Introduction

WHO has defined the six building blocks of public health system, one of which is health workforce.\(^{(1)}\) Health workforce is central to advancing health agenda. The health sector, more than any other sector, depends on people to carry out its mission. In any health care system, it is health workers — professionals, technicians, and auxiliaries — who determine what services will be offered; when, where, and to what extent they will be utilized; and as a result, what impact the services will have on the health status of individuals. The success of health activities depends largely on the effectiveness and quality with which these resources are managed and are essential for achievement of national and global health goals.

The public health sector in India is presently plagued by shortages of human resources. Organizational hierarchies and divisions create additional bottlenecks that can only be addressed through systematic re-structuring and decentralization. In public health sector, district level architecture is the basic implementation and direct supervisory unit for all health programs. Robust and effective human resources for health (HRH) architecture at district level is needed for implementation of increasing number of health programs and confronting existing and emerging public health challenges. In this regard, it has been suggested that the specific responsibilities and accountabilities of key actors needs to be redefined to achieve equity in health care in India.\(^{(2)}\)

In Maharashtra, there is fairly well developed public health cadre and public health managers are available for public health implementation. Additionally infrastructure and HRH strengthening of the public health system has been done through Maharashtra Health System Development Project (MHSDP) and National Rural Health Mission (NRHM), but redefining scope of key health positions at the district level is yet to be attempted.\(^{(3)}\) With increasing number and intensity of public health programs it is expected to have effective supervisory structure at district level and probably their role also need to be redefined. It has been suggested that greater autonomy and progressive HR policy will support organizational commitment\(^{(4,5)}\) and consequently better output. It is critical at this juncture to strengthen the district level HRH architecture in Public Health Department of Maharashtra. The present article discusses the context of positioning and maximizing the output of district level health officers, rendering greater autonomy and streamlining their roles in department of public health in Maharashtra. In this regard the article also tries to articulate the challenges faced by existing district level HRH architecture and discusses the possible changes required to face these challenges.

Present District Level HRH Architecture in Department of Public Health, Maharashtra

Physical as well as HRH infrastructure in Maharashtra seem to be well developed and functioning effectively. Maharashtra is one of the first states to establish...
the norm of one PHC per 30,000 population and one sub-center per 5000 population in the early eighties. Additionally, three disease control programs viz., tuberculosis, leprosy, and malaria/NVBDPC are administered and coordinated through three separate offices at district level while blindness control program is under supervision of civil surgeon. Traditionally public health stream is supposed to work in rural areas through the network of Primary Health Centers, sub-centers, and dispensaries, supervised by District Health Officer. This system is integrated with Zilla Parishad and local self government. Operations of public health department in rural areas are managed by District Health Officer (DHO), supported by one additional DHO and one or two assistant district health officers (ADHO’s). He/she is also supported by District Malaria Officer, District Tuberculosis Officer, Assistant Director of Health Services (leprosy). Epidemic Medical Officer and Medical Officer — District Training Team. Public health system is basically established for providing basic/primary clinical care at peripheral level and implementation of National Health Programs. Along with this, clinical stream under the supervision of Civil Surgeon (CS) is supposed to provide secondary and tertiary care as well as specialist medical services though the network of district, sub-district, rural and cottage hospitals. Traditionally assumed functions of district hospital and rural hospitals are limited to care of patients attending the hospital. However, situation has changed rapidly in last decade and these hospitals are also required to be involved increasingly and intensively in community-based activities. Introduction of NRHM in 2005 has substantially increased the public health responsibility of rural and district hospitals and involvement in National Health Programs. Subsequently contractual health staff has been provided in rural hospitals for delivering outreach services. Civil Surgeon is supported by two Resident Medical Officer’s — one for the outreach activity (RMO-OR) and another for clinical services (RMO-CL) at district hospital. The posts of all district-level officers viz., DHO, CS, ADHS, DTO, RMO’s and ADHO’s are equivalent posts. Conventionally, senior officials are posted on following positions: DHO/CS and ADHS (leprosy). However, this is not an exclusive rule. Although, above-mentioned architecture of HRH is considered effective for district level supervision of health programs and responding to public health challenges in a district, the lack of autonomy and clearly documented HR policy coupled with shortage of officers are making optimum utilization of human resource difficult.

**Challenges for district level HRH architecture**

District health officer is responsible for the implementation of National Health Programs in rural areas. Almost all health personnel in rural area are administered through DHO and are usually observed to be responding to DHO. Priorities set by DHO usually become their priorities and implementation of various programs differs with priority accorded by DHO to a particular program. Priorities of DHO’s and CS change throughout the year depending on disease burden in a particular period e.g., most of the outbreaks occur in summer and early rainy season so the emphasis during this period is on epidemic control. During the third and fourth quarter of year the entire emphasis is usually on family planning and NRHM expenditure. Although DHO is expected to monitor all national health programs in rural areas and CS in urban areas, as there are independent program managers for Malaria, Leprosy, TB and HIV, DHO/CS are usually excluded from primary review of these programs. Hence, field-level staffs who are directly reporting to DHO or CS may not be equally responsive to activities related to these programs that are managed by relatively independent offices. Consequently it is observed that the priority for these programs are lacking in peripheral health machinery. The DHO and CS are generally over-burdened because of their engagement in several ongoing programs and additional programs being added sometime without adequate consultation. The DHO’s work burden seems to be further increased due to relative underutilization of supportive officers at district level for e.g., Assistant DHOs. Similar situation is with Civil Surgeon’s Office where there is only one public health specialist working as a RMO (OR) responsible for outreach activities. This officer is from DHO cader and may not be motivated to work at this position because of less responsive team members toward implementation of public health programs, coupled with the fact that appropriate human resource for outreach services are lacking in urban areas. Although at present, availability of outreach staff at urban hospital’s (RH/SDH) due to NRHM has improved scenario to some extent. This is probably highlighted by the fact that most of these positions are vacant in state.

