

# Need for Proactive Role of IAPSM and other Public Health Professional Bodies in Roll out of Public Health Management Cadre in India

## INTRODUCTION

India has made substantial progress in health since independence. The life expectancy has increased to 70 years, which is more than double of what it was at the time of independence. The progress has recently accelerated with the maternal mortality ratio coming down from 540 in 1990 to 103 in 2017–19 and child mortality from 126 in 1990 to 34 in 2021.<sup>[1]</sup> However, this is not commensurate with India's globally recognized excellence in economics, technology, medical, and space technology fields. An important feature of countries with good health indicators, both developed and developing, across the world and some Indian states is the presence of an adequately resourced public health cadre, with trained public health functionaries, often supported by ring-fenced health budgets.<sup>[2]</sup> The well-trained public health professionals with authority and resources can address health in a comprehensive manner. The health needs of the whole population are met with such professionals. These functionaries protect the healthy community from disease exposure, risk factors, environmental threats, and provide clinical care and rehabilitation to sick individuals.<sup>[3]</sup>

In India, public health interventions are delivered by health functionaries from grass root level up to specialists in tertiary level hospitals. Health, being a state subject, public health professionals, including community medicine specialists, are not placed in public health positions in most states except a few, such as Tamil Nadu and Maharashtra.<sup>[2]</sup> This compromises the effectiveness and efficacy of public health programs, resulting in poor health outcomes.<sup>[2]</sup> The recent COVID-19 pandemic has underlined the urgent need of public health professionals in a dedicated public health cadre to effectively plan, manage, and implement health interventions from the community up to hospitals and coordinate with all related sectors, stakeholders, and ministries.

## PROGRESS ON PUBLIC HEALTH CADRE IN INDIA SO FAR

Many committees since 1946 have recommended the establishment of a public health cadre across states: The Bhole Committee, 1946 made recommendations for the training of the public health workforce.<sup>[4]</sup> The High-Level Expert Group on Universal Health Coverage (2012) recommended the establishment of an All-India Public Health Cadre.<sup>[5]</sup>

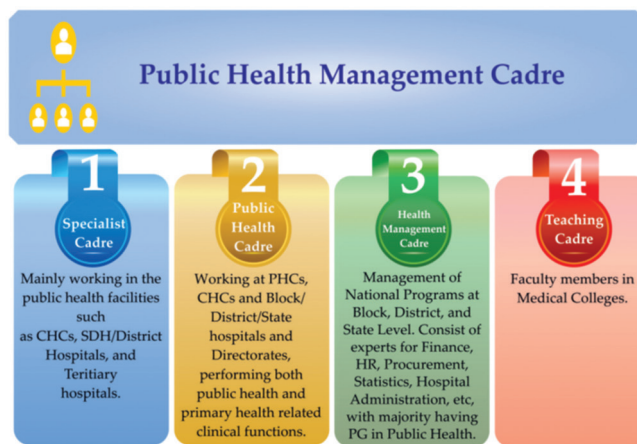
The Steering Committee on the 12<sup>th</sup> 5-year plan (2012) called for the establishment of public health cadres and the

Public Health Act.<sup>[6]</sup> On 9 October 2014, a meeting of health secretaries approved to strengthen public health cadres in states. The National Health Policy (NHP) (2017) envisages creating a multidisciplinary public health management cadre (PHMC). At a workshop held in Gujarat in 2019 to seek states' views, most of the states responded positively to implement the concept. The 13<sup>th</sup> Conference of the Central Council of Health and Family Welfare on 10–11 October 2019 resolved to create the PHMC in their states and union territories by 2022. A review of PHMC across states showed that the states are at different stages of implementation and can be broadly divided into four groups: (1) a well-established cadre, e.g., Tamil Nadu and Maharashtra; (2) some select components of the cadre in place, e.g. West Bengal, Rajasthan, and Kerala; (3) those actively pursuing cadre formation, e.g. Odisha, Madhya Pradesh, and Chhattisgarh; and (4) states still planning to set up public health cadre; e.g. Karnataka, Haryana, and some north east states.<sup>[2]</sup>

