Pathways to a Successful Public Health Cadre in the North East

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1. Public Health in India

According to the World Health Organization (WHO), 'Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole'. In India, public health (PH) was used synonymously with provision of health care facilities until recently. The advent of the COVID-19 pandemic proved that just providing medical care was not enough to fight the pandemic, but simultaneous efforts in other areas such as research, vaccine production, health promotion, equitable distribution, and real time data analysis was necessary. Although all these functions come under the domain of PH, they are not defined as such. The current health system only defines and measures the availability of health care facilities and health care professionals, but not PH measures undertaken, even though these are undertaken in various capacities.

1.1. Defining Public Health Functions

The Institute of Medicine's 1988 report (Walker, 1989) was one of the first efforts to clarify what PH entails on a practical level. It emphasised on three core PH functions: assessment, policy development, and assurance.

Figure 1: Essential Public Health Functions

Source: The figure has been developed based on World Bank's essential public health functions-based mapping tool

In 2004, World Bank (WB) adapted an Essential Public Health Functions (EPHF) framework that was originally developed by the Centers for Disease Control and Prevention (CDC) and the Pan American Health Organization for Latin American countries for the Indian context (Gupta et al., 2004). Known as the Governance Knowledge Sharing Program, WB implemented this EPHF framework at the national, state, and district levels of India, and more specifically in Karnataka. Twelve EPHF were finalised based on inputs and feedback received from various PH experts of India. World Bank (WB) also developed survey instruments (World Bank, n.d.) to help understand and assess the PH system's performance against the 12 EPHF. Separate survey instruments were developed and administered at the national, state and district levels.

Based on a review of the 12 EPHFs by WB, we developed an EPHF-based mapping tool to understand the functioning of a state's PH system. The EPHF-based mapping tool includes the following 11 functions:

1) Health situation monitoring and analysis
2) Epidemiological surveillance/disease prevention and control
3) Research and development on PH
4) Policy and planning
5) Budgeting and financial management
6) Health promotion and education
7) Reducing the impact of emergencies and disasters on health
8) Regulation and enforcement of PH
9) Assuring a competent PH workforce
10) Ensuring quality population-based health services and
11) Environmental health and sanitation (Figure 1).

Methods and Challenges in Conducting the Study

A combination of research methods was used, which included expert consultations, literature and policy reviews, personal interviews of stakeholders, and primary and secondary data analyses to evaluate the prerequisites for a public health cadre (PHC) in the states of Assam, Manipur, Meghalaya, and Nagaland. Semi-structured interviews with government officials and consultations with PH experts (from non-governmental organisations, academia, and retired officers) were conducted to gather their perspectives on the need for a dedicated PHC and its implications and challenges, cadre structure, eligibility and qualifications, pre-conditions for having a successful cadre, and other foreseeable advantages and limitations. An attempt was also made to understand the extent to which the current health care system in the four states incorporated the 11 EPHF by administering an EPHF mapping tool to district level health officials. Finally, a roundtable was organised in August 2022 In Meghalaya to disseminate and discuss the findings of the study. The discussion was attended by officials from the study states as well as from Mizoram. The EPHF findings were modified accordingly based on proceedings of the roundtable.

The study was conducted between the second and third waves of COVID-19, which led to cancellation of field plans. In addition to the constraint of securing time with officials busy with COVID-19 management, the non-availability of documents with description of roles and responsibilities of the PH leadership/management with the health departments also acted as barriers.

1.2. Public Health Cadre in India

All the functions mentioned above are already being undertaken in various capacities within health and other relevant ministries in India. However, to give PH its due importance and streamline its functions, there is a need for a specialised workforce trained in PH. A management cadre for PH has been long recommended, most recently by the National Health Policy of 2017, and an expert committee for the formation of a PH management cadre came out with recommendations for the same in 2020-21. The Ministry of Health and Family Welfare also introduced a curriculum for the Master of Public Health (MPH) course in 2017-18 as the first step towards training PH professionals in the country.

Tamil Nadu is one of the few states in India that has already had a separate directorate for public health cadre (PHC), which was established in 1922. This cadre is separate from medical services cadre (focusing on secondary and tertiary care) and focuses on the management of PH measures at the population level and is inclusive of primary health care. This separation has been credited with the state's organised approach to health planning as well as cost-effectiveness of health care in the state(Das Gupta, Desikachari, Somanathan, & Padmanaban, 2009). Furthermore, this is replicable in other states. Odisha too has undertaken the formation of a PHC recently and they have done so after undertaking a complete analysis of their workforce and adding on PH professional posts as needed at each tier of health department. Setting up a PH management cadre for a state in a country as diverse as India requires an understanding of each state's health landscape, fiscal capacity, current workforce, and organisation. Our study at Centre for Budget and Policy Studies, which this policy brief is based on, aimed to understand whether the four North East Indian states of Assam, Manipur, Meghalaya, and Nagaland require a PH management cadre, and if so, how should that be determined. To do this, we tried to understand the current state of PH functions in each of these states. We also sought to bring in an understanding of the current health landscape and financial position of these states in order to suggest a pathway.

