PUBLIC HEALTH FOUNDATION OF INDIA

INDIA HEALTH BEAT

THE WORLD BANK

Supporting Evidence-based Policies and Implementation

Volume 1
Number 4

CHALLENGES IN RECRUITMENT OF DOCTORS BY GOVERNMENT*

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This note describes some of the problems found in recruiting new doctors to the government health care system, drawing on the recent experiences in three cases: the Central Health Service (CHS), the Uttar Pradesh (UP) government health care system and Tamil Nadu government health care system. In comparing the different experiences of recruitment in the three cases, the policy note highlights institutional issues and the incentives built into an employment package as important for further consideration in the aim to scale up the numbers of government doctors.

FRAMING THE PROBLEM

Insufficient numbers of doctors in government health care service provision throughout the country, both general medical officers and specialists, has been a matter of government concern for some time (7th Plan, 1985-89; Bajaj Report, 1987; NHP 2002; NCMH 2005). This has come to the fore as evidenced by significant government efforts to scale-up health care delivery through the National Rural Health Mission (NRHM). The Government of India has increased its financial allocation to health through NRHM and set out a new Indian Public Health Standard (IPHS) – norms for health facilities that, to be achieved, will require many more doctors to enter public service[1].

Increasing the numbers of physicians in government service and particularly for the staffing of rural and lower level health facilities is a multi-dimensional problem. One useful way to look at it is in terms of three related processes – production of physicians, recruitment to government service, and retention. In this note, we will focus primarily on institutional factors affecting physician recruitment and the incentives in the employment package offered to the physician.

EXAMPLES OF RECENT EXPERIENCES IN PHYSICIAN RECRUITMENT IN UTTAR PRADESH, TAMIL NADU AND TO THE CHS

Figures 1-3 show very different experiences in the three cases under study in their ability to successfully recruit physicians into government service. Variation is also evident in the quality of basic information available with government on the numbers who do join. In the CHS, fewer doctors were selected than the existing vacancies; significantly fewer still joined. For both states, the numbers of applicants were vastly more than the vacancies, but fewer physicians than the numbers required were selected largely due to the shortage or absence of applicants in certain specializations such as anatomy, community medicine, obstetrics, gynecology, pathology, physiology and forensic medicine.[2] In UP, no data was available on the numbers who joined since the districts had to report whether a doctor has taken up a post. Invariably, districts in UP reported vacancies but not accurate data on numbers that joined after receiving initial posting orders. This is an important lacuna to be addressed. On the basis of current anecdotal evidence from the UP Directorate, numbers joining were generally much lower than the vacancies to be filled and therefore similar to the CHS experience. Data from a recent recruitment cycle in Tamil Nadu (TN) demonstrate it has better performance in the numbers that are selected and join compared to the CHS.[3]

EXPLAINING THE DIFFERENCES IN PHYSICIAN RECRUITMENT

The causes of these differences are complex. While the experience of the CHS, TN and UP cannot be generalized to other states, they highlight important constraints to successful recruitment. Some of them stem from the *institutional context*. Others relate to either organizational issues within the health department or to coordination issues between the health and other government agencies involved in recruitment, such as the Public Service Commission. But

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* Health workers in sufficient numbers, in the right places, and adequately trained, motivated and supported are the backbone of an effective, equitable, and efficient health care system. Success in creating and sustaining an effective health workforce in India to achieve national health goals will require sound policy and creative and committed implementation. More and better information on human resources for health in India is one element needed to achieve this. This policy note summarizes recent and ongoing work in support of India's health work force goals. For the full report, *see Raha, S. et al "HRH: A Political Economy and Institutional Analysis of the Indian Context" HRH Technical Report #2 at www.hrhindia.org*

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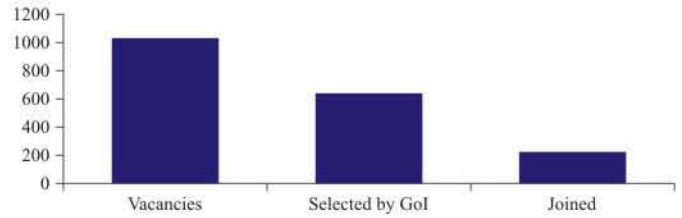
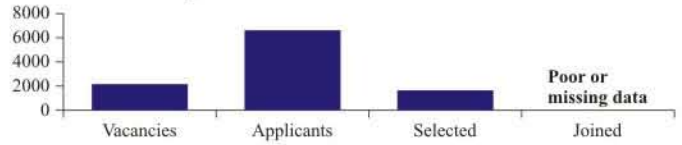
Figure 1: Doctor Recruitment in CHS
CMSE Batches 2004-06 and Specialists 2005-07