## CENTRAL GUIDANCE FOR IMPLEMENTATION OF PHMC

The guidance for implementation issued from Ministry of Health and Family Welfare (MoHFW) proposes to reorganize state health manpower into four cadres under the structural framework of PHMC [Figure 1]:

1. Specialist cadre: This cadre will comprise various specialists with postgraduate degrees in different categories of clinical specialists.
2. Public health cadre: This cadre will comprise medical doctors with public health qualification, such as MD



**Figure 1:** Proposed structural framework of public health management cadre (source 4)

in Preventive and Social Medicine (PSM) or other postgraduate public health degrees.

3. Health management cadre: This cadre will include health and other professionals for running the national programmes and public health functions from block level upwards. They will have two streams: a) graduates with postgraduate qualification in Public Health (approximately, 70% of the cadre) and b) MBAs in Human Resources, procurement/Supply Chain, Finance, Operations, Hospital, Health Management, or other relevant qualification (approximately, 30% of the cadres). The states have the flexibility to adapt it as per local context and requirements.
4. Teaching cadre: This cadre is for medical colleges and will be organized and reorganized based on National Medical Commission guidelines revised from time to time.

The implementation guidance booklet includes the following core principles:

1. Each of the four cadres will be distinctive with flexibility for inter-cadre deputation wherever necessary and criteria for qualification are met.
2. Existing general duty medical officers in public health cadre with specified years (3–5 years) of service will be required to do a master's course (1/2/3-year) in public health for promotion in the cadre. For new recruitment to public health cadre, MBBS doctors with MD PSM/Community Medicine or diploma in Public Health can be given preference.
3. Increments/special pay to acquire qualifications should be encouraged for in-service doctors.
4. The chief and block medical officer shall be from a public health cadre; The states may consider those from specialist cadre for these positions, and the ratio may be decided by the state.
5. Specialists will join at a higher scale in specialist cadre to attract them to government sectors.

The guidance for implementation includes the following for career progression in NHMC:

1. Incentives may be given to motivate the workforce to take up public health courses.
2. The mechanism of convergence of functions of the public health cadre and specialist cadre needs to be established at various levels in the state.
3. The existing district health society may serve as a platform for convergence between public health and clinical functions.
4. For all four cadres, the process of recruitment, number of posts at various health locations, and career progression need to be clearly defined.
5. States will take initiatives to scale up and expand public health courses and identify relevant institutions to support the states. Various types of professionals who may support public health functions are also broadly defined in National Health Policy (NHP) 2017.

6. Initiate urgent and time-bound actions for the creation of public health, health management, and specialist cadres.<sup>[4]</sup>

## ROLE OF INDIAN ASSOCIATION OF PREVENTIVE AND SOCIAL MEDICINE (IAPSM) AND OTHER PUBLIC HEALTH PROFESSIONAL BODIES

The IAPSM founded in 1974 is a “not for profit” professional organization of specialists in epidemiology, health management, health promotion, and family medicine dedicated to the promotion of public health through expertise of its members to the development of public health policies, and advocate for education, research, and programs of community medicine and providing a forum for the regular exchange of views and information.

IAPSM has played a pivotal role in its advocacy efforts for establishment of public health cadre through a) scientific publications in its peer-reviewed journal *Indian Journal of Community Medicine*<sup>[2]</sup>, b) dissemination of findings of research and advocacy work done by members in presentations to various policy makers and bureaucrats who join as dignitaries in its annual national and state conferences, and c) participation in various committees and experts' groups at National Institution for Transforming India (NITI) Aayog and MoHFW and at the state level.

With successful advocacy efforts and contribution of the public health professional bodies, the Guidance for Implementation, Public Health Management Cadre, 2022 has been released on 16 April 2022 and states have been asked to implement the PHMC, it is important that the PSM and public health experts at the national and state actively engage in shaping the structure and functions of public health management cadre from grass root level to the directorate in the states. States have committed to establish public health cadres and have initiated concerted efforts in this direction. This is a window of opportunity for IAPSM experts to guide the states to maximize the role of public health professionals in the health system at the state level. Once it is formalized, changing it will be difficult.

