Government of Meghalaya

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STUDY TO UNDERSTAND OPERATIONAL & POLICY BARRIERS AMONGST SPECIALIST DOCTORS IN MEGHALAYA

DEVELOPING STRATEGY AND MANAGEMENT FRAMEWORK FOR HUMAN RESOURCES FOR HEALTH (HRH) IN MEGHALAYA

MEGHALAYA HEALTH SYSTEMS STRENGTHENING PROJECT (MEGHSSP)

December 2022

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Acronyms

ACP	:	Assured Career Progression
APAR	:	Annual Performance Appraisal Reports
AYUSH	:	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
CHC	:	Community Health Centre
CHO	:	Community Health Officer
CT	:	Computed tomography
DDHS,	:	Deputy Director Health Services
DH	:	District Hospital
DHS	:	Directorate of Health Services
DoHFW	:	Department of Health and Family Welfare
EIS	:	Employee Information System
ENT	:	Ear, nose, and throat
ERCP	:	Endoscopic retrograde cholangiopancreatography
FI	:	Field Investigator
HR	:	Human Resource
HRH	:	Human Resources for Health
HRMIS	:	Human Resource Management Information System
ICU	:	Intensive Care Unit
IMR	:	Infant Mortality Rate
IPHS	:	Indian Public Health Standards
LSAS	:	Life Saving Anesthesia Skills
MACP	:	Modified Assured Career Progression Scheme
MBBS	:	Bachelor of Medicine, Bachelor of Surgery
MCH	:	Maternal & Child Health

MHSSP	:	Meghalaya Health Systems Strengthening Project
MMR	:	Maternal Mortality Rate
MO	:	Medical Officer
MPSC	:	Meghalaya Public Service Commission
MS	:	Medical Superintendent
NFRA	:	Needle Radiofrequency Ablation
NHM	:	National Health Mission
NICU	:	Neonatal Intensive Care Unit
NMHP	:	National Mental. Health Programme
NPCDCS	:	National Programme for Prevention & Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke
OOPE	:	Out-of-Pocket Expenditure
OT	:	Operation Theatre
PG	:	Post-Graduation
PHC	:	Public Health Centre
PHFI	:	Public Health Foundation of India
PHMC	:	Public Health Management Cadre
RHFWTC	:	Regional Health & Family Welfare Training Centre
SC	:	Sub Centre
SDH	:	Sub-District Hospital
UT	:	Union Territory

Background

The National Health Policy 2017 taking cognizance of the fact that a multidisciplinary workforce is required for managing various programs under National Health Mission (NHM), envisaged creation of a multidisciplinary Public Health Management Cadre (PHMC) in all states/UTs. So, the Ministry of Health & Family Welfare, Government of India (GoI), recently released The Booklet for Public Health Management Cadre which acts as a guidance for implementation of four key cadres across India. Setting up such a streamlined cadre, the booklet says, will help states achieve best utilization of expertise and talent for ensuring health for all. It will also help address the need to segregate service providers as per clinical and public health functions among various types of cadres with flexibilities as per the functional requirement of states. Released in 2022, the booklet mandates the establishment of cadres with clear segregation into the following four categories:

1. **Specialist Cadre**: mainly working in the public health facilities such as Community Health Centres (CHC), Sub-District Hospitals (SDH)/District Hospitals (DH), and tertiary hospitals
2. **Public Health Cadre**: working at Public Health Centres (PHCs), CHCs, and block/district/state hospitals and directorates, performing both public health and primary health related clinical functions
3. **Health Management Cadre**: management of national programs at block, district, and state levels. Consists of experts for finance, Human Resource (HR), procurement, statistics, hospital administration, etc., with majority having Post Graduation in Public Health
4. **Teaching Cadre**: Faculty members in medical colleges

In the context of Meghalaya, the segregation of such cadres is not available. However, the Meghalaya Health Service Rules, 1990 (Department of Health & Family Welfare, 1990) specifies that the doctors and specialists under Department of Health & Family Welfare are divided into the following three categories:

1. Common Posts
2. General Duty Stream
3. Specialist Stream

The Meghalaya Health Systems Strengthening Project (MHSSP) implemented by the Department of Health and Family Welfare Department (DoHFW), Government of Meghalaya (GoM), has been designed to improve management capacity, quality, and utilization of health services in Meghalaya. Under the project, developing a Human Resources for Health (HRH) strategy and management framework is a key component under which the current study has been carried out. While the study fits into the larger framework of the HRH strategy, it also enables the implementation of the public health management cadre.

Research suggests that shortages of skilled health workers in India must be examined in relation to domestic policies on training, recruitment, and retention rather than viewed as a direct consequence of the international migration of health workers.[1] Understanding the shortage of specialist doctors in Meghalaya, it has been found that there are two key factors leading to the issue:

- **Irregular recruitment:** Pause in the recruitment of regular staff leading to shortage of specialists in the DoHFW and increase in number of 3(f) specialists with no scope of career progression
- **Migrating specialists:** Post graduates not returning to the state despite signing a bond [2]and prefer paying it off rather than return to a state with no scope for specialists' career

The lack of specialists further has an impact on the availability and accessibility of quality care. Having a specialist cadre policy, thus, might impact the retention of the state's specialists and address some of the following issues:

[1] Walton-Roberts, M., Runnels, V., Rajan, S.I. et al. Causes, consequences, and policy responses to the migration of health workers: key findings from India. Hum Resour Health 15, 28 (2017). https://doi.org/10.1186/s12960-017-0199-y

[2] Meghalaya has a policy of reserving seats ("state quota") for medical students in various medical colleges across India. The state had had a policy where all MBBS students nominated under state quota are required to sign a bond that mandates them to serve in a rural post for at least five years after the completion of their studies.

- Lack of specialists in certain districts leading to out-of-pocket expenditure (OOPE) for the public which includes:
    - Bearing costs for travelling inter-district as well as outside the state
    - Subjection to exorbitant healthcare bills when care received at private healthcare facilities
    - Non-validity of available health insurance offered by state government in out-of-state hospitals
- Rise in MMR and IMR in the absence of specialists in some districts
- Increase in work load for existing specialists due to a skewed specialist to population ratio

Objectives of the study

The *'Study to understand operational & policy barriers amongst specialist doctors in Meghalaya'* aims at examining the current scenario with regards to specialists in the state; interact with them, carefully understand their challenges and enablers and based on the same bring about a comprehensive framework of policy related solutions for the Government of Meghalaya.

Figure 1: Objectives of the study

The study also contextualizes its findings with its understanding of the Meghalaya Health Service Rules, 1990 (1990 service rules). It is a key policy document that drives the functions of the doctors and specialists in the state and is a good reference point for understanding the current status of specialists from the policy perspective. It provides an apt background for understanding the current qualitative discussions undertaken through the study with specialists.

Finally, as specified in objective 3, the solutions would enable the DoHFW to drive the policymaking process for Specialist Cadre in Meghalaya. More importantly, the study would enable the state to adhere to the mandate of the MoHFW to segregate its health cadres into the four categories as specified above.

Introduction

Multiple cadres exist in each state and the key cadres include medical doctors, nurses, allied health professionals, public health nurses, Community Health Officers (CHOs), etc. In keeping with the principle of the Public Health Management Cadre, which is also in alignment with the objectives of the National Health Policy 2017, it is imperative for Meghalaya to bring forth the specialist cadre along with other three cadres to achieve overall service delivery to the state's population. It should also be noted that there are only few states in India which have a public health related cadre, which is separate from the clinical cadre. These states will also act as replicable models for Meghalaya and can be found in Annexure IV of the report.

At present, in Meghalaya, there are 14 Government Hospitals, 28 Community Health Centres (CHCs), 112 Primary Health Centres (PHCs) besides 450 Sub-Centres (SCs)[3].

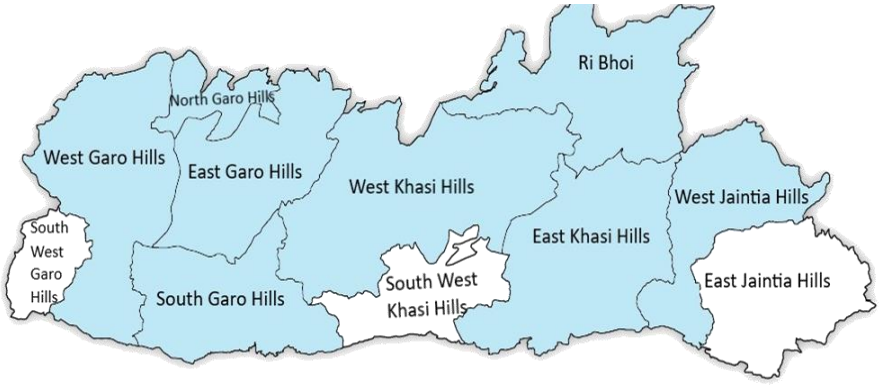
1. Primary and secondary data collection

Secondary review, qualitative discussions and HRH satisfaction survey with specialists was conducted. Details of each exercise listed below:

- Qualitative discussions (Annexure I):
- HRH satisfaction survey (Annexure II):
- Secondary review (Annexure III):

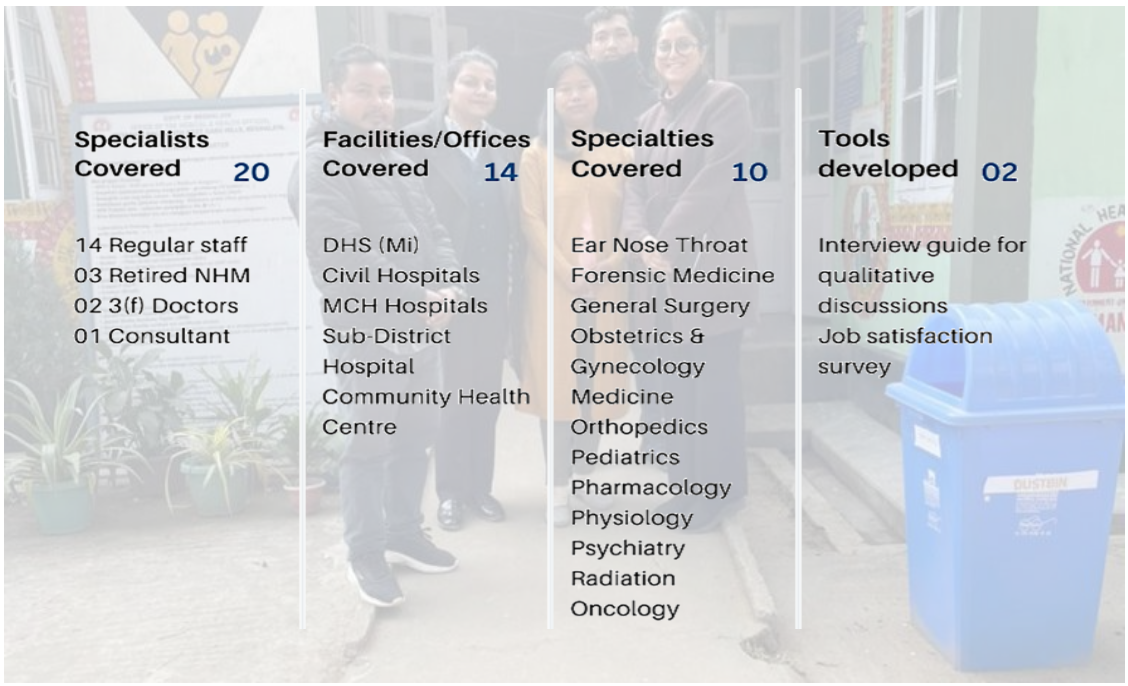
A qualitative study was undertaken, in which 20 semi-structured interviews were carried out with specialists across the state. In addition, a close-ended questionnaire was also administered in the form of a job satisfaction survey specialists, along with observations from secondary desk review which includes data pertaining to specialists as well as review of existing state policies for HRH.

Figure 2: Overview of study coverage across districts



A semi-structured interview questionnaire tool was developed and paired with the job satisfaction tool to conduct qualitative discussions with and collect qualitative information from specialists respectively. Questions ranged from motivators for specialists to remain at their posting to barriers they faced regularly while at work.

Figure 3:Overview of specialties, specialists, facilities covered and tools developed



[3] Statistics, Department of Health & Family Welfare, Government of Meghalaya

Figure 4: Process

Parameters for the interview guide included:

- Understanding skillset versus job profile
- Challenges faced during recruitment
- Issues faced while practicing specialty
- Motivators for continuing job effectively
- Existence of a career growth plan for specialists
- History of transfers and the transfer process
- Awareness of the state's transfer policy
- Preference for clinical or administrative work
- Opportunities for receiving training and what trainings would specialists benefit from
- Satisfaction regarding benefits and salary at present
- Recommendations against the issues listed as well as overall recommendations for the government to retain specialists at the health facilities

Areas of job satisfaction survey included work support, teamwork, working hours, promotions, recognition and relationships, communication, management, remuneration, incentives, leadership as well as training and development. The overall sample size of respondents was 46 (25.4% of specialists).

The findings derived were further extrapolated with the 1990 service rules (Department of Health & Family Welfare, 1990), HRH data for regular and contractual staff which includes MEG EIS data provided by the Directorate of Accounts and Treasuries and NHM data. Data was also collated from existing sources such as Megha Health Insurance Scheme to understand other parameters such as the public private sector engagement of specialists, in-position specialists, vacancies.