2. The North East Region

2.1. Background of the North East Region and National Health Mission

The North East Region houses 7.9% of India's population. All North East states, in addition to being in the high-risk seismological area, have to frequently overcome geographical challenges such as frequent floods and landslides. This makes provision of infrastructure and, therefore, transport difficult.

Statistics from National Family Health Surveys (NFHS-3, NFHS-4, and NFHS-5 from 2005-06 to 2019-20) show that there have been significant improvements in child mortality rates in all four states, which was even better than the national average in 2019-20. However, delivery of health care services, like percentage of institution births, immunisation coverage, etc., remain below the national average. Vulnerable populations like the tea communities, populations living in Char in Assam, or people living in the valley regions of Meghalaya, etc. show poorer health indicators than the general population. The states also have a high burden of communicable as well as non-communicable diseases at a time when the burden on communicable diseases is reducing in other states in the country. All four states face a large shortage of specialists (more than 90%) (physicians, paediatricians, surgeons, and gynaecologists) in public health facilities. The states also have higher percentage of children who have poorer immunisation coverage and lower percentage of institutional deliveries as compared to national figures. In addition, the number of medical colleges

as well institutions offering MPH courses in the NER is low. In fact, there are no medical colleges in Nagaland, and only Meghalaya has institutions offering an MPH. Table 1 below compares c maternal and child health indicators between the four states and India.

The states also have low own source revenue and are thus heavily dependent on the central government for funds. Most central government schemes in the NER are funded in the ratio of 90:10, with the state's contribution only being 10%. This holds true for the National Health Mission (NHM), a centrally sponsored scheme as well, which undertakes expenditures on almost all areas of PHwithin the health department. In these states, NHM expenditures averaged to more than 50% of their PH expenditure (PHE), as per the individual state budget analysis between 2018 to 2021. Due to its high monetary contribution to health expenditure in the NER states, the NHM wields greater influence on decision-making processes in the states. The NHM also funds a large PH workforce, without whom the health system in the state will be stalled. However, this workforce does not possess the benefits of permanent state employment. Introduction of a PHC cannot ignore the presence of NHM and its contribution.

Table 1: Child and Maternal Indicators for Assam, Meghalaya, Manipur, Nagaland, and India

States	Infant Mortality Rate (Per 1000 life births)	Under-5 Mortality Rate (Per 1000 life births)	Wasting (%)	Stunting (%)	Institutional Births (%)	Immunisation Coverage (%)
Assam	31.9	39.1	21.7	35.3	84.1	66.4
Meghalaya	32.3	40.0	12.1	46.5	58.1	63.8
Manipur	25.0	30.0	9.9	23.4	78.9	68.8
Nagaland	23.4	33.0	19.1	32.7	45.7	57.9
India	35.2	41.9	19.3	35.5	88.6	76.4

Source: State and National Family Health Survey 5 reports (2019-21).

