order 1
6. Tribal note

1. GR Graduate and Post Graduate
    a. GR dated 20th June 2012
    b. THIS IS NON-FINANCIAL INCENTIVE
    c. Medical Officers and Officials serving in the State's difficult *(durgam)*, very difficult (ateedurgam), tribal and naxallite areas will be given additional marks while calculating final scores of entrace exams of PGs and G (I am not clear how G= graduation fits.
        i. 10% additional marks to a maximum of 30%
        ii. This benefit is NOT APPLIABLE to those in-service in such areas after 19 June 2010

2. Difficult areas PHC
    a. GR dated 19 June 2010
    b. This document is basically related to the above GR for mainly listing out the institutions that come under the purview of this benefit to MOs who have worked there

3. GR naxallite allowance
    a. GR dated 6 August 2002
    b. This GR is issued by the State Tribal Department – Special Action Programme applicable to Naxalite areas
    c. This GR is applicable to all departments and **health department is not spelt out separately**
    d. This is about the guidelines for the appointment of efficient officials in the Naxalite areas and various incentive to them
    e. The gist of the GR is as below:

    To appoint competent employees and officers in naxalite/tribal areas of Chandrapur and Gadchirolli district. The Government of Maharashtra has laid few directives under the GR No. TRF – 2000/3/12 dated 6th August 2002.

    - Gadchirolli and Chandrapur are area with dense forest. These areas have a tribal population and are naxalite prone. Authorities, officers, and employees of government working in these areas face a numerous difficulties. Thus, to appoint competent officers/ workers/employees the following points have been used as directives.
    - Employees recruited in the IPS, IAS and IFS with low pay grade should serve their first posting in the tribal and naxalite areas.

- If promoted during their service, they should serve in the tribal area for at least 3 years
- Employees whose age is above 50 years should not be posted in these areas
- The work done by the officers in charge should be reported in the confidential report submitted by them to the government

Improvements/amendments made in the new version for employees

- According to the new amendment, employees will be given free quarters for a period of 3 years instead of 2 years
- Incentives: all the employees will be given 15% more of the basic pay as incentive, OR minimum Rs.200 OR maximum of Rs.500 per month. These incentives will be applicable only for earned leave and not for commuted leave.
- Transfers: if the employ has served in the tribal/ naxalite area for complete 3 years, then he will be transferred to place of his choice.

Additional amendments:

- Employees whose family is away and the employee is serving in tribal/naxalite area, can apply for leave twice a year to visit his family.
- Additional allowance will be made if the employee wants to buy a 2 wheeler.
- Police officers who have lost their life during duty will be given a special medal and the family will receive a compensation of 2 lakh from the government.
- Employees serving in group A to group D will get promotion on one scale basis.

4. Penalty order 2
    a. GR dated 28 May 2010
    b. It is considered that government spends tax payers money on providing medical education & dental education in government and corporation medical hospitals. Money spent on the students is far in comparison to the fees. This is tax payers money wherein they should benefit from this contribution. This is the thinking behind this GR.
    c. Students (PG and graduation) studying in Government or Corporation Medical colleges have to work in government service post education for a specified period under a bond
    d. In case they do not comply to the service the, appropriate penalty will be recovered from them under this bond.
    e. Increase in penalty has been considered by the government under this GR
        i. Super speciality bond = 2 years; penalty increased from 25 Lakhs to 2 Crores (order implementation from 2010)
        ii. PG bond = 1 year: penalty increased from 15 Lakhs to 50 Lakhs (order implementation from 2011)

5. Tribal note
    a. Details are specified as point in this note

➢ <u>These Schemes are</u>

- Hardship Allowances
- Co-ordination Cell at District Hospital
- Medical Officer at CHC/PHC (Special Plan)

Hardship Allowances

There are many Public health institutions in State which are situated. In remote tribal areas which are often affected by leftist extremism. Regular government Doctors, Specialists and nurses are not willing to go to these places. These areas do not have private specialty Hospitals so there is limitation to appoint Contractual Doctor Considering these problems we introduce hardship allowance to the Doctors and nurses working in difficult tribal or extremism affected areas. Monthly Allowance to these officers and staff is shown in following table.

Sr. No.	Cadre		Monthly remuneration (Lakhs)
1	ANM		0.06
2	Staff Nurse/LHV		0.08
3	Medical Officer – BAMS	Group ---- A	0.15
		Group ---- B	0.12
4	Medical Officer – MBBS		0.15
5	Specialist (Physician/Pediatrician, Surgeon/Gynecologist and Anesthetist)		0.22

Hardship allowances will be given with following conditions

Hardship allowances will be given 10 out of 15 tribal Districts of Maharashtra. These Districts are

Amravati, Chandrpur , Dhule , Gadchiroli ,Gondia , Nanded , Nandurbar , Nashik , Thane ,Yevatmal.

- Hardship Allowance is introduced to motivate Mos, Specialist and Nurses working in difficult areas of the State.
- Hardship Allowance is applicable to the Staff and the medical officers getting salaries from treasury funds.
- The Hardship Allowances is to be paid by Bank Cheque.

Hardship Allowance is being made applicable to only 5 Specialist that is Medicine, Surgery, Ob-Gy, Pediatrics and Anesthesia.

CO-ORDINATION CELL FOR TRIBES

Health Institutions (SCs, PHCs, CHCs etc.) have to refer patients to District Hospitals in emergency majority of the District Hospitals are 300 bedded and above. These Hospitals have Different Sections for Registration, Laboratory checkup, X-ray medicines etc . Tribal Patients do not understand the language and there is delay in getting all the formalities done. Because of such environment Patients are not willing to stay in hospitals and money of the times insists for discharge even if the condition of patient is critical.

Considering Such Situation we Started Co-ordination cell at Amravati, Gadchiroli, Nashik, Thane, Nandurbar.

Patients health Condition required treatment and expected time of arrival is communicated. One cell member takes the responsibility and informs the casualty MO to cell Concerned Specialists. When Patient arrives, the Co-ordination Cell accompanied the patient till emergency is over from registration to laboratory and report collection. After emergency is over the patients are asked to contact the cell in case of any difficulty in hospital. During the stay in Hospital cell member visits the patient twice daily for any difficulty. Transport arrangement is also made if required after discharge.

There will be one Supervisor and four Coordinators in the cell.
Supervisor should be at least 12th Standard Pass and Co-coordinators Should be at last 10th Pass.
Two Coordinators will be Males and two will be Females. This can be Changed as per need by Districts.
Coordinators and Supervisor must be from tribal community and able to Speak local tribal language prevalent in district or in patients coming to DH.

MEDICAL OFFICER AT CHC/PHC(SPECIAL PLAN)

In Maharashtra State Gadchiroli, Amravati (Melghat area only) and Nandurbar which are most backward and do not have health facilities nearby. These areas have very high (3 times the State average) MMR and almost double IMR. Considering this provide special package to specialists in these areas.

Hospitals under Scheme

District	Name of CHCs	Beds	Specialist	Remark
Gadchiroli	SDH Aheri	50	0	Very remote and LEA affected areas. Except Dhanora all other more than look away from DH. No Specialist facility available since establishment.
	RH Sironcha	30	0	
	RH Bhamragad	30	0	
	RH Dhanora	30	1	
	RH Etapali	30	0	
Amravati (Melghat)	SDH Dharni	50	3	Very remote reserve forest area. very high IMR and MMR. No specialist Services available.
	RH Chikaldara	30	0	
	RH Churi	30	2	
Nandurbar	RH Akkalkuma	30	2	Very remote area within Satpuda mountain range and Narmada river. No Specialist available since establishment
	RH Dhadgaon	30	2	
	RH Molgi	30	2	

Salary of Specialist

1) Rs.70,000/- pm Consolidated Salary.
2) Additional Allowances:-
   Rs.5000/- pm for post graduate degree holder.
   Rs.200/- pm emergency attended to physician
   Rs.500/- major surgery to Surgeon
   Rs.100/- per assisted delivery and Rs.500/-cesarean section to Gynecologist
   Rs.200/- Critically ill child admitted to Pediatrician.
   Rs.500/- Major Surgery to Anesthetist.
   Total remuneration will amount to approximately Rs .1.00 Lakh per month.
   Other facilities:- one attendant for house work . Mobile charges Rs.300/- pm.

3.2SERVING OF BOND IN FACILIITES FOR DIFFERENT CATEGORIES OF DOCTORS (2007-2013)

From DMER, year-wise data on admissions and bond compliance for each of the government medical college in the state was collected. This data was for graduation, post-graduation and super-specialization level.

Following table gives collated figures at state level for MBBS seats and their bond compliance.

Table 1: Maharashtra State Graduate Seats (MBBS) and the Details about Bond

Academic Year	Number of Colleges	Admission Completing	Bond Completed	Bond did not Complete and did not pay	Number of Students Paid Penalty	Penalty Received in Rs.
1998-99	10	1197	69	838	59	9226343
1999-2000	10	1200	57	841	74	10457374
2000-2001	10	1216	91	836	102	12909698
2001-2002	10	1163	43	699	288	33110388
2002-2003	10	1297	68	687	275	29482337
2003-2004	12	1394	101	844	250	30231095
2004 - 2005	12	1468	264	850	147	26034345
2005 - 2006	12	1448	194	726	281	37591022
2006 - 2007	12	1462	148	642	413	43321826
2007 - 2008	14	1554	69	829	462	48541630
2008 - 2009	13	1612	59	824	379	46779468
2009 - 2010	13	1523	84	824	200	26513134
2010 - 2011	13	1518	150	904	57	29523641
2011 - 2012	13	1566	227	1084	52	26013874
2012 - 2013	10	1050	21	480	36	14395089

Table 2: Maharashtra State Post Graduate Seats and the Details about Bond

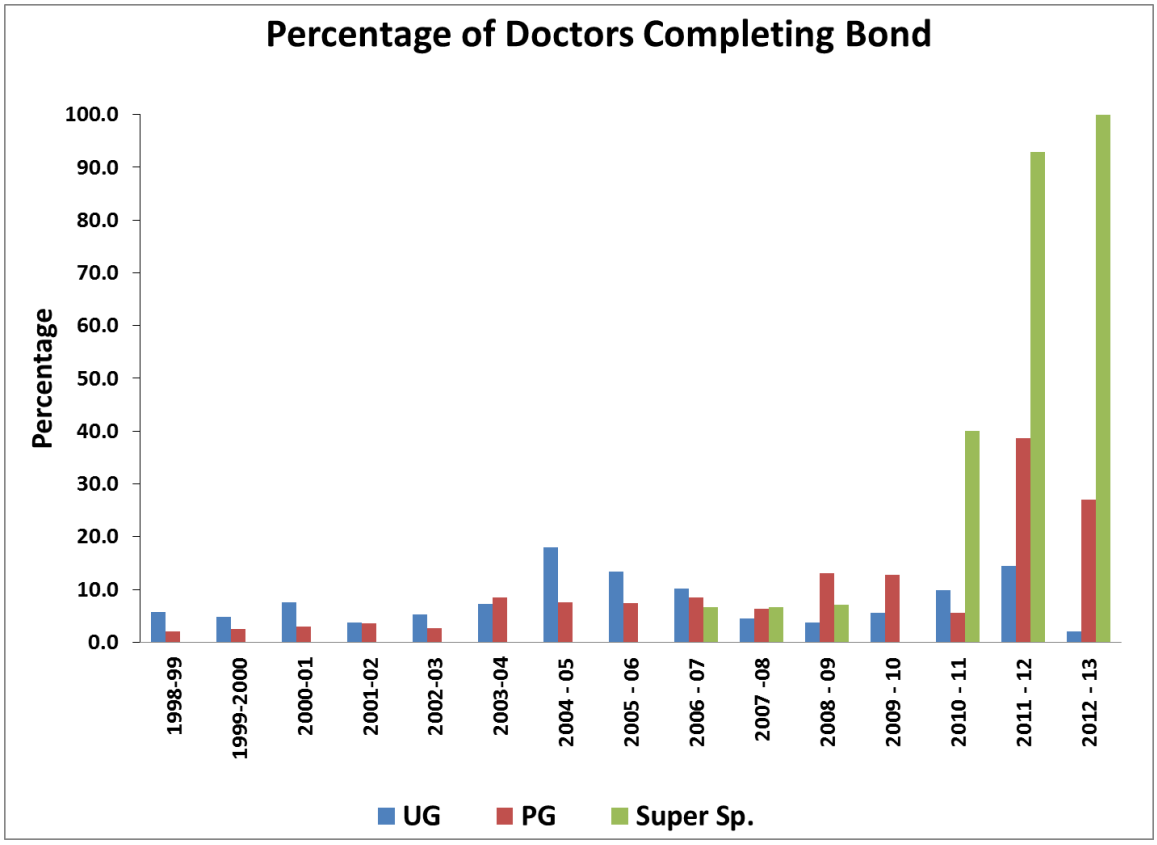
Academic Year	Number of Colleges	Admission	Bond Completed	Bond did not Complete and did not pay	Number of Students Paid Penalty	Penalty Received in Rs.
1998-99	6	1197	69	838	59	92,26,343
1999-2000	6	1200	57	841	74	104,57,374
2000-2001	6	1216	91	836	102	129,09,698
2001-2002	6	1163	43	699	288	331,10,388
2002-2003	6	1297	68	687	275	294,82,337
2003-2004	8	1394	101	844	250	302,31,095
2004 - 2005	8	1468	264	850	147	260,34,345
2005 - 2006	8	1448	194	726	281	375,91,022
2006 - 2007	8	1462	148	642	413	433,21,826
2007 - 2008	8	1554	69	829	462	485,41,630
2008 - 2009	8	1612	59	824	379	467,79,468

