Draft Policy for Rational and Transparent Deployment of Health Human Resources in Chhattisgarh

Preamble: Government of Chhattisgarh recognizes the critical importance of skilled Human Resources in ensuring comprehensive healthcare services for all people of the state. The state will strive to improve the availability and skills of adequate and motivated health workforce in all parts of the state. Transparency will also be ensured in deployment of human resources.

Policy Objectives:

- To ensure availability of required health HR through better recruitment as well as retention, particularly in tribal and rural areas
- To ensure transparency in postings, promotions and transfers of health HR
- To ensure that Specialists are posted in institutions matching their qualification
- To increase motivation, learning and growth opportunities for health HR

Important Definitions:

1. **Categories of health HR:** The policy looks at health HR in three main categories:
   a) Specialists –defined as MBBS holding any post-graduate degree or diploma in a clinical or para-clinical stream irrespective of whether they were recruited in a Specialist post or not
   b) Medical Officers – MBBS degree holders
   c) Other Staff - Staff other than Specialists and Medical Officers: Includes medical graduates from streams recognized by Government other than Modern medicine, Dental Surgeons, Assistant Medical Officers, Nurses, Para-medical, Managerial and Support staff

2. **State and District cadre:**
   State Cadre: Specialists, MOs, Dental Surgeons, Ayush Officers
   District Cadre: All staff who are not in state cadre
   (The above includes staff working across all directorates under the DoHFW – AYUSH, Medical Education, Health Services, Family Welfare)
3. **Critical vacancies:** If filled posts in a cadre in any facility are below 50% of the sanctioned strength, the number of posts needed to reach 50% level will be called 'Critical Vacancies'. For Specialists, the above limit will be 20%. For MOs, positions in PHCs are not to be classified as 'Critical Vacancy', but this can be amended in future.

   Once more than 90% of facilities reach the above stage for any of the cadres, the threshold limits in the above definition can be revised upwards for the concerned cadre.

4. Categories of facilities:

Health Facilities will be categorized into 3 categories based on their location (size of city and its remoteness): Category A (centrally located cities), Category B (moderate remoteness), Category C (extreme remoteness)

Key Provisions in the Policy (proposed):

1. Closing Gaps in availability of health HR by filling Vacancies

The state will aim to reduce vacancies:

a) Specialists: vacancies reduced to less than 50% of the sanctioned strength within 5 years
b) MOs: vacancies reduced to less than 10% of the sanctioned strength within 5 years
c) Other staff: vacancies reduced to less than 10% of the sanctioned strength within 2 years.

For each cadre, the concerned authorities will advertise positions and organise recruitments atleast once in every six months till there are no vacancies left. This will be reviewed regularly. The number of facilities reaching the 50% threshold cadre-wise will be reviewed each month.

The following Recruitment strategies will be employed in addition to other efforts:

a) For Specialists, strategies similar to Bijapur will be employed. Special salary packages for Category C posts will be implemented.
b) For MOs, Campus recruitments and walk-in recruitments will be done for MBBS will be done. Special salary packages for Category C posts will be implemented.
c) Support will be provided to NHM, Vertical Programmes and Districts for handling recruitments by using empanelment of HR Recruitment agencies.

Current Vacancies and Market Availability:

- Specialists (PG doctors) – 80% vacancies, Market availability is constrained
- Medical Officers (MBBS) – 50% vacancies, Market availability improving, will not be a constraint in 3-5 years
- Staff other than Specialists and Medical Officers – 10% to 30% vacancies, Adequate number of candidates are available for most cadres e.g. there are 169 regular Staff Nurse vacancies in Bastar division whereas there have been 310 pass-outs belonging to Bastar in last two years alone. More than 4000 GNM/BSc Nurses are graduating each year and it can help in reducing nurse vacancies. For lab technicians, the constraint can be resolved by getting the 2-year Diploma (DMLT) course recognized by state paramedical council.

Payment packages and incentives like CRMC will be given wide publicity and mentioned in advertisements. In addition, incentives based on performance as teams will be implemented for high-priority activities. Special awards and fellowships (CM Fellowships) will be given for HR showing exceptional performance in difficult areas.

Additional facilities will be provided to encourage the HR to stay in Category C areas in terms of housing, support for education of children, additional housing for families to stay in cities etc.

2. Postings

After each recruitment, postings will be first prioritized to fill the 'Critical Vacancies' of the concerned cadre. Within the category of critical vacancies, first the District level posts will be filled, then FRU CHCs, followed by CHCs and PHCs. All staff recruited in state cadre will have to do compulsory service of at-least 2 years in facilities in Category C.

Specialist will be posted against specialist posts only. The posts of Specialists will be divided into types of specialities necessary at District Hospital, FRU CHC and CHC levels.

It will be ensured that each PHC has atleast one AMO. Co-location of AYUSH Officers with PHCs will be promoted so that most of the PHCs also have an AYUSH officer in addition to an AMO.