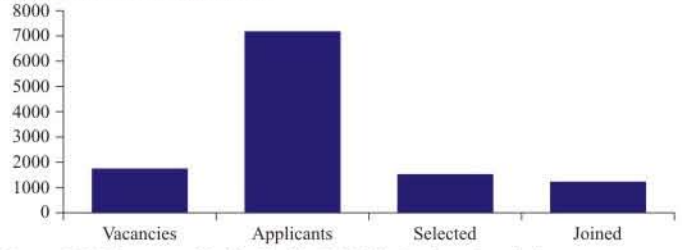
Source: CCA, MoHFW

Figure 2: Doctor Recruitment in Uttar Pradesh
Round of 2005 Requisition



Source: UP Ministry of Health, UP Public Service Commission

Figure 3: Doctor Recruitment in Tamil Nadu
Round of 2003 Requisition



Source: TN Directorate of Public Health, TN Public Services Commission

our case studies also identify causes of low performance that relate to an *incentive environment*, including the scope and content of the employment package offered to physicians under recruitment. The remainder of this note focuses on the institutional and the incentive-based causes separately.

A. Institutional issues

Data from different recruitment rounds for the CHS show that significantly large numbers of offers are cancelled at a late stage in the recruitment process; that is, subsequent to offer letters issued. This would imply that doctors are keen to participate in early stages of the recruitment process, but by the time offer letters are received, far fewer remain interested to join. Although there is no single cause that may be attributable for this decline in interest of doctors, the length of the recruitment process itself is probably a contributing factor. The entirety of the recruitment process that engages the health departments and the respective Public Service Commission takes close to eighteen months in both to recruit physicians to the CHS and in UP. While the Union Public Service Commission (UPSC) conducts the Combined Medical Services Examination (CMSE) for physicians applying to join the CHS, the UP Public Services Commission conducts no such entrance examination. In contrast, even though the TN Public Services Commission conducts separate entrance examination for each specialization and oral interviews, evidence demonstrates that the entire process is shorter by months than for CHS and UP, taking no more than a year to complete.

Due to budgetary reasons, 'vacancies' declared and advertised are based on the unfilled numbers of *sanctioned* posts, which do not necessarily match population-norm requirements. As per the GOI norms, the number of doctors required at PHC and CHC are 83,945 with a present shortfall of 61,672. With the adoption of IPHS norms, the extent of the recruitment problem is significantly more acute. Numbers of doctors required increase to 183,153 with an over 60% increase of the current shortfall in doctors at these facilities to 160,880 (Rao-NHSRC, 2008). The numbers of declared vacancies remain much fewer. Especially in light of the Central Government's aim to reach IPHS standards, the recruitment challenge of physicians is consequently significantly under-represented in the number of sanctioned posts to fill.

In UP such under-representation, in *sanctioned numbers* of doctors the government system requires, can adversely effect recruitment. In this state, reports from the districts are the basis for ascertaining whether a doctor in government service is active. Acknowledging reporting deficiencies, the UP Directorate admits many of the 2278 doctors at entry-level may not currently be active in the system. The process for determining a 'vacancy,' when a non-practicing doctor remains on registers is furthermore lengthy since the UP Public Services Commission needs to confirm that a doctor recruited by the Commission is no longer in active service. At the institutional level of the UP Directorate, the resulting challenge may be summed up in the following way: there exists an undisputable need to recruit more doctors, but since the total number of doctors (practicing and non-practicing) who remained on the rolls exceeded the numbers *sanctioned*, no recruitment could be possible. In contrast, all recruitment of entry-level doctors into government service in TN has been centralized into a single nodal agency responsible – the Directorate of Public Health and Preventive Medicine (DPH). Information on numbers who join are available from the nodal agency that has a tracking system for determining active and non-active doctors.[4]

B. Incentives in the employment package

Tamil Nadu, helped therefore by a more favorable institutional context than UP, has also addressed the challenges in recruitment of doctors through adopting schemes that adopt a multi-pronged approach. These schemes aim to provide an employment *package* with incentives to attract and retain the physician to government service.