2009 - 2010	8	1523	84	824	200	265,13,134
2010 - 2011	8	1518	150	904	57	295,23,641
2011 - 2012	8	1566	227	1084	52	260,13,874
2012 - 2013	7	1050	21	480	36	143,95,089

Table 3: Maharashtra State Super Specialty Seats and the Details about Bond

Academic Year	Number of Colleges	Admission Completing	Bond Completed	Bond did not Complete and did not pay	Number of Students Paid Penalty	Penalty Received in Rs.
1998-99	1	15	0	15		
1999-2000	1	15	0	15		
2000-2001	1	15	0	15		
2001-2002	1	15	0	15		
2002-2003	1	15	0	15		
2003-2004	1	15	0	15		
2004 - 2005	1	15	0	15		
2005 - 2006	1	14	0	14		
2006 - 2007	1	15	1	14		
2007 - 2008	1	15	1	14		
2008 - 2009	1	14	1	13		
2009 - 2010	1	15	0	15		
2010 - 2011	1	15	6	9		
2011 - 2012	1	14	13	1		
2012 - 2013	1	15	15	0		

Figure 1: Percentage of Doctors Completing Bond for Graduate, Post-graduate and Super-specialization: Trend over the years

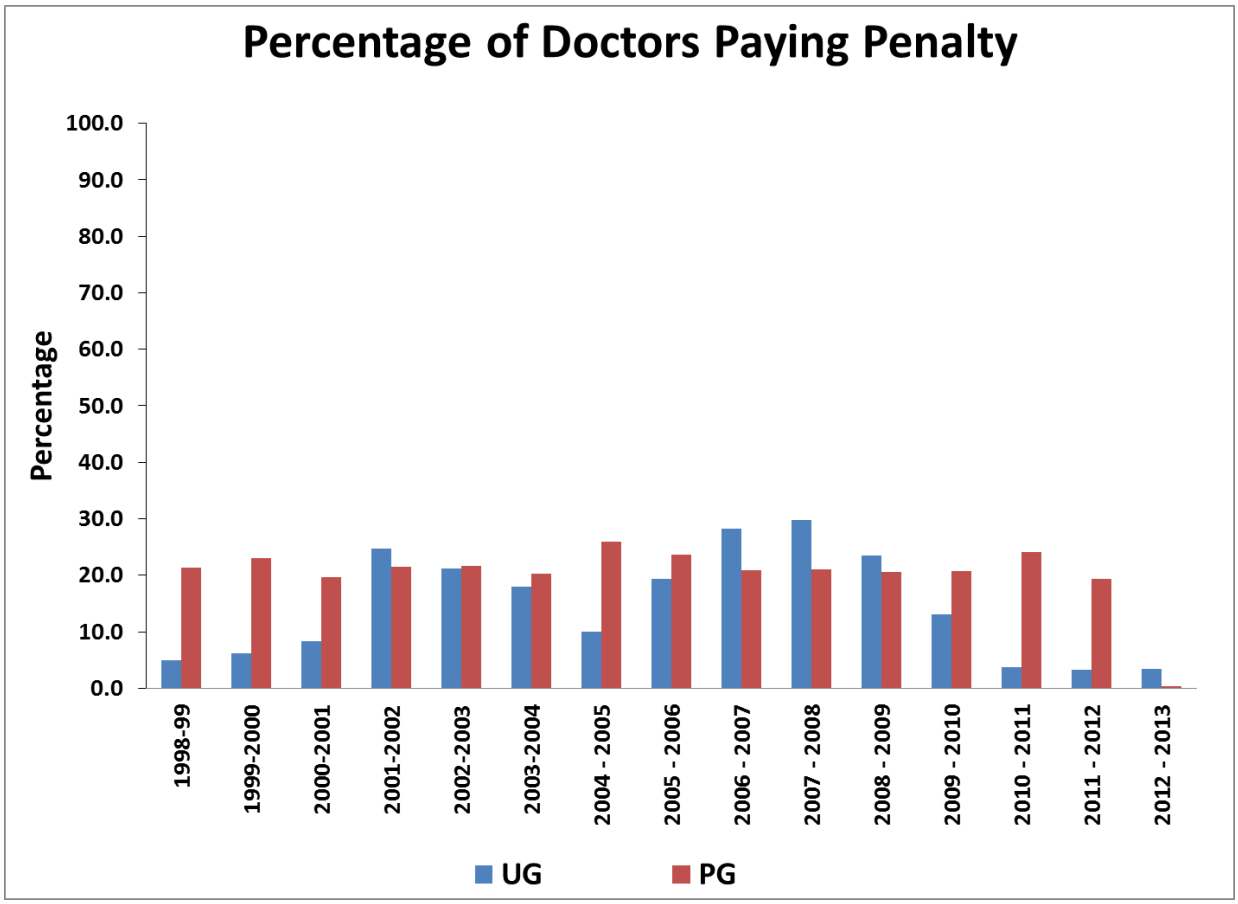


This graph gives percentage of doctors completing bond by level of education.

It could be seen that, the percentage of UG is still fluctuating. It has not yet crossed 20%. This could be because the MBBS doctors prefer to prepare for PG. Even the doctors are allowed to complete this bond along with the PG bond.

There is significant increase in percentage of PG and super specialist doctors completing the bond over the years.

Figure 2: Percentage of Doctors Paying Penalty over years for Graduation, Post-graduation and Super-specialization



This graph shows the percentage of doctors by category, paying penalty.

It could be seen that in the initial years percentage of MBBS doctors paying penalty is less but it started increasing from 2001-02, where doctors have preferred to pay and come out of the bond. Again it has come down in 2010-11.

But, the percentage of PGs paying penalty has been constant around 20%. i.e. PGs have opted to pay the bond amount even though it is increased over the years.

SECTION IV

PRIMARY DATA: INTERVIEWS

4.1 PERSPECTIVES OF VARIOUS DOCTORS

4.2 PERSPECTIVE OF OFFICIALS

4.1 Perspectives of Doctors at different levels of their Profession

I. RESPONSE OF MBBS DOCTORS CURRENTLY SERVING THE BOND:

There were 32 respondents in this category.

Most reported a monthly salary of over Rs 45000 but a couple reported a salary between Rs 40,000 and Rs 45,000.

PERCEPTIONS ABOUT THE BOND

Joining public service without the bond

Of the 32 respondents, 12 said they would **join the public service** without the bond.

One of the reasons listed for readiness to join the public service without the bond was “For experience”. A few of those willing to join the public service without the bond said they were willing to do so only after completing their MD & one of these said he was willing to serve after doing MD so as to serve the community.

Among reasons listed for unwillingness to join public service without the bond, factors like poor infrastructure and time needed to prepare for MD were mentioned.

Joining rural service without the bond

Of the 32, 4 said they would **join the rural service** without the bond.

Reasons given included the desire to serve the rural community or help rural poor people. Some also said such postings provided experience and a provided exposure to a larger variety of patients. One respondent said posting for rural service are good and sometimes city postings are also given.

Among reasons for unwillingness to join the rural service, respondents cited the desire to pursue higher education, desire to set up private practice, poor infrastructure, excessive work, dislike of rural postings, poor accommodation in rural postings, and likely poor usage of complete knowledge in the rural set up.

Awareness about bond conditions

Only 2 respondents reported not being aware of bond conditions, while the rest reported being aware.

Most respondents reported that bond conditions involved 1 year compulsory rural service and a penalty of Rs 5 lakh (some additionally mentioned that the Rs 5 lakh penalty had an interest applied in case of default). A few had signed bonds where the bond condition included 2 years of service and Rs 1.5 lakh as penalty which was later revised to 1 year and Rs. 5 lakh as penalty.

Regarding revision of penalty fee to Rs. 10 lakh, only 6 respondents were NOT aware that such a revision had occurred, but the rest said that the penalty fee had been revised to Rs. 10 lakh. Some were also aware of the penalty being increased to Rs. 15 lakh for MD doctors.

Satisfaction Levels

Of the 32, 17 respondents expressed that they were satisfied. A few of these said that they had on the whole a positive experience of the posting, but also experienced some negative aspects. Negative aspects included inability to study for further tests or break in education. Reasons cited for positive satisfaction levels included good facilities. One respondent who cited good facilities had been posted in Gadchiroli and said the facilities there were good and he was able to learn about ground level health issues. The only negative aspect according to him related to the supply of medicines. Another respondent who cited good facilities had been posted in Pune, where the negative aspect was problems with non-medical staff. Another respondent was happy with the posting at a place close to the highway.

Some were satisfied with the bond but said that facilities were not good.

Of the 15 respondents who were dissatisfied with the bond, many expressed inability to pursue studies as the reason, while many others expressed poor facilities and problems with staff as the reason.

Issues with adherence to the bond

Of the 32, as many as 18 respondents said there were issues with respect to adherence to the bond. Factors cited as issues included:

controlling approach of system, irregular paycheques, poor salaries, poor living facilities/accommodation, infrastructural problems, system is not well organized and no pre-training period for new MOs, political influence with respect to posting, work more administrative than clinical, rural hospitals do not have specialists, posting causes a break in preparation for post-graduate studies, remote postings with poor accessibility, AND no travelling allowance given.

Socio-cultural factors inhibiting or facilitating serving in rural areas

Many respondents said that there were no socio-cultural factors that either facilitated or inhibited serving in rural areas and major factors were those of infrastructure, living conditions, and accessibility. A few respondents cited political pressure as a socio-cultural inhibiting factor. Two respondents cited poor awareness/literacy levels of rural folks as an inhibiting factor.

Will they serve in the public sector after post-graduation?

When asked if they would serve in the public sector after post-graduation, 13 out of the 32 respondents said yes and 1 respondent said “maybe”. Most who said yes felt that once their education was completed, they would like to serve in rural areas. Some expressed the

desire to help the community, while some felt the public sector would provide them with good exposure. A few also mentioned good pay scales as a reason.

Those who said no cited reasons like desire to go for private practice and complete knowledge not being used in PHCs and RHs due to poor infrastructure.

AWARENESS ABOUT GOVERNMENT RETENTION SCHEMES

Awareness

When asked about awareness about schemes to attract skilled health professionals to remote areas, only 9 respondents of the 32 answered in the affirmative. Of these, only a few could specify what these schemes included.

