Developing medical leadership in India: A mission impossible?

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ABSTRACT

Purpose Globally, there has been a call to enhance medical leadership in healthcare, although we know little about how this objective has been pursued in low-income middle-income contexts such as India. This paper highlights the opportunities to strengthen leadership in this context, while also considering the obstacles to this change and how they might be overcome.

Methods The paper draws on a review of available secondary sources including published journal articles in the academic and grey literature, reports published by the Indian government and transnational organisations. The search focused specifically on medical leadership, clinical leadership, management and governance in the Indian healthcare system.

Findings India is currently in the throes of the world’s biggest experiment in universal healthcare popularly known as ‘Modicare’. However, these reforms have been criticised with regard to the lack of solid healthcare management framework in the country. The current National Health Policy highlights the need for specialised ‘public health management cadre, human resource governance and leadership development’. Nevertheless, the available research highlights a gap in the research on this topic, specifically about the development of medical leadership competencies. Our findings highlight not only the opportunities to develop medical leadership but also the obstacles to this process. Inadequate training and education, spiralling workloads, low salaries in the public sector and a growing culture of kickbacks have all stifled the opportunities to develop medical leadership but also the potential obstacles to enhancing medical leadership are of a qualitatively different order of magnitude.

Conclusions While the Indian government is now focusing more on the need to strengthen medical leadership, there are significant barriers to change. In future, building leadership capabilities will require deeper reforms in training, regulation and remuneration of doctors to generate sufficient incentives especially in the public sector.

INTRODUCTION

A distinctive feature of healthcare reforms globally has been the drive to co-opt doctors into management roles. Linked to this have also been calls to encourage a wider constituency of clinical professionals, including those who may never become managers, to engage in ‘leadership’ activities. Indeed, with many professional bodies now actively supporting or—in some instances—driving these changes, medical leadership has moved from ‘the dark side to centre stage’. Increasingly, medical leadership is assumed to be crucial for higher organisational performance as well as developing novel care delivery strategies, organisational structures and governance.

However, management concerns do not feature in the formal education and training of doctors, which continues to reinforce what Sinclair terms an ‘exclusive professional identity’ linked to strong occupational cultures of ‘individualism’. Hospitals have traditionally been organised as ‘split hierarchies’ with doctors ‘remaining somewhat apart’ from administrative roles and responsibilities. Indeed, it is notable in the UK-National Health Service (NHS), that even after three decades of reform, there still remains a pressing need for ‘dialogue and conflict resolution’ to improve ‘doctor–manager relationships’. While these challenges are present in any healthcare system, they will also be mediated by the specific national conditions of reform. Such differences are apparent both within developed healthcare systems—such as in Europe—and between these contexts and developing systems where, arguably, the potential obstacles to enhancing medical leadership are of a qualitatively different order of magnitude.

India is a prime example of this (still) developing and struggling model of medical leadership. Recently, the Indian healthcare system has undergone dramatic changes with the application of two very ambitious health reforms: Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)13 and Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)14 popularly known as ‘Modicare’. These reforms are thought to be ‘game-changers’ in the delivery of health services. However, weaknesses in the application of the PMSSY scheme have been noted with regard to the lack of solid healthcare management framework. Similarly, the Modicare has been criticised stating it as an improperly planned, ill-conceived and mere populist announcement.

Partly for these reasons, calls to strengthen medical leadership capabilities have grown in India. For the first time ever, the Ministry of Health noted ‘human resource management is critical to health system strengthening and healthcare delivery’ and recommended the development of leadership skills, strengthening human resource governance in public health system, through establishment of robust recruitment, selection, promotion and transfer postings policies. This same report called for the introduction of a Public Health Management Cadre, with an appropriate career structure to attract professionals with medical and non-medical qualifications.

How realistic are these objectives of developing medical leadership in India? A study conducted by one of the authors found significant medical leadership competency gaps among doctors from public and private sector hospitals especially in...
the areas of management, professionalism and governance.\textsuperscript{18, 19} Like many other countries, medical leadership in India continues to be viewed as a peripheral activity.\textsuperscript{20} If doctors acquire leadership skills at all, this is only through ad hoc on the job experiences and self-funded learning—effectively ‘by chance’. As we shall see, this problem is compounded by competing priorities of reform and the general absence of incentives (notably financial) for doctors—especially those in public sector—to engage with medical leadership.