Incentive of regularization into Service: The mixed record of contractual hiring of physicians into government service in UP and TN make clear why additional incentives matter. To bypass lengthy regular recruitment through the Public Services Commission, recruiting physicians on a contractual basis was attempted in UP and suitable candidates instantly recruited in a walk-in interview at the district. When the scheme in UP initially paid the contractual doctor a third less than regularized doctors but

allowed private practice, few responded since the remuneration was too low. In a modified scheme, the contractual doctor was disallowed private practice, but now paid the same as regularized doctors. The scheme had largely appealed to doctors already practicing in the same rural area. The possibility of continued private practice in the initial scheme provided the doctor an incentive to build credibility and a network of patients through the public health centre, without terminating his existing source of income. With private practice disallowed in the modified scheme, it appealed even less to local practitioners and only those who had been idle or with very few patients entered into contract. In late 2007, two years after the scheme was introduced, only 611 doctors on contract existed while large vacancies persisted. Moreover, genuinely interested applicants to a career in government service keen to be regularized for job security and other benefits petitioned the High Court to ban the contractual system, which the Court upheld.

Doctors are hired on temporary basis in TN, unlike in UP, through an Employment Exchange with the understanding (an incentive) that their services shall be regularized. To be regularized, they need to appear for a "special qualifying examination" the Tamil Nadu Public Services Commission (TNPSC) conducts. This "special" examination is an incentive since the candidate on contractual appointment requires only a minimal pass (and not a high grade unlike in regular recruitment) to be selected. Data shows almost all contractual doctors eligible for the "Special Qualifying Examination" pass it. In 2005 alone, 1249 physicians were recruited through the Employment Exchange. Private practice alongside government service is legally permitted in TN. Consequently, recruiting contractual doctors on the same pay-scale as regularized doctors has been more successful in TN than UP, due largely to the additional incentives of possible future regularization into service and retaining a legal private practice.

Length of stay in rural area: Some such incentive schemes can be more successful than others in nominally recruiting doctors but not sufficiently attractive for them to take up the posting the scheme requires. For instance, Tamil Nadu introduced a Zonal System in 1996 to recruit doctors to the under-served remote areas of the State. While recruitment of doctors to entry-level specialist positions was retained on a State-wide basis, the recruitment of all General Assistant Surgeons became *on a zonal basis* with the State divided into nine 'zones'. Doctors appointed to these entry-level positions were to be from the same zone as their hometown, but had to serve for a minimum period of 10 years in that zone. The system failed and recruitment was centralized to the DPH in 2000, as noted above.

Due to the rule that a doctor should serve in a particular zone for minimum of 10 years, of which 5 in rural service, doctors remained reluctant to work in zones of their hometown not of their preferred personal choice. Records from the DPH show that even those selected through the zonal process continued to avoid postings in these zones, by resorting to various unstated means despite orders of postings to deficient areas. This resulted in an anomaly of doctors awaiting postings on one hand and shortage of doctors on the other hand. This defeated the main objective of the Zonal System.

Over the last two years, however, TN recognizes 'experience' in drawing up the Merit List on which entry into a post-graduate (PG) course of study in Government medical colleges is based. The entrance examination accounts for 90 marks of the total maximum of 100 attainable, with 10 marks exclusively reserved for 'experience' in specified rural or hilly areas. One mark is awarded for each completed year in a defined rural area for both in-service and non-service candidates up to a maximum of ten marks or ten years of such service. For service in hilly areas, 2 marks are awarded at the completion of each year up to a maximum of 5 years of such service. The extent to which such an incentive works in recruiting doctors keen on PG education to rural or hilly areas remains to be evaluated.