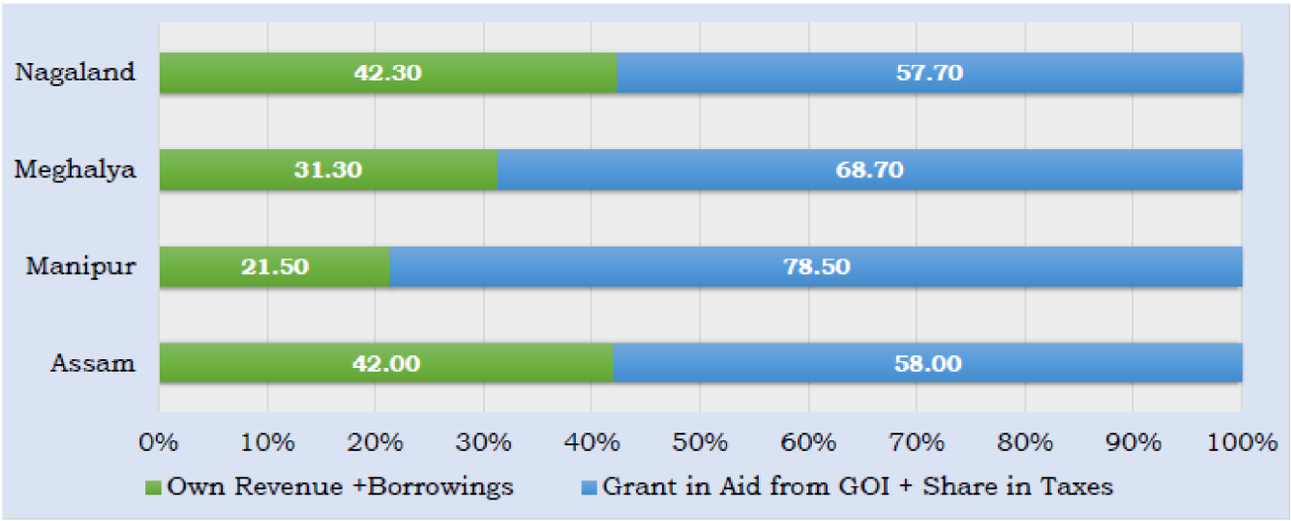
2.2. Financial Landscape

The four states, given their geographical contexts, have high costs and revenue disabilities and are compensated by Finance Commission grants through tax devolution. The low revenue generating capacity accompanied by the higher cost for provision of services in the hilly terrain makes these states highly dependent on Government of India (GoI). Successive finance commissions have tried to address this issue through their recommendations using general purpose transfers (tax devolution) and special purpose transfers (grant-in-aid). The average transfers from the GoI (tax devolution and grant-in-aid) to the four states in the years 2017-18 to 2021-22 was 57.7% in Nagaland, 58% in Assam[1], 68.7% in Meghalaya and 78.5% in Manipur (Figure 2). Total health expenditure (THE) as a percentage of total expenditure in the states was the highest in Meghalaya in 2021-22 at 8.6% and lowest in Manipur at 4%; Assam and Nagaland's health expenditure stood at 6.8% and 6.5%, respectively during the same period. However, higher health expenditure did not necessarily translate to higher PHE[2]. Manipur, with the lowest THE, had a PHE of 34% which was higher than the PHE in Meghalaya (27%). The proportion of PHE to THE was highest in Assam at 49% in 2021-22, while it was 13% in Nagaland.

[1] The analysis for Assam is from the period 2015-16 to 2021-22.

[[2]Public health expenditure included all expenditure under Sub Major Head-06 (Public Health) within Major Head 2210 (Medical and Public Health) and expenditures related to public health such as training pertaining to maternal and public health, school health scheme, public health programs like tuberculosis, National Health Mission, cancer, malaria, cholera, dysentery, leprosy, filaria, goitre, AIDS and STD immunisation, health and family welfare training centres and capital outlay related to public health programs (within 4210). Public health expenditure also included public water supply expenditures (state level program expenditures under Major Head 2215) and portion of 10% under disaster management (Major Head 2245).

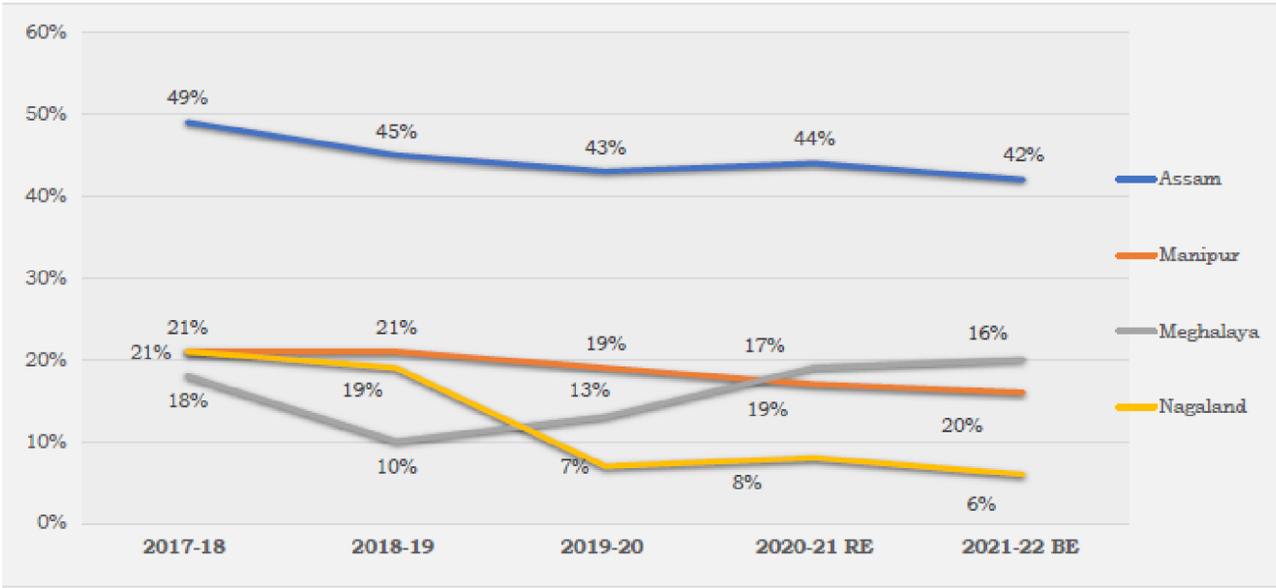
Figure 2: Average Percentage Share of Own Source Revenue and Government of India Transfers for Four North East States from 2016-17 to 2021-22



Source: State budget documents from 2016-17 to 2021-22.