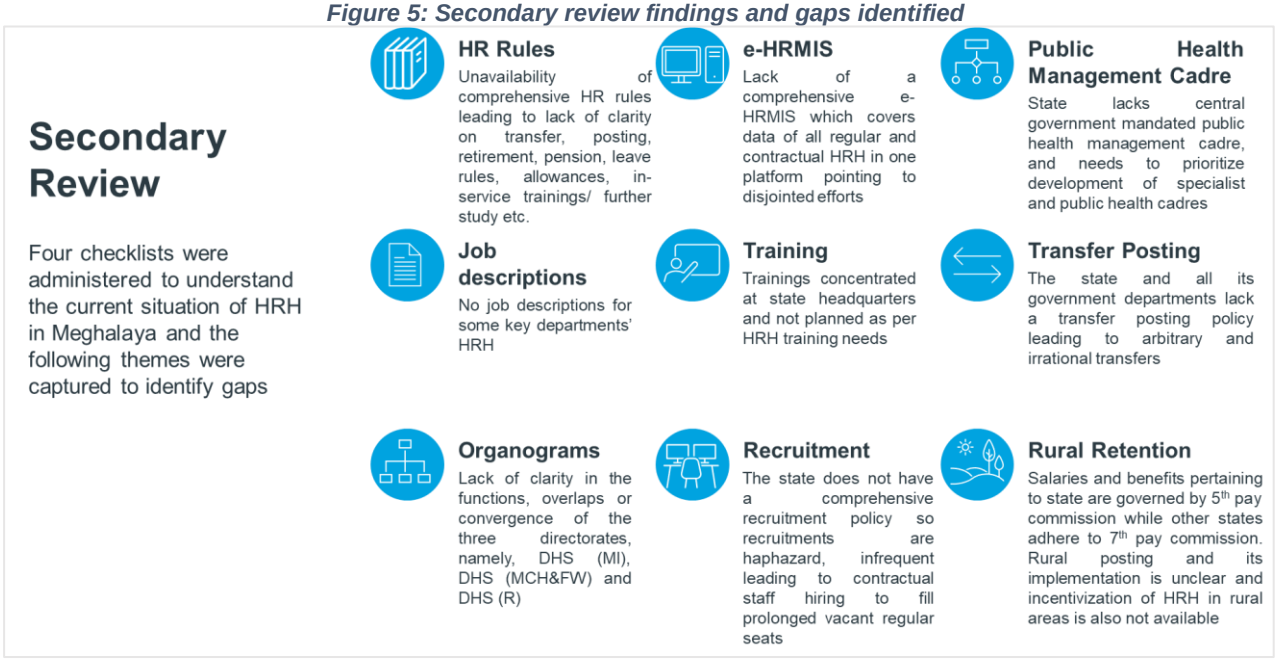
Both the tools along with the data provided by the state and collated from other sources helped capture socio-demographic profile of specialists, their gender-wise distribution, understanding of specialists holding regular positions versus specialists holding contractual positions3(f) contractual positions.

2. Findings

2.1. Findings from secondary review

A secondary review was conducted with the objective of understanding the current mechanism of the administration at the Directorates, availability of job descriptions, policies, key cadres among others. Gaps were identified across nine broad themes which have been summarized below:

Figure 5: Secondary review findings and gaps identified

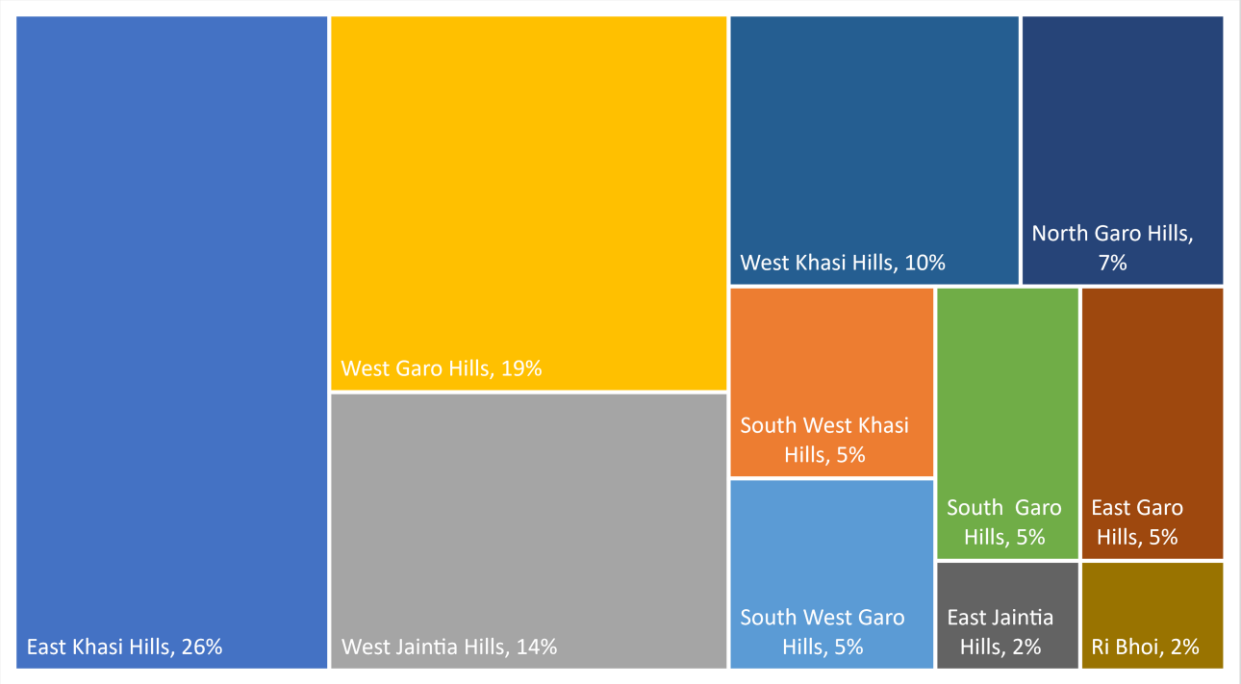


All the nine themes resonate with the current findings and further strengthen the need for the state to have a specialist cadre policy.

2.2. Findings from data collection

In the context of specialists across Meghalaya, there are 42 facilities where specialists can be posted and are divided into district hospitals and Community Health Centres (CHCs). Given below illustration provides an understanding of district wise hospitals and CHCs in the state:

Figure 6: Distribution of government hospitals & CHCs



	EKH	SWKH	WJH	WGH	SWGH	SGH	NGH	EGH	EJH	RB	WKH
Hospitals	4	0	2	2	1	1	0	1	0	1	2
CHCs	7	2	4	6	1	1	3	1	1	0	2

From the above, it is evident that most of the hospitals are in East Khasi Hills which has the state headquarters, followed by West Garo Hills (which also has a sub-district hospital), West Jaintia Hills and West Khasi Hills. Three districts, namely, South West Khasi Hills, North Garo Hills and East Jaintia Hills do not have district hospitals but merely CHCs. One district, namely, Ri Bhoi, has one district hospital which is Civil Hospital Nongpoh.

Shortage of Specialists

The shortage of specialists in the government healthcare facilities has been long discussed within the state of Meghalaya along with the understanding of the fact that the recruitment process for healthcare workforce has also suffered due to no recruitments conducted since the past several years.

Studies across the last decade have shown that health systems in India face a shortage of specialists and doctors apart from not having the requisite infrastructure. The National Rural Health Mission was able to address various healthcare challenges at state and district levels to a considerable extent. However, the availability of specialist doctors, especially at the peripheral level still remains a challenge.[4]

There has been sparse literature covering the issues pertaining to shortage of specialists in the northeastern states, let alone Meghalaya. A qualitative study conducted by PHFI in 2014 factored in responses from four specialists in the state. It stated that it was ‘rare’ to find CHCs with the right mix of specialists, i.e., surgeon, physician, obstetrician and gynaecologist, paediatrician, and anaesthetist.

In the context of the northeastern states, specifically Meghalaya, a study published in 2014 reported that all the northeastern states are suffering from severe shortage of specialist doctors and radiographers in

[4] Pandey P, Sharma S. In the dark even after a decade! A 10-year analysis of India's National Rural Health Mission: Is family medicine the answer to the shortage of specialist doctor in India? J Family Med Prim Care. 2017 Apr-Jun;6(2):204-207. doi: 10.4103/jfmpc.jfmpc_254_16. PMID: 29302518; PMCID: PMC5749057.

CHCs[5].Although the study discusses some crucial issues such as irrational postings and transfers, political interference, among others, as reasons for difficulty in retaining overall health workforce in the periphery, a focused study to closely examine the specialist environment in the state is needed.

So, to address the challenges faced by the state in terms of specialists as well as by the latter themselves, the *'Study to understand operational & policy barriers amongst specialist doctors in Meghalaya'* was initiated to generate qualitative evidence to affect positive policy reformation and bring about a comprehensive specialist cadre policy.

During secondary review, it was ascertained that there are 320 specialist posts in the state which are sanctioned, and 33 specialists hold positions for specialties without sanctioned posts. Of the sanctioned posts, only 148 (--%) positions are filled, and 172 (-%) vacant positions exist. Among the filled positions 48% specialists are females and 52% are males. The proportion of reported vacancies differed at various levels of the health system -Civil Hospitals (59%), CHCs (33%), MCH Hospitals (8%), Meghalaya Institute of Mental Health & Neuro Sciences (3%) and Reid Provincial Chest Hospital (2%).[6] The detailed information is available in the figure below:

Figure 7: Specialists in Meghalaya[7]

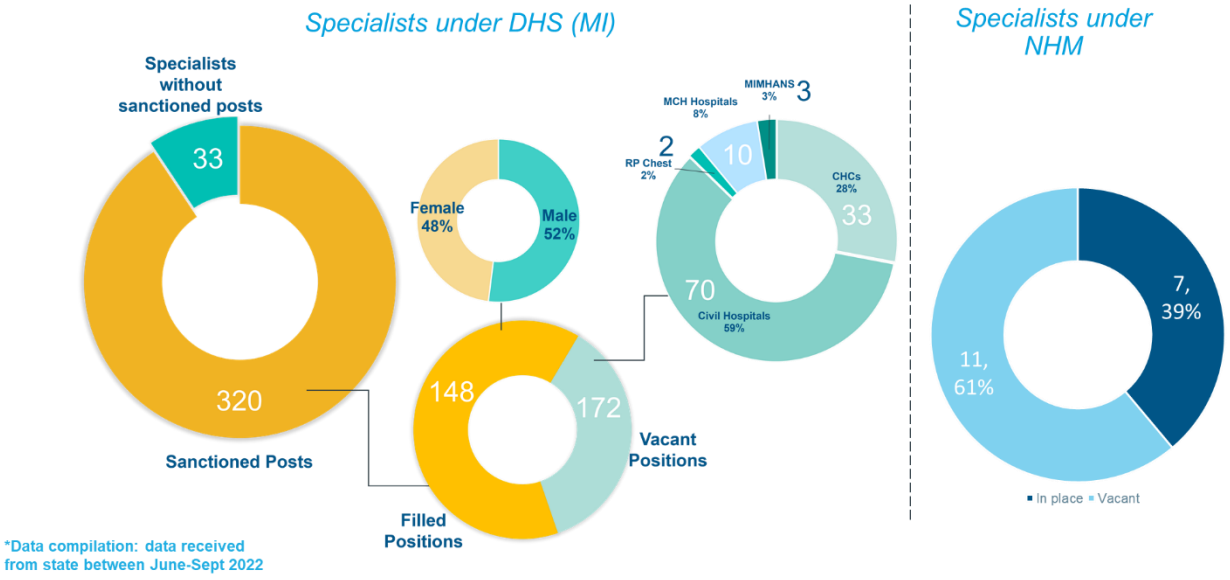
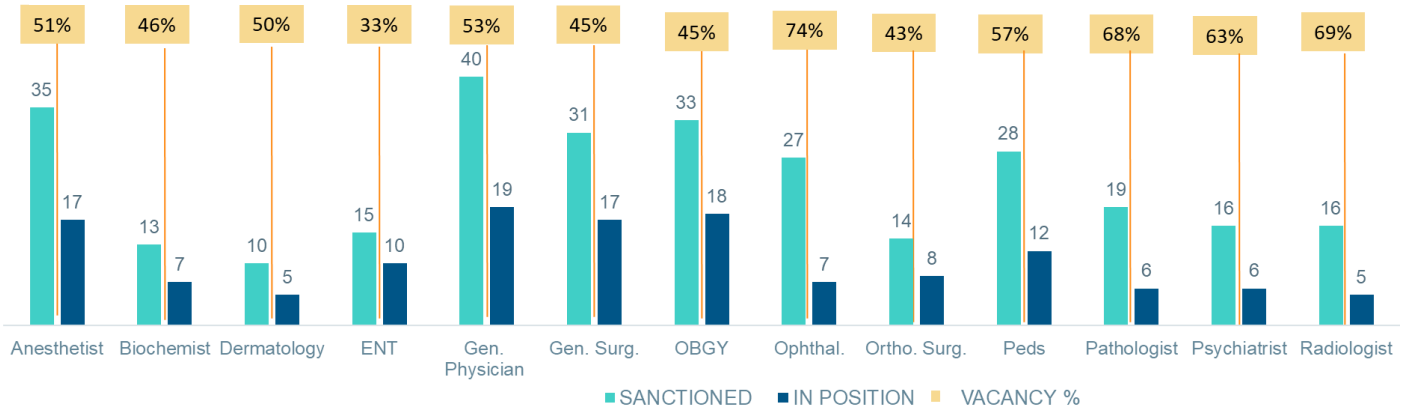


Figure 8: Specialist vacancies in Meghalaya (DoHFW)*



[5] Saikia, Dilip, and Kalyani Kangkana Das. "Access to public health-care in the rural Northeast India." (2016).