3. Separation of Clinical and Public-Health cadres

The cadres of Doctors will be separated into two streams – a) Clinical cadre b) Public Health cadre. This will give the state the following benefits:

a) avoiding deployment of HR with clinical skills for non-clinical roles
b) improving department's capacity for public health management
c) creating clear career pathways including promotions for both streams, creating opportunities and motivation for doctors to build on relevant experience and skills

The following table indicates how the responsibilities and reporting structure will look like with separation of cadres:

<table>
<tr><th>Level</th><th>Clinical Cadre</th><th>Public Health Cadre</th></tr>
<tr><td>Block</td><td>Block Medical Officer (Incharge of CHC)</td><td>Block Public Health Officer (PHCs report to him/her)</td></tr>
<tr><td rowspan="2">District</td><td>District Medical Officer (Incharge of District Hospital, also BMOs report to him/her)</td><td>District Public Health Officer (BPHOs report to him/her)- assisted by District Programme Officers</td></tr>
<tr><td colspan="2">Chief Medical and Health Officer (CMHO) – overall incharge - both DMO and DPHO report to him/her</td></tr>
<tr><td rowspan="4">State</td><td>Deputy/Joint Directors (Medical) or Assistant/Associate Professors in Medical College</td><td>Deputy/Joint Directors (Public Health)</td></tr>
<tr><td>Director (Medical)</td><td>Director (Public Health)</td></tr>
<tr><td colspan="2">Commissioner</td></tr>
<tr><td colspan="2">Principal Secretary</td></tr>
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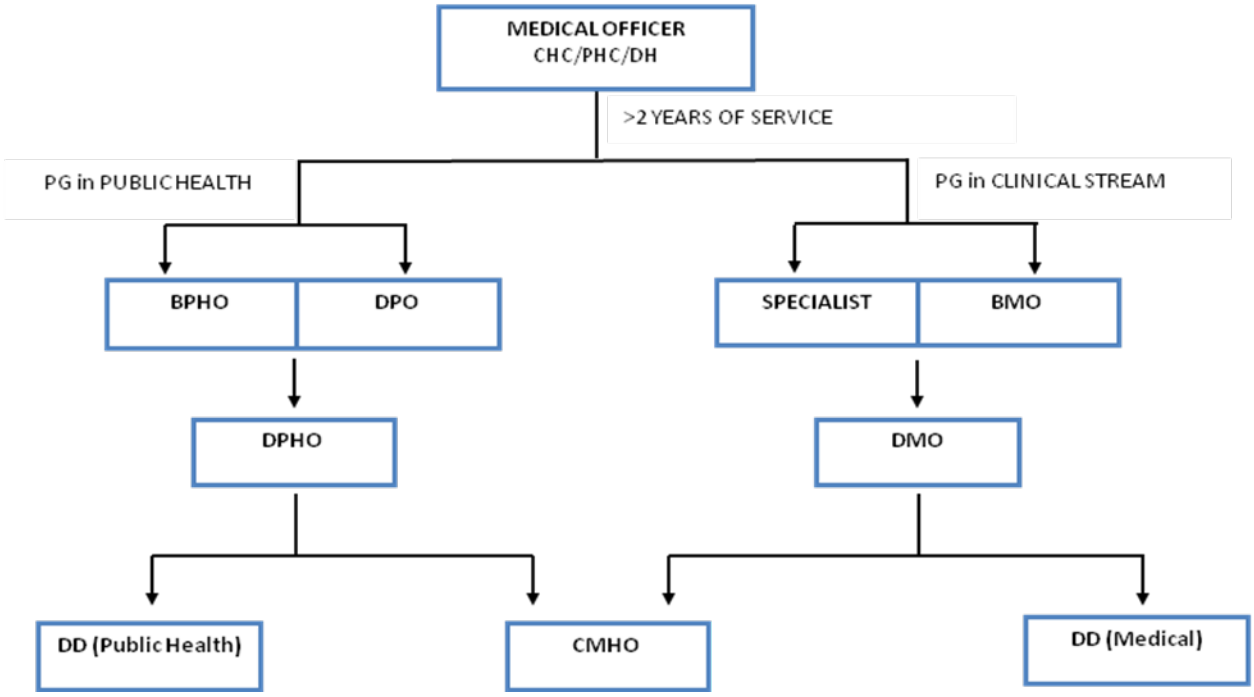
MBBS Doctors will join as general duty MOs. After minimum 5 years of service, they can choose to continue as MOs or choose to get promoted after attaining additional qualification of at-least one year duration course. MOs attaining public-health qualification can then get promoted as BPHOs or District Programme Officers based on a seniority-based merit list. MOs attaining post-graduate clinical qualification get promoted as BMOs or Specialists in district hospitals or as Assistant Professors in Medical Colleges. Specialists in district hospitals can also get promoted as Associate Professors in Medical Colleges.