One respondent said incentives include in-service quota for post-graduate admission if MO is placed in a difficult PHC.

Regarding financial measures, 1 respondent mentioned house rental allowance while another respondent mentioned higher salary for hilly regions.

With respect to regulatory measures, a couple of respondents named bonds as the compulsory measures.

Current Posting and receipt of such incentives

Of the 32 respondents, 19 reported had rural posting. Of the 19, only 1 respondent reported having a difficult posting. However, no special incentive was given to this respondent.

Asked about awareness about financial incentives for doctors working in difficult areas, 11 of the respondents replied in the affirmative but only 3 respondents said they knew of some person who had received such an incentive. Of these 3, 1 respondent said that such incentives were paid only to those holding a permanent MO post and not to those working in the bond duration.

Regarding their views on these schemes, many did not comment while a few said such schemes were not useful. Other feedback included comments on the salary which was considered low and it was felt that salary and NPA should be increased.

Other than getting a post-graduate diploma through grace marks, there was no other benefit received according to the respondents.

In general, it was felt that the scheme had no positive outcome and only 4 or 5 respondents said the scheme had positive outcome.

SUGGESTIONS AND FEEDBACK

Regulatory Bond:

The following suggestions were made:

- Bond should be after PG degree/diploma, and if it is after UG, it should not be for more than 6 months.
- Two PG entrance attempts after MBBS should be allowed before starting.
- Bond should not be made compulsory.
- Bond for one year, one year services in rural area.
- Bond can be compulsory but extra allowance should be provided and working hours decreased.
- There should be good infrastructure, good living facilities, transport facility, and salary should more than Rs. 1 lakh per month, plus there should be protection for LMO
- Number of MOs at each PHC should be increased.
- There should be some flexibility in bond completion if they are serving. The tenure should not be increased as in some other states they don't even serve any bond.
- As the MO post belongs to class II, serving a bond is good, but it should be given on time.
- Instead of a bond, there should be motivation and basic information has to be provided to all MBBS/other health personnel.
- Bond is essential but there is a problem in implementation of bond--time between application for service and receipt of order is long.
- With respect to continuation in service, preference for PG should also be given to bonded candidates for in-service PG.
- The bond should be for 6 months only.
- For time for completion of bond the duration should be increased, while conditions penalty should be decreased.
- PG doctors get good exposure through MO-ship, hence the bond system should be applied nationwide.
- Discrimination in postings should not be there.
- People who complete bond should get extra % in PG entrance exam.
- Posting should be near home
- Include bond period in MBBS tenure- one year after that becomes too much.

Financial Incentives:

There were varying views on financial incentives. The following are the views expressed:

- According to 4 respondents financial incentives are OK whereas 3 respondents mentioned financial incentives should be increased.
- MOs should be allowed to use the PHC vehicle for transportation.
- Higher incentives should be given for difficult areas
- Increment and medical reimbursement should be there.
- Salary should be increased to Rs 70000-Rs.80000/-
- Payment should be increased with regard to work load.

Non-financial incentives:

- Housing facilities and transport facilities
- Reservation for MBBS seats should be available for children of doctors who do rural service.
- Working hours should be 8 hours for each MO.
- there must be any provision for the security/safety of MOs especially those working in remote areas.
- Good housing facilities should be provided.
- Support should be provided in case of political pressure.

General:

Overall, general comments were similar to those expressed specifically for **Regulatory Bond, Financial Incentives,** and **Non-financial incentives** and covered the following aspects:

- Provision of good and safe living facilities, quality standard of living.
- Provision of good infrastructure at the facility of posting including better office space and changing rooms.
- Increased salaries for those serving the bond and timely payment of salaries. Bonus payments to doctors who perform well.
- Defined or decreased work hours.
- Increase number of MOs at the PHC.
- In-service quota for PG admission to cover even non-difficult areas.
- Decrease in bond serving period
- Providing basic training before sending the order for rural posting.
- Remove the regulatory bond instead strengthen the 2 months PSM posting in MBBS internship, so that those who really have the intention of joining the rural health services will get the necessary experience and they will join it willingly.
- For specialists to join the public service, any one day of work should given instead of total work.
- Give permanent posts to those who want to continue with the service.
- Have regular training programmes for MOs and supporting staff in new medical interventions and treatments.
- Motivate the students regarding nation's need.
- Bond should be served also to those studying in private medical colleges.
- Support those serving bond against interfering politicians.

II. RESPONSE OF MD DOCTORS CURRENTLY SERVING THE BOND:

There were 43 respondents in this category. Respondents reported a salary of over Rs. 45000.

PERCEPTIONS ABOUT THE BOND:

Joining the public service without the bond

Of the 43 respondents, 25 said they would **join the public service** without the bond. Compared with 12 out of 32 MBBS doctors, the proportion is slightly higher and perhaps pertains to the fact that MD doctors have completed their education.

Reasons listed for readiness to join the public service without the bond included desire to serve or give back to the community and to help the poor. One respondent said he was ready to join the public service provided that the requisite equipment and medical supply was available and there was no corruption.

Reasons listed for unwillingness to join public service without the bond included desire to study even further and desire to join the private sector.

Joining the rural service without the bond

Of the 43, 6 said they would **join the rural service** without the bond.

Reasons given included stability of job. One respondent said he would like to continue as he was posted to his native place and another said he would like to live in the village. One respondent said he had done PSM to serve the community and working in a government set up would provide the right kind of exposure.

Among reasons for unwillingness to join the rural service and preference for public service respondents stated reasons like interest in public health systems, public service will be a source of job satisfaction, will keep them in touch with academics, and public service will provide ability to serve the community.

Regarding specific issues about rural posting, factors cited were: no proper infrastructure, relocation issues for rural areas, no option if one wanted to stay with one's family, political interference, and no job satisfaction.

Other cited factors were: only option for non-clinical branches of medicine, lecturership only option for MD in pathology, study time would be lost because of the bond, interest in teaching, and the desire to pursue Ph.D.

According to one respondent, joining the rural service would adversely affect career opportunities. Another respondent said there is better learning exposure in private hospitals.

Awareness about bond conditions

Only 4 respondents reported not being aware of bond conditions and 1 respondent was aware but not fully aware, while the rest reported being aware.

Most respondents were able to specify the bond period for MD doctors as 1 year and the bond penalty amount as Rs. 15 lakh. Two respondents provided additional details-that one cannot leave India for 5 years if one does not serve the bond.

A couple of respondents additionally specified bond duration as 2 years for MBBS doctors and bond penalty as Rs. 5 lakh.

A few respondents did not mention the bond duration and mentioned only the penalty amount as Rs 15 lakh while one respondent could only say that a penalty was involved.

Regarding revision of penalty fees, 20 out of 43 respondents said they were not aware. From among those who knew that there had been a revision, some did not know the new penalty fee amount. Some who did not know the new amount stated that the penalty fee tends to increase every year. A few stated that the penalty fee was now Rs 50 lakh. One respondent provided further details and stated that the new penalty fee was Rs 50 lakh for PG and Rs 2 crore for super-specialty.

Satisfaction Levels

Of the 43 respondents, 1 did not respond. Positive satisfaction levels were reported by 15 respondents and negative satisfaction levels by 17 respondents. There were 10 respondents who said their bond experience had both positive and negative attributes.

Reasons cited for positive satisfaction levels included gathering good work experience, good salary, and the desire to work in public health. One respondent said he was happy as he was working as Assistant Professor, another said he was happy as he liked teaching/lecturer-ship. One respondent said serving a bond was good and 1 year was sufficient. One respondent said his specific learning was useful on the job and he got a tertiary facility to work at.

Different reasons were cited for negative satisfaction levels. One respondent said there was a two month delay in having his bond served and thus time was wasted. Another said his specialty was non-clinical but he was posted in medicine. A similar complaint was made be another respondent who had done microbiology but was now doing MO work. One respondent said the absence of job guarantee made it a negative experience and a similar sentiment was expressed by another respondent who said that the future was uncertain.

There were 10 respondents who said that although there were positives to the bond, there were some problems as well. Problems listed included having to do administrative work, salaries not given on time, and being posted far from home. One respondent said he had job satisfaction but family life was adversely affected. Another said bonds are good but one needs to get posting in one’s place of interest. One respondent with MS ophthalmology said there are no ophthalmology OTs hence his knowledge is not used. Two respondents said the nature of work was not fixed and ideally should be based on specialty. Both said they

had to carry out post mortems which were not their area of work. Another respondent said the negative part was-having to do administrative work as well.

Issues with adherence to the bond

A large number of respondents (30 out of 43) said there were issues with respect to adhering to the bond.

Specific issues cited included: poor salaries, no job guarantee, unsatisfactory accommodation including issues of security, no scope for application of clinical knowledge, having to do administrative tasks, administrative problems, posting in incorrect profile (specific examples cited: ENT posted for medico-legal cases or specialists having to work as generalists), inability of pursue further education, and rude behaviour towards qualified medical doctors.

Poor infrastructure was cited as an issue. This includes inadequacy of medicines, inadequacy of equipment, insufficient staff, power failures due to load shedding, and no mobile range

Political interference or political pressure was also cited as an issue. One respondent said unethical practices have to be followed in treatment due to political pressure.

Other issues include having to deal with post-mortems and deliveries in emergencies of which they have no experience. Lack of co-operation at such times adds to the problem according to one respondent.

Socio-cultural factors inhibiting or facilitating serving in rural areas

When asked about socio-cultural factors affecting those serving in the rural areas, a lot of respondents tended to speak about living conditions or poor accommodation, poor transport, poor food and drinking water, political pressure, and lack of infrastructure at the health facility (inadequacy of equipment and medicine supply). Poor security was an important factor cited especially so for female doctors.

Some respondents said socio-cultural factors specific to rural areas were illiteracy and low awareness levels. Language barriers leading to inability to convince people were also cited. One respondent said that a traditional mindset in rural areas can prevent practice of skills such as laproscopy and IVF.

Will they serve in the public sector after post-graduation?

There were 17 respondents who said they were ready to serve in the public sector after post-graduation. Reasons for readiness to serve included an interest in public service, wanting to serve the community, ability to apply one's knowledge in the field. A few said that public service provided for stability and a few others said that if given assurance of permanent jobs, they would like to serve. One respondent cited the reasons that after the sixth pay commission, salaries were good hence he was ready to serve.

One respondent was ready to serve if there was a functional OT. One respondent had not yet decided.

On the other hand, 6 respondents said they would not like to serve under the bond. Reasons cited included the desire to continue education and the desire to go for private practice. Another reason cited was that work was more administrative rather than clinical.

The question was not applicable for the rest of the respondents (18) who were already serving or had signed the bond.

AWARENESS ABOUT GOVERNMENT RETENTION SCHEMES

Awareness

Regarding schemes to attract skilled health professionals to remote areas, only 13 respondents from the 43 answered in the affirmative. Of these, a few specified details of such schemes. A few said such schemes involved regulatory measures and a few others said that such schemes involved financial incentives. A few mentioned both regulatory measures and financial measures. One respondent provided details of regulatory measures as the compulsory bond. Some who mentioned financial incentives provided details. Details mentioned included higher salaries for those working in tribal areas, higher salaries for those working in naxalite areas, and higher salaries for those working in difficult areas.

Current Posting and receipt of such incentives

As seen above, there were 18 respondents who were already serving or had signed the bond and of these 17 respondents had an urban posting and only 1 had a rural posting. The respondent with the rural posting said it was not a difficult posting.

Regarding awareness about financial incentives for doctors working in difficult areas, 17 of the respondents said they knew about it but only 4 provided further details. Three respondents said the incentives included higher salaries. One respondent said incentives included higher salaries and allowances.

Many respondents did not provide their opinion on the schemes and only 12 respondents commented on them. Of these, five respondents said the schemes are good and helpful. Other comments made included: such schemes are of no use unless facilities are upgraded, the government needs to both upgrade facilities as well as increase incentives to doctors, such schemes are needed as the doctor population ratio varies between rural and urban areas, the only benefit of such schemes is the stipend.