[6] Data provided by state as of October 2022

[7] To be revised once updated numbers are provided by DHS (MI)

Super Specialists' sanctioned positions vacant in state:

1. Cardiothoracic surgery (1,1)
2. Endocrinologist (1,1)
3. Gastro-enterologist (1,1)
4. Medical Oncologist (1,1)
5. Neurologist (2,1)
6. Nephrologist (1,1)

Sanctioned positions for specialists with no vacancies in state:

1. Cardiologist (1,1)
2. Microbiologist (3,3)
3. Oncologist
4. Pediatric Surgeon (1,1)
5. Radiotherapist (3,1)
6. Radiation oncologist (1,6)

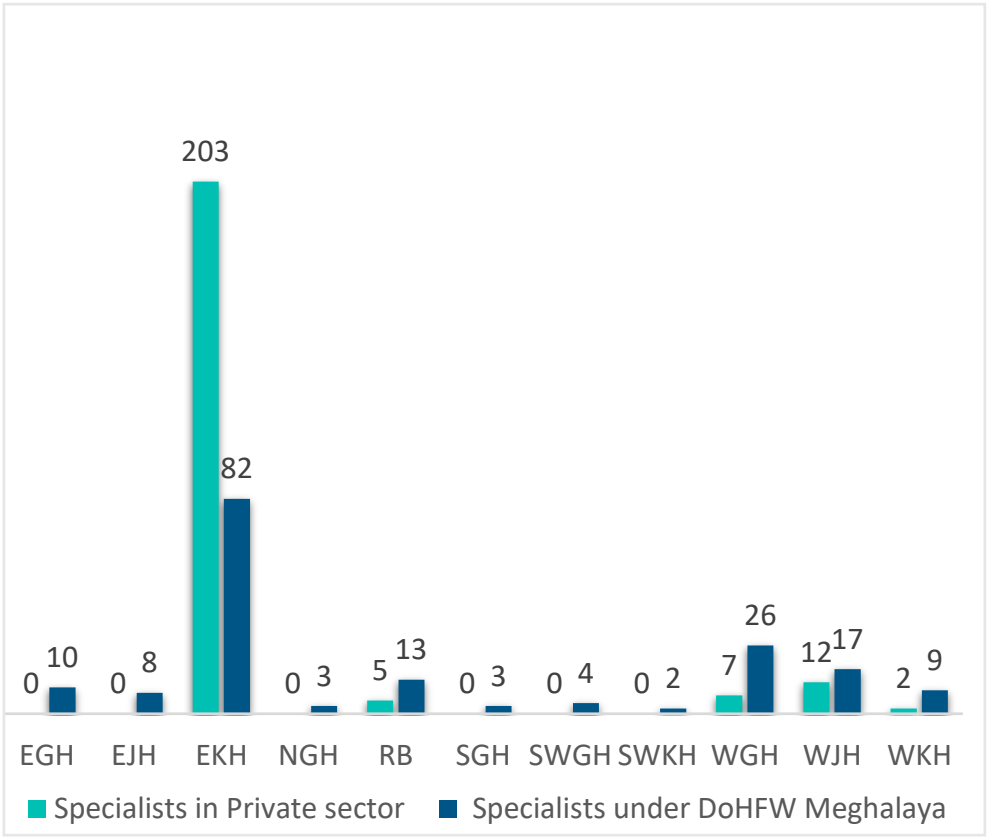
***Data compilation: data received from state between June-Sept 2022**

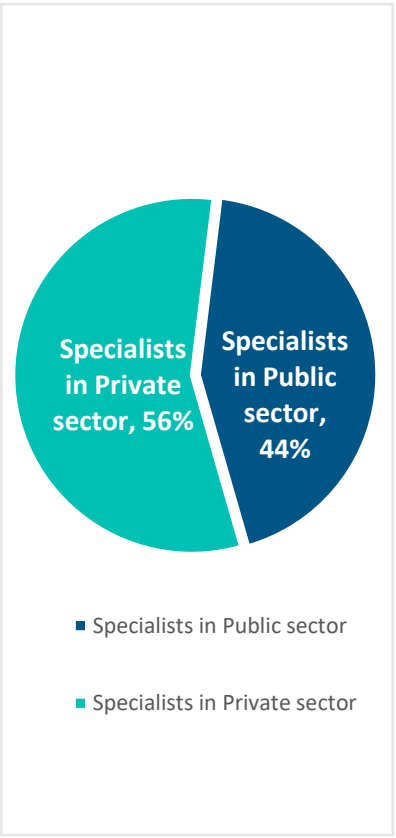
When we analyze specialist vacancies as per state sanctioned positions vacancies are observed across all specialties and substantially high vacancy is seen for ophthalmologists (74%), followed by radiologists (69%), pathologists (68%), and pediatricians (57%). The graph below shows key specialist vacancies in the state along with the lack of super-specialists based on the sanctioned posts for the same:

Further, the data from Megha Health Insurance Scheme helped understand the segregation of specialists across the state between the public and private sector with 56% being in the private sector and 44% in the public sector. Details of the public vs. private sector segregation of specialists are provided below:

The district and gender wise segregation of specialists collated from available data provided by state shows that the specialists are concentrated in East Khasi Hills (82) with Shillong as the state headquarter and has four hospitals and seven CHCs. While West Garo Hills has two district level hospitals and six CHCs, it has only 26 specialists. Over 50% of districts evidently have a lack of specialists with the bottom three being South West Khasi Hills (2), North Garo Hills (does not have any specialists despite state data reflecting three in position) and South Garo Hills (3). Further, the segregation of specialists across the state

Figure 9: Public and private sector specialists in state

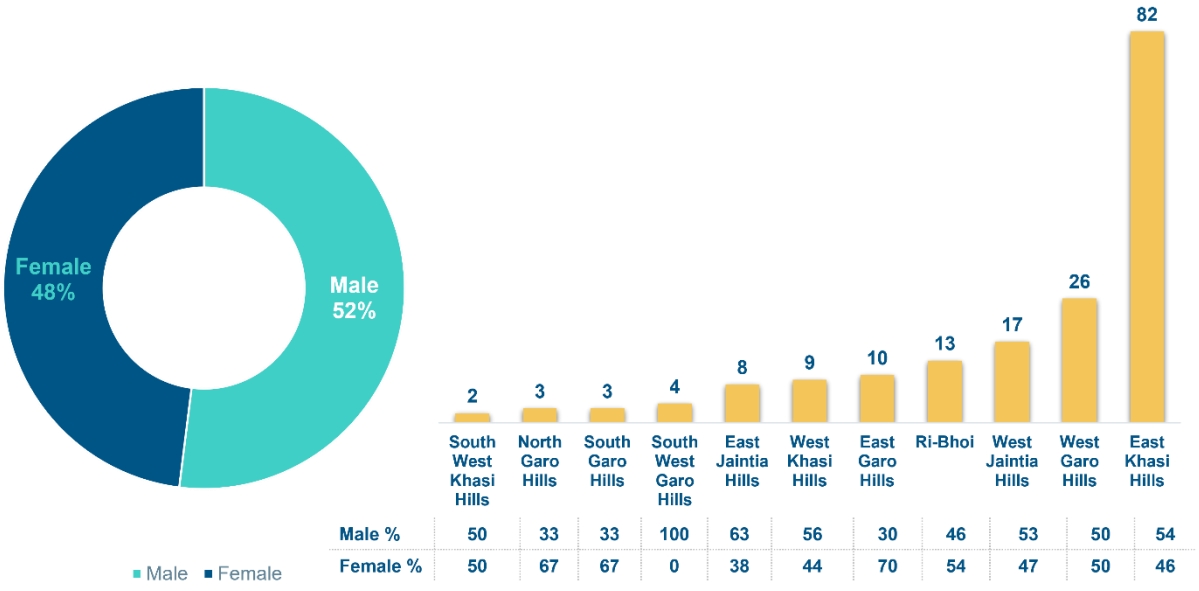




between the public and private sector evidently stands at 56% being in the private sector and 44% in the public sector. East Khasi Hills, again, has the most concentration of specialists in the private sector (203 specialists), followed by West Jaintia Hills having about 12 specialists. However, when we see the overall district wise distribution, it is clear that even though six districts do not have specialists in private practice, it is still a preferred sector over the government sector.

Over half of the specialists in Meghalaya are male (52%) and the remaining specialists are female (48%). When broken down district wise, the four specialists in Southwest Garo Hills are all male. Five districts have > 50% female specialists, namely, East Garo Hills (70%), North Garo Hills (67%), South Garo Hills (67%), Ri Bhoi (54%), West Garo Hills (50%) and South West Khasi Hills (50%). Detailed chart below:

*Figure 10: District & gender wise specialists in Meghalaya (DoHFW)**



2.3. Key findings from in-depth interviews with specialists

After conducting 20 interviews with specialists across various positions in the DoHFW, the findings were divided into two broad categories, further categorized into four sub-categories each, in terms of barriers faced by specialists as follows:

- Operations related barriers
- Policy related barriers

The enablers were identified as suggestions/recommendations by the specialists to the state and the same has been presented in this report.

RECOMMENDATIONS BY SPECIALISTS

- Revisiting recruitment policy and simplification of recruitment process; chalk out recruitment plan for contractual specialists
- Development of transparent posting transfer policy with no political or external interference
- Revisiting salary of regular and contractual specialists . Examination of private and other state models for strong incentive policy including difficult area posting and performance-based benefits
- Designing and instating a clear career progression plan for regular and contractual specialists and parallel positions for clinical specialists at par with existing administrative positions

Operations related barriers

1. Lack of defined roles & responsibilities

Over two thirds (67%) of the specialists interviewed felt that their roles were not very different from that of Medical & Health Officers (M&HOs), and in fact some felt that there were no job role differences between a Grade III and a Grade II specialists' job either; some were dealing with administrative responsibilities while others felt that they could benefit from either reduction of responsibilities or given incentives for taking on more responsibilities compared to their counterparts. Additional responsibilities included: quality assurance, medical emergency, management of interns & AYUSH Medical Officers (MOs).

67%

Or 13.4 specialists felt lack of defined roles & responsibilities

No defined clear roles & responsibilities of specialist doctors based on their specialization (Clinical/Non-Clinical) & seniority (administrative/clinical function) that differentiates with roles & responsibilities of M&HOs

Overburdened

"We're asked to take responsibilities beyond our regular duty. They call me head of department only when something goes wrong. Even though I am burdened with as much work as my junior, I do not get to choose the type of work I want to do"

A senior gynecologist as a representative of the specialty, for instance, felt urgent need to segregate their responsibilities – that they either receive only clinical duties or administrative duties and not both. They felt that such a system was flawed as it put a senior level specialist up for accountability for failures of the department while overlooking the burden of responsibilities. Further, reportedly the specialists who were recruited under 3(f) contract, majorly worked at the position of an M&HO which is two levels below that of an entry level regular post of a Junior Specialist. There were a few non-clinical specialists who did not know how to raise the issue of dealing with clinical service delivery jobs which was beyond their scope of work. For instance, pharmacologists and physiologists are expected to take on role of clinical specialists such as that of surgeons or gynecologists.

2. Unavailability of specialist skill-mix for optimum service delivery

Majority of the specialists felt that they did not find the right mix of specialists to support their functions at facilities they were posted in. Facilities where specialists are posted are often lacking in terms of

92%

Or 18.4 specialists felt lack of specialist skill mix to function optimally

Inexistence of right specialist skill-mix to deliver the healthcare services effectively at CHCs & above i.e. OBGY & anesthetist; surgeon & anesthetist; general physician & pathologist; Orthopedic & radiologist & paramedical staff as proposed in the IPHS norms

Program implementation a challenge

"We don't have medical oncologist, surgical oncologist, counsellor, a physiotherapist, GNM as per the needs of NPCDCS program"

Loss of skills in absence of anesthetist

"There is a surgeon who can't do surgeries in the absence of an anesthetist and currently works as an MO while losing his surgical skills"

Unavailability of diagnostic specialists

"As general physicians, we also require the other specialist doctors with diagnostic skills i.e., pathologists, radiologist, microbiologists, biochemists

specialist combinations such as anesthetist and surgeon or anesthetist and obstetrician. Further, it was found that certain district hospitals lacked diagnosticians such as pathologists, radiologists, etc. Not having such investigators, impacts the function of specialists treating patients. Intensive Care Units (ICUs) and trauma centers had inadequate anesthetists or in some cases an anesthetist was divided between two operation theatres (OT) rooms in a facility, making it difficult for specialists to schedule surgeries and provide timely interventions and treatment. It was also found that an MCH facility did not have a senior gynecologist. It was also recorded that there is a lack of clinical support staff for implementation of National Health Programmes such as National Programme for Prevention & Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS), National Mental. Health Programme (NMHP), etc. Some key findings illustrated as verbatims below:

3. Inadequate Infrastructure & Logistics

The availability of HRH is key to providing quality service delivery is a given. However, in the absence of adequate infrastructure for the HRH to function, service delivery alone is a challenge, let alone ensuring quality of service. Majority of the specialists indicated lack of infrastructure and two-thirds of them also pointed to lack of medicines to function optimally at their place of posting. Examples cited were: a Maternal & Child Health facility did not have Neonatal Intensive Care Unit (NICU), a district hospital(s) lacked requisite number of functional OTs, certain facilities grappled with lack of funds to replenish medical and surgical supplies.