CAREER PATHWAY FOR CLINICAL & PUBLIC HEALTH CADRE



Similarly, career pathways will be implemented for other important cadres especially Nursing. For AMOs, experiments will be done for creating career pathways e.g. AMOs after 10 years of experience and a public-health course can be considered for Consultant roles assisting District Programme Officers.

4 Transfers: The policy regarding transfers of health staff will be guided by the aims of improving availability of HR in remote areas, increasing transparency and ensuring that skills of specialists are well-utilised.

All transfers will be done in months of April-May. All transfers will be done through a process of counseling except for – Project-based posts, CMHO, CS (Incharge District Hospital), Joint or Deputy Directors, District Ayush Officers. For counseling, the choice will be based on weighted length of service and the weights will be 1.00, 1.50 and 2.00 for category A, B and C facilities respectively. In all kinds of transfers for specialists, it will be ensured that there is no specialty-mismatch due to the transfers. For state cadre, transfers will be allowed across directorates e.g. DME staff can be posted

under DHS and vice versa. There will be no transfers for contractual staff. For district cadres, no transfers will be allowed on disciplinary grounds (commonly referred to as “Administrative reasons”).

The following types of transfers will be implemented in the following order (1 to 6):

Compulsory Transfers:

1. All staff who have not completed minimum two years of service in Category C facilities, will be transferred against critical vacancies.
2. All Specialists (with PG degree or Diploma) working in non-specialist posts will be transferred to specialist posts, starting from critical vacancies.
3. If a facility has staff above the sanctioned limit, such surplus staff will be transferred starting from critical vacancies.
4. Special Transfers in Public Interest: In order to fill a high-priority need of the department, Government can transfer upto 1% limit of any cadre in a year.

Optional Transfers:

5. Staff will be eligible to seek transfer to critical vacancies in Category B facilities after completing compulsory service in Category C facilities.
6. Staff after 3 years of minimum continuous service in any facility will be able to apply for transfer to critical vacancies.

Mutual transfers:

7. Mutual transfers will be allowed based on written application from both staff and transfer will be subject to both being eligible.

Transfers on Sympathetic grounds: Apart from above categories, transfers will be allowed for cases requiring transfers for serious illnesses etc. The order of prioritizing such transfers will be - terminally ill, to retire in 2 years, disabled, widow, then husband-wife cases then rest of severely ill cases. However, such transfers will be allowed only against a vacancy.

5 Regularisation of contractual staff: All contractual staff will be regularized after completing five years of service based on a written test. Such regularizations will be against existing vacancies. In addition, assessments will be carried out to find which staff-positions are needed for long-term and therefore need to be regularized.

Regularisation versus Contractualisation:

Job-security is known to improve motivation of human resources. It builds long-term stake for the staff in their jobs and creates loyalty towards the institution. Retention improves as a result of regularisation. Regularisation can help in further promoting a positive relationship between health staff and community. States like Tamil Nadu which have better-functioning health-systems in the country are staffed higher proportion of regular staff.

For contractual jobs, retention has been poor. Often, repeated recruitments are needed and investment in contractual staff in form of Training also goes waste. Contractualisation of health jobs may also cause inability to recruit skilled staff. E.g. the state has been unable to find or retain even MBBS doctors for Urban PHCs and SNCUs in centrally located urban areas because of the contractual nature of jobs. The demerits of contractual jobs can be offset to some extent by offering substantially higher salaries. Even then, contractualisation can create a division between the staff and possibility of discrimination and grievances. Better accountability can be expected

Training: Capacity building programmes will be aligned to health-needs of the population, for removing mismatch in facility-wise available skills, to meet the needs of career pathways of various cadres and for enhancing overall skills to provide better services. Since the state has faced shortage of specialists and doctors historically, task-shifting will remain a key strategy for some time to come. E.g. Assistant Medical Officers manage PHCs due to shortage of MOs. However, as the availability of MOs improves, AMOs can be utilized more and more for running clinics in sub-centres upgraded as health and wellnesss centres. Training courses will be designed to meet the evolving roles of various cadres.

Some of the strategic areas of capacity-building will include:

a) Skill upgradation of AMOs
b) Training of Ayush Officers, including bridge-courses to be able to serve Primary Healthcare provision needs especially for the National programmes
c) Training of MOs in high-priority skills and courses like CPS to reduce gaps in specialist-care
d) Prioritising recruitment of Mitanins trained as ANM/GNM, especially in tribal blocks, as they offer several advantages like -previously learned skills and community-orientation, being local inhabitants and tuned to local culture – all of which are known to result in better retention.

Medical education is another area of capacity creation. The policy will aim to ensure that candidates from tribal areas find adequate opportunities to get trained in medical professional courses especially MBBS. Medical Colleges will also contribute towards Continued Medical Education of doctors.