Incentive of reservation of seats for PG: TN was the first of the states to reserve 50% of seats in each specialist branch of post-graduate study for in-service candidates, in addition to those in-service candidates selected in the 'open category'.[5] This measure has been implemented as an inducement for Bachelors of Medicine (MBBS) students, eager on further education, to join government service. In addition, the government pays in-service candidates a regular monthly stipend during the course of their studies, which covers tuition fees. Interested in-service candidates for further education are compulsorily required to execute a bond for a significant sum (currently 10 lakh rupees for degree courses) as security amount with the undertaking that they will serve the TN Government till retirement or, in some specialist fields, 15 years. Table 1 shows significant numbers of in-service doctors availed of reserved PG-seats in recent years, but whether this scheme directly resulted in increased recruitment of MBBS-trained doctors into government service, remains also to be evaluated.

CONCLUSIONS AND POLICY IMPLICATIONS

There is a requirement to secure substantially more doctors in the government health system, especially in light of the aim to reach IPHS norms in all health facilities. The number of sanctioned posts currently in the country represents a significant under-provision in relation to this requirement. Creating posts may be necessary but it is not sufficient; nor is it the answer to the recruitment challenge where the apparatus of recruitment may be very faulty. This note described through three select cases that a faulty recruitment apparatus matters for both regular and contractual staff – i.e. simply using contractual staff did not always solve the problem (e.g. UP experience). Both institutional factors and

Table 1: Candidates utilizing the PG-Incentive in Tamil Nadu (*recent years*)

Year	In-Service Candidate	Private Candidate	Total Selected	Percentage of in-service in total selected
2002	289	333	622	46.46
2004	296	438	734	40.33
2005	295	415	710	41.55
2006	314	316	630	49.84
2007	298	367	665	44.81
2008	271	344	615	44.06

Source: DME, Tamil Nadu Government

"the package" (incentives) matter.[6] Both may require a multi-pronged approach to the recruitment challenge, as seen in the several measures (successful and not) that have been attempted by government in TN over the years. Above all, evidence from this note suggests solving recruitment issues requires more robust state-specific analyses, policies and action strategies. Focusing on increasing financing to expand and fill posts in the current state contexts is unlikely to bring in the numbers of physicians the health system requires.

NEXT STEPS/RECOMMENDATIONS FOR ACTION

Reform the institutional apparatus around doctor recruitment so that the time required for a recruitment cycle is reduced; publicly available, well maintained information on numbers who join posts after a recruitment cycle exist; the level of attrition after joining is recorded; and the exact location of current vacancies is available.

Review of recruitment targets with reference to realistic estimates of capacity and yield. In this regard, the current IPHS-suggested numbers are an ambitious increase over the current workforce strength and officially sanctioned numbers. Official data reported for the states of Gujarat, Rajasthan, West Bengal and Uttarakhand (as examples) suggest that reaching the IPHS targets require that the current workforce of medical officers increase 3.4, 3.5, 7.3 and 3.8 times, respectively. For specialist doctors, it needs to increase 28.5, 5.1, 6.3 and 5.3 times, respectively (based on calculation from the March 2007 RHS Bulletin and the IPHS norms for a Primary Health Centre and a Community Health Centre. Given past experience, these targets may require reconsideration for the immediate future.

Incentive packages offered in states such as TN (that include 50% reservation for PG studies; possibility of regularization for contractual doctors; additional marks in PG entrance for rural/hilly postings) need to be urgently evaluated and, if proven successful, replicated in other states.

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[1] Achieving IPHS norms would also require increases in other types of health workers, which is discussed in Note No. 5 of this volume.

[2] For detailed data, see Raha, S. et al "HRH: A Political Economy and Institutional Analysis of the Indian Context" HRH Technical Report #2 at www.hrhindia.org

[3] An important incentive the states offer over the CHS to physicians is a posting in likely their 'home state'. On the other hand, the CHS provides opportunities of postings that are mostly not rural.

[4] Here, 'active' doctors refer to those on the rolls and have reported to duty and 'absenteeism' is checked by the DPH through occasional visits but cannot be ruled out.

[5] Here 'open category' refers to the remaining 50% of seats to which all medical students from the state may apply, including the 15% open to candidates nationwide through examination.

[6] See Note No. 6 of this volume on career preferences of medical students.

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India Health Beat is produced by the Public Health Foundation of India and the World Bank's Health, Nutrition and Population unit located in Delhi. The Notes are a vehicle for disseminating policy-relevant research, case studies and experiences pertinent to the Indian health system. We welcome submissions from Indian researchers and the donor community. Enquiries should be made to Nira Singh (nsingh2@worldbank.org).