Professionalizing public health management

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GIVEN the huge disease burden staring at India, an emerging concern is strengthening the public health system that is weakening because of the poor quality of leadership and management at all levels of health governance. In the absence of good leadership the best of policies suffer from poor implementation. General administrators and medical specialists underestimate the complexity of the sector and the sophistication in management skills that is required. They fail to understand that public health is a specialty, distinct from knowledge of medical sciences, and that the expertise in the latter does not imply competence in public health.

While training in public health skills has been emphasized in every major review or expert committee report on the Indian health system, it is only in the last decade that the creation of a public health cadre has gained attention. A public health cadre means a section of the workforce, qualified in public health and whose job description consists of largely organizing public interventions, addressing social and environment determinants of health as well as undertaking managerial roles in the delivery of healthcare services, especially primary healthcare.

This is not a new idea. At least two states, Tamil Nadu and Maharashtra have had such a cadre in place since the 1930s. What is new is that such a cadre is now being perceived as essential for improving the functioning of public health systems across all states. The Ministry of Health and Family Welfare at the Centre and institutions like the Planning Commission earlier and National Institution for Transforming India (NITI Aayog) at present, are actively promoting its adoption across all states.[1]

This paper provides an overview of recent policy documents to discuss the different ways in which the public health cadre has been conceived. It then examines the roles that are required to be performed by this cadre and analyzes the current players. It also examines the adequacy of the ongoing training programmes in relation to the multiple expectations of such a cadre. The paper concludes with a suggested list of principles to guide the way forward.

During the colonial period, efforts for the creation of public health cadres were made, starting with their establishment, in Tamil Nadu and Maharashtra, and followed by the recommendations of the Bhore Committee that called for the training of a public health workforce to provide comprehensive healthcare for India's population.[2] This recommendation found renewed interest in recent times in the 12th Five Year Plan (FYP) that states:

'Insufficient focus on public health is a major weakness of the system and must be urgently corrected. Effective public health management requires a certain degree of expertise. There is an urgent, real need for a dedicated

1. Government of India, Report of the Working Group on Progress and Performance of National Rural Health Mission (NRHM) and Suggestions for the 12th Five Year Plan (2012-2017). The Planning Commission, New Delhi, 2011.

2. Government of India, Report of the Health Survey and Development Committee. GoI, Bombay, 1946.

public health cadre (with support teams comprising of epidemiologists, entomologists, public health nurses, inspectors and male multipurpose workers) backed by appropriate regulation at the state level. At present, only Tamil Nadu has a dedicated public health cadre. In other states, the erstwhile public health cadre has been merged with the regular medical cadre. The choice of having a separate Directorate of Public Health on the lines of Tamil Nadu or incorporating it suitably in the existing set-up will be left to the judgment of states.'[3]

Clearly, the two main concerns for creating a public health cadre are better public health management and an improved regulatory functioning of the health department at the Centre and state levels. With the change in government in 2014, a new National Health Policy (NHP-2017) was adopted. NHP-2017 declared that public health cadre was a policy prerequisite to effectively address social determinants of health and enforce regulatory provisions,[4] reiterating the need for it to be multidisciplinary in character and professionally qualified.

One reason for such a renewed interest was the National Rural Health Mission.[5] The NRHM led to a large influx of management, accounting and information technology (IT) cadres at the district and state levels. Initially these were drawn from an assortment of management and social work qualifications. But stimulated by this growing space within and by an increasing recognition of public health as a desirable skill set, there was a rapid expansion of programmes for acquiring postgraduate qualifications in public health courses. The number of universities or institutes offering such programmes, increased from about three in 2006 to over 44 as of today.[6]

This in turn set off a response within the directorates to acknowledge the role of professionalizing public health management and the need to have professional public health experts within them. Many studies have been attributing Tamil Nadu's better public health performance to the existence of such a cadre resulting in advocating similar arrangements across states.[7]

Another completely divergent rationale for professionalizing management was the policy directions that called for shifting the role of government from one of a provider to a purchaser of services. The net result is there are now four overlapping expectations of a public health cadre:

1. Public health specialists focused on public goods activities such as vector control, disease surveillance, waste disposal, and prevention of food adulteration and food safety. The skills are focused in epidemiology and environmental health.
2. Public health managers of primary healthcare and district health systems. These managers are expected to be in charge of programmes like immunization, care in pregnancy, and control of disease like tuberculosis (TB), Leprosy and HIV as well as risk factor management for non-communicable diseases (NCDs). This work expands considerably when screening and management of chronic illnesses becomes part of the primary healthcare package.
3. Health system administrators adept at planning, workforce management, logistics, contracting private players, regulatory functions and data analytics.
4. Specialized skills in emerging domains whose basis is non-medical like health economics, public health informatics, and health communication.