When asked about benefits of the scheme many respondents did not answer and from among the few who answered, most said the only benefit was the stipend. Another respondent said the benefit included exposure to rural areas.

Only 6 respondents viewed the scheme as positive. Some who found the scheme positive said the compulsion element ensures that at least some doctors are present in rural areas. For those not finding the scheme negative, the issues were poor infrastructure (equipment, medicine supply), housing, transport; and not receiving postings in their specialty areas.

SUGGESTIONS AND FEEDBACK

Regulatory Bond:

The following suggestions were made:

Duration and Time:

- 6-month/1-year duration is sufficient so that each batch of students can serve.
- The bond should be served after completion of education.
- Bond should be served after confirmation of PG seats.
- Bonds should be compulsory after MBBS and only compulsory after post-graduation if there is work for specific specialist.

Penalty Fees:

- Penalty fees are needed else it would have become optional.
- The penalty amount should be further increased.

Placement and postings:

- Postings should be given according to where one wants to settle down.
- Proper placement is required.
- There should be uniformity in postings.
- There should be choice about place of posting.
- Specialists should work in interest area and not in general OPD or medico-legal cases.

Policies and Criteria:

- Policies and criteria for bonds should be fixed and not be changed so frequently.
- Same rules should be applied to all.
- The bond policy should be closed, needy candidates should made permanent.
- There should no option to get out of serving the bond. Both private and govt colleges should serve the bond, it should be implemented.

Compensation:

- Students serving for a year should get adequate financial compensation as an inadequate salary after investing so many years on their education is a necessity.

Facilities

- Quality of life in rural areas needs to be improved so that doctors have at least basic level living conditions.
- Facilities should have the necessary infrastructure, equipment, medicine supply, and adequate staff.

Regulatory

- Penalty should be reduced

Financial Incentives

- Financial incentives including salaries should be increased to promote the MBBS doctors to work in rural areas
- Financial incentives should be increased to match those in private practice.
- Doctors serving in rural areas should get more payment than those in urban areas
- There should be extra allowances and family benefits
- There should be additional payment for working overtime.

Non-financial incentives

- Additional bonus marks should be given for PG entrance to those who serve the bond,
- The bond should not be compulsory but if a permanent post is offered along with provision of advanced courses in the respective fields, doctors may be drawn to the scheme.
- Doctors should be given permanent posts in government after bond else they face job issues i.e., provide job security.
- provide off after a night duty, vacation 6 monthly to help doctors away from hometown
- Quarters and vehicles should be provided.
- Security at living places should be provided.
- Required essential services must be provided at living quarters.
- Work hours should be comfortable and fixed.
- Health facility infrastructure should be improved and include adequate equipment, medicine supply, along with adequate and well-trained staff.
- Payments should be timely.

General:

Once again, suggestions received in the above three categories were echoed as general comments. In addition to the above feedback, a few additional suggestions/remarks were made. These include:

- Specialized doctors should not be asked to work in faculty and department other than their specialization. (“No one with super-specialization would like to work in a PHC.”)
- Non-allotment of DMO/CMO duties and PM duties to specialized PG doctors.
- In case of rural/remote areas, instead of placing one doctor there for 1 year, why not arrange for rotational duties? For example, 6 doctors can work in a rural place for 2 months by rotation in 1 year and for rest of the time they can work at a district-level government facility. For the period of 2 months in the rural area they should be additional benefits in their salary.
- It is difficult to motivate people to work in rural areas or public service. So those who want to work should be given chance.
- It is essential to increase the number of PG seats in government colleges and to make lecturers permanent.
- The bond should be made compulsory for other streams also like engineering, nursing, and law as well so that overall condition of villages improves.
- Vacancies should be increased as the number of posts are fewer as compared to the number of doctors. For example, there are 22 Microbiology graduates but only 3 posts for Microbiology.
- Instead of bond make it an internship of 1.5 years
- Bond should be served to clinical people as work is clinical.
- One should be allowed to do posting anywhere in India People from Tamil Nadu have 3 year bond so they come here and take our seats. There should be a provision for bond in military service
- Once you sign bond there is no clarity about bond rules. Without intimation and without notice, bond rules should not be changed.
- Uniform rules and regulations are must. Rules should not change every year.
- PG bonds should be given in tertiary care hospitals where there are facilities. Salary is less in Maharashtra, should be increased.
- Married candidates should be given posting near family
- In Maharashtra, there are 3 bonds, there should be only one bond.
- It is difficult to motivate people to work in rural areas or public service. So those who want to work should be given chance.
- Females should be allowed maternity leave
- Political and senior officers interference should be checked
- Health insurance/life insurance should be provided to doctors working in rural or difficult areas.
- Health insurance/life insurance should be provided to doctors working in rural or difficult areas.

III. RESPONSE OF MBBS DOCTORS WAITING FOR BOND RELATED POSTING:

There were 21 respondents in this category. Respondents reported a salary of less than Rs.30,000.

PERCEPTIONS ABOUT THE BOND:

Joining the public service without the bond

Of the 21 respondents, only 3 said they would **join the public service** even without the bond. This proportion is far lower as compared to 12 out of 32 for MBBS doctors and 25 out of 43 for MD doctors.

Three were no reasons cited by those that said yes to joining the public service or those who replied in the negative.

Joining the rural service without the bond

Similarly, with respect to **joining the rural service** without the bond only 2 out of 21 respondents replied in the affirmative.

No reasons were cited by those saying yes. Those who said “No” to joining the rural service cited reasons like absence of proper facilities in rural areas, absence of infrastructure (equipment, drug supply) in health facilities, and insufficient remuneration. One respondent said rural service should be mandatory only after post-graduate education and not after MBBS.

Awareness about bond conditions

Only 2 out of the 21 respondents said they were not aware about the bond conditions.

Regarding details, 12 out of 21 respondents said the bond involved 1 year of compulsory service, else there was a penalty fee of Rs. 10 lakh. From amongst these 12 respondents, there was one respondent who additionally specified that one cannot leave India for 5 years if one does not serve the bond.

There were 3 respondents who stated that the bond involved 1 year compulsory service, else there was a penalty fee of R. 5 lakh.

There were 3 respondents who only mentioned the penalty amount and not the duration of compulsory service. Of these three, 2 respondents said the penalty amount was Rs.10 lakh, while 1 respondent said it was Rs.5 lakh.

There was one respondent who said if a person immediately obtained the PG seat, it could be combined with the PG bond.

With respect to revision of penalty fees, only 7 of the 21 respondents said they were aware of it. Four respondents from among the 7 said that penalty fees had been increased, but only 1 respondent from among these 4 specified the new amount. He stated that the new

penalty amount was Rs.15 lakh. One respondent said that penalty fees had been increased and not serving the bond meant non-eligibility for state post-graduation. The second respondent said that after revision, rural service was compulsory for PG admission.

Satisfaction Levels

Negative satisfaction levels were registered by 19 out of 21 of the respondents, while the remaining 2 said they had just signed the bond but had yet to experience the work under the bond.

Many of the respondents said the reason for dissatisfaction was that the bond came in the way of higher studies and should not be made compulsory at the undergraduate level.

One respondent said that he did not get to directly handle patients so the experience did not help build confidence.

Issues with adherence to the bond

Only one respondent did NOT have issues with adherence to the bond, while the remaining 20 had issues with adherence.

Issues that respondents cited were: bonds should be served for all streams and not just to medical doctors, bonds should be served after MD rather than after MBBS, bonds should be served to even those graduating from private medical colleges, no job guarantee after completion of the bond, having to wait for posting, inadequate infrastructure at health facility (equipment, medicine supply), poor salaries, poor living facilities, poor sanitation, quarters not provided and have to look for own accommodation, lack of safety, and political interference.

Socio-cultural factors inhibiting or facilitating serving in rural areas

Regarding the socio-cultural factors in rural areas, many respondents mentioned poor living conditions and accommodation, poor transport, and poor infrastructure at health facilities.

Actual socio-cultural constraints were also mentioned by many of the respondents. These included the language problem, political interference, the presence of quacks and lack of trust in modern medicine, poor awareness levels and low acceptability of government health facilities especially in interior rural areas, and lack of co-operation from non-medical staff who are often untrained or poorly trained.

Will they serve in the public sector after post-graduation?

Only 8 out of the 21 respondents said they would serve in the public sector after post-graduation, but 2 out of these 8 said they would do so because it was compulsory. The others cited reasons like doing one's duty, being able to deliver better care after post-graduation, and genuine desire to serve.

Reasons cited by those said they were not ready to serve included little opportunity for personal growth, poor salaries, poor infrastructure at the government health facilities, and the desire to study even further.

AWARENESS ABOUT GOVERNMENT RETENTION SCHEMES

Awareness

Of the 21 respondents, only 5 said they were aware of the schemes present to attract skilled health professional to remote areas.

Of these 5, one respondent described details of the scheme as reservation of seat and provision of accommodation. One respondent only mentioned reservation of seat. Three respondents said the scheme included high salary and a penalty if the bond was not served.

Current Posting and receipt of such incentives

Four of the respondents had currently got an urban posting, while the others had not yet got a posting.

Regarding awareness about financial incentives for doctors working in difficult areas, 5 respondents answered in the affirmative. Only 1 respondent provided further details and said that salaries for difficult areas are likely to be increased in the future.

Only 10 out of 21 respondents provided their opinion about the schemes. One respondent said the bond should not exist. Quite a few others said the scheme was not useful and came in the way of studying as there was no time for studying. Two respondents said that the duration of 1 year was too long and one of additionally said that salaries paid were low. Only one respondent said the scheme was satisfactory.

Few respondents answered the question about the benefits of the scheme. One said the scheme was devoid of benefits. Another said that the stipend was the only benefit. Other benefits listed were grace marks for PG admission proportional to number of years served, and reservation for PG admission.

Only 1 respondent had a positive view of the scheme citing the reason as a positive outcome. For those who perceived the scheme as negative, the issues were poor infrastructure at government health facilities, having to do administrative work, political pressure, and compulsion.

SUGGESTIONS AND FEEDBACK

Regulatory Bond:

Suggestions were made as follows:

Policies and Criteria

- The bond should be mandatory for all under graduates from different field and deemed universities must also be included.
- The bond should be made compulsory for government as well as private colleges.

- Bonds should be made voluntary and the hometown should be given as posting.
- Bonds should be served only after post-graduation, so as to provide quality care.
- Bonds can be made compulsory but after sufficient attempts for post-graduation entrance.
- More financial incentives are required.

Duration and Time

- Duration of bond should be reduced in order to make it more sensible.

Penalty Fees

- Penalty fees should be decreased for SC, ST, and OBC doctors.
- There should be no penalty.

Financial Incentives

- Salaries must be increased.
- The current payment to MBBS doctors is very meagre. Even AYUSH doctors get a lot more compared to skill level.
- MBBS doctors should get at least 12 lakh per year.
- People in rural postings should get 25% higher salaries than those in urban posting.
- Payment for the MBBS and skilled doctors should be Rs 10 to 15 lakh per year.
- The stipend should bee at least Rs. 1 lakh per month or more.
- Take-home (net) salary should be Rs. 50,000.
- As the work is 24/7, higher financial incentives are needed.

Non-Financial Incentives

- Doctors must be provided with clean and hygienic living quarters/accommodation along with security.
- Working hours must be reduced.
- Doctors who serve the bond should be given additional marks in the post-graduate exam as an added incentive.
- Health facilities must be well-equipped with the requisite infrastructure, equipment, and drug supply.
- Doctors may be willing to serve voluntarily after some years of practice.
- Combine bond with internship.