As mentioned earlier, 90% of PHE in all the four states is footed by the GoI, under NHM. While Manipur's proportion of NHM expenditure in PHE averaged at 57.8% for the five years, that of Nagaland was 60.9%, of Meghalaya was 65.7%, and of Assam was the highest at 81.9%. Hence, NHM plays a vital role in funding all PH. However, NHM expenditure (as percentage of THE) in all states except Meghalaya has been continuously coming down in the last five years from 2017-18 to 2021-22 (Figure 3).

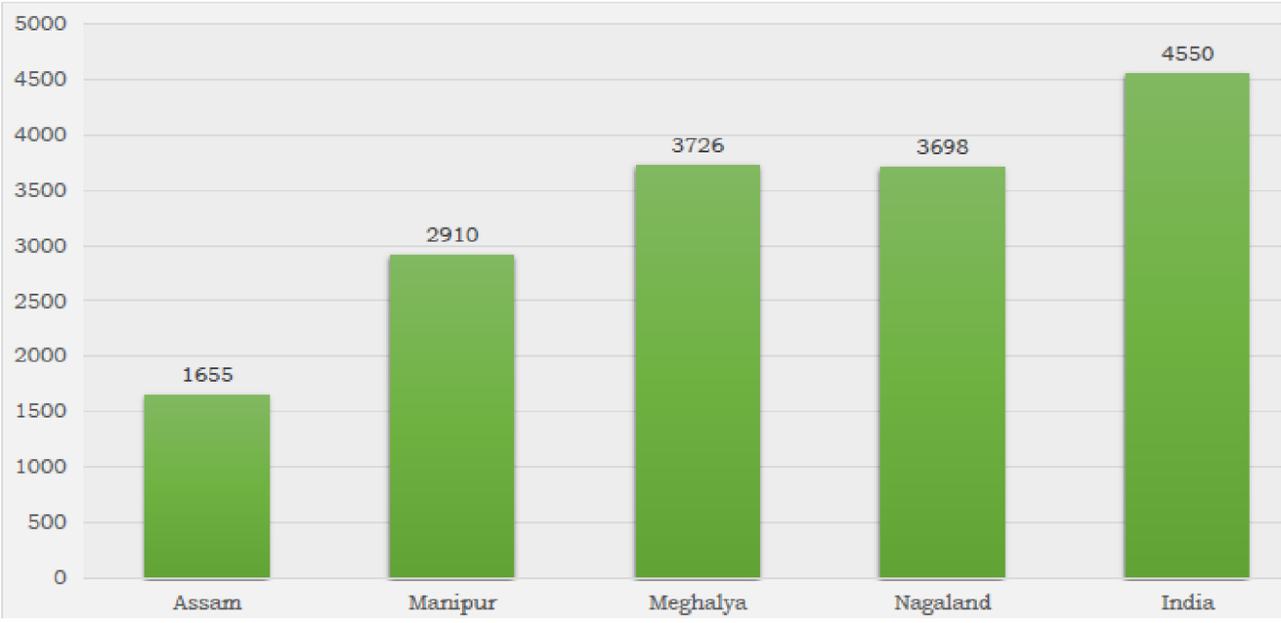
Figure 3: Proportion of National Health Mission Expenditure to Total Health Expenditure in the Four North East States from 2017-18 to 2021-22



Source: State budget documents from 2016-17 to 2021-22.
Note: RE stands for Revised Estimates, and BE stands for Budgeted Expenditure.

Declining public health expenditure may mean an increase in out-of-pocket expenditures (OOPE) for families. Our analysis of the per capita expenditure in the four study states showed that the average per capita expenditure on health was highest in Manipur at INR 3,726 and lowest in Assam at INR 1,655, from 2017-18 to 2021-22. This is similar to national health estimates on per capita government health expenditures for 2018-19. The national per capita expenditure stands at INR 4550 (Figure 4). The NFHS-5 shows that (OOPE on delivery in PH facilities has hardly decreased in any of the four states. In fact, it increased in Manipur and Assam between 2015-16 and 2019-20 (), and it is higher than the national average in both years. According to the National Health Accounts report, households are the highest contributors to current health expenditures, of which 53% comes from OOPE (National Health Systems Resource Centre, 2022).

Figure 4: Per Capita Total Health Expenditure for Assam, Meghalaya, Manipur, Nagaland, and India for the year 2018-19



Source: Calculated from respective State Budget Documents and National Health Accounts Report for India

2.3. Essential Public Health Functions

The 11 PH functions mentioned earlier are covered in various capacities in all the states. Although PH is a state subject, health schemes and policies in almost all states have been following the centre's directive, especially in the last two decades. As already seen, NHM undertakes a large portion of the states' PHE, and it does so in a multitude of ways. Hence, almost every PH function is carried out under the NHM in some capacity. As NHM functioning is similar in all four states, the extent to which each function under EPHF is carried out in all the states is similar too. For example, epidemiological surveillance function is carried out under the Integrated Disease Surveillance Programme (IDSP) in all four states and works almost identically in all four. We discuss below each function as seen in the four states. The following inferences have been gathered from interviews of district and state officials of the respective states. Table 2 gives more details of state-wise inferences on seven major EPHF.