75%

Or 15 specialists felt they did not have ample infrastructure and logistics at their posting

Inadequate infrastructure (e.g. OT) machinery, equipment & support staff (technicians, paramedics, OT Assistant etc.) for ensuring patients are treated optimally by specialists

Lack of OTs

"There are two OTs but only one is functional. There is always a problem of scheduling surgeries between general surgery, ENT and plastic surgery patients and my (orthopedic) department"

No NICU at MCH facility

"We can't even provide basic care to the patients. While treating a patient, I needed IV drips. However, the staff nurse told me it is not available"

Loss of skills in absence of surgical equipment

"I am losing my skill sets due to lack of functional OT & other surgical equipment"

Conversely, availability of certain equipment but no human resource to run the equipment was reportedly leading to wastage of resources and equipment. In some other cases, a facility which did not even have a CT Scan machine, had CT Scan technicians. These technicians were used in the X-ray department in the interim and had probably out of practice of handling a CT Scan machine by the time the equipment had been made available at the facility, leading to need to retrain the technicians.

4. Lack of grievance redressal mechanism

Although during the secondary desk review it was ascertained that the DoHFW has an internal grievance redressal committee, it's current role, capacity, constitution and functionality at present could not be clarified or determined. However, its specified role, as understood, is limited to examining complaints of employees belonging to Schedule Tribe on matters related to:

a. non- maintenance of reservation roster and filling up of reserved vacancies
b. discrimination in promotion/Modified Assured Career Progression (MACP)/Assured Career Progression (ACP)
c. non-appointment on compassionate grounds
d. adverse/downgrading of Annual Performance Appraisal Reports (APARs)
e. termination/dismissal from services
f. discrimination in transfer/posting
g. denial of pensioner benefits

The committee, it was also specified, works with the Social Welfare Department to address grievances by submitting quarterly reports to the latter.

84%

Or 16.8 specialists felt the need for an effective grievance redressal mechanism

Unclear grievance redressal mechanism for enabling specialist to express their grievances and seek solutions concerning disagreements arising from working conditions, transfers, employment practices or differences of interpretation of policy etc.

Unanswered letters to the DoHFW

"I have written at least three letters to the DHS to understand why I was posted at a facility where my skills cannot be used. No answer. I'm a surgeon and I'm not able to do surgery at my current posting"

Lack of rational appointment of leadership to address issues

"The heads of departments/ facilities are often MBBS qualified and do not understand the plight of specialists"

As elaborated above, existing grievance redressal mechanism does not have grievances of specialists or staff facing operational issues at the facility level in its purview and needs to be formalized and made more robust.

Another key finding was that specialists lack confidence in redressal of their clinical grievances in few hospitals where Medical Superintendents (MS) are MBBS doctors. The contention being that the specialists' specific issues were not addressed satisfactorily by MS who did not have full understanding of the specialists' issues.

Other than the above, there is lack of clarity in escalation process for grievances at office of the District Medical & Health Officer (DM&HO) & Directorate of Health Services (DHS) level for resolving issues of healthcare staff which often leads to frustration among specialists and other staff members.

Policy barriers

1. Low Salary & Incentives

Majority (88%) of the specialists interviewed felt their salary and incentives were not at par with other states or even the private sector. It was found that the State's 5th pay commission is two commissions behind other states leading to low pay structure for specialists, doctors and other health cadres.

88%

Or 17.6 specialists said they had low salaries

Salaries not at par with other states along with additional monetary incentives based on place of posting, risk taken and remoteness of posting. Salaries at 5th pay commission compared to other states at 7th pay commission leading to slow and minimal increments

5th Pay Commission

"Many are getting more since they are on 7th pay commission and we are on 5th pay commission"

NE states get more

"In comparison to other states, in particular, other neighboring North Eastern states such as Nagaland, Arunachal Pradesh and Mizoram, our salary is low"

There is also a lack of clarity in salary structure differentiation between doctors and specialists with low Winter and Risk allowance given to the specialist doctors. It was also determined that no separate incentivization for specialists on difficult area posting was in place. Additionally, special/performance-based incentive package for specialists is unavailable.

2. No Clear Career Progression Path

Two thirds of the specialists (67%) felt unclear about their career progression path. This is in keeping with the operational barriers discussed above in relation of clarity on roles and responsibilities of specialists as against M&HOs. Also, a specialist appointed under 3(f) does not have any avenues of growth or progression until they qualify in the MPSC exams and pass the interview round which has not been held for almost seven years. At present, due to the unavailability of a specialist cadre, specialists are given the work responsibilities of M&HOs. There is lack of information on career trajectory and slow career growth based on duration of service in a single grade/position.

67%

Or 13.4 specialists said they did not have clarity on their career path

Unclear career trajectory that fails to distinguish between M&HO & specialist duties. Long duration of promotion cycle to progress from Grades and delays receiving promotions

Revision of duration of service for promotion

"In 2007, promotion was supposed to be at 6 years for entry level specialist but there were internal protests against the early promotions of the specialists as against MBBS doctors. It was raised to the DHS to even out the number of years taken for promotion by both generalist and specialist"

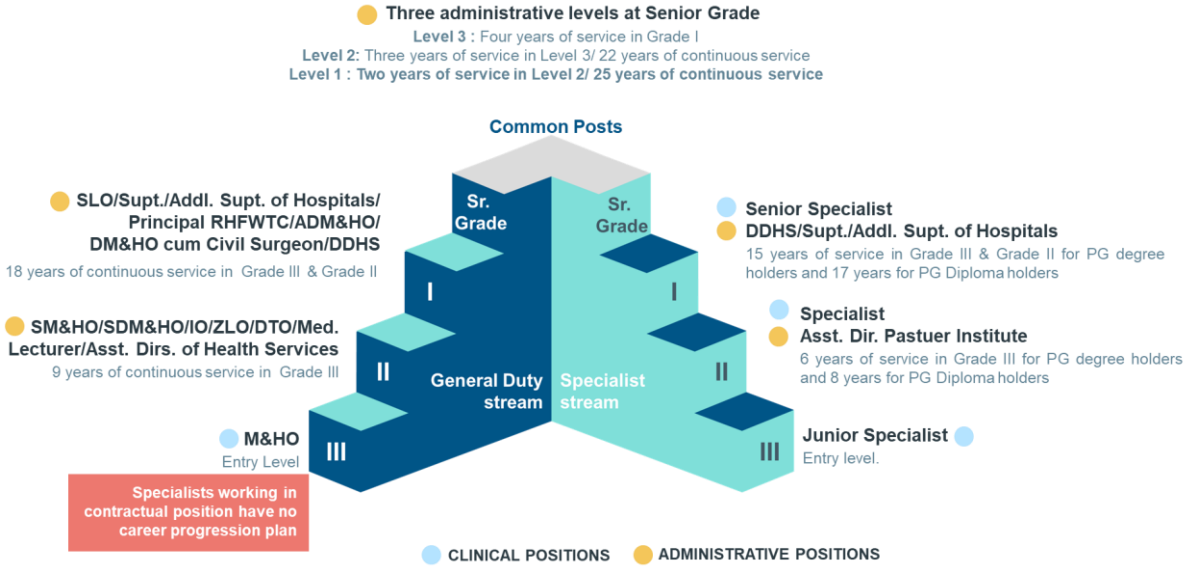
3(f) specialist as M&HO

"I am not eligible for promotions since I am on 3(f) which means I go for contract renewal every four months. In fact, my pay scale is L-15 compared to a regular entry level specialist's which is L-17"

Promotions are also based on inter-se seniority as was evident from the 1990 service rules. However, during the specialist qualitative discussions, it was evident that they found performance-based promotions or career growth fairer than the current system. For instance, a specialist working 24x7 in an emergency

section did not understand why s/he would be paid lower than a dental surgeon who is paid well despite having lower work load and are exempt from emergency duty. . However, the career progression of both were at the same time and based on seniority. It was also noted in the 1990 service rules that a post graduate degree did not help a specialist's career progression and s/he would have to join service at the same level as an MBBS doctor. It was also determined that, although the Meghalaya Health Service Rules, 1990 specifies difference in duration spent in one grade to be eligible for promotion between an MBBS doctor and a specialist, in reality the duration for progression is the same. Illustration of the Meghalaya Health Service Rules, 1990 career progression provided below:

Figure 11: M&HO vs Specialist career progression as per Meghalaya Health Service Rules, 1990



Discussions with top officials of DHS, Medical Institutions and specialists, reflect the same finding, i.e., the progression of a specialist is at the same pace and level as that of an M&HO. It leads to the conclusion that career progression for specialists in Meghalaya is not linked with higher education/PG degree. More importantly, both the specialist discussions and the Meghalaya Health Service Rules, 1990 revealed that there is no parallel growth trajectory for a specialist interested to continue clinical service without losing opportunity for promotions. This grossly affects the ability of a specialist to choose a career in clinical practice alone due to unavailability of a specific cadre allowing for promotions even as one retains their clinical practice.

Let us assume that a student who opts to be an MBBS graduate at the age of 17 and completes it by the time s/he turns 22 (or 22 and half) returns to state on a bond whereby s/he must serve in rural areas for five years and then applies for postgraduation at the age of 27 or 28 years, completes their PG and returns to service at the age of 31 years. So, the specialist, in this case, spends 18 years in clinical service and then, to avoid losing promotion, move on to an administrative post at the age of 49 with remaining nine years to be served through administrative responsibilities.

If we keep in mind the retirement age limit in Meghalaya at 58 years and unlikely entry in service at a young age for factors mentioned above as well as including irregular recruitments by the State, it reflects the systemic flaw in not being conducive for specialists to continue clinical practice without forgoing promotion, have sufficient time to progress to the highest level of their clinical career. Compare the specialists' situation in Meghalaya in context of retirement age with that of central government doctors' retirement age at 60 years which has been further relaxed to as late as 65 years in 2017.

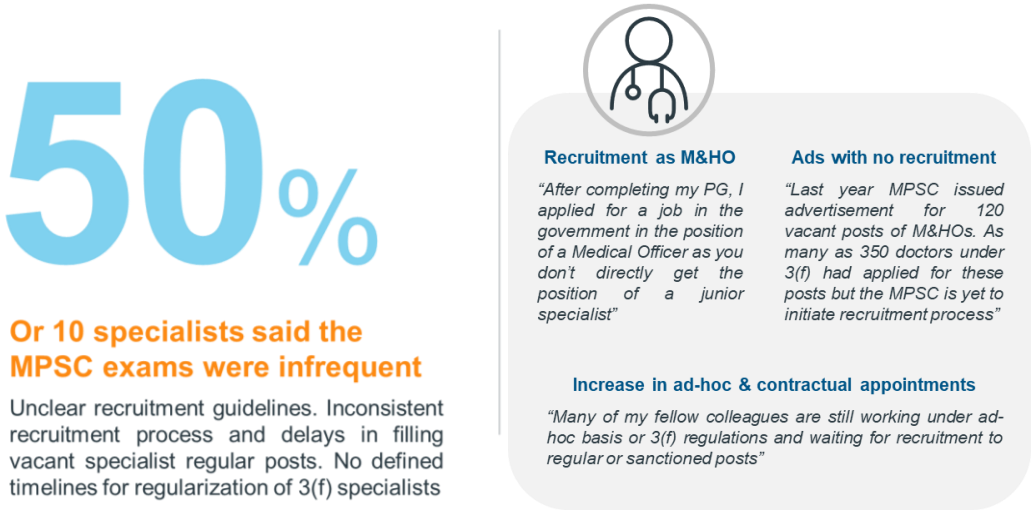
When you look at the same from the perspective of the 3(f) contractual specialists recruited as M&HOs at the age of 31 serving since 2015 and regularized in 2022, their progression faces a lag of seven years (38 years old) and their service under contract is not factored in neither during recruitment nor for promotion. So, by the time they complete their term in grade II and begin service in grade I, they are already 53 with only six years left for retirement. This too, then, points to the flawed career progression mechanism for key

HRH such as the specialists in the state, especially when one of the key issues is the shortage of such specialists within the state.

The current Meghalaya Health Service Rules, 1990 also does not factor in the presence of specialists interested in taking up teaching in the state. It can be understood that due to the absence of a Medical College, the same could not have been envisioned or amended with time. However, with the recent introduction and implementation of the the **AD**option of **A**lternate models for **R**esponding to **SH**ortage of medical specialists (ADARSH) Project, the possibility of the same has not yet been explored.

3. Irregularity in Recruitment Process

An important observation was that despite existence of recruitment guidelines in Meghalaya Health Service Rules 1990, regular and timely recruitment as per vacancies is not being undertaken. Also, there is no clear government policy to encourage post graduate doctors to join the state medical services.



Half of the specialists interviewed felt that the recruitment process has become irregular. It is clear that the last recruitment advertisement that was posted by the state in relation to recruitment for DoHFW was in 2017 and the last recruitment was conducted even before 2017, leading to an obvious shortage of specialists within DoHFW. This also led to the recruitment of specialists as M&HOs under 3(f) mechanism, which led to further challenges in terms of career progression which was touched upon in the operational barriers section.

It was also found that the average age for an entry level specialist in the regular category was close to 27 years old over the last decade with the last recruitment done in 2014. The youngest to join service was 23 years old in 2011 and the oldest specialist recruited was 31 years old in 2012. The lull in recruitment of regular specialists over six years points to a gross flaw in the recruitment system as per Meghalaya Public Service Commission (MPSC) and needs urgent intervention to address the shortage of specialists within the system. Models of Tamil Nadu and West Bengal Recruitment boards can act as apt guidance for the state to delink from MPSC and instate an autonomous recruitment board for medical cadres. Additionally, the lag in recruitment leading to hiring of specialists on contract leading to stunted growth also points to the fact that they would be regularized at a much later stage as and when the next recruitment drive is commenced. Based on the qualitative discussions and the situation analysis findings, if we consider a specialist recruited as a 3(f) contractual employee by the state in 2015, the specialist will have spent seven years on contract after having completed post-graduation at the age of, let us assume, 27 years (factoring in the average age of entry as discussed above). Let us also assume that the eventual recruitment drive takes place in 2022 at which point the specialist has turned 34 years old with little to no guarantee of regularization. The late recruitment of a qualified specialist into the system affects their career progression where their seven years of hard work is not counted during recruitment. In addition, while regularized employees since 2011 to 2014 get at least three decades to serve in the DoHFW and receive some benefits and incentives, a 3(f)-specialist

recruited in 2015 on contract loses out on seven years of employee benefits and incentives while delivering the same volume of work.