General

Suggestions made in the above three categories were often repeated as general comments. In addition to the above feedback, a few additional suggestions/remarks were made. These include:

- There should not be mandatory rural posting after MBBS as the duration of study itself is so long and there is 1-year compulsory internship after that.
- Posting should be combined with internship and preferred postings should be given. There should be 3 months periodic/rotation as part of internship
- Instead of MBBS students, ask BHMS students to do rural posting as they anyway practice allopath. Reduce the bond regulations and allow other doctors (BAMS,BHMSetc.) to serve people at the primary level. Specialist like MBBS doctors cannot do sufficient work in inadequate facilities at the PHC level-it is a waste of their knowledge and intelligence.
- More doctors should be posted at each PHC so as to ensure that work hours are not longer than 8 hours. Increase the number of MO postings per PHC.
- Bonds should be after served after PG so that quality work is delivered. MBBS doctors mainly refer out cases.
- A better infrastructure of rural hospitals will ensure that there is minimum referral to secondary and tertiary health care.
- There should be no political interference.
- Increase the number of post-graduate seats in Government medical colleges and not in private medical colleges.
- Living facilities for the family of the doctors should be made available.
- The regulatory and mandatory approach is not helpful, but if the conditions are made attractive, many doctors will gladly join rural services voluntarily. The regulatory approach after MBBS comes in the way of higher education. If more salaries are offered in rural posting as compared to urban postings, doctors would voluntarily do rural service.
- Prevalence of quacks must be reduced.
- The bond should be made compulsory for other streams also like engineering, nursing, law, et/.c so that the overall infrastructure of villages improves.
- Ensure that doctors posted get clinical experience.
- Make lecturer-ships permanent.
- There should be proper regulation of postings. Two years ago, MO posts were not vacant.
- Cross-pathy should be banned.
- There should be proportionate allocation of post- and under-graduate seats.
- Formal training for working as an MO in rural areas should be provided.
- Allow under-graduate students to enrol for post-graduate courses so that they can have sufficient experience and training for treating patients.
- How can specialty doctors work when there is no availability of OT, OT staff, anesthesia, medicines, etc.?

IV. RESPONSE OF THOSE PURSUING MD:

There were 39 respondents who were pursuing MD. Respondents reported a salary of over Rs 30,000.

PERCEPTIONS ABOUT THE BOND:

Joining the public service without the bond

From among the 39 respondents, 23 said yes to **join the public service** without the bond. This proportion is almost equal to that for MD doctors where 25 out of 43 had replied in the affirmative.

Reasons listed for willingness to join the public service without the bond included: financial security and permanent job, since rural posting is inconvenient, desire to serve the community, and interest in health administration.

One out of the 23 respondents who said he was willing to join said he wanted a posting in his native place in UP, while another respondent who was willing to join said he would join if the salary was good and there were retirement benefits.

Reasons listed for lack of readiness to join the public service included lack of facilities, low salary, interest in research and further studies, and political pressure.

Joining the rural service without the bond

Out of 39 respondents, only 7 said yes they would **join the rural service** without the bond.

Reasons for wishing to join the rural service included desire to serve the nation, desire to help/serve the rural community, to get exposure, helps upgrade knowledge, good income, rural population needs more inputs due to poor access,

Reasons for not wanting to join the rural service included poor facilities/infrastructure in rural areas, inadequate infrastructure at health facilities (equipment medicine supply, staff, MOs), public service provides better exposure and job satisfaction than rural service, already in public service, no dearth of jobs elsewhere, desire to work in private practice, no future opportunities, and no authority in rural postings.

Awareness about bond conditions

Only 4 out of the 39 respondents said they were not aware of bond conditions, while the rest reported that they were aware.

Most of the 35 respondents who replied in the affirmative were able to furnish either partial or major details about the bond conditions, but information was not necessarily updated or accurate. Thus, 30 out of 35 respondents specified the duration of compulsory service to be 1 year, but reported variable penalty amounts. Thus, from among these 30 respondents, 10 stated that the penalty amount was Rs. 50 lakh, 8 respondents stated that it was R. 5 lakh, 3 respondents said that it was Rs. 1 lakh, 2 respondents said that it was Rs. 15 lakh, 2

respondents said that it was Rs. 20 lakh, 1 respondent quoted the penalty amount to be Rs. 2 lakh, and 1 respondent said the penalty amount was Rs. 10 lakh.

Apart from these 30 respondents, there were 3 respondents who did not specify duration of service. Thus, 1 respondent merely named penalty amount as Rs. 5 lakh but did not specify duration of service. Another also named penalty amount as Rs. 5 lakh and added that 20 days leave was allowed but once again did not specify duration of compulsory service. The third said the penalty amount was Rs. 50 lakh, and then Rs. 10 lakh.

There were 2 respondents who specified duration of compulsory service to be 6 years. One of these named the penalty amount as Rs. 20 lakh, and the other as Rs. 50 lakh.

Asked about awareness about revision of penalty fees, 16 out of the 39 respondents said they were aware. However, from among these 16, a few said that penalty fees had increased but did not specify the amount. Some others said penalty fees had increased from Rs. 5 lakh to Rs. 15 lakh, and some said it had increased to Rs. 50 lakh. Some others who had said the penalty fee was Rs. 1 lakh said that after revision, the penalty fee had increased to Rs. 5 lakh. One respondent also spoke about the increased duration of the bond from 1 year to 2 years.

Satisfaction Levels

Out of the 39 respondents, 10 said they were satisfied with the bond. Many from among these 10 respondents, though satisfied, mentioned some negative aspect they had to face. One said that the work experience was good but the compulsion element was not. Two of the respondents said that they were satisfied, but inadequacy of supplies such as gloves, needles, and syringes was a negative aspect. One doctor said he was satisfied since he got an urban posting. Another said the actual work gave him satisfaction but living conditions in rural areas are problematic. Similarly, another respondent said that serving the bond was alright but accessibility must be considered before giving a posting.

While 5 of the respondents did not answer the question, the remaining 24 respondents said they were not satisfied with the bond. Reasons cited included: should not be compulsory, came in the way of appearing for post-graduation entrance exam, bond is not practical, those working under bond do not provide quality services, improper working conditions, waste of knowledge due to having only administrative work and doing referrals, political interference, low salaries, and poor living facilities provided.

Issues with adherence to the bond

A large number of respondents (31 out of 39) said they had issues with adherence to the bond, while 7 said they had no issues. One respondent did not answer the question.

Issues that were cited include: disturbs family life, poor living facilities provided, poor salaries, compulsion element is annoying, no permanent job after completion of bond, bond interrupts education, inadequate equipment at government health facilities, corruption, lack of supervision, and hostile attitude of general public in rural areas.

Socio-cultural factors inhibiting or facilitating serving in rural areas

Regarding socio-cultural factors that could affect those serving in rural areas, factors mentioned rather pertained to living conditions, the absence of proper facilities/manpower, and even low remuneration. Thus, respondents mentioned poor living facilities with poor security, poorly equipped health facilities with low manpower and inadequate supply of medicines, poor roads and transport, poor quality of food, low salaries, lack of training provided to MOs serving the bond, long working hours, no time to study,

Actual socio-cultural factors mentioned included political pressure, language differences, and lack of co-operation from people and non-medical staff.

Will they serve in the public sector after post-graduation?

Out of 39 respondents, 23 said they would serve in the public sector and 1 said that he was already in public service. Out of these 23, one said he would join public service if he did not find an academic post elsewhere and another said he would do it only if the posting was in an urban area, and a third said that he would do it only if it was in his area of specialization. Around 3 or 4 respondents from among the 23 said they would join since it was compulsory

Reasons cited for saying yes were completing the bond, desire to serve the rural community (needy/poor people), good salary, need the money, and to gain experience and get exposure.

Those who said “no” cited reasons like wanting to pursue higher studies, bond unsuitable for the non-clinical line, family constraints, no job security, poorly equipped government health facilities, corruption, lack of safety, and poor rural infrastructure including lack of transport.

AWARENESS ABOUT GOVERNMENT RETENTION SCHEMES

Awareness

Asked about whether they were aware of schemes to attract skilled health professionals, only 6 out of 39 respondents said they were of these schemes. Only 5 out of these 6 gave further details.

One respondent mentioned low-rate house loans. One respondent mentioned regulatory measures and another mentioned financial and regulatory measures (compulsory bond). One respondent specified financial measures to include GPF and GST. One respondent said that 30% marks are added in the entrance exam for those serving in tribal areas.

Current Posting and receipt of such incentives

Only 1 respondent currently had a rural posting and 1 said he had a rural posting in the past.

Only two respondents were aware about financial incentives for doctors working in difficult areas. One said the incentive was higher salary in naxalite areas. The second said he knew of a person in the naxalite area who received a salary that was Rs. 10,000 more than for other postings.

Many of the respondents did not give their opinions about the schemes and only 8 respondents gave their comments.

One respondent said schemes are attractive only on paper. Another said working in rural areas is difficult. Another respondent said what schemes offer is not adequate, while another said that the salary should be higher. Two other respondents labelled the schemes as negative.

Only 2 out of the 8 respondents who commented said the schemes were good/positive/beneficial.

Specifically asked about the benefits of the scheme, the following responses were received: stipend during study period, lectureship in medical college after completing MD, grace marks, and separate quota for “in-house” post-graduate seats. A few respondents said there are no benefits.

Only 11 respondents viewed the scheme as positive. Reasons they cited included: higher stipend and housing facilities, getting a job immediately after graduation, exposure to rural health services, provided experience and motivation, MO-ship helps to get admission in the post-graduate course, and brings in more doctors to rural areas.

The respondents who viewed the scheme as negative gave the following reasons: higher financial incentives needed, poor basic facilities in rural areas, doctors would rather live in metro cities, and permanent postings are not given.

SUGGESTIONS AND FEEDBACK

Regulatory Bond:

There were differing views on whether there should be a regulatory bond, when it should be served (after UG or PG), to whom it should be served, and how it should be managed. The following views were expressed on whether a bond should be served or not:

- There should be no bond/compulsion as it tends to bring into service people who are not interested in serving the public.
- There should be just one bond either for UGs or for PGs.
- After UG, the bond should be made compulsory.
- Bond should be served but only after PG.
- Bond must be mandatory to all MBBS students and should be allowed for PG
- Bond would be effective if made compulsory. Bond is a positive factor.
- A regulatory bond is necessary.
- Bond should not be compulsory for getting admission in PG course.
- Bond should be made compulsory but not within 1 year of completion of internship.
- Compulsory service should be there and no penalty or option should be allowed.
- At least for non-clinical branches, the bond should not be there.
- Bond should be applicable to private institutions as well.

- Bond should be scrapped, instead appoint a permanent MO in the rural setup with all benefits. This will change the picture of rural health scene.
- The bond causes a clash between UG completion and PG entrance.
- One year of service is essential but there should be leniency about how and when one can serve, eg., within 5 years of completion of studies.
- Paper work should be reduced.
- The order should be given on time.
- Bond can be served but the 6 year tenure is very high.
- Leave for studying should be given.
- After completion of bond period, govt should give the chance for regular service without gap

Regarding postings, the following suggestions were made:

- For non-clinical branches, bond service should be given in medical colleges.
- Service area should be according to domicile. Candidate from rural areas should be given rural areas. If close to home, then doctors can think of going there.
- People should get posting according to place of choice.

Regarding penalty fees the suggestions were:

- There should be no penalty fees.
- Rs. 5 lakh penalty is sufficient.
- Penalty fees being high, makes it mandatory to go for rural postings. This is difficult to sustain due to bad and unethical issues and bad work atmosphere.

Financial Incentives

The following suggestions were made:

- Salary should be increased.
- Salary in rural areas should be increased.
- In rural areas, salary should be Rs. 1 lakh per month.
- Financial benefits must also take care of children's education and have housing loans, NPA while pursuing PG degree.
- Salaries should be equivalent to those in the private sector.
- Salaries must be equivalent to Class 2 Group A service.
- Doctors should additionally be paid per patient.

Non-financial incentives

Non financial incentives that doctors wanted included:

- Decent accommodation with safety and security, proper food

- Additional facilities such as Internet
- Vehicles for transportation
- Allowances such as travelling alliance, servants allowance etc
- Permanent job from first day of service
- Proper working hours (8 hours)
- No unnecessary administrative workload
- Sufficient leave including 6 months maternity leave with pay and leave for genuine court summons and MLCs
- Improved infrastructure of the health facility with proper equipment and supplies and staff
- Housing also provided in the urban setting
- Provide gross marks/reservation for those who complete rural bond
- Assurance of getting in for PG
- Three doctors should be there at each facility in rural areas as they need 24*7 service.