In this paper, we develop what is to our knowledge the first considered review of this topic, focusing on the question of whether developing medical leadership in India is a mission impossible? As a primary source of information, we draw on a review of published journal articles, reports and other appropriate materials accessible in the public domain. Information about Indian healthcare system, its governance and current reforms were obtained from government websites. Although the paper focuses on the situation prior to the outbreak of the COVID-19 pandemic, the concerns raised about the challenges of engaging doctors in leadership in the Indian healthcare system remain valid.

**Medical leadership: the evidence base**

In health systems around the world, poor patient care and adverse events have been identified, leading health systems to call for strong medical leadership\textsuperscript{21, 22} However, as noted earlier, the involvement of doctors in the running of services is not only limited to those who take on (so-called hybrid) formal management roles, but also those performing leadership activities. These forms of leadership may exist at levels, including the co-ordination of small-scale improvement projects at the front line, right through to service development projects (eg, around the redesign of patient pathways), in which clinicians may work across professional and sometimes organisational boundaries. These informal, or distributed, leadership roles may be critical in reshaping services and involve ‘processes and skills that may or may not reside in formally designated leaders’.\textsuperscript{22}

There is now a growing evidence base to support the claim that greater medical involvement in leadership positions, especially at the strategic levels, can have important benefits for service performance.\textsuperscript{23, 24} It is suggested that ‘in a healthcare system that is complex, troubled and challenging, the doctor CEOs (Chief Executive Officers) bring a unique set of skills to the business of medicine’, as they better understand clinical challenges and general patients’ needs.\textsuperscript{3} Through greater involvement of doctors in management, hospitals not only will benefit from a higher quality of strategic decisions but also from a more concrete implementation of decisions taken.

One way in which to develop and inspire doctors to become leaders is through the creation of leadership competency models. There is growing evidence that suggests that leadership development programmes can enhance individual competence and performance using versatile, multiple training techniques adapted to organisational contexts. Kakemam and Goodall,\textsuperscript{25} for example, used data from 72 general hospitals in Tehran and found that the average performance scores for hospitals with clinical managers and non-clinically trained managers were equal to 96.68 ± 5.50 and 89.78 ± 7.20, respectively (p < 0.001).

Hence, it is argued that medical leaders have a vital strategic and organisational role in creating open, accessible and compassionate environments. Generally speaking, hospitals that involved doctors in management and leadership tend to perform better.\textsuperscript{3} Nevertheless, as mentioned, although health systems around the world share similar basic structures, the context in which medical leadership is exercised may vary from high-income to low-to-middle-income settings. In general, low-income and middle-income environments suffer from under-resourced or poorly managed health systems that may challenge medical leadership and how healthcare providers conceptualise and perceive it. In what follows, we now address this concern, focusing specifically on the Indian experience.

**Background: the Indian healthcare system**

Public healthcare system in India is a three-tier structure (primary, secondary and tertiary) funded through general taxes. About 65% of the population pay out-of-pocket. The healthcare system is a federal structure, with state governments responsible for the delivery of services and central government taking care of medical education, regulatory mechanisms, pharmaceutical manufacturing and national health programmes.\textsuperscript{26}

Public expenditure was estimated at only 1.3% of the gross domestic product (GDP) in 2012–13, rising from 1.00% in 2005. By contrast, private health expenditure was 2.69% of GDP.\textsuperscript{27} Therefore, the private sector, although largely unregulated, is the major supplier of health facilities and preferred by many because of its availability and efficiency. The latter is borne out by a study conducted by Bhatia and Cleland\textsuperscript{28} comparing healthcare for female outpatients in south-central India. This reported that ‘private practitioners are providing a better service, defined in relation to consultation time, privacy and likelihood of receiving information about diagnosis and prognosis, than their public sector counterparts’.\textsuperscript{29}