Another issue pointed out by specialists in the state was the recruitment process. Normatively, the recruitment of specialists is done through written exams and interview under the Meghalaya Public Services Commission (MPSC). In a recent development, the newly formed Meghalaya Medical Services Recruitment Board, the specialists were recruited based on merit through written test, question papers for which were unvarying from the ones designed for MO MBBS doctors.

4. Lack of Clarity on Postings & Transfers of Specialists

The state does not have a transfer and posting policy leading to irrational transfers of HRH across the state which includes specialists. Majority (92%) of the specialists interviewed said that there was no clear transfer policy while the remaining 8% were not sure of the existence of such a policy.

92%

Or 18.4 specialists said the state does not have a posting transfer policy

Irrational transfers as a result of lack of a comprehensive posting transfer policy. No defined duration of postings and transfers leading to confusion and existence of a non-transparent and unfair system

Political influence

"The best position with my qualification as pharmacologist is at Civil Hospital or DHS & DM&HO for providing my services in procurement of drugs, formulation of essential drugs & antibiotic policy, prescription audit, etc. But, people with good political influence get the posting at these places"

Irrational posting

"If the government is sending a specialist to a facility, they should make all the amenities available for a specialist to function. Right now I have to refer most of my patients to Civil Hospital, Shillong"

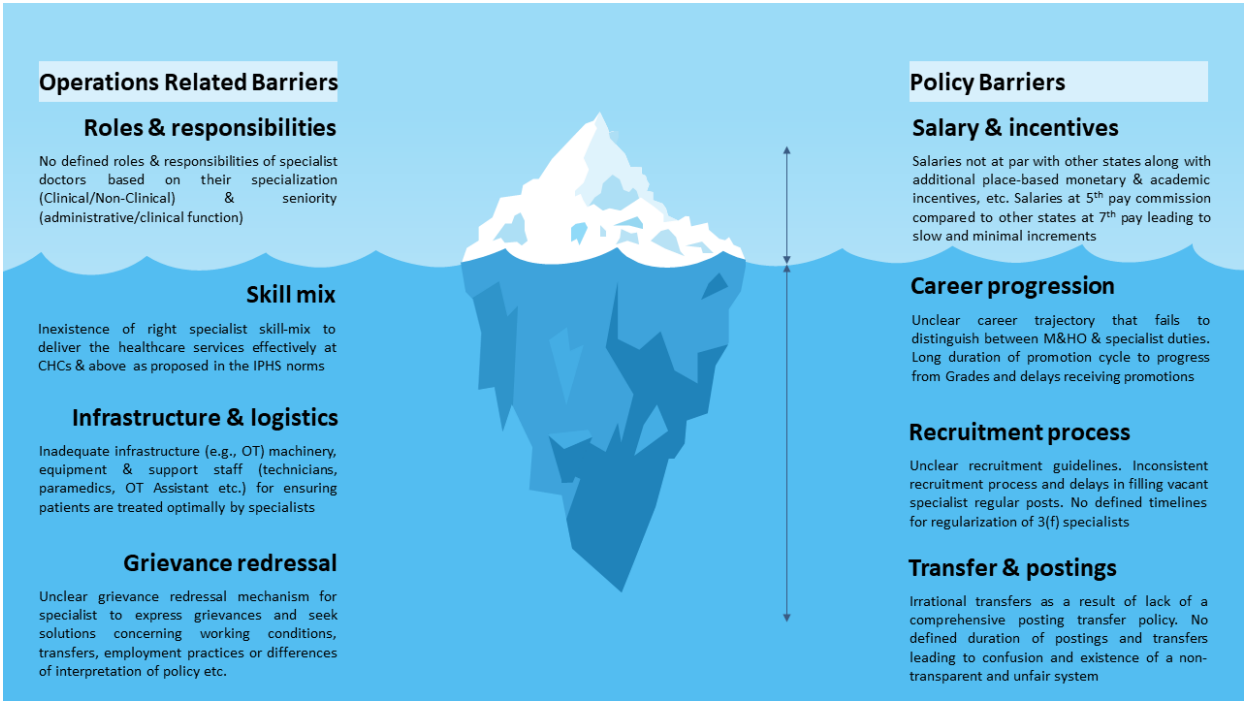
Transfers and postings are arbitrary due to lack of defined duration of postings. While the unavailability of a transfer posting policy affects the overall HRH in Meghalaya under the DoHFW, it is more unsettling for specialists as the arbitrary transfers inevitably lead to several or all of the operational barriers discussed above. If the operational barriers listed above are factored in while developing the transfer posting policy in keeping with the IPHS norms, sanctioned posts by state, among other factors such as district wise disease burden, etc, the rationalization of postings and transfers would be augmented along with availability of right HRH at the right place and at the right time. The same will be further discussed in the recommendations section.

Findings from discussions with specialists points to their arbitrary placement at facilities where they are unable to practice their skills, one such example being that of Pharmacology.

Another key finding was the reported role of political clout in determining the transfers and postings of HRH, including specialists.

Given below is an overview of the categorized barriers as discussed above:

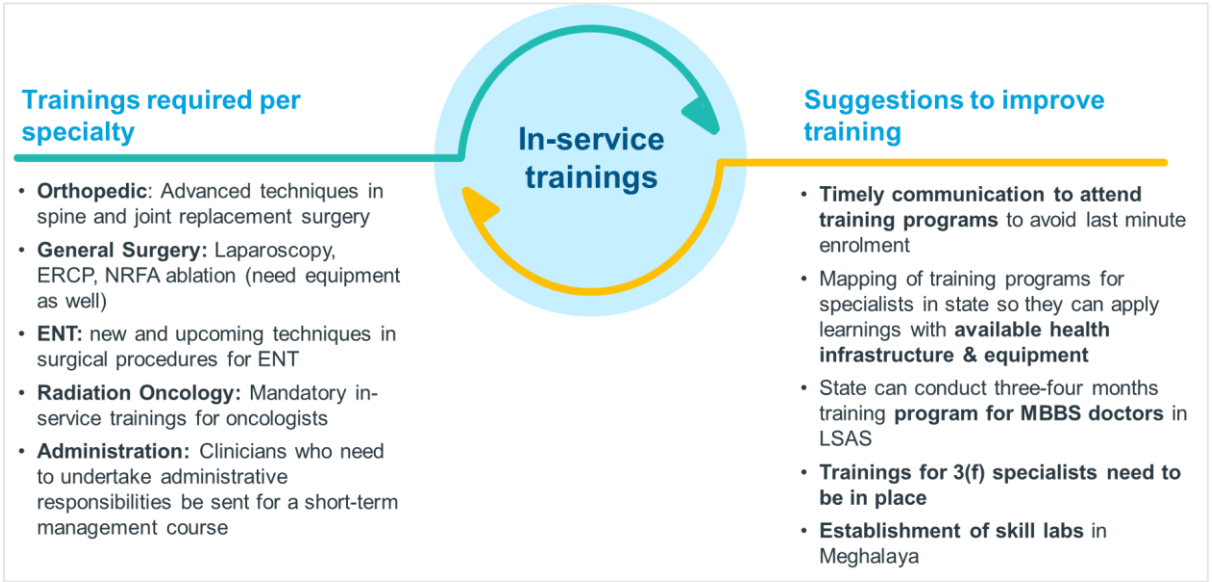
Figure 12: Overview of barriers faced by specialists



In-service trainings

During an erstwhile exercise undertaken to understand the HRH situation in Meghalaya, several documents pertaining to the state's DoHFW and its Regional Health & Family Welfare Training Centre (RHFWTC) were reviewed under the secondary desk review process. Gap analysis of the current training infrastructure, materials, calendarization, budget allocation among other factors was done which identified the need for decentralizing the training of Human Resources for Health from state headquarters to various districts and creation of trainers at district level. This was substantiated by additional questions included in both tools --- and---- used for this study. Training need assessment, for HRH and specifically specialists, was beyond the scope of the study and hence not undertaken.

Figure 13: In-service training needs and suggestions provided by specialists of Meghalaya



However, the common findings from all these exercises points to 1) the need for avenues to enroll medical officers and specialists interested in administrative work in a short-term public health management course, 2) development of a mechanism by the state to train MBBS doctors in LSAS,3) inclusion of 3(f) specialists in training programs, 4) establishment of skill labs and, most importantly, 5) mapping of training programs in alignment with availability of infrastructure, logistics and equipment at the place of posting of specialists.

Specialists interviewed in specialties such as orthopedic felt that they could learn advanced techniques in spine and joint replacement surgery. General surgeons interviewed mentioned the need for trainings in laparoscopy, Endoscopic retrograde cholangiopancreatography (ERCP), Needle radiofrequency ablation (NFRA), along with availability of equipment. Several specialists felt they needed a short-term course on management in order to handle administrative work entrusted to them at joining.

HR Effectiveness and Satisfaction Survey Findings

The HR Effectiveness and satisfaction survey tool was developed as part of the overall HRH enumeration exercise (under the HRH component of the Meghalaya Health Systems Strengthening Project) which is ongoing in the state. In keeping with the findings of the current study, the survey, alternately referred to as, job satisfaction survey, has been utilized as a resource to do a quick dipstick of the satisfaction level of specialists and other health cadres across the state.

The overall HRH effectiveness and satisfaction survey was designed with a sample size of 5% (295) HRH across the state. Out of the sample, approximately, five additional specialists were added to the original sample of specialists (14) to be covered. The survey's expected outcome was to gain insights into key issues related to human resource satisfaction, motivation, effectiveness, and health impact. The same parameters were also analyzed as part of the specialist study and a visual representation of the same has been provided below.

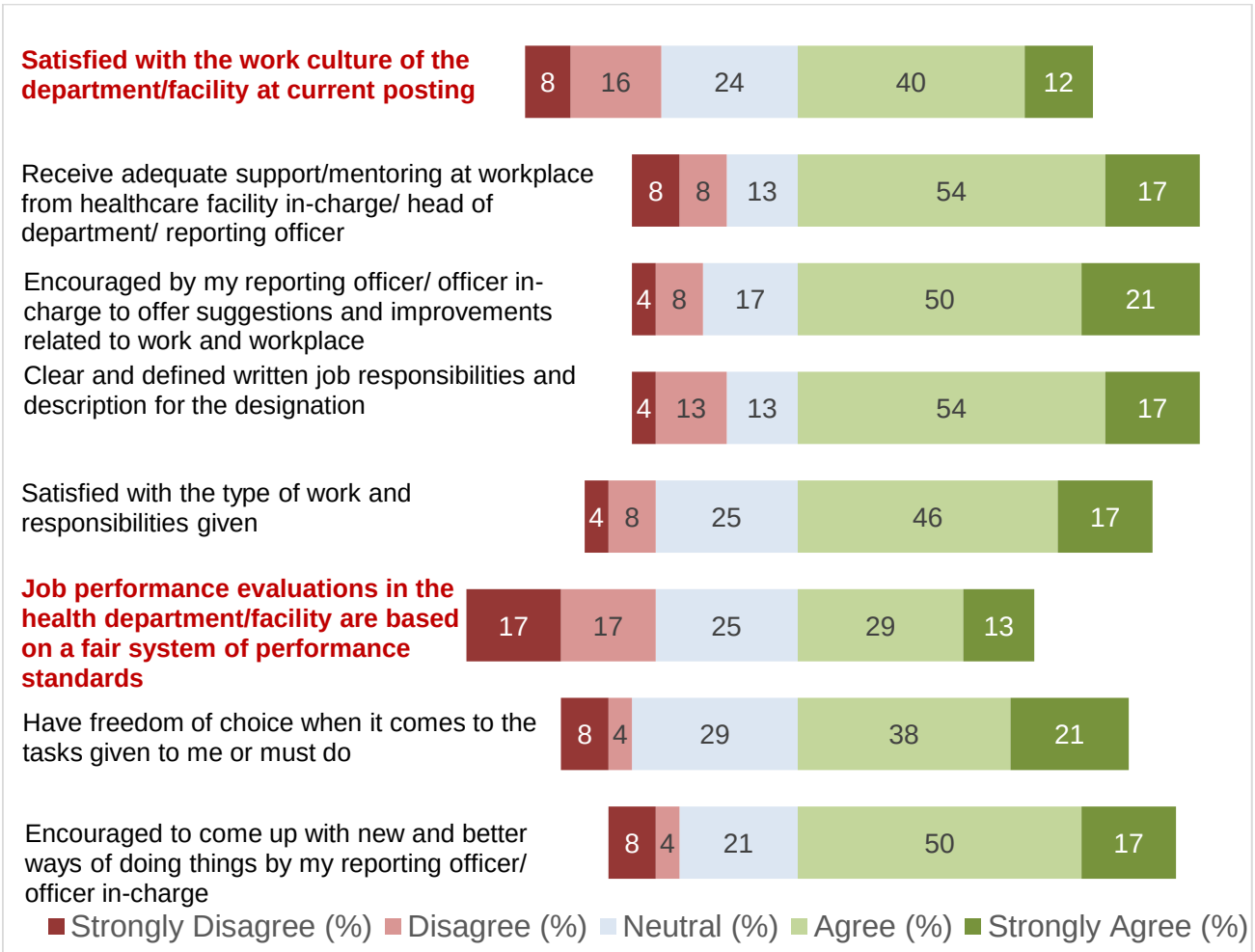
A total of 31 specialists voluntarily participated in the survey, at the time of this reporting, which was administered through an online link and where possible implemented by Field Investigators (FIs) engaged for HRH enumeration with basic face to face interaction for assistance with the survey form. The survey collected information on 10 crucial areas of job satisfaction as listed in the adjacent figure.