General:

Once again, suggestions received in the above three categories were echoed as general comments. In addition to the above feedback, a few additional suggestions/remarks were made. These include:

- As a part of ethics we are bound to serve to the rural areas. The experience will permanently change our attitude towards Public Health.
- In service bond is too long to serve- 6yrs.
- Posting should be based on rank
- Females should be exempted from bond or should be given according to their convenience.
- Female candidates should get posting near home.
- Rotational service can be offered like 1 month in a year.
- Doctors should have access to transport and should not feel the distance from urban areas, they should be in contact with urban areas.
- Promotions should be fast.
- Transfers should be avoided if the job is convenient for candidate. Govt should retain the candidates and should give all facilities.
- Whatever knowledge we gain, we cannot apply because of lack of technical infrastructure and local politics. We have to refer out many cases. We should be able to apply knowledge.
- There should be separation of clinical and technical work.
- Too much interference of political people in PHC at village level should be checked.
- The security issue, especially after post-mortem of high profile cases, where MO pressurized and threatened to change the report is also an important aspect.

- Some supervision for doctors should be there. Higher authorities supervising should be from technical field only. Administration should be in hand of technical people of same field.
- Bonded candidates should not be given charge of RH/PHC OR administrative charge.
- Bond should be according to specialization.
- It is an absurd idea to serve specialists and super-specialists to rural areas, as people do not require them there. Instead send MBBS doctors to rural areas and give them all benefits of permanent employee of government and provide them with all facilities.
- Specialists should be given more pay if they agree for non-practice.
- Government should stop providing national programs for every disease. It is of no use. Instead the govt should appoint doctor and with required qualifications and administration skills in rural areas and we only can change the face of rural health service in India.
- Improve medico-legal work in every district by a forensic expert.
- Increase the post for Asst. Professor in every medical college with corresponding to medical students.
- Public involvement for improvement and acceptance of services is needed.

V. RESPONSE OF DOCTORS CONTINUING RURAL SERVICE AFTER THE BOND PERIOD:

There were 37 respondents in this category. Respondents reported a monthly salary of about Rs.45,000.

PERCEPTIONS ABOUT THE BOND:

Joining the public service without the bond

There were 12 respondents who were already in public service without the bond and 17 respondents said they would **join the public service** without the bond.

Those who were serving or ready to serve in the public service without the bond cited reasons like: serving at medical college at native place, desire to serve the most needy society, desire to work for the betterment of society, financial reasons, job satisfaction from serving the poor, hope to get admission through in-service quota, opportunity to serve cancer patients in the only government cancer hospital in Maharashtra, facilities like children's education, and the desire to do lecturer-ship.

The reason cited for unwillingness to join public service was better opportunities in private practice.

Joining the rural service without the bond

As observed previously, 12 respondents were already in public service. From the remaining 25 respondents, only 2 said they would **join the rural service** without the bond.

Reasons cited included stability of job.

Reasons that were listed for unwillingness to join the rural service without the bond included inability to apply knowledge in the rural set-up, poor rural living conditions, inadequate facilities provided in rural areas, political interference, and poor salary.

Awareness about bond conditions

In this group, a very high number, 34 out of 37 reported being aware of bond conditions, while 3 respondents said they were not aware.

Varied answers were however received regarding details of bonds. Answers may have varied based on the year in which each respondent signed the bond.

Thus, 12 respondents said the bond duration was 1 year and the penalty was Rs 1 lakh. The second largest group comprised of 7 respondents who said that the bond duration was 1 year and the penalty amount was Rs 5 lakh. Five respondents said the bond duration was 2 years and the penalty was Rs 1 lakh. Three respondents said the bond duration was 1 year and the penalty was Rs 15 lakh. Two respondents said the bond duration was 3 years and the penalty was Rs 15 lakh. One respondent said the bond duration was 2 years and the

penalty was Rs 1.5 lakh. Another said bond duration was 3 years and the penalty was Rs 5 lakh.

One respondent cited bond duration and penalty amounts for both the MBBS and post-graduate doctors--1 year and Rs 1 lakh for the former and 1 year and Rs 15 lakh for the latter. One respondent said that the penalty amount was Rs 5 lakh and the bond involved serving for 5 years in India and for 1 year in the government.

Regarding the revision of penalty fees and bond, 22 respondents said they were aware of this. From among these 22, 4 respondents reported the revised penalty fee to be Rs 50 lakh, while 9 respondents reported the revised penalty fee to be Rs 5 lakh. The revised penalty fee was reported to be Rs 10 lakh by 3 respondents, while the rest did not specify revised penalty fee. From among the 22 respondents, revised duration of 1 year was only specified by 4 respondents.

Satisfaction Levels

Positive satisfaction levels were expressed by 21 of the respondents, while the rest were not satisfied.

Reasons listed for positive satisfaction included: getting a job immediately, good learning experience, obtaining practical knowledge, and desire to work in the government services. One respondent who expressed positive satisfaction however complained about not getting the experience letter for his work.

Reasons listed for negative satisfaction levels included: scheme not implemented properly, poor housing and other facilities provided in rural areas, poor transportation, inadequate facilities at the health facility, and long work hours. One general surgeon complained that he had to work in a women's hospital where there was no surgical work.

Issues with adherence to the bond

Of the 37 respondents, 14 said they had no issues with adhering to the bond and 3 respondents did not respond to the question. The remaining 20 respondents said they had issues with adherence to the bond.

Specific issues that arose with respect to adherence to the bond included: poor living facilities/accommodation, no job guarantee after serving bond, 6 months wait before getting posting, delays in payment of salaries, separation from family, do not get to apply clinical knowledge, administrative problems at the health facilities, inappropriate rural postings, poor infrastructure in rural areas, poor salaries, bond interferes with higher education, no specialist posts in rural hospitals hence specialists reluctant to serve in rural areas, political interference, poorly equipped rural health facilities including inadequate supply of medicines,

Socio-cultural factors inhibiting or facilitating serving in rural areas

Asked about socio-cultural factors that affect those serving in rural areas, many respondents spoke about the poor infra-structure in rural areas including poor educational facilities for

children, poor roads and transport, sub-standard living quarters, poor sanitation, and issues related to supply of water and electricity.

Negative socio-cultural issues listed were: political interference by local politicians and ZP officials, lack of awareness and illiteracy, and lack of safety due to alcohol consumption in the village.

One respondent said the facilitating socio-cultural factor was that those doctors who served well got a lot of respect and affection from the village community.

Will they serve in the public sector after post-graduation?

Regarding willingness to serve in the public sector after post-graduation, 11 respondents said they were willing. In addition, there were 7 respondents who were already serving in the public sector.

Reasons for readiness to serve in the public sector included the desire to serve the needy, financial need, job satisfaction through serving low socio-economic group of people, in-service PG quota, and stability of job.

Those unwilling to serve cited reasons such as: government expects more than they can deliver while providing infrastructure that is less than what they would expect, there is no scope for application of knowledge, working hours are not fixed, inadequate facilities in rural areas, and absence of infrastructure for orthopaedic doctors.

AWARENESS ABOUT GOVERNMENT RETENTION SCHEMES

Awareness

From among 37 respondents, only 10 respondents said they were aware regarding schemes to attract skilled health professionals to remote areas. Only a few from among the 10 respondents provided further details of such schemes. The details provided by these were as follows: financial incentives such as increments and higher NPA, compulsory bond, and incentives such as in-service quota for PG.

Current Posting and receipt of such incentives

Only 3 respondents reported that they had a rural posting but only 1 of the 3 said the posting was difficult. He said no special financial incentives were given but additional 10% marks were added for entrance exams.

With respect to being aware about the financial incentives for doctors working in difficult areas, 17 of the respondents said they knew about it. Further details were provided by only 3 from among these 17. Two respondents said they had themselves worked in tribal areas but had not received extra financial incentives. One respondent said he knew people in difficult postings received a monthly salary that was higher by Rs 4000 or Rs 5000.

Only 16 out of 39 respondents provided their views/opinions on the schemes. Views were varied and some said the schemes were good or beneficial, while others said they were not

of much use. Other specific comments on the schemes include: not good enough to attract an MBBS degree holder; salaries and NPA may be high, but it is difficult to work due to constraints like inadequate rural facilities and political pressure; higher salary should be given; overload of work in rural areas; just Rs 4000 extra each month is not a sufficient incentive for working in tribal areas; and if specialists are posted in tribal areas, incentives should be given accordingly.

When asked about benefits of the scheme, 7 respondents said that the stipend/salary was the benefit of the scheme. Three of the respondents said the scheme had no benefits. One respondent said that the government needs to do more to attract specialists to work in rural areas. The rest of the respondents either did not answer the question or said they did not know about the benefits of the scheme.

Only 3 respondents the scheme was positive, while a fourth respondent said that this would be dependent on the socio-economic status of the candidate who served the bond. From among the 3 respondents who rated the scheme as positive, 1 said that it was essential to increase quota for in-service PG and to increase grace marks in entrance exams.

From among 4 respondents who did not view the scheme as positive, 1 respondent said the scheme had not made much of a difference. Another said the scheme was unable to attract doctors as it did not provide sufficient incentives. One respondent said the salary was inadequate. One respondent said the scheme had too many lacunae.

The remaining 29 respondents either did not respond to the question or said they did not know.

SUGGESTIONS AND FEEDBACK

Regulatory Bond:

The following suggestions were made:

Policy:

- Bond should be voluntary.
- Bond is good. It should have 6 months rural and 6 months tribal posting.
- Bond should be compulsory even for those who wish to go outside India for higher studies.
- The policy should be changed, divided duties should be given-gynaecology, paediatrics, obstetrics—two to three doctors in divided duties for 2 days a week each, two or three days government service, and remaining days private practice should be allowed.
- PG admission should not be allowed unless one completes bond.
- It is good that posting is given in RH after PG.
- There should be preference for PG seat if one has completed bond.Immediate jobs should be provided to bonded doctors and immediately relieve bond if there is no job available.

There are delays in the process. The period varies from weeks to months. There is no fixed guideline about this.

- Need more posts in the govt setting for specialists to be absorbed following completion of PG courses, so they can serve the bond as specialists.
- Bond should be compulsory for private and government college students both.
- Bond must be of 1 year for MBBS and MD combined.
- Tenure should be 1 year max.
- There should be a 1-year bond for both UG and PG students and residential facilities should be provided with provision of mess, particular specialty should be given his own specialty work.
- The post PG bond tenure must be reduced.
- Bond completion should be compulsory for private medical college students.
- Bond should be compulsory to all medicos without any penalty fees.
- Only one bond after UG should be there. Time limit should be only 1 year.
- Primary training for working in rural area should be given.

Posting:

- Posting should be given near native place or as preferred by candidate.
- Posting should be given according to choice of place.

Penalty Fees:

- Current penalty fee of Rs 10 lakh bond is sufficient for retaining doctors for 2 years.
- Penalty fee should not be more than Rs 1 lakh.
- Penalty should not be so high--if one does not want to continue the person can pay the penalty.
- Affordable penalty fees should be there.
- Penalty fees should be decreased.

Other:

- There should be political support.
- Respect should be given to candidates.

Financial Incentives

The following suggestions were made about salary/payments:

- Payment should be double.
- Give same salary as that paid to the permanent MO.
- Salary should be Rs 1lakh per month.

- Pay salary along with 50% of basic NPA.
- More appealing salary structure and additional leaves are needed.
- Financial incentives must be increased.
- Payment should be as per IT industry
- Pay scale should be increased
- Incentives should be increased
- Salaries should be doubled.
- Payments should be increased as they are lower as compared to other states
- Incentives and payment should be increased.
- Payments should be increased.
- Salaries should be paid on time.