While the boundaries between these four domains could be blurred, there can be little doubt that each has distinct skill sets.

The emergence of this cadre is taking place in the context of a contestation between general administrators and medical professionals; as well as a contestation within medical professionals for leadership and responsibilities. Clinicians who have completed many years of service would not like to report to public health officers who are junior to them in age and seniority merely because administrative positions are reserved for the latter. But clinicians may fail to invest time in learning the professional skills needed for administration, or reduce their clinical work, which is their main source of professional satisfaction.

Similarly, general administrators who serve as mission directors of the National Health Mission are empowered to act on public health issues with support from public health consultants recruited directly, making them less dependent on Directorates of Health.[8]

3. Government of India, *Twelfth Five Year Plan (2012-2017) Social Sectors – Vol III*. The Planning Commission, Sage Publications, Delhi, 2013, pp. 31-32.

4. Ministry of Health and Family Welfare, National Health Policy-2017, p. 27. Available at http://cdsco.nic.in/writereaddata/National-Health-Policy.pdf accessed on 10 October 2018.

5. Ministry of Health and Family Welfare, National Rural Health Mission: Meeting People's Health Needs in Rural Areas – Framework for Implementation 2005-12. Government of India, New Delhi, 2005.

6. R. Tiwari, H. Negandh and S. Zodpey, 'Current Status of Master of Public Health Programmes in India: A Scoping Review', *WHO South-East Asia Journal of Public Health* 7(1), April 2018, pp. 29-35.

7. M. Dasgupta, B. Desikachari, R. Shukla, T. Somanathan, P. Padmanaban and K. Datta, 'How Might India's Public Health Systems Be Strengthened? Lessons From Tamil Nadu', *Economic and Political Weekly* 45(10), 2010, pp. 46-60; D. Balabanova, A. Mills and C. Lesong et. al., 'Good Health at Low Cost 25 Years on: Lessons for the Future of Health System Strengthening, *The Lancet* 381, 2013, pp. 2118-33.

In light of these set of complexities, discussions regarding the development of public health cadres tend to revolve around seniority, promotions, reporting relationships and financial and non-financial powers. The difficulty in negotiating these turfs and terrains of power and accountability is one reason why it has been difficult in many states to push this policy reform and replicate the Tamil Nadu model.

The public health cadre in Tamil Nadu goes back to 1939 when the then Madras Province's Public Health Act was adopted.[9] This was one of the two cadres: The PH cadre that came under the Public Health Directorate and the Medical Services cadre under the Directorate of Medical Services – each having their own budgets and administrative structures.[10]

The PH cadre in Tamil Nadu manages the primary health services and the administrative work and positions associated with it. Fresh medical graduates join as municipal health officers or as medical officers in Primary Health Centres. Those desirous of joining the PH cadre have to complete a diploma in public health (from Madras Medical College) within four years of joining, in order to be regularized and become eligible for promotion to deputy director.

The deputy directors of public health get allocated to one of the three posts: as head of the primary health services at the district level; principal of the six training institutes; or as faculty in the Department of Community Medicine in medical colleges, provided they have a postgraduate degree. Within the State Directorates of Public Health, public health professionals can rise to become joint directors, additional directors and director. In TN, the PH cadre is small, consisting of less than 180 personnel as compared to over 18000 in the medical services. The important lesson is that this cadre takes professional pride in the good management of the public health facilities, and sets its goals in terms of management and not clinical care. In contrast, those opting for clinical practice could go on to becoming assistant surgeons and civil surgeons working in hospitals and on promotion, could occupy senior management positions in hospitals and specialist services.[11]

Maharashtra is a large state divided into seven administrative circles (regions) based on a geographical spread, with each circle comprising a handful of districts. Each of these regions is administratively headed by deputy directors. Civil surgeons and district health officers of all districts report to the deputy directors of their respective regions. All deputy directors then further report to all four joint directors, who also look after certain thematic areas. Maharashtra has carved out separate posts in the public health cadre at the block (taluk health officer) and district level (district health officer) wherein a medical officer with postgraduate (PG) qualification in public health or community medicine gets preference for selection.[12] This preference is said to remain in the selection of more senior positions also but unlike in Tamil Nadu, the higher posts are open to even those who may not necessarily have any public health qualifications.