Figure 14: HR Effectiveness & Satisfaction Survey components

1. Key findings from the job satisfaction survey

1. Work Support

- Nearly one-third of the specialists felt dissatisfied with performance evaluations
- One-fourth of the specialists were dissatisfied with the work culture

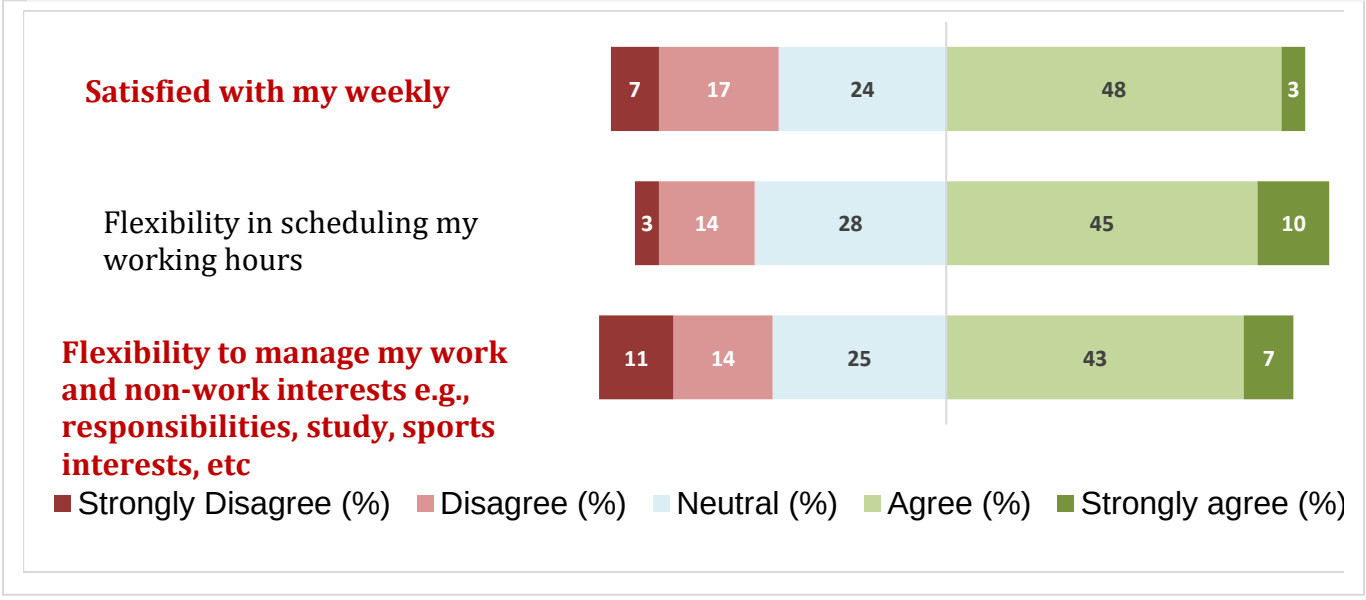


2. Team Work

- Nearly one fourth of the specialists felt that there was a lack of team spirit and did not feel that they were part of a team
- Around one third of the specialists felt that most employees at their posting were not enjoying their work
- Close to one fifth believed that most employees did not understand the mission of the health

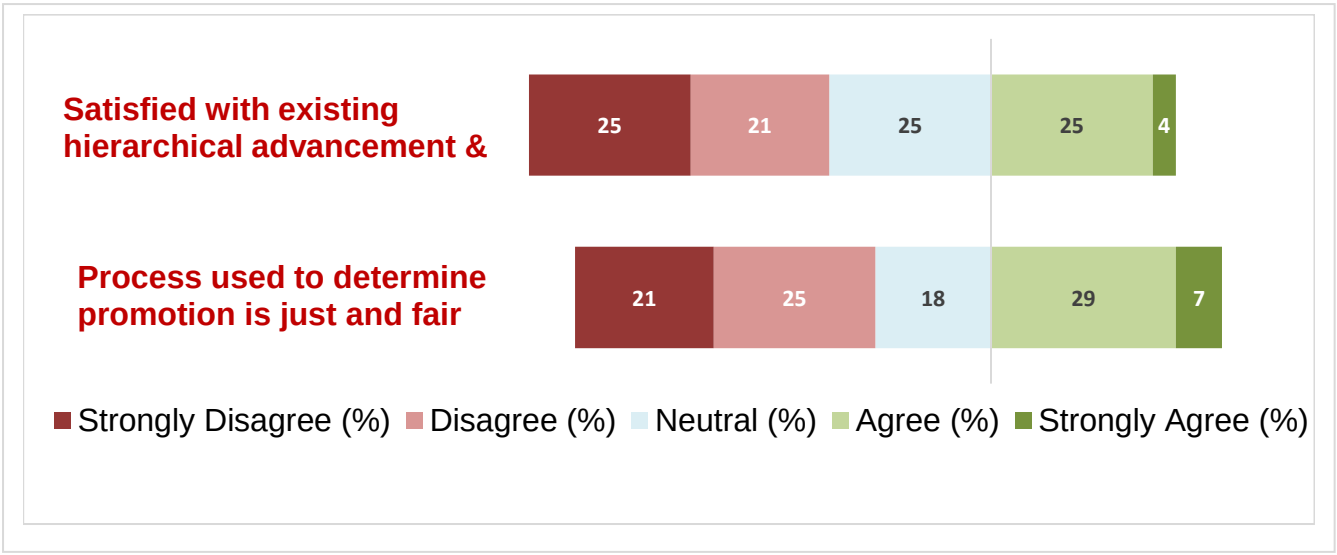
3. Working Hours

- Nearly one fourth of the specialists felt that there was a lack of team spirit and did not feel that they were part of a team
- Around one third of the specialists felt that most employees at their posting were not enjoying their work
- Close to one fifth believed that most employees did not understand the mission of the health department and its functions



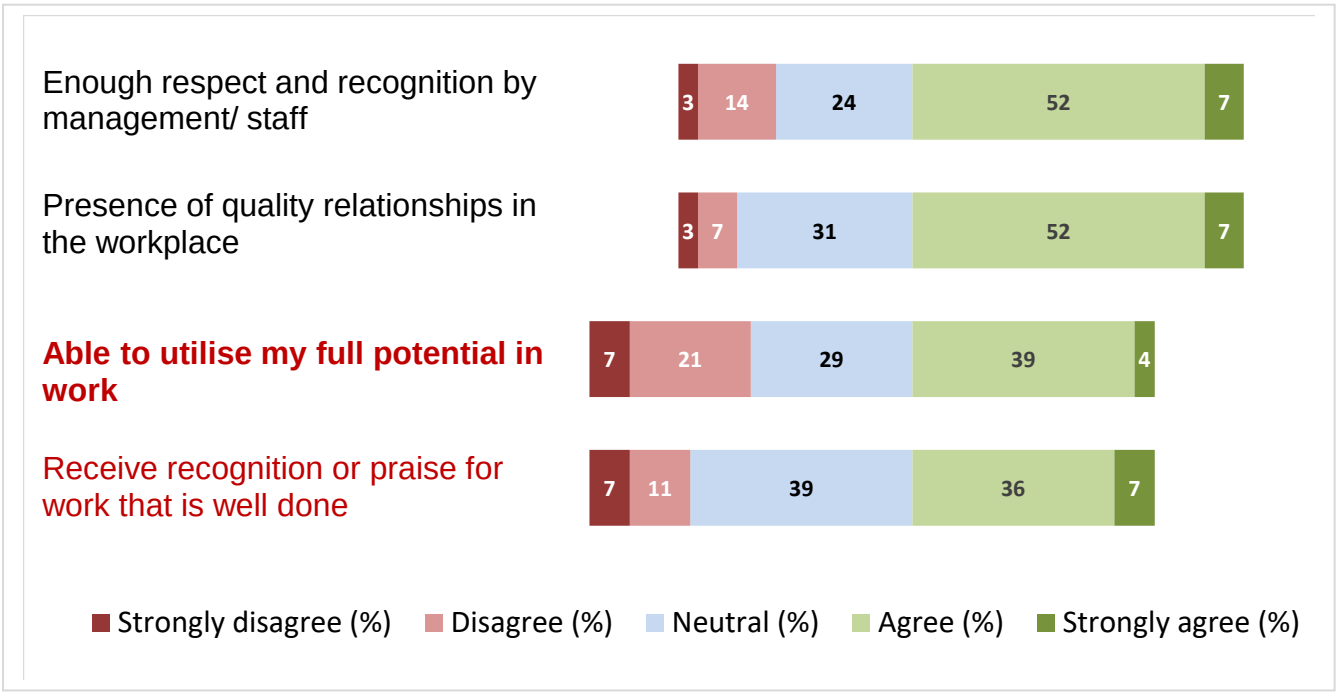
4. Promotion

- Close to half the specialists were dissatisfied with the existing hierarchical advancement and promotion opportunities.
- Similarly, nearly half the specialists surveyed felt that process to determine promotions was not just and fair



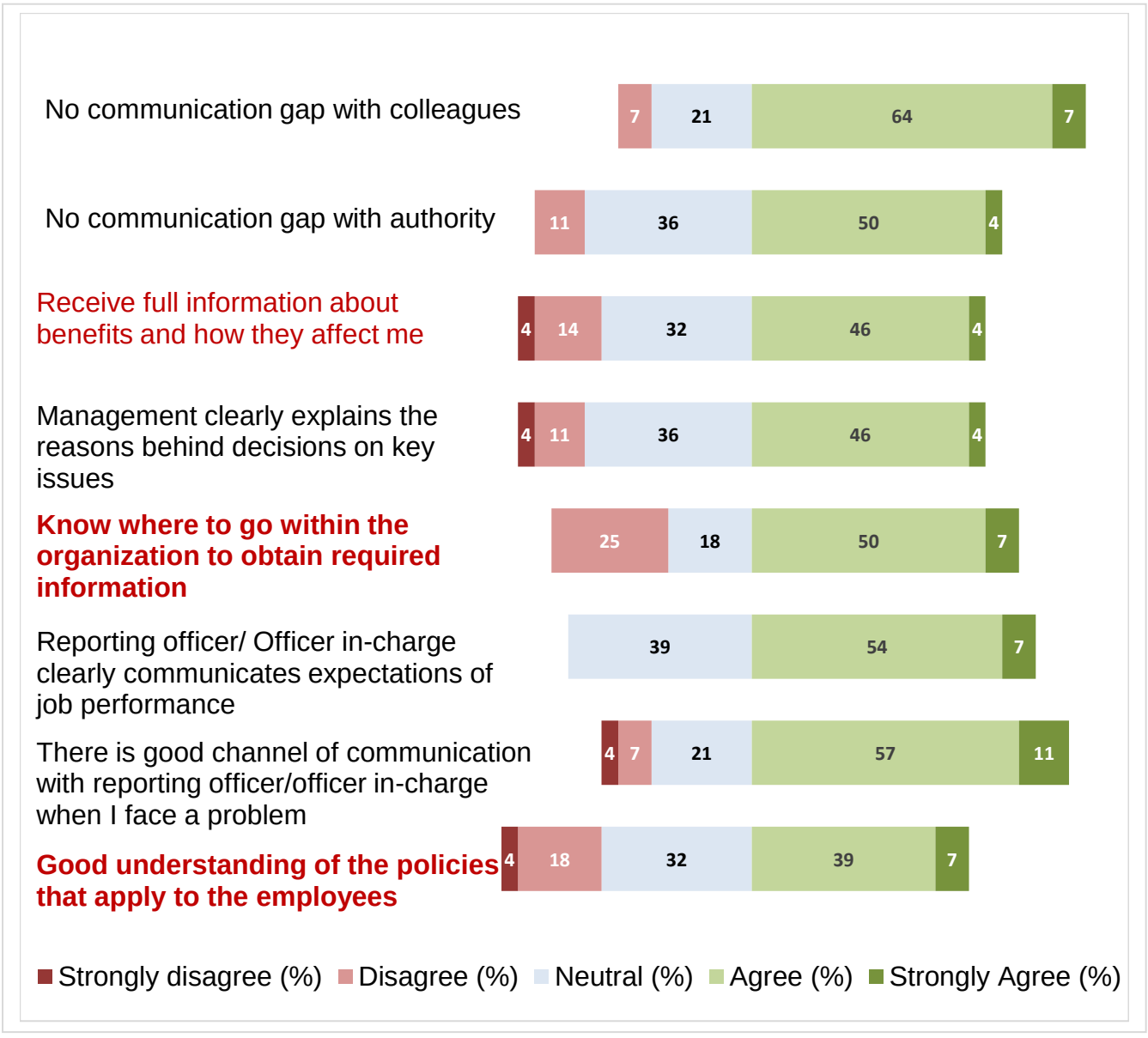
5. Recognition & relationship

- Over one-fourth of the specialists surveyed did not feel that they could work to the best of their ability at their posting
- Close to one fifth felt they did not receive enough praise or recognition at the workplace