Health Situation Monitoring and Analysis

Currently, all data are in silos as these are collected programme wise, with some, like maternal and child health, getting the most importance under NHM. Monitoring of data quality, data analysis, and dissemination needs to be further improved. All data analysis and its inferences are taken up at the state levels with limited involvement of district officials.

Epidemiological Surveillance

The IDSP unit at the district level functions well in all four states to identify and monitor the levels of 6 syndromes and 20 diseases. This programme got a boost after the COVID-19 pandemic. The nodal officials are district and state surveillance officers who have received epidemiological and statistical training. However, all states suffer from lack of requisite laboratory facilities.

Research

All four states have little or no state-led research in PH. Even though there is a sub-cadre within the health services for research in Meghalaya at the Pasteur institute, the focus is more on vaccine development and tuned towards fundamental research with no focus on public health.

Policy and Planning

Policy and planning are largely driven by NHM initiatives and involve limited inputs from the district level officials. Although Assam has a Public Health Act, it is non-functional. Meghalaya's health policy came into effect in 2021 and emphasises the need to improve its health indicators by incorporating the social determinants of health. Due to the limited fiscal space available to these states and their high dependence on GoI, their ability to take up schemes specific to the state is limited, and they follow central guidelines and policies.

Budgeting and Financial Management

Budgeting and financial management for PH is mainly undertaken at the state level with limited district involvement. Districts propose their requirements in terms of budget; however, final decisions are made at the state level. As the NHM is the major contributor to PHE, budgetary decisions and allocations follow guidelines dictated by the centre.

Health Promotion and Education

Every programme has a separate Information, Education, Communication cell, and health promotion is conducted regularly for big programmes. It is difficult to undertake health promotion without the help of the community, and it is hard to reach remote locations. In Nagaland, the involvement and support of the church, church-affiliated organisations, and women's organisations have been very good in creating awareness.

Reducing the Impact of Outbreaks, Emergencies, and Disasters on Health

Disaster management and emergencies are managed mainly by the state and district disaster management authorities with co-operation of various other departments like health, law enforcement, etc. However, intersectoral co-ordination needs to be strengthened. The response of IDSP/health department was strengthened in response to COVID-19 outbreak in all four states.

Regulation and Enforcement in Public Health

Enforcement of laws regarding the licensing of health care and related facilities are undertaken under the health department (for example, the Nagaland Health Care Establishments Act). The health department also undertakes limited enforcement on ensuring food safety, but enforcement of laws on water safety and sanitation fall under the Pollution Control Board or local governing bodies.

Assuring a Competent Public Health workforce

The PH administrative workforce consists of mainly physicians. They have no PH training and receive only programme-specific training under the NHM. Health services cadre is discussed in detail in the following section.

Ensuring Quality Population-Based Health Services

Apart from the Indian Public Health Standards for health facilities, there is a programme, Kayakalp, for quality assurance of services. However, Kayakalp was not well known among the district interviewees.

Environmental Health and Sanitation

The health department does not play an active role in this domain. Public Health Engineering Department, local governing bodies, and the Pollution Control Board play a bigger role and co-ordinate with other departments as required.

Table 2: Rating of Existing Status of Seven Essential Public Health Functions in the Study States

Functions	Assam	Manipur	Meghalaya	Nagaland
Health Situation Monitoring and analysis, and Disease surveillance and analysis	Currently, all data are in silos, with some like infectious diseases and maternal and child health getting the most importance. A well-established system under the IDSP was strengthened due to COVID-19. Data is collected, but there is a lack of technical ability to maintain data, conduct analysis, and gather inferences.	There is a robust process for collecting program-wise segregated data. The NHM provides technological support and training for the same. Monitoring of data quality, data analysis, and dissemination needs to be further improved. Surveillance exists, but analysis does not. Medical officers focus only on their clinical responsibilities, and their poor reporting on diseases and diagnosis makes surveillance very challenging	Every institution/department has its own data surveillance, but at the district level, it is done by the DSO, who is specialised in surveillance. There is also a PH specialist who does the evaluation. However, the state lacks laboratory tools and dedicated staff.	The IDSP unit at the district level functions well to identify and monitor the levels of various diseases. The district programme officers along with partnership agency (United Nations Development Programme), chief medical officer, and deputy chief medical officer ascertain if the data can be used for analysis. There is a lack of adequate frontline workers to regularly collect data on the population's health status
Assuring a competent Health workforce	Require periodic training. Need for specific public health (PH) courses, incentives, capacity building for improving motivation and for better inferences	Recruitment of workforce trained in PH is not being prioritised. Post-recruitment, there is a lack of training programmes on PH.	There exist vacancies and infrastructure shortfall, and there is no PH training.	Most training is confined to programme-specific requirements.
Planning and Policy	There have been recent initiatives to develop a policy. It is a work in progress. The planning is NHM-focused though.	The NHM did bring the rigour to the planning process, which was lacking earlier. Policy and planning are a top-down approach, wherein programme guidelines specified by the centre are being executed by the state/district. There is a lack of a decentralised planning process.	The state is the only one with health policy. However, as with other states, inputs are taken from district officials, but no consultations are held with them.	Policy and planning in relation to PH is largely driven by the NHM, and it is thus is highly centralised.

