PMR In India: SWOT Analysis and Way Forward

"PMR has great flexibility..it will bent rather than break"

Randall L Braddom

Historical Perspective:

Globally PMR began in the fourth decade of the last century in the USA mainly on World War 2 veterans, primarily by Dr. Frank Krusen. In India, the movement started in 1960's after the China war for the war disabled by Prof. Sant, AIPMR, Mumbai

Important Milestones For PMR Education

MCI recognised PMR as optional subject for undergraduate course in medical colleges in 90s followed by including it as optional for internship. MCI recognised MD PMR in 1979 at IPGMER as pioneer institute in India with annual intake of 2

NBE recognised PMR for PG education in 80s and in 2014 prepared a competency based syllabus and is currently developing a syllabus for subspecialty fellowships.

Current Scenario In PMR Education

Out of total 412 medical colleges in India PMR department is present in 27 medical colleges in 23 states and Union Territory. MCI registered faculty is 116 till 2016. Total PG admission capacity is 66: diploma-10, degree-50 and DNB-6

PG as present preference-- Aspirant preference defines professional values (linked to PG training) which in turn are proportional to rank opting for PMR during PG counselling. It has been seen that PMR seats are generally filled after other clinical specialities have been taken up and just before or along with other pre & para clinical seats.

Quality Assurance of PMR education:- Regulatory bodies like MCI/NBE for prescribing standards, universities for maintaining or adoption of these standards, medical colleges for practicing the standards and professional bodies like IAPMR as activist, influences and watch groups. Quality depends on syllabus, teaching technology, faculty development programme, assessment tools/method and UG/PG appraisal.

Strengths, Opportunities and Positive Trends As In 2016

1. Physiatrists are increasing in number and quality with growth of the speciality
2. Public or professional recognition is improving leading to better income and more job opportunities in all sectors.
3. Reimbursement schemes/ health insurance schemes are becoming more PMR intervention inclusive.
4. National/Global policy document mentions Rehab core:- global disability action plan (GDAP 2019-2022),APL (2016), Global alliance for technology assistance GATE(2016) , SDG(2015-2030),MCI action/proposal of NMC,opening of new AIIMS provides enabling environment for growth of PMR.

5 Physiatrists are being promoted to senior positions in health services which would help the future of the subject-there is one PMR special DG who is due for DGHS, there are 2 PMR experts retired from senior positions of Government of India, there are 12 PMR experts retired from senior positions of state government.

6. New income in enhancing areas are opening up like facility owner,manager,group practice,insurance consultancy, universal health coverage packages for PIVD,medico legal services,International health and public health physiatry.

7. Concrete action is going on to ensure that PMR is listed as essential speciality for PG education by MCI at the earliest and at the same time partnership of professional bodies with Ministry of Health and Family Welfare / State Health Department is being thought of for faculty production for 412 medical colleges

Weakness and Threats As In 2016:

1. Legislation- the shift of disease burden from communicable to non communicable disease in India, is increasing the disability burden which requires PMR care, but the government is not prepared till date in spite of national health policy draft 2015& 13 th FYP having decided to allocate funds(3%plan funds) to that effect.
2. PMR education- few medical colleges having PG facility, research facility, lack of assertion by PMR specialist to show cause the value addition of the subject,sole approach by the Physiatrists with lack of partnerships which other specialist and poor publication record and very poor import factor.
3. PMR JOB- resistance to interstate moment for job, where to enter private sector, not much of rehabilitation opportunities outside government sector, interventions mostly not covered by Health Insurance etc.
4. Patient- lack of in-depth knowledge of payment service among individuals, intervention team and unrealistic expectation of patients and unclear understanding of disability and its levels with PMR.

Conclusion:

future belongs not to those who predict it but to those who make it. So ask what future you want for yourself, your family and your speciality and how do you want to achieve it.

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