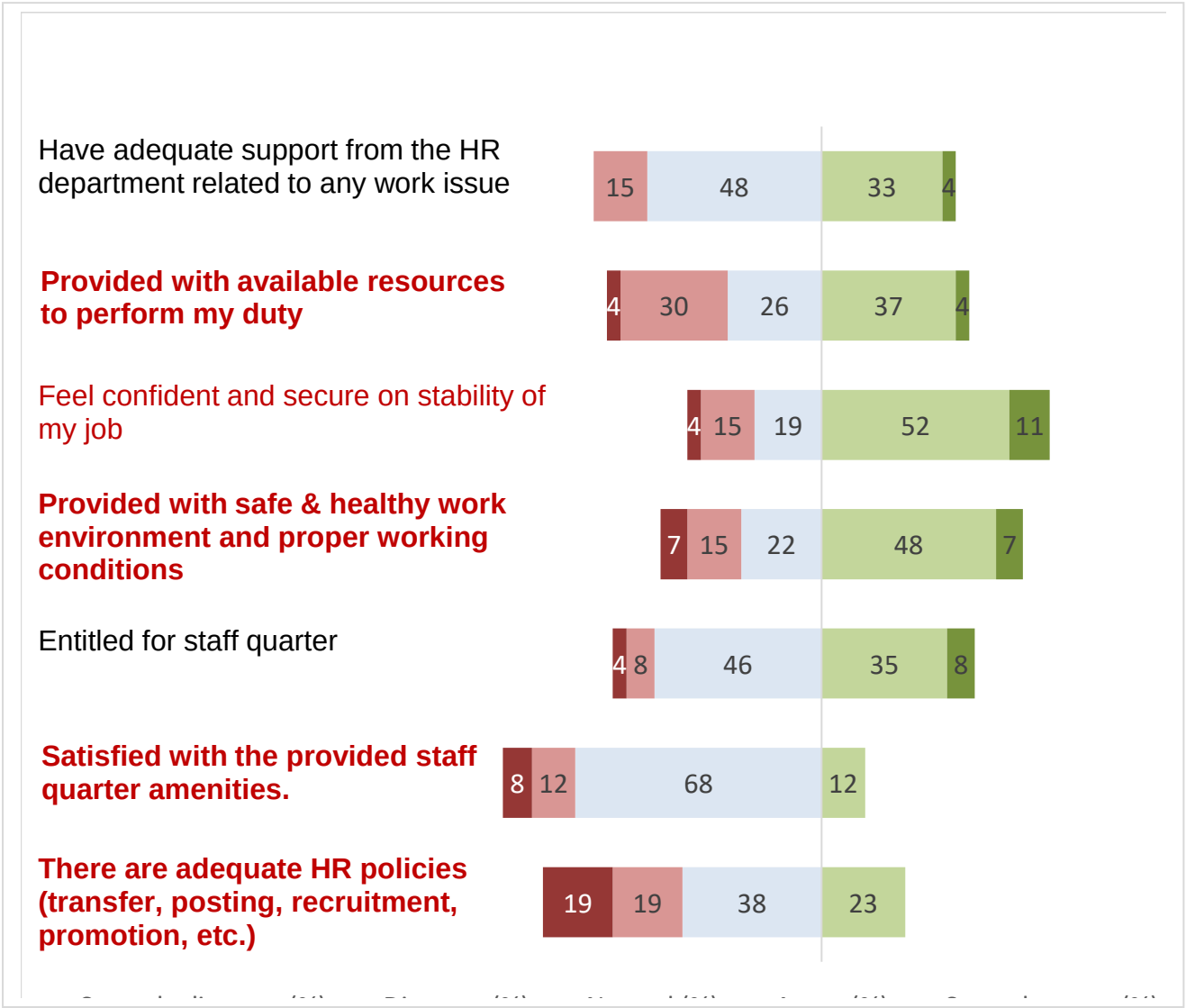
6. Communication

- One-fourth of the specialists surveyed did not feel confident that they knew where to go to obtain required information related to their work
- Close to one-fourth also did not feel that they had a sound understanding of the policies pertaining to employees
- Close to one-fifth also felt they did not have requisite information for the benefits they are entitled to and how they impact them



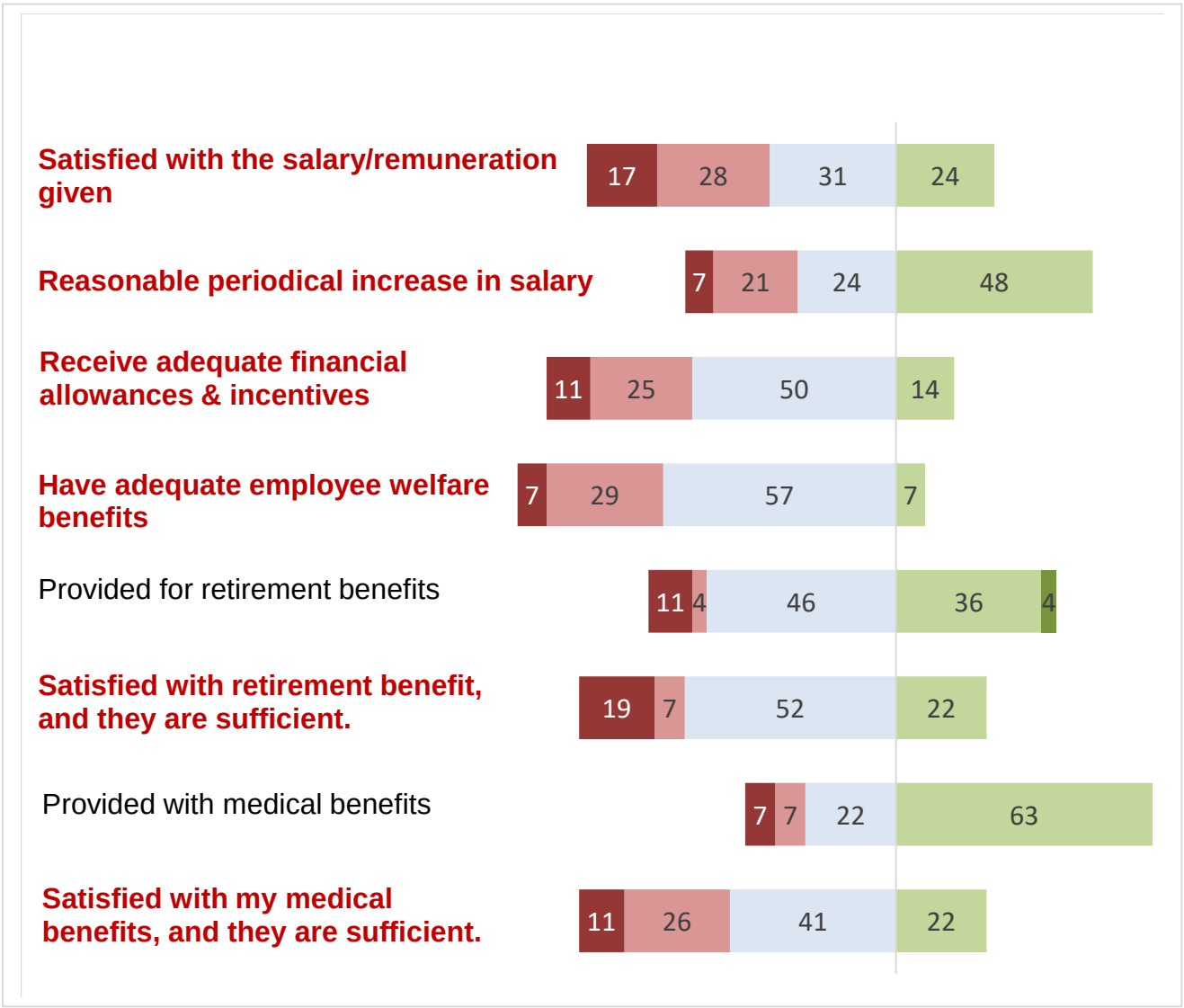
7. HRH Management

- A little over one-third of the specialists surveyed did not feel they were provided with available resources to perform their duty optimally
- Nearly two-fifth also felt their work is not governed by adequate HRH policies such as transfer posting, recruitment, and promotions.
- One-fifth did not feel they had a safe and healthy work environment with proper working conditions
- Again, one-fifth were not satisfied with the staff quarter amenities provided
- Close to one-fifth also did not feel confident and secure about the stability of their job



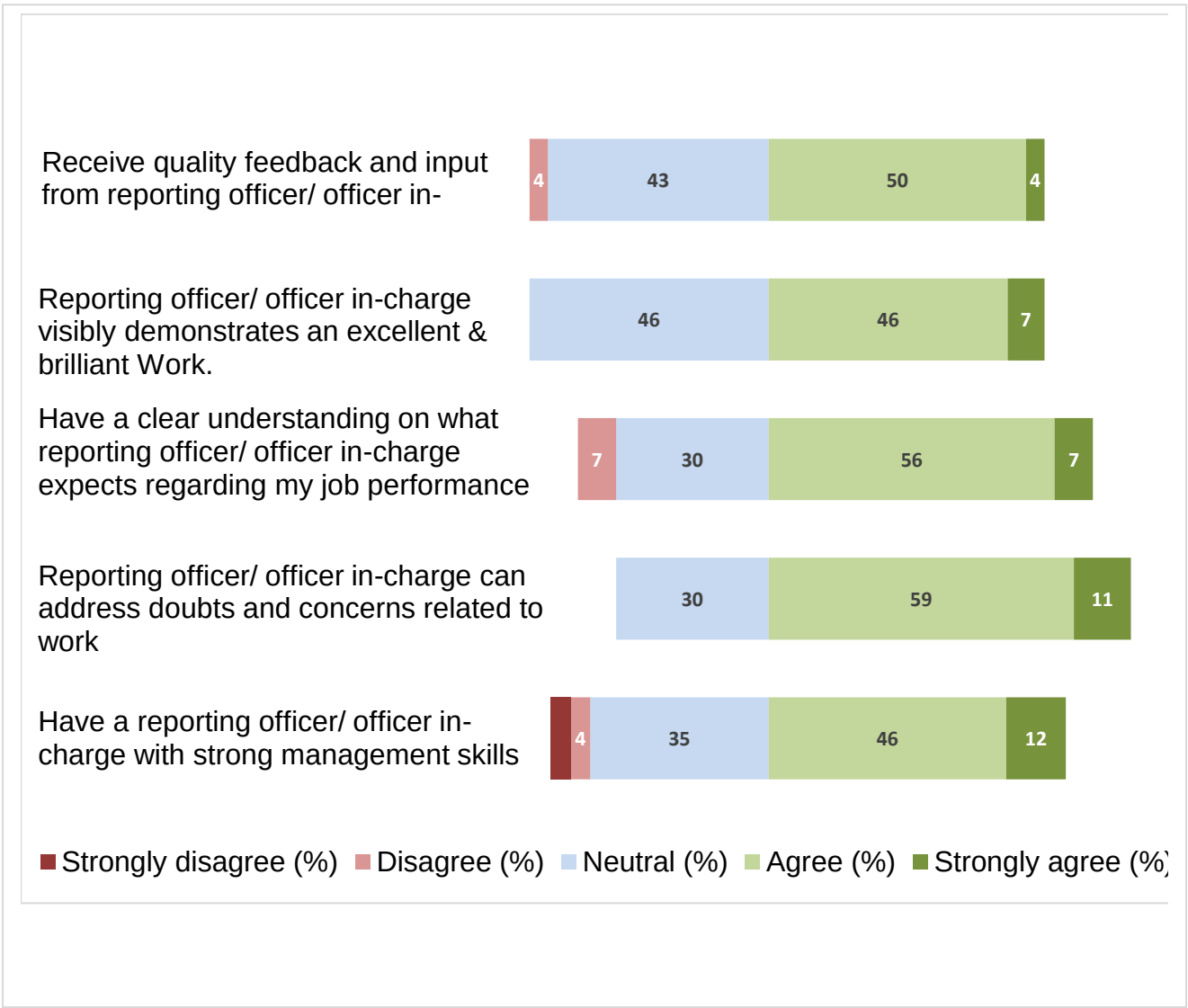
8. Pay and Incentives

- Over two-fifth of the specialists surveyed felt dissatisfied with the current salary
- Additionally, over one-fourth felt they did not have periodic increase in their salary
- Over one-third of the specialists felt they did not have adequate welfare benefits
- More specifically, one-third also were not satisfied with the medical benefits and felt they were insufficient
- Further, over one-third of the specialists felt they did not receive adequate financial allowances and incentives
- One-fourth of the specialists felt their retirement were insufficient