Approximately 70% of India’s population live in rural areas while nearly 75% of dispensaries, 60% of hospitals and 80% of doctors are in urban areas—serving only 30% of population. Of all qualified workers, 77.4% are located in urban areas. In rural India, only 37% of people have access to inpatient facilities within a 5 km distance and only 68% have access to an outpatient department. Poor access is further compounded by the fact that a majority of the rural population suffer from low levels of education, sanitation and safe drinking water.\textsuperscript{30}

Turning to the workforce, the medical profession in India, perhaps more so than in other developing contexts are strongly divided between modern (allopathic) and traditional—AYUSH (Ayurvedic, Unani, Siddha and Homeopathy) wings. The former normally involves a 5.5-year course not dissimilar to the western model. In theory, to become an Ayurvedic doctor, one has to acquire Bachelor of Ayurvedic Medicine and Surgery also requiring 5 years of study. In a significant step towards the establishment of a robust medical regulation system, India’s government passed the National Medical Commission Bill (2019).\textsuperscript{31} This set up a National Medical Council as an umbrella regulatory agency with provisions to reform medical education and, controversially, to address severe workforce shortages by allowing AYUSH doctors and other informal practitioners the right to practice ‘western’ medicine. So far, the Indian Medical Association has strongly resisted this reform, alleging that the government is effectively legalising quackery. While such claims have been vehemently denied, there can be little doubt that these reforms have undermined morale and possibly also the willingness of doctors to engage more with leadership and management roles.

Looking ahead challenges associated with population growth, structural deficiencies in the quality and funding of public and private healthcare, large gaps between urban and rural populations in access to healthcare and inadequacies in the training
and skills of practitioners are only likely to become more acute. The hope is that many of these concerns will be addressed by the PMSSY and AB-PMJAY reforms that are still ongoing. However, whether these reforms will be sufficient is open to question, especially in the aftermath of COVID-19. Related to this is also the question of management and specifically medical leadership capabilities to support the implementation of reforms, a topic we now turn to in the remainder of this paper.

Developing medical leadership in India: progress so far
Recently, there has been an increased interest in the goal of developing leadership capacity among doctors in India. Although this process is still in its infancy, numerous healthcare organisations and universities have moved in this direction. An early example of this was the All India Institute of Medical Sciences (AIIMS), New Delhi—an elite tertiary hospital—that introduced the first master’s programme in hospital administration in 1961. Today, more than 100 universities now offer such programmes. Government also plans to establish 22 AIIMS institutions across the country, under PMSSY (of these new AIIMS, six are already functional), which is likely to give a similar boost to leadership initiatives in India. These master programmes—although limited to formal education—at least provide the medical graduates with an initial introduction to management.

However, so far moves to support medical leadership have been piecemeal and have yet to extend to all levels of the healthcare system. India has not established its own leadership competence structure for medical management capacity development, for example, similar to the NHS Medical Leadership Competency Framework (MLCF) or CanMEDS framework of the Royal College of Physicians and Surgeons of Canada. The available research highlights a massive gap between the theory and practice of medical leadership—even in the better resourced tertiary hospitals of the public and private sectors. A notable example of this is a recent study of leadership competencies of doctors (N=540) in public and private hospitals in India. Finally, as elsewhere, creating dedicated time for leadership training and education in the tight medical curriculum in India poses a further challenge. This is especially true given that medical leadership in India is still not recognised as a distinct specialty.

In addition to these general challenges associated with shifting the culture and practice of medicine, which apply in any setting, there are a number of more specific obstacles to engaging doctors in leadership roles that apply especially to India. Most obviously, are wider labour shortages and workload pressures on doctors, that are likely to severely limit the time and space available for leadership training or practice (WHO, 2016). Growing pressure on these doctors is linked to rising rates of absenteeism and stress and to fostering a culture of bribery (see below). By contrast, tertiary hospitals in urban areas are better resourced (especially in private hospitals). Here senior doctors are expected to manage and lead the teams and develop leadership competencies. However, even in these tertiary settings, the challenge of meeting demand for medical services is acute and rising, thus limiting time for leadership development. For example, AIIMS, Delhi, attended approximately 4 million outpatients, 0.25 million inpatients and performed >0.2 million surgical procedures in 2018–2019.