Functions	Assam	Manipur	Meghalaya	Nagaland
Budgeting and Financial Management	Directorates prepare budgets under the principal secretary. The NHM budget is based on the district health action plans at state level. The focus is mainly on health facilities and not on PH, with minimal involvement of district. The NHM has brought structure to financial processes.	Public health (PH) is entirely supported by NHM. The state government does not run any programmes to address state specific issues. While the district programme manager (under NHM) said that they fully received the allocated budgets, the district nodal officers disagreed on the same.	The budgets are prepared only for NHM at the district level. The final decision is made at the state level.	Public health is entirely supported by NHM. The proposed budget is never fully approved. Whatever gets approved too is released very late. The delay in release of funds leads to under-utilization, but the percentage of funds utilized has a bearing on next year's allocation. So, it has become a vicious cycle.
Reducing the impact of outbreaks, emergencies, and disasters on health	There is a separate disaster management authority at the district level under the district commissioner, who coordinates with NHM and IDSP for outbreaks; however, co-ordination with line departments can be improved.	A disaster management team led by the district commissioner has been constituted in each district. The chief medical officer is part of this team. Inter-departmental collaboration needs to be further strengthened and happen throughout the year and not only during disaster response.	Through the district commissioner's office, meetings and instructions are released for emergency preparedness in collaboration with disaster management department. However, the instructions are outdated.	A rapid response team has been constituted in each district to respond to any outbreak or health disasters. There is a need for a better trained workforce and equipment to handle emergencies.
Research, development of innovative PH solutions	This is managed by the medical research department. It has no PH research agenda.	No institution is conducting research on local issues, such as the increasing cases of non-communicable diseases in the state.	There is no specific research agenda at district level. The state is the only one amongst the four with an institution for PH (privately-run)	The state does not have a PH research agenda
Ensuring Quality of population-based services	Presence of IPHS standards for institutes	Kayakalp, National Quality Assurance Standards incentivisation/citizen's charter (perspectives) are used to evaluate quality.	Internal quality assurance of internal evaluation and central evaluations is done every year.	

Note: IDSP stands for Integrated Disease Surveillance Programme; DSO stands for District Surveillance Officer; IEC stands for Information, Education, and Communication; IPHS stands for Indian Public Health Standards; and NHM stands for National Health Mission.
Only 7 EPHFs have been described here, as these were discussed in detail during the roundtable held in Meghalaya. EPHF 1& 2 have been combined as answers for both of them were frequently interchanged and had overlapping issues.
Note: Green indicates that the function is well defined and undertaken in the state.
Orange denotes that the function is not that well defined yet and is undertaken at some capacity in the state.
Red indicates that the function does not occur at all in the state.
These colours are coded according to the responses received at the roundtable conference held in Meghalaya in August 2022.

Source: Based on field interviews of district and state officials as well as from 'Round table to disseminate the findings of the North East Cadre study', held in Shillong, Meghalaya in August 2022.

3. Creation of a Public Health Cadre in four North East States: Factors to consider

There are several factors that need to be carefully evaluated before embarking on the journey of creating a dedicated PHC. Foremost among them is to understand the desirability for having a PHC, followed by what cadre structure would be most effective for the state. Then comes identifying a talent pipeline along with training requirements and, last but not the least, the financial resources to support the formation of a PHC. The four NER states in discussion here are very unique when compared to other Indian states in terms of challenging terrains, borders, and low revenue generating capacity, thus leading to an increased dependency on support from the centre. Many of their governance decisions are led by the centre's directive. However, the decision to form a dedicated PHC should take into account local factors and ground realities of this region. The following figures (Figures 5 – 8) discuss the pros and cons of four major factors, based on field interviews and consultants, that need to be considered before a state sets up a PHC. These four factors are as listed below:

1) Whether the state requires a cadre
2) Deciding what cadre structure best suits the state(s)
3) Availability of skilled workers and their training and development and
4) Financial resources

Figure 5: Establishment of a Public Health Cadre (PHC)

Reasons for a PHC

1. It can focus on public health and not just provision of healthcare.
2. It can provide a career pathway for the entire PH workforce, such as Accredited Social Health Activists (ASHAs), programme managers, etc.
3. It can prioritise currently-neglected PH functions like research, policy planning and budgeting, etc.
4. It will reinforce improved administrative and managerial capacity to the state's health department. National Health Mission is an example for this.