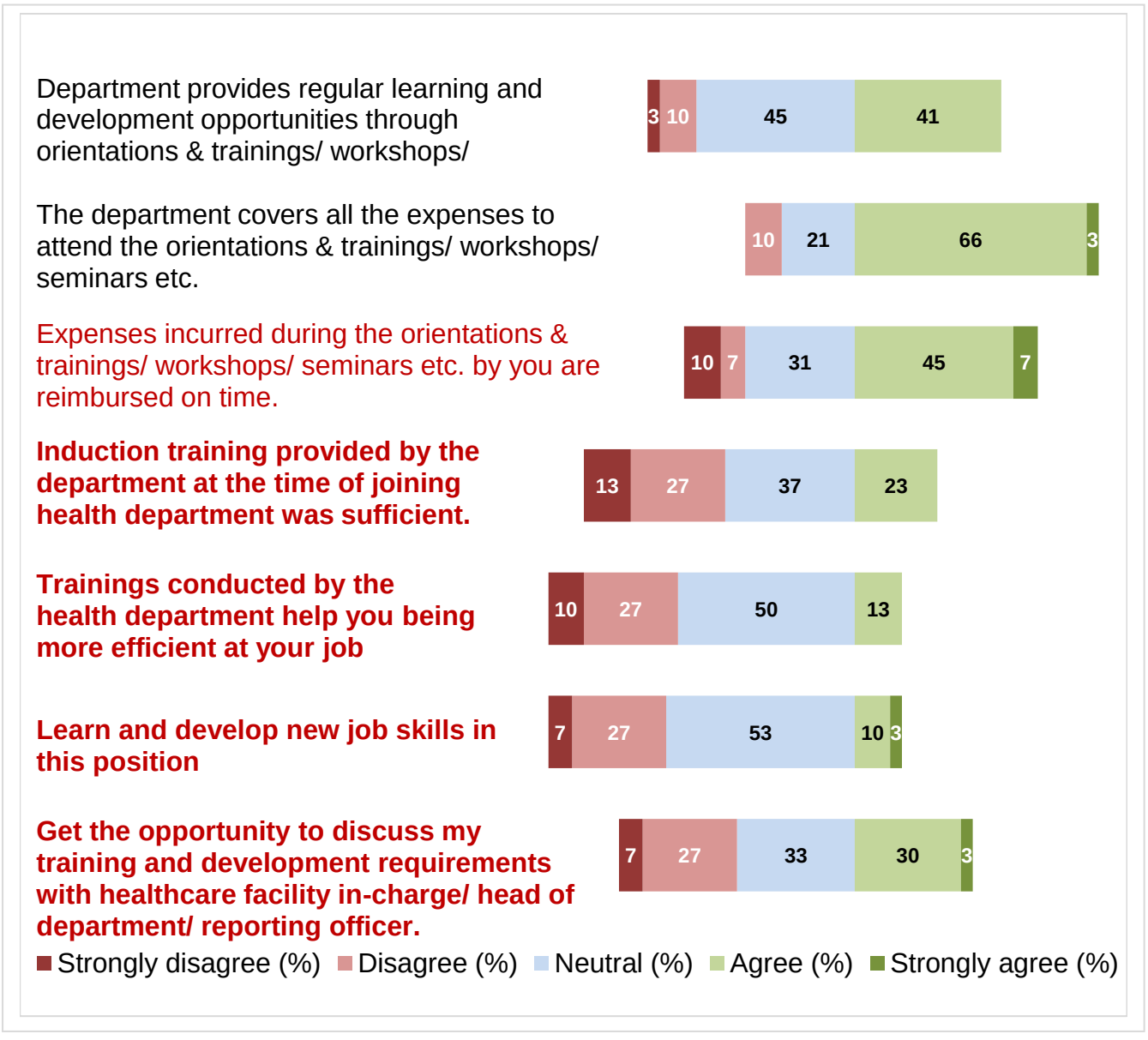
9. Leadership

- Many respondents (approx.. over one-third) indicated neutral responses towards the parameters included in the survey with regards to leadership
- It cannot be overlooked that an even larger chunk (over 50%) of the specialists surveyed were largely satisfied with the leadership and indicated the same in all parameters as illustrated



10. Training & Development

- Two-fifth of the specialists disagreed that there was any induction training conducted
- Close to two-fifth also felt that the trainings offered by the health department did not enable them to work efficiently
- One-third felt that they did not learn and develop new job skills in their current position.
- Similarly, one-third also felt lack of opportunity to discussion training and development needs with facility in-charge/head of department and/or reporting officer
- A small number (close to one-fifth) of specialists also felt that the expenses incurred during orientation and trainings/workshops/seminars were not reimbursed on time



2. Triangulating findings from job satisfaction survey and specialist study findings

Commonality of findings were found between the survey and study's qualitative discussions undertaken with the specialists and the same reflect a strong correlation between across four key parameters. under the following components:

- Firstly, an **overall dissatisfaction with working hours** where over half (57%) the surveyed specialists felt there was no work life balance. The same was recorded among specialists during qualitative discussions where over two thirds (67%) of the specialists felt burnout due to extensive work hours and responsibilities and one fourth (25%) felt burnout sometimes
- Secondly, overall **dissatisfaction with promotion process and system** was logged with over half (57%) the specialists feeling dissatisfied with existing hierarchical advancement & promotion opportunities and did not find the process used to determine promotion is just and fair. Additionally, of the half of the specialists, one third (34%) of the specialists surveyed felt that their job performance evaluations in the health department/facility are not based on a fair system of performance standards. This resonates with the findings from the specialist study where several specialists expressed the absence of performance-based indicators to rationalize promotions
- Thirdly, over half (53%) of the specialists surveyed felt **dissatisfied with the existing salary/remuneration**, indicated that there was no reasonable periodical increase in salary, did not feel they received adequate financial allowances & incentives, employee welfare benefits, were dissatisfied with retirement benefits and medical benefits and their inadequacy. This aligns with the study findings where majority (92%) of the specialists did not have sufficient salary and benefits compared to counterparts in other northeastern or larger states across the country
- Lastly, a little less than half (45%) of the specialists surveyed felt the **need for training and development opportunities**. Of the 45% specialists, two-fifth felt the need for induction training, one third felt current trainings do not help efficiency, and that they do not have avenues to discuss training needs along with expressing dissatisfaction towards inability to develop new skills at their current position. This aligns with the findings from the specialist study whereby specialists felt that they were often "overtrained" in the absence of tools to implement trainings, did not find avenues to flag the inability by DHS to provide timely notification on trainings to enable timely participation.

3. Discussion

The findings in the present study bring out a set of existing HRH challenges faced by specialists working with the DoHFW in the State of Meghalaya. However, it also brings out suggestions for improvement that can be instrumental in addressing the challenges faced by specialists within the system, as well as the inequities in numbers and distribution of specialists existing in the state's health department.

While the study covers various key aspects that the state can use as guidance to develop the specialist cadre policy, it does not succeed in providing a clearer picture of the existing data related to specialists within the state.[8] This shortcoming is also a result of lack of clarity on the sanctioned positions and vacancies for specialists which needs to be streamlined.

However, it also needs to be understood that, currently, there is **lack of a mechanism to map available HRH with the vacancies of various categories of health professionals** like doctors, nurses, and other paramedical staff existing in public health facilities as per Indian public health standards (IPHS) norms or even as per international standards. This is true for several states across the country (Sarwal, 2022). One tool for doing so is **digital record keeping** of all key data pertaining to HRH and adherence to central government mandate for instating **a robust e-HRMIS**. The state's initiative under MHSSP to undertake **HRH enumeration** will enable the same.

The study underlines **the lag in recruitment of overall HRH** as a result of the **prolonged recruitment lull** under the **Meghalaya Public Service Commission (MPSC).** It points to the need for prioritizing essential service recruitments beyond the walk-in processes, contractual on-boarding as well as NHM recruitments. Section 2.2 of this study shows the data from Megha Health Insurance Scheme which helped understand the segregation of specialists across the state between the public and private sector with 56% being in the private sector and 44% in the public sector. This can be viewed in correlation to the key findings from specialists interviewed, one third (33%) of whom were interested in joining the private sector, and 8% were considering the same or were not sure. So apart from recruitment, the study also points to **the retention of specialists**.

Further, **the process of recruitment for specialists** also needs to be revisited given the context of the recent written test-based examination for entry of specialists. It must be discerned by the State whether they would choose **lateral entry of specialists** within the system given the shortage of specialists as is the case with **Uttar Pradesh** that allows for lateral entry by merely assessing proof of qualification or would it prepare a **written test mechanism** as is the case with **Sikkim** where two papers are prepared (details in figure below), or would it begin **a mechanism of weightage based on qualifications and years of service** (government or private) as is the case with **Maharashtra**.

From the **placement and transfer** perspective, the State needs to take care that the specialists **not be instated below the CHC level**, ensure **availability of an enabling environment** at their work posting in terms of skill mix, equipment, logistics and infrastructure.

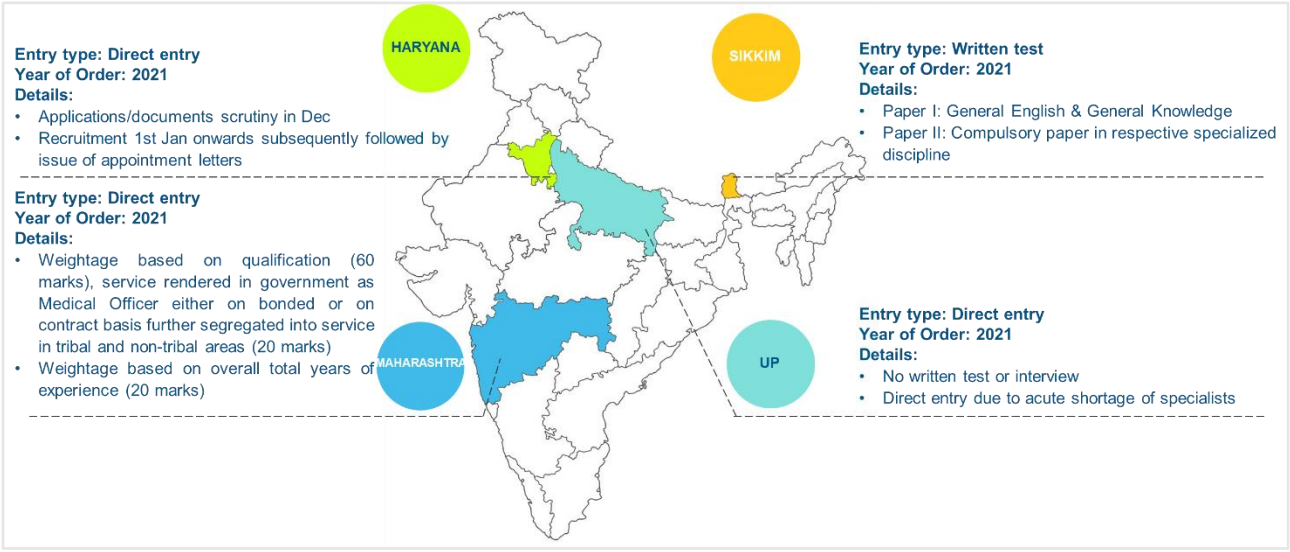
During the specialist discussion, it was determined that due to non-availability of a medical college, **lack of teaching institutes/hospitals and opportunities,** certain specialists and their specialization lacked practical application and the same specialists can be utilized in the field of teaching. During the secondary review, it was found that the Government of Meghalaya had recently published its State Health Policy which also mentioned **the ADARSH Project** which has been initiated by the State in the recent past. The teaching faculty at Ganesh Das Maternal & Child Health Hospital and Civil Hospital, Shillong, East Khasi Hills have been put in place and, thus, the State should view this as an opportunity for incoming specialists to join the teaching faculty of the two hospitals to pave way for **gradual development of the teaching cadre**. Specialties such as Physiology, Anatomy and Pharmacology, among others, can be integrated in the area of academic teaching

[8] To be revised once updated numbers are provided by DHS (MI)

either in the budding teaching hospitals of the State government or a mechanism for inducting them into NEIGHRIMS has to be chalked out.

Given the context of the assumption-based scenarios (for a 31-year old regular entry specialist and a 38-year-old 3f specialists having seven years of prior experience) presented regarding the progression of specialists under the Meghalaya Health Service Rules 1990, the State needs to **revisit the retirement age of specialists** to leverage existing specialists and their skill set to address issue of vacancies subsequently **tackling the issue of shortage of specialists** in the state.

Figure 15: Entry type for specialists in some states of India



The study also urges the state to undertake **a deep dive into successful systems and models of HRH management that have worked vis-à-vis the restructuring of health service cadres** which enables unclogging of the career progression of specialists, **instating of strong attraction and retention plan** through a bouquet of incentives, **development of a robust training plan** to upskill existing specialists, and bringing about an **airtight transfer and posting policy** which is transparent and fair.

The varied interactions with existing specialists in Meghalaya's public health system revealed the brewing disillusionment with the government system, majorly due to deterrents such as arbitrary transfers and its lackluster work environment. Specialists with varied functional and policy related grievances have expressed their disillusionment towards the current system and approach of administrative departments towards decision-making with regards to them. In this regard, the State needs to take stock of this aspect as well to be better placed when developing the specialist cadre policy.

Finally, **the development of a specialist cadre policy can be driven by this study** while also paving way for **creation of the public health cadre followed by the health management cadre and finally the teaching cadre, or in the order of priority governed by the PHMC Booklet's guidance.**

4. Conclusion & Way Forward

Through the secondary review findings, interview guide for qualitative interaction & discussion with specialists, as well as implementation of the job satisfaction tool (HR Effectiveness & Satisfaction Tool), we gained insights into the operational and policy related barriers faced by specialists. Through the tools, specialists were also provided with the opportunity to give recommendations to the government which have been logged in the report and factored in under the discussion section of the report for development of the specialist cadre policy.

The recommendations provided to the state are in two parts: one being recommendations by specialists interviewed for the study (section 2.3) and another being comprehensive best practice-based recommendations derived as part of the study in keeping with the former (Annexure IV).

The following illustration is a summarization of all the recommendations as a result of the findings from this study:

Figure 16: Formation of specialist cadre policy based on recommendations

The recommendations can also act as a springboard for development of further strategies for policy reform with regards to other health cadres. The successful implementation of the specialist cadre policy can pave way for the formation or reformation of policies related to other key health cadres such as nurses. However, as a next step, the state needs to analyze the findings and recommendations thus chalked out to understand feasibility, turnaround time for advocacy, decision making and final implementation of the same.

DISCLAIMER

- The analyses, their interpretation, and related information contained herein are made and provided subject to the assumptions, methodologies, caveats, and variables described in this report and are based on third party sources and data reasonably believed to be reliable. No warranty is made as to the completeness or accuracy of such third-party sources or data.
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