Out of Seven Class I officers from public health cader at the district level, four officers (60%) viz three assistant DHO’s and RMO (OR) do not have adequate autonomy to execute responsibilities bestowed upon them. This may possibly affect the sense of accountability, resulting in suboptimal output. There are two/three ADHO’s for assisting DHO in implementation of programs. These are usually equivalent Class-I officers with probably least independent authority compared with officials from any other state or ZP Class-I officers in Maharashtra. As the utilization of these officers rests on DHO, their moral and output may differs in different districts. Additionally, as
after particular seniority ADHO’s can compete for the position of DHO, certain level of insecurity probably makes their relations far more complicated to have gainful output.

NRHM tries to bring the decentralized and participatory planning which has been successful to some extent but overall implementation is still least autonomy to district/subdistrict level officers in decision-making processes, leading to procedural delays and suboptimal utilization of resources. NRHM seems to have relied heavily on infusion of contractual workforce instead of revisiting these issues in the context of existing HRH architecture and overall human resource policy for sustainable improvement.

**Proposed changes in district level HRH architecture**

Scope of this discussion is for possible redefining of role and scope of district level class 1 officers/managers among whole lot of HRH operational at district as well as sub-district level. Rational for proposed change is improving output through more autonomy and responsibility to all Class-I district officials in public health department. With increasing burden of public health engagements it is felt that dedicated supervisory officer at district level is needed apart from Deputy Director at regional level. In order to facilitate this, positions of DHO and CS need to be upgraded so that these positions are meant for supervising all public health programs in the district in rural and urban areas, respectively. Up gradation of post may be considered equivalent to the rank of Deputy Director Health Services or at least to the level of Additional CEO of Zilla Parishad. Providing them overall supervisory powers and not making them specifically responsible for individual programs, more justice could be rendered to all the programs. This may also minimize insecurity factor to certain extent as posting at these positions will be through promotion rather than positioning or placement.

Positions of other Class-I district officers may be reorganized and can be designated as district nodal officers for the particular program. Present district level officer’s viz., three assistant DHOs, ADHS (leprosy), DTO, and RMO (OR) can be re-designated as nodal officers or district program officers (DPO). Health programs [activities] can be grouped under related heads and nodal officers or DPO’s may be assigned to it. Some of these groups can be RCH program (NRHM), Epidemic control plus IDSP, Tuberculosis, Leprosy, HIV and other health activities and programs, NVBDCP, and Urban health. Accordingly there can be six nodal officers/DPO’s at the district level. These can be RCH/NRHM Nodal Officer, Epidemic and IDSP Nodal Officer, Nodal Officer for TB, Nodal Officer for Leprosy, Nodal Officer for Urban Health, and Nodal Officer for NVBDCP. All these establishments can be in state sector like present day District TB or Leprosy offices. These nodal officers should be independent officers with particular responsibility and offices. They will either report to DHO or CS depending on their scope of program, e.g., urban health program officer or program officers for blindness control may report to civil surgeon while program officer for TB/NVBDCP/HIV may reports to DHO.RMO (CL) can be re-designated as Medical Superintendent of the district hospital reporting to civil surgeon thus relieving direct responsibility of CS in a day to day clinical matters. Thus CS position can be better utilized for improving urban health system. Grouping of various health programs can be further discussed to make the refinements. Apart from these programs whenever new programs are introduced additional responsibility of such programs or campaigns can be specifically bestowed to related nodal officers. Reduction in medical support staff in DHO and CS offices due to shifting of program officers can be supplemented with class-II public health specialist or medical officers. Present discussion is suggestive and further refinement of roles and responsibilities can be debated e.g., engineering wing of NRHM can be directly supervised by DHO and CS in their respective areas. Clinical services and particular secondary and tertiary care are important component of public health delivery system and civil surgeon is at its helm. With independent program officers for urban health and medical superintendent of district hospital like medical superintendent of womens hospital CS may be able to supervise more effectively, both the clinical as well as programmatic services. Making the structure independent and relatively autonomous efficiency of public health delivery system would likely to be improved.

Concept of independent district nodal officers/district program officers is to give them autonomy and individual responsibilities, which would expectedly, improve the accountability and output of officers and strengthen the supervision of programs. Up gradation of DHO and CS posts would make the availability of dedicated supervisory as well as coordinating officer at district level for all programs giving boost to supervisory structure.

Apart from the concept of autonomy, clear and sustainable HR policy is need of the hour for health department. It is surprising that despite the requirement of largest chunk of qualified and highly skilled workforce and shortage of these human resources for very long time, written, well publicized and comprehensive HR policy is not available. In this regard a case study by central bureau of health intelligence recommended that state health directorate should have a full-fledged HR department with specialized staff and dedicated
budget. Though this recommendation has been based on case study in Gujarat and MP, the dedicated HR policy is also perceived to be the need of public health department of Maharashtra.

Limitations

Any structural change in the system definitely poses certain challenges. This is being the policy change it needs to be approved at highest level in the government. Changes also require adaptation at field level which may take long time and consequently program may be adversely affected for such period. Despite these challenges, it is felt that observations and understanding of present situation demands appropriate changes at district level. There is also a need to understand that suggesting such changes at district level may not be the sole remedy for woes of public health department which definitely need to be supported by appropriate HR policy.

Present manuscript is limited by the fact that suggestions are based on personal observations while closely working with public health department, observing the functioning of the department and discussion with some key stakeholders. Presently there is no systematic evidence or supportive literature available for supporting proposed changes, but this is the effort to generate the discussion on one aspect of HRH architecture reforms at district level in public health department of Maharashtra.

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