Reasons against PHC

1. It will increase gaps in staff dedicated towards PH and those towards clinical care.
2. There will be challenges in ensuring parity with regard to promotions and career progression between the clinical cadre and PHC, both belonging to the same department.
3. Revamping a PH system is only possible if it is state-led and adequately funded.

Figure 6: Public Health Cadre (PHC) Structure

Pros

1. A single regional cadre could be created for a bunch of smaller neighbouring states, such as North East states, except Assam.
2. Entry level for the cadre should be at the primary care level itself.
3. A block is a good starting point for a PHC. A block public health offer qualified in PH can manage supervisors (at a cluster itself), who, in turn, can manage the frontline PH workers.
4. The PHC structure should also provide promotional avenues for various professionals who are not medical doctors, such as (a) frontline workers (ASHAs and auxiliary nurse midwives); (b) technical staff (such as epidemiologists and entomologists).

Cons

1. Getting the seven North East states (except Assam) to come together and frame common cadre and recruitment rules, including posting and transfers across the states, could be challenging.
2. Having a PH official at the PHC level will lead to almost doubling the number of positions of the existing health service cadre. This will have huge financial implications.
3. At the block level, a PH official may not gain experience in both clinical services and PH.
4. creating a PHC can have an impact on the career progression of clinical specialists since most senior positions in the directorate are occupied by them.

Figure 7: Skill Development for Public Health Cadre (PHC)

Pros

1. The PHC should be required to be trained/qualified in PH.
2. Programmes similar to Bachelor of Community Health for the position of community health officer in Assam can be considered as a solution for providing necessary skilled workforce in these states.
3. A foundation course on PH needs to be at-least 6-12 months long for it be comprehensive and effective. Short-term courses/programme based trainings give a very limited orientation.
4. Training/skills upgradation in PH related disciplines should also be provided to frontline health workers and technical staff so that it can create opportunities for them to join the PHC.

Cons

1. Many states in the North East are facing an acute shortage of doctors/generalists, let alone specialists trained in PH.
2. Multi-disciplinaries are highly valued, but it will require creating new positions in the health department/cadre. Many of the existing PH-related positions, such as chief medical officers, etc., also require clinical training, and they can thus only be performed by medical professionals.
3. Considering the acute shortage of doctors, it is not feasible to sanction study leave or give time off from work for officials to attend long term PH training.

Figure 8: Financial Environment required to form a Public Health Cadre (PHC)

Financial requirement in PHC

1. State governments need to evaluate if certain PH-related posts can be surrendered as they are no longer relevant to the existing disease burden of the state.
2. If support from Government of India (GoI) (grant-in aid funding for National Health Mission) is channeled through or tied to the PHC, it can pave the way for its smooth implementation in these states.
3. Health expenditure, on an average, hovers around 7% of the state's expenditure, which is a good fraction, but it is also subject to the higher funding support by GoI.
4. Training current employees in PH is one of the most cost-effective options, while the state undertakes a long-term plan of setting up a PHC.

Issues in Financing PHC

1. Ensuring that an entire PH workforce is part of the cadre will be financially challenging for most states as this translates to a huge number of employees who will need to be provided with government social security benefits.
2. The average share of own revenue (tax and non-tax together) for the period between 2015-16 and 2021-22 accounted for 27%, 8%, 19% and 6% for Assam, Manipur, Meghalaya, and Nagaland, respectively. This indicates a very heavy dependence on the GoI transfers in the form of both tax share and grant-in-aid.
3. Transfers from GoI (tax devolution and grant-in-aid) are very critical for the states and account for 58%, 80%, 69% and 59% of total revenues for Assam, Manipur, Meghalaya, and Nagaland, respectively. This fiscal position inhibits state governments from making big ticket expenditures, especially where GoI has a role.