The states need support of experts in getting clarity on the institutional framework, effectiveness, utility, and governance arrangements for setting up PHMC. Here, the role of effective advocacy through professional bodies, such as IAPSM, other professional bodies, and academic institutions is critical.

The guidance document<sup>[4]</sup> gives directions to the states, and its interpretation for implementation at the state level may vary. The following areas need special attention while supporting the states:

1. Health care is a team effort: The document focuses on the specialists and managers. However, the delivery of health care, including clinical care and management of public health needs a team to deliver. During the roll out,

- the state government need to include and strengthen all functionaries involved in the delivery of public health programs and clinical care. These include nurses, physiotherapists, occupational therapists, pharmacists, lab technicians, auxiliary nurse midwives, male multipurpose workers, attendants, specialists of various aspects of public health, etc., with an effective team approach to deliver services and programmes.
2. Focus on fully functional health care facilities and public health institutions: The states should look at making health facilities fully functional with allocated staff posted and required supplies available. Only then efficient functioning of health facilities will be possible. Looking at each category of functionaries and supplies in a disjointed manner will not be effective. The criteria for fully functional units should be developed for every facility from subcenter up to program management units at the state level. The approach of task shifting should be considered for efficient delivery of health care,
  3. Public health orientation of clinicians for delivery of evidence-based quality clinical services: In addition to strengthening public health and health management cadres, there is also a need to improve the public health orientation of specialists and clinicians in the teaching cadre to improve evidence-based quality of services and research in health care delivery across the country. The inclusion of public health subjects in their clinical training should be considered,
  4. Full-time public health personnel: The guidance note includes. "...flexibility for inter-cadre deputation wherever necessary, if criteria of qualification are met." It is often seen that clinicians who take up public health management positions continue to do clinical work at the cost of their public health responsibilities. This must stop. A clinician opting for a public health or health management position must give up clinical practice and give an undertaking for full-time public health position opted for and stop all clinical work.
  5. Coordination of the four cadres: It is important that the work of all four cadres is carried out in a coordinated manner for effective delivery of routine service, emergencies such as epidemics and pandemics, and to achieve national health policy goals. A mechanism of coordination should be put in place at the district, regional, and state levels.
  6. Engaging the private sector: The private sector is playing an increasing role in the delivery of health care at all primary, secondary, and tertiary levels. There is a need for states to spell out the mechanism to effectively engage the private sector with these four cadres for achieving health goals.
  7. Avert the possibility of equating medical PSM postgraduates with non-medical public health/management postgraduates, certificate courses, diploma holders, etc. The guidance note gives flexibility to states.
  8. Provide technical support to states in designing the cadres, rules, regulations, recruitment process, and career progression particularly in public health and health management cadre, generally in specialist and teaching cadres.
  9. Many states are establishing committees for rolling out PHMC. It is important the experts from IAPSM and other professional bodies actively engage as members of these committees or support the committees to work out various aspects from the initial stages.
  10. Monitoring progress and preparing and submitting state-specific inputs by state chapters and experts and bringing to the attention of IAPSM national level office bearers to take up issues that need attention at MoHFW and other relevant bodies such as National Health Systems Resource Centre (NHSRC).

## CONCLUSION

IAPSM has played an important role in advocating for the public health cadre. It is heartening to see that the guidance note has been issued by the central government to the states to roll it out. All state health ministers have already agreed to its rollout. Although all four cadres need our attention, we need to focus on shaping the roll-out of the public health and health management cadre, and coordination among the four cadres and with the private sector. We need to ensure that doctors with formal qualifications in preventive and social medicine are put in leadership positions supported by other professionals qualified in public health management and related areas. IAPSM bodies at national and state levels through its members should proactively support the rollout of PHMC as members of the committees set up to roll it out or supporting members of these committees in all states.

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