Non-financial incentives

Working Hours:

- Fixed working hours are needed.
- It should be an 8-hour work schedule.
- Duty hours should be such that doctors get to enjoy personal life also.

Accommodation and other facilities:

- Accommodation facility should be given.
- Standard living quarters, water and electricity should be provided.
- Other facilities and transportation should be made available.
- Good infrastructure, vehicles, and transport facility.
- Vehicles should be provided for tribal areas.
- Security should be provided.
- Accommodation for family should be provided.

Infrastructure of rural health facilities:

- Additional manpower like 3 MOs per PHC and 4 staff nurses per PHC are needed.
- Make working conditions at the RH better, provide all required medicines and needed infrastructure.

Other incentives:

- Make bonded doctors permanent in health sector
- Government should make strong and friendly policies regarding in-service PG degree-diploma seats rather than neglecting in-service people.

Additional Suggestions:

Once again, suggestions received in the above three categories were echoed as general comments. In addition to the above feedback, a few additional suggestions/remarks were made. These include:

- “As per my experience, government is forcing the doctors to serve in a rural area and on the other hand not increasing vacancies in PHC, RH or SDH. The government wants to improve the health services in rural area and on the other hand it is torturing the doctors by not providing adequate security there.”
- Government should give 5 years to complete the bond because of study for PG. So, period relaxation is needed. Salary should be increased as the workload is high.

- “Political interference should be decreased, it is the reason why MOs do not continues, CMEs should be organised for junior people.”
- School facilities should be provided for doctor's children.
- Bond should be voluntary or stopped. Instead create more employment options in public service and rural service.
- Postings should be according to specialization.
- Those who are willing should be allowed to continue bond
- Bonded candidates should get facilities that employees get.
- “Doctors should be allowed to complete the bond after result of PG entrance and PG admission. There is problem between private and government students. Govt students lag behind by 1 year due to bond. There should be equal rules for everyone. If you are sending a cardio-surgeon in rural area, then develop that much infrastructure. Posting and exposure to rural area is must but provide infrastructure. Also make posts available according to specialization. There is no lab facility available for para-clinical doctors in rural area, hence it is of no use for doctors like us.”
- “Doctors should work in rural/remote places to gain that experience also ONLY if all facilities are provided. Specialists are not needed at rural places as all infrastructure is not available e.g. cath-lab for a cardiologist cannot be made available at RH. Hence, only interns and PGs should have experience of work in rural India for limited period i.e. 3/6 months.”
- Give posting nearest place of home to be continued even after bond completion.
- “Before joining the public service there should be orientation programme in which there should be serial lectures and demonstration for the newbies about their duties and responsibilities, how to tackle the administrative and medico-legal roles and what are the optimal standard required in case of diversion and knowledge to work at that level.”
- “When I decided to join rural service, I had to wait for 2 months to get an order in DD office Aurangabad. I just want the answer why is it so? I just had to wait 6 hrs sitting on waiting chair to get response from DD. Respect the doctors, they are sacrificing their whole life for the people only. Coming to bond compulsion- this bond service is for government college students, why not to private college students? Make it compulsory for all. For medical officer, appoint BAMS / BHMS doctors in rural area as assistant. that would become easier and effective way to serve in a rural/urban area.

VI. RESPONSE TO THE BOND BY DEFAULTERS WHO PAID THE REQUISITE PENALTY:

There were 19 respondents in this category.

ISSUES RELATED TO BOND AND NON-COMPLIANCE:

Awareness about bond conditions

From among the 19 respondents, 18 said they were aware of the bond conditions and only 1 said they were not aware.

Based on when the bond had been signed, the bond duration varied between 1 and 2 years and the penalty amount varied between Rs 1 lakh and Rs 5 lakh.

Regarding revision of penalty fees, 8 of the respondents said they were not aware of the revision. After revision, the duration had been revised to 2 years for many of the respondents and the penalty fee had been revised to Rs 10 lakh for many.

When did they decide to default and details about penalty paid

A majority of the respondents (15 out of 19) said they decided to default while studying for MBBS/PG. Three respondents said they decided to default while waiting for placement, while just 1 respondent said he decided to default while waiting for the bond to happen. Three respondents did not answer the question.

The reason for default as “due to PG admission” was reported by 6 of the respondents, while preparation for PG/PG entrance was cited as a reason by many other respondents. One respondent did not get the PG admission in her area of choice and decided to serve the bond in the year she had to wait for PG admission.

A couple of respondents said that they resigned as they did not get postings of their choice. Two respondents said their posting was temporary and hence the bond was broken. Of these, 1 said that his service was not continued after 23 months. The other said that he paid default fees due to compulsion of the DMER despite the fact that a permanent MO was brought in to replace him, which resulted in the bond being broken.

There is no specific mention in policy in this regard; however the recruitment is done through the state appointment board

All respondents in this category paid the penalty and the amounts varied depending of their specific bond terms and conditions varying between Rs 1 lakh and amounts higher than Rs 7 lakh owing to interest being added to the penalty amount.

Satisfaction Levels

While 9 respondents said they had negative satisfaction levels from the bond, only 2 respondents had positive comments on the bond. The rest of the respondents did not answer the question.

Reasons cited for negative satisfaction levels included: poor infrastructure at the rural health facility with shortage of medicines (according to 1 respondent, only medication available was pain killers) and bond period is too long and interferes with studies.

With respect to positive satisfaction levels, the comment was that the bond should be made compulsory for all batches and students should be informed at the start of the course itself.

Issues with adherence to the bond

As expected from this group, 15 out of 19 respondents said they had issues with adherence to the bond. Only 3 respondents said they had no issues with adherence to the bond, while the rest of the respondents did not answer the question.

Issues cited were: despite willingness, did not get appointment/appointment was terminated and had to pay penalty (cited by 6 respondents); poor living facilities provided including poor housing, security, sanitation, and insufficient water supply; corruption; too much of administrative work; no time for PG studies; unsuitable place of posting especially for females; bond duration too long; temporary job; and low salary.

Socio-cultural factors inhibiting or facilitating serving in rural areas

When asked about socio-cultural factors that affect those serving in the rural areas, factors mentioned were insufficient time to study, inability to adjust to rural life, inadequate living facilities including lack of transport and poor communication facilities, political interference, delayed salary payment, and poorly equipped rural health facilities with shortage of medicines.

Hardly any actual socio-cultural issues were cited.

AWARENESS ABOUT GOVERNMENT RETENTION SCHEMES

Awareness

Asked about awareness of schemes to attract skilled health professionals, 17 out of 19 respondents said they were not aware or did not respond to the question. Only 2 respondents said they were aware. When asked to provide details, one of these 2 respondents said schemes involved financial incentives. The second said schemes included a 15% to 20% reservation for PG admission.

Past Posting and receipt of such incentives

When asked about specifications of posting (rural/urban), 6 respondents said their posting had been rural, 2 respondents reported urban posting, while the rest did not reply or had not served at any posting at all. Of the 6 reporting a rural posting, only 1 respondent said it had been a difficult posting.

None of the respondents replied to the question on awareness about financial incentives for difficult areas or provided any details of the same. Additionally, only 1 respondent had a

comment when asked about views/perceptions on the scheme. His response was that such schemes are good only for permanent MOs.

When asked about the benefits of the scheme 17 respondents did no answer the question or said they did not know, while 4 respondents said the scheme had no benefits. One respondent said the monthly stipend was the benefit received from the scheme.

While 17 respondents did not provide comments of whether the scheme is positive or not, 2 respondents said the scheme had positive outcomes, and 1 respondent said the scheme had no positive outcome. One of the respondents who said the scheme was positive said that doctors do not get permanent appointments and therefore get frustrated. The second respondent who found the scheme positive said the high salary was a good aspect of the scheme. The one who said that scheme had no positive outcome said the government needed to improve infrastructure in rural areas.

SUGGESTIONS AND FEEDBACK

To Increase Scope:

The following suggestions were received:

Policy Related:

- Make MO posts permanent first.
- Allot number of vacancies by merit. Bond should be dissolved for those who cannot get MO-ship for more than 2 years by issuing certificates.
- Instead of bonds make the service compulsory for all.
- There should be a uniform policy and bonds should be served not just to those from government colleges, but also those from private colleges.
- Bond should be served after completion of PG. If served after UG, studying becomes difficult after a break.
- There should be no bond after MBBS or there should be option that it can be completed after PG
- Those willing to work in difficult areas and wishing to work there lifelong should be encouraged and given permanent jobs, so they will work for better health service.

Work Hours:

- Stipulated work hours are needed. There should be an 8-hour work limit.
- If there are 2 or 3 MOs posted at each place, work hours can get regulated.

Infrastructure and facilities:

- Rural area infrastructure should be improved. This includes water and sanitation, schools, roads, etc.
- Rural areas have poor housing, safety, no mobile range, etc. This should change.

- Condition of PHCs and other rural facilities is bad due to inadequate equipment, supply of medicines, and other factors like interruption in electricity supply and water supply. There are no ambulances in PHCs. This should be improved.

Incentives:

- Salaries must be increased.
- Higher salaries must be paid for rural postings.
- There should be extra marks or reservation for bond completing candidates in PG exam.
- Give preference in PG entrance exam for doctors working in rural areas.
- Travel allowance should be given.

Posting:

- Posting should be given on preference.
- Posting should be given close to residence of doctors.

Information:

- Information about bond is not given clearly before admission to MBBS.
- Doctors should be informed that the rural posting has been made compulsory. Provide information that the interest on bond starts from the commencement of bond itself.
- Any type of information should be sent via email. Doctors would like to serve, but it is not possible for everyone to check DMER website every time. Instead, they should send info about schemes, rules/regulations etc by email.

Penalty Fees:

- Paying penalty is difficult for middle class and low middle class, higher class will always do this.
- Penalty fees are huge and should be made more reasonable so that middle class people can afford them.

General:

Many general suggestions overlapped with what was suggested above. A few additional remarks made include:

- Arrange administrative training for the new MO.
- MO is a doctor, so let him do clinical job only. Avoid giving administrative work to the MO; Increase payment and give permission for private practice

- Specialists should be given more pay if they agree for non-practice.
- There is too much interference in PHC of political people, including goons and from village panchayat. This should be checked.
- Permanent posting must be given after bond.
- Provide all the facilities in PHC area, e.g insurance, accommodation, vehicle etc.

VII. RESPONSE TO THE BOND BY DEFAULTERS WHO DID NOT PAY PENALTY:

There were 10 respondents in this category.

ISSUES RELATED TO BOND AND NON-COMPLIANCE:

Awareness about bond conditions

Out of 10 respondents, 9 said they were aware of the bond conditions.

Depending on when the bond agreement had been signed, the bond duration varied between 1 and 2 years and the bond penalty varied between Rs 1 lakh and Rs 10 lakh. Penalty amounts reported were Rs 1 lakh, Rs 5 lakh, and Rs 10 lakh. One respondent reported that the bond condition in addition to the 1 year service was not being allowed to go abroad for 5 years.

With respect to the revision of penalty fees, 6 of the respondents said they were aware of the revision. Many respondents reported that after revision, the penalty fee had been hiked to Rs 10 lakh. One respondent said the penalty fee had been increased to Rs 20 lakh.

When did they decide to default and details about penalty payment

As many as 9 out of 10 respondents said they decided to default while studying for MBBS/PG. One respondent said he decided to default while waiting for the bond to happen.

The reason for default was in order to study/prepare for PG was reported by 7 of the respondents. Of these, 2 respondents also said they would like to serve in rural areas, but after completion of PG.

From the remaining 3 respondents, 2 cited inadequate rural facilities overall and at the health centres as the reason for default. One respondent said there were no vacancies at the time as the reason for default.

None of the respondents in this category had paid the penalty for default. Reasons for not paying the penalty included: will serve the bond after PG, wanted to serve but conditions at the PHC made it impossible, the amount is too high and not affordable, and will submit/have submitted affidavit about serving after PG.

Satisfaction Levels

While 4 respondents did not answer the question or said they did not know, 5 respondents expressed negative satisfaction levels and 1 respondent said he had both negative and positive experience from the bond.