The district health officer is a medical officer with a postgraduate qualification in public health or community medicine who has served for at least three years in regular service. He or she has administrative powers at sub-district hospitals, rural hospitals, and primary health centres and health sub-centres, besides handling management of national programmes, whereas the civil surgeon is in charge of district hospitals and general hospitals. The post of civil surgeon and assistant surgeons is for clinicians.[13]

Odisha is the only state that successfully responded to the sustained policy push since 2007 to create a PH cadre. In 2014, Odisha announced the creation of 578 posts under PH cadre out of a total of 6719 posts for medical officers. Of these 578 posts, 314 are posts of block public health officers, which is the entry point for this cadre. They then rise to district health officer positions. Public health qualifications are essential for this cadre. The usual problems of resistance from clinical and specialist cadre were avoided by creating, in parallel, promotional avenues for these cadres as well.[14]

In the last decade, many states have attempted to undertake measures to introduce a public health cadre (Chhattisgarh, Kerala, Bihar, Punjab,

8. Government of India, High Level Expert Group Report on Universal Health Coverage for India. The Planning Commission of India, New Delhi, 2011.

9. R. Parthasarathi and S. Sinha, Towards a Better Health Care Delivery System: The Tamil Nadu Model', *Indian Journal of Community Medicine* 41(4), October-December 2016, pp. 302-304.

10. D. Balabanova, A. Mills and C. Lesong et. al., 2013, op. cit., fn.7.

11. Ibid.

12. N. Sharma, Maharashtra Public Health Workforce Study Issues and Challenges. National Health Systems Resource Centre, New Delhi, 2013. Available at: http://nhsrc-india. org/sites/default/files/Maharashtra% 20Public%20Health% 20Workforce%20 Report.pdf accessed on 10 October 2018.

13. Ibid.

14. Government of Odisha, Odisha Technical and Management Support Group Phase II. Department of Health and Family Welfare, GoO, Odisha, 2014. Available at: http://www.nrhmorissa.gov.in/writereaddata/Upload/Documents/11.%20PH%20cadre%20restructuring% 20final%2030.10.2014 %20pdf%201%20of%203.pdf accessed on 10 October 2018.

West Bengal, Assam, among others).[15] Due to the emergence of different forms of resistance, efforts have not been very fruitful. This has resulted in a massive expansion of consultant positions requiring public health qualification and skills appointed in temporarily created contractual positions with varied designations.

A significant contribution of the National Health Mission is the massive demand it generated for public health professionals. Positions of district managers were created – about three such positions per district and over 10 to 15 at the state level, adding up to about 2500 public health professionals. Within the Ministry of Health and Family Welfare, the National Health Systems Resource Centre and the State Health Systems Resource Centres, over 400 public health professionals were appointed. In addition, positions were also created in research institutions (NCDC, ICMR) and technical support agencies of various development partners (WHO, UNICEF, BMGF, USAID etc) and corporate firms providing technical assistance (among others IPE Global, Tata Trust, Piramal Health). So, even while there is a furious discussion about creating a public health cadre, within a period of 10 years, close to 4000 to 5000 such professionals have been deployed within the system. Though they have contributed to every aspect of policy, planning and implementation, discussions on a public health cadre tends to ignore the importance of this development.

Appointing the above workforce on a contractual basis has, however, given rise to a large number of problems ranging from uncertain tenures to relational issues with the permanent staff and mid-level managers. Given these adverse factors there is a high turnover and the failure or inability of the system to retain and nurture this huge capacity it has created, even while complaining of a lack of skills and capacity. Clearly, it is time to consider these professionals as an important element of the public health workforce and evolve a cadre structure for them.

Such a policy to absorb talent is required even in the well structured state of Tamil Nadu. A deputy director in charge of a programme (immunization, tuberculosis, mental illness etc) or a systems component (procurement, emergency services etc) would need to be supported by a multidisciplinary team, some of whom could even be fresh graduates. As the existing structures of permanent jobs in a directorate or department do not allow for building such teams, this requirement is often fulfilled by appointing ad hoc consultants.