4. Recommended Pathway for States to Consider

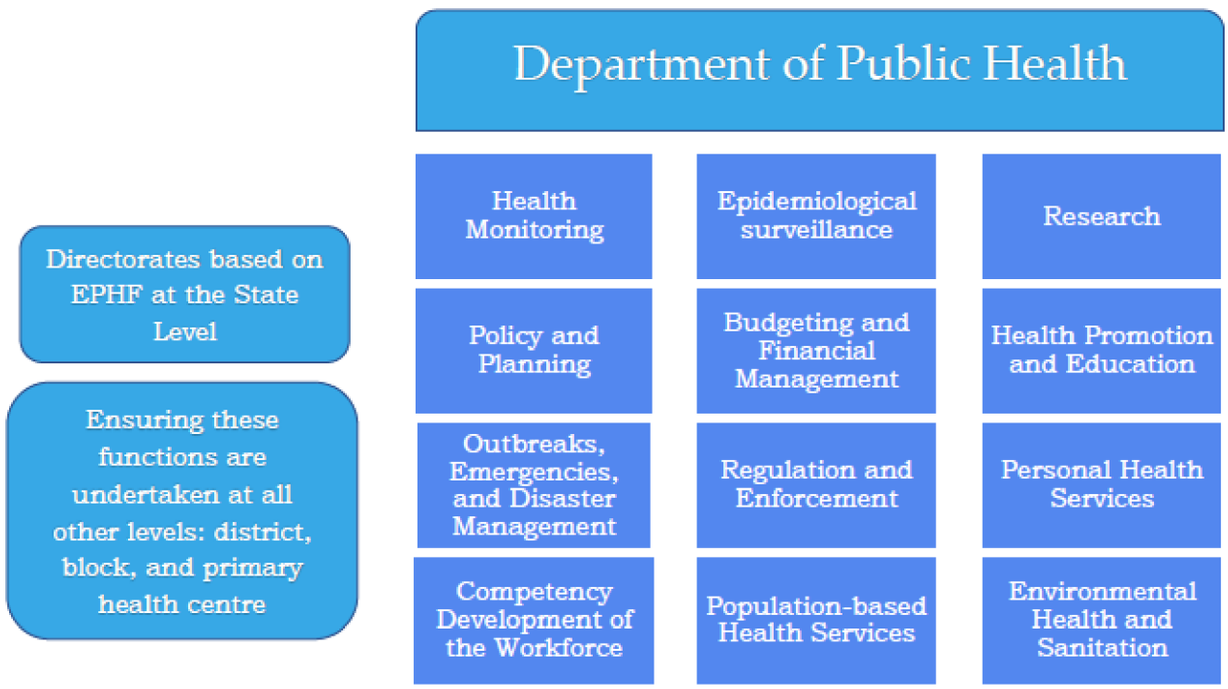
The rationale behind creating the EPHF framework was always to go beyond performance assessment and foment concrete action to improve PH practice, thus ultimately strengthening the overall health system. According to WHO, the EPHF framework helps countries to better organise capacities and institutions that underpin their PH services. A couple of countries that have done this well are Costa Rica and Argentina. Between 2004 and 2005, Costa Rica leveraged the EPHF framework to readjust its existing organisational structure of the Ministry of Health (for example, through the creation of a research department). Since 2007, Argentina has been using the EPHF approach to strengthen the organisation of the Ministry of Health (for example, through the creation of directorates of chronic non-communicable diseases and vector-borne diseases at the national level and health promotion units at the provincial level).

We recommend that states should work towards a long-term vision of realigning their health department based on the 12 EPHF of the World Bank (Figure 9). This would also mean that -

(i) the outlook shall not be limited to curative and individual care but include and prioritise preventive and population level health care, and (ii) it will adapt the 12 EPHF such that it aligns with the state's health care priorities.

The existing Department of Health and Family Welfare should be rechristened as Department of Public Health since the EPHF extend beyond just PH to also encompass clinical care, medical education, research, disaster management, and health promotion to name a few.

Figure 9: Department of Public Health based on Essential Public Health Functions (EPHF)



To traverse along the recommended pathway, we recommend that states in NER undertake the following ten steps.

1. States should determine EPHF that are most critical for the state and suitably adapt them as required. States could also look at combining synergistic EPHF to ensure effective implementation of the same.

2. States should map how EPHF will be executed at each level: state, district, block, and primary care level. For example, what aspects of data collection for disease surveillance need to be carried out at the primary health care, block, district, and state levels.

3. Mapping of EPHF should also include envisioning a newly organised workforce that can effectively implement it across all levels. Apart from clearly defining the roles and responsibilities of the various positions of this newly organised workforce, the mapping exercise should identify the infrastructure needs as well.

4. States should classify the positions as i) cadre or non-cadre from a roles and responsibilities perspective, and ii) clinical, PH, or common/both from a functional perspective. They should also finalise the eligibility criteria/educational qualifications and desired experience needed for these positions, along with pathways for career progression.

5. Based on the above point, states should arrive at a cadre structure for PH and clinical specialists along with sub-cadres for other positions that are classified as either frontline, technical, or support functions.

6. Sates should identify gaps between the existing workforce and the newly organised workforce in terms of i) labour and ii) training.

7. States should develop a blueprint that provides solutions to how these gaps can be potentially filled, such as a specific short-term training programme or setting up of a training institute in PH to build a talent pipeline.

8. To begin with, states should implement the blueprint at the directorate level within the first five years (short-term). The reason for going top-down is due to the criticality of the directorate level while also having lesser gaps to fill in terms of workforce.

9. Next, they should implement the blueprint at the district level within five to ten years (mid-term).

10. Finally, they should implement the blueprint at block level and below within the next 10 to 15 years (long-term).

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