Reasons cited for negative satisfaction levels poorly equipped rural health facilities, poor accessibility in rural areas, why must only medical doctors serve the bond, and lack of vacancies to serve the bond.

The respondent who had both negative and positive experience said the positive aspect was that he could serve the rural community but the negative aspect was the compulsion element.

Issues with adherence to the bond

Similarly, as expected from a group of defaulters, 8 out of 10 respondents said they had issues with adhering to the bond.

Issues cited were: no time to study or pursue higher education; poor facilities at the rural health centres including inadequate medicine supply and no equipment; no training given before joining; political interference; and poor infrastructure in rural areas including poor housing, sanitation, transport, communication.

Socio-cultural factors inhibiting or facilitating serving in rural areas

Socio-cultural factors affecting rural service that respondents mentioned included political interference, lack of co-operation from the community, public awareness issues, lack of co-operation from non-medical staff at the facilities,

Other factors cited were inadequately equipped health centres in rural areas, lack of facilities at health centres leading to frequent referrals even for X-rays, no freedom for MO to take decisions.

AWARENESS ABOUT GOVERNMENT RETENTION SCHEMES

Awareness

When asked whether they were aware of schemes to attract skilled health professionals, 8 out of 10 respondents replied in the negative.

Of the 2 respondents who said they were aware of the schemes mentioned financial incentives. The second gave more details and mentioned HRA and DA as financial incentive and the in-service PG quota as the non-financial incentive.

Past Posting and receipt of such incentives

With respect to specifications or type of posting (rural/urban), only 1 out of 10 respondents said his posting had been rural, while 1 respondent had been given a rural posting but had not joined it.

None of the respondents had had a difficult posting.

None of the respondents answered the question about awareness of financial incentives for difficult areas nor did they provide any details about financial incentives.

Similarly, only 2 respondents provided any comment on their views/perceptions about the scheme. One said the scheme was good but benefits given were not adequate, while the other said the scheme was good but there should be a sufficient number of vacancies and a suitable posting should be given.

Asked about benefits of the scheme, 9 of respondents did not reply, but 1 respondent said the stipend and hostel facilities were the benefit of the scheme.

On whether the scheme was positive or not only 2 respondents replied to the question. Of the 2 who replied, 1 said the scheme had positive outcome but vacancies should be available on time and 1 said the scheme was not useful due to factors like long working hours, delayed salaries, and no DA being paid.

SUGGESTIONS AND FEEDBACK

To Increase Scope:

The following suggestions were received:

- The bond should be served after completion of PG education so that doctors can complete their education and serve the rural community more effectively.
- Government is unable to have enough of vacancies for all MBBS and PGs and till this is achieved, penalty fees cannot be charged.
- No uniformity in policy as bond is served only to medicos.
- Bond should be served to medicos from private colleges as well.
- Bond period should be 6 months.
- Monthly stipend should be increased.
- There should be flexibility in the way in which bond period is completed.
- Penalty fees should not be hiked by Rs 5 lakh as middle class people cannot afford to pay.

General:

Many general suggestions overlapped with what was suggested above. A few additional remarks made include:

- Medical students are allowed 2 attempts to get admission for PG and bond is served after that. This is appropriate.

- Bond served before PG comes in the way of education.
- There is not much learning from serving in rural centres.
- Salary should be at least Rs 80,000 per month.
- The real problem is vacancies. The government does not have that many vacancies.
- Bond service or penalty fee should not be made compulsory in PG admission.
- MOs should be allowed to do only clinical work and have fixed working hours.

SECTION V

5.1 Qualitative Interviews

5.2 Recommendations

5.1 Qualitative Interviews with Officials

After interviewing through Medical Officer, District level, Regional level and state officials following issues emerged in nut shell. This is divided in two parts.

First the Bond Process is discussed:

From a student government gets bond filled

A. At the time of admission of MBBS. All original documents required for admission, are retained by college (Dean of respective college);which are handed over to student at the time of completion of bond that is along with Bond discharge certificate. In case student does not complete the bond which is of one year, then there is fine of Rs. 10 lakh which is in effect from 2008.
B. While applying for post-graduation again student has to sign bond which is of one year and for breach of bond student has to pay Rs. 50 lakh
C. Student has to agree for bond of one year once again if student seeks admission in Government College for super specialty or in case student fails to serve for one year then student has to pay to Govt Rs. 2 Cr.

It means student has to serve for 3 years in total as in Govt orders it is not clear of total bond period. So each bond is presumed as separate.

Service for bond period is counted:

1. If student works in Public Health Department - posting anywhere, where the post of Medical officer is there. It may be regular or contractual as under NRHM
2. If student accepts the post of faculty in Medical College.
3. Previously Senior Resident posts were considered for bond completion in any medical college Hospital. However now only on merit basis at 4 places only in state are considered.

Now in system one has to consider before posting for bond completion certain other things like

- ✓ Qualification: e.g. post-graduate doctor – one cannot post at PHC – It started strictly after 2010
- ✓ Handicap
- ✓ If lady doctor and she is married
- ✓ If lady doctor and she is pregnant

History of Bond implementation is also very interesting. It is not once and final. year of bond, penalty went on changing. As for example in 2003-04 when acute shortage of MO started , then Bond process before PG started strictly which resulted against advertisement of 900 doctors, Government received applications about 4000 which resulted in withdrawal of Bond in 2006.

Similar instance occurred in 2009 where again because of shortage of MO again bond process started strictly which resulted of same history as of 2004-05.

There are25 private medical colleges. Government is not keen to make bond compulsion for the students of private colleges and even students of same colleges of whose fees is borne or exempted or supported by government. In case government takes decision to implement bond for these students one can get about 1600 students from Govt colleges and about 1700 students from Private.

For Bond recovery,Dean of Medical college from which student had passed has to initiate action. Dean has to communicate to District Collector for Bond recovery. It is the only action. Results are 0% for mostly for bond recovery. Generally students who are going abroad or some students of their own pay the bond amount

There is another view to see entire from the point of view of process point of implementation.

There are two types of bonds.

1. It is for local state of Maharashtra- To serve state govt. It is now of Rs 10 Lakh
   This bond has to be signed by student while taking admission form. All the original documents while seeking admission are retained by college.
2. For Abroad-Two criteria are there. First student has to submit bond release certificate and secondly he/she has to pay penalty. Penalty till last year was Rs 1 lakh and now it is Rs 10 lakh. In case student does not submit bond release certificate, then he/she hast pay bond amount now of Rs 10 lakh additionally. Bond release certificate – student has to apply to DMER and then DMER asks Dean to issue

After student pass 3rd MBBS he/she has following options available:

- Either to serve state which can be done either joining as faculty in medical college or joining as senior resident or join in PHD as Medical officer. However Dean's office is not aware of the fact that who has got job? Where? For How much period? Hence not possible for deans office to initiate action unless there is communication to them. Moreover Dean's office is not aware of the process of bond recovery as it expected to be done by Revenue Department. Amount recovered up till now is the

amount student has deposited on their own when student came down for obtaining NOC for going abroad or for some PG

- To go for post-graduation-Here student has now to request for extension of bond serving period because of PG selection. Student has to submit now one more bond for it. In case student is going in other university/state/abroad, then student has to submit additional documents NOC, Migration and Transfer certificate. Sometimes student at this juncture request for original certificates; e.g. For DNB courses then original are given to student with permission from DMER with a condition to return those after 12 days. However it is not monitored further. Interestingly DMER also has no power to take action in case if somebody does not return original documents

This is as far as Bond process.

Now in short measures and views on those:

A) Financial Measures: Various Measures state initiated especially for Naxalite Area , Tribal and difficult area mostly from Tribal and Hilly under various heads like
   a) Naxalite allowance
   b) One step above- Additional increment if joined in the specified area
   c) Under NRHM- additional incentive ranging from 18000 to 24000 depending on qualification

   In short in some pockets MO are likely to get all 3 types quoted above and one can get more than 1 lakh also.

   However experience tells that those are not lucrative for doctors to join and work. Hardly 5% doctors retain in spite of these financial measures

B) Non-financial Measures: Government introduced this from career development point of view in which M.O gets weightage of 3 marks each year which are added in weightage of CET for post-graduation if he/she works in notified PHC. PHC are notified by Government. There is good response for this scheme and doctors retain to work here. PHC are notified by government. All are not that difficult. Here needs justified criteria's and really difficult PHCs

Comments on existing Regulatory measures-

Here doctors are called by DMER and they are supposed to join any Govt identified jobs for bond completion. It is not necessarily only Public Health Department (PHD) rural area. It may be Medical College or Army or corporation some hospitals. Those who come for PHD, doctors are asked to give choice of circle (District where the vacancy is there). Then doctors are allotted to circle Dy. DHS and one he/she reaches there, then gets further exact posting order. As per recent High Court Directives, post graduate. Doctors are only to be posted at

RH- if Diploma Holders while Degree holders are at District Hospital. One they are posted, they are not supposed to transfer for period of one year that is bond completion.

Experience tells us

1. There are about 10 % doctors who are sincere. They do well and we get good service to community
2. While about 20 % just try to complete the bond period. We can say just try to complete period. So lack of quality service delivery
3. Remaining majority try to remain either absent or bring various type of pressures on controlling officer or corrupt practices start which is difficult to prove – however ultimately resulting in community does not get desired services at all
4. If doctors serving the bond leave before completion of bond for pursuing the post-graduation, then it becomes difficult to keep track and recovering the penalty amount from them. Neither medical college, nor the Public Health Department is able to take any action against them. Currently revenue department tries to recover the amount.
   For Bond recovery, Dean of Medical College from where student had passed has to initiate action. Dean has to communicate to District Collector for Bond recovery. Recovery is almost 0%. Generally students who are going abroad or some students pay the bond amount on their own.
   This should be redesigned and implementation should be made smoother.

On one side this is the problem. On other side:

Doctors about 10 to 20 %; who are sincere and after completion of bond and those who wish to continue for them also not easy. Because after completion of bond, they are continued as temporary and on regular basis because of service matter problem starts like continuity, seniority etc. All ultimately are resulting in failure on part of government; to get them involved in good spirit when vacancies are there in spite of doctors willing to work because of bureaucratic process. Selection process through MPSC which was occurring previously, and reason as it was not occurring regularly; Government took initiative to recruit MO through a different board and tried to keep out of purview. Government is trying to simplify the process of recruitment.

5.2 RECOMMENDATIONS

Are given in form of questions to think at policy level

- It is not necessary to have medical officers with MBBS qualifications. There is evidence that doctors with BAMS qualifications are easily available, and they do stay in the service. The PHCs function smoothly with these doctors as well.
  It can be decided to have two doctors at PHC; one with MBBS qualifications and one with BAMS qualifications. This will also be in line with the GOI policy to promote AYUSH.
- However in case we wish to go only for MBBS doctors only , then following recommendations are submitted
  - Bond process should be started at private medical colleges as well; as some percentage of seats' fees is borne by government.
  - It was seen recently that, large number of doctors were available through open advertisement; there is need to think over the decision of appointing through bonded candidates.
  - Non-finance measures like selection for PG, career development; are equally important and attractive toward retaining them along with finance measures. Other incentives like well-furnished accommodation should be provided to these doctors.
  - Basic criteria for recruitment of MOs; is MBBS qualifications. So, there is no need to have other systems like MPSC to qualify for the recruitment. The doctors could be ranked on the basis of their MBBS scores and posting could be as per the vacancies available.
  - The process of recruiting doctors could be decentralized and district could be given authority to recruit doctors as MO. Willingness to work could be considered
  - Doctors from other states, with similar qualifications, also should be encouraged to apply and to be made eligible
  - The entire bond process implementation should be at DMER level.
  - Transfer policy to be based on seniority and for seniors the accessible facilities should be offered, as with seniority family liability is also more and need to be looked with humane approach.
  - Seniority should be counted from the day of joining for completion of bond.
  - The bond system could be introduced by GOI in the form of an act at central level; which could be adhered to across the country.