Most central to the issue of creating public health cadres is by providing high quality training in public health management. Yet, we know little of the match between skills imparted and skills needed and the effectiveness of different training programmes. As compared to three institutions offering MPH in 2005, there are currently at least 44 institutions with MPH programmes.[16] Of these, 26 are private institutions and 18 are government. Most of them are two year courses. In addition, there are a number of one year diploma courses in public health offered by a few universities. One of these programmes was set up by Public Health Foundation of India (PHFI) across many institutions largely for in-service candidates.

Since 2005, there has been a significant increase of postgraduates in Preventive and Social Medicine (PSM). Though traditionally the PSM programme has remained centred around epidemiology and environment health, there has, of late, been a much greater engagement with health systems and health policy studies. This is obviously spurred by both the growing opportunity for public health specialists and a response to the growth in the number of schools of public health. Together, these institutions produce nearly 700 Masters in Public Health annually. During the period 2007-16, an estimated 4100 persons are reported to have graduated with an employment rate exceeding 90%.[17] There are also a number of Masters in Business Administration (MBA) in hospital management and healthcare that produce graduates with a greater orientation to the private sector.

The content and quality of these programmes vary widely across institutions. Most courses have some level of engagement with basics of management, epidemiology and bio-statistics, health policy, health economics and the social and behavioural aspects of health. The problem, however, is more in the transaction that could be disconnected with practice and real life issues and problems, making the graduating student inadequately prepared for what lies ahead. The theoretical frameworks to support problem solving and policy in the context of developing nations need to evolve. This then begs the question: would public health education and a public health cadre be a game changer for the strengthening public health systems or only provide some incremental gains, or perhaps, even become a part of the problem?

15. S. Kumar, V. Bothra and D. Mairembam, 'A Dedicated Public Health Cadre: Urgent and Critical to Improve Health in India', *Indian Journal of Community Medicine* 41(4), 2016, pp, 253-255.

16. R. Tiwari, H. Negandh and S. Zodpey, 2018, op. cit., fn. 6.

17. Ibid.

Despite the recent interest in public health cadres, evidence on their effectiveness needs further study. Anecdotally, there are clinicians who have done well in administrative roles and many with public health qualifications who have done poorly. The better performance of Tamil Nadu and Maharashtra have other drivers too, while there are states that have done well, but have no public health cadre. Since there are no studies that inform us, we can consider a few core principles to guide us build a 'programme theory' (or theory of change) of how public health cadres contribute to strengthening public health services. These principles can be the basis of operationalizing the development of public health cadres.

First, that the creation of a cadre permits willing medical personnel to undertake administrative and managerial positions as opposed to clinical practice. Two, that a cadre is more than possessing a professional qualification and that training is not a one-time affair. It is the work experience interspersed with mid-career training that builds the competence of a cadre over time. This requires an investment far beyond just providing higher salary and perks. It means that individuals in this cadre, irrespective of whether they are state or central cadre, must have work experience at district and management levels – again at the state and Centre. For senior levels, while work experience in international organizations and policy making and agenda setting roles would be useful, experience in working in academics or research or not-for-profit health service organizations could be invaluable. Discussions on public health cadre tends to focus on entry level qualifications and seldom examines and provides for acquisitions of experience over a span of time and institutional settings.

Third, that there must be limited opportunities for lateral entry of clinicians into administrative roles as clinical skills is one of the necessary disciplines in the multidisciplinary mix required for public health administration. Promotional avenues for clinicians should not get adversely affected because of the creation of such a cadre.

Fourth, and essential principle, that entry for non-medical professionals be provided. About one fourth to half of the cadre should be drawn from non-medical backgrounds that must include economics, financing, communication, informatics, the social sciences and allied health specialties – trained or oriented in public health and integrated into the cadre or a separate sub-cadre.

Fifth and perhaps the most important principle, that there must be adequate powers and resources provided to this cadre to make good use of their capacity and hold them accountable for performance of the public health systems.

The renewed interest among policy makers for the creation of a public health cadre in all states is a positive development as there are enough grounds to suggest that this could lead to improved population health outcomes. Policy makers need to formulate policies for the provision of high quality training of public health professionals and an appropriate workforce management to get optimal returns. The creation of accountability mechanisms for the functioning of the public health cadre, with mechanisms for coordination with the clinical and specialists cadre would be a challenge, but one that is critically required for strengthening India's capacity to reduce the disease burden, ensure health security and promote well-being and population health.