A related problem in India is the low level of qualifications generally in the medical workforce, a fact that makes developing leadership skills a secondary priority. A WHO (2016) report, The Health Workforce in India (Human Resource and Health Observer Series) revealed that many individuals claiming to be doctors in their occupation did not have the prerequisite qualifications. Among allopathic doctors, only 31.4% were educated up to secondary school level and 57.3% did not have a medical qualification, whereas 58% of doctors in urban areas had a medical degree, only 19% of those had such a qualification in rural areas. Interestingly, the percentage of female doctors with a medical degree was more than their male counterparts. These conclusions were also supported by the National Sample Survey on the health workforce, which reported availability of 2.5 million health professionals (20.9 per 10 000 population) in 2011–2012. Unfortunately, a majority (56.4%) were unqualified, including AYUSH practitioners (56.1% unqualified), with a massive disparity between urban and rural areas—with urban doctors 11.4 times more likely to be qualified than their counterparts in rural settings. Hence, these skill gaps, combined with rising work demands, pose a major challenge for India’s healthcare system. While they do not negate the need to invest in medical leadership, they ensure that such investments will take a back seat when compared with the arguably more pressing demand to enhance the basic supply of appropriately trained clinical professionals.

Added to these pressures are questions about the incentive for doctors to devote time to developing leadership skills and practices. As per National Health Profile of India, only 10% of the 0.1 million registered allopathic doctors in India work in public sector. However, a further problem, especially in the public sector concerns, the relatively poor remuneration of doctors. This fact has meant that many doctors in the public sector are focusing their attention on transferring into private sector hospitals, where pay and opportunities for professional development are greater. For many, the goal is to escape the public sector rather than contribute to service improvement through leadership work that is unlikely to be rewarded.

These same pressures may also have much to do with growing levels of corruption and the reliance of doctors on kickbacks and bribes to supplement their total reward package. Healthcare is considered to be one of the most corrupt services in India.
and harms the doctor–patient relationship. Transparency International (2019) revealed that in India 290 million people pay bribes to health services every year and patients were referred to hospitals by quacks, middlemen and doctors receiving kickbacks. Another study of corruption among doctors revealed that unreasonable medication prescriptions, referral kickbacks and unnecessary inquiries and surgical processes were prevalent in India. These problems are well understood in India although there is very limited control. As a result, corrupt practices continue to generate waste and compromise the quality of health services. However, what they also imply is that many doctors will have even less time or inclination to focus on leadership development. As has been noted in some European healthcare systems, the perceived need of doctors to supplement their income by focusing on additional services (paid for by patients, out of pocket) is likely to crowd out investments in leadership that currently attract no rewards.

Discussion and Conclusions

The push to reform the healthcare system in India has grown significantly and, increasingly, enhancing medical leadership is part of this process. The need for reform arises from the inefficient use of scarce resources, poor access to public healthcare, especially in rural areas and severe limitations on the training and supply of the clinical workforce. Nevertheless, without leadership capabilities on the ground, the prospects for reform seem bleak. To address this concern, government, universities and professional bodies have started to explore how to develop leadership capabilities. As we saw, for the first time ever, India’s National Health Policy (2017) highlights the need for a specialised ‘Public Health Management Cadre, Human resource governance and Leadership development’. The Indian government is proposing setting up a framework for public health leadership in all states based on related disciplines and advocates an appropriate career structure and recruitment system to attract young and talented professionals from different backgrounds. In this respect, as in the English NHS, India is seeking to develop leadership competencies across its entire health workforce, including non-clinical administrators. However, what has been given most prominence in this paper is the specific drive to develop medical leadership. In India, the latter seems especially important given the very rigid professional status hierarchy and much higher rates of unqualified staff in areas such as nursing and pharmacy.

However, as we have seen, these reforms are starting from a very low base. The available research suggests that even in the best resourced parts of the health system, a wide gap is perceived between leadership competencies that exist and those, which are needed. Added to this are potentially even more serious obstacles to supporting and engaging a wider population of doctors in the process of leadership development. These arise from more fundamental challenges associated with poor resources, skill deficiencies and—from a western perspective—true eye-watering disparities in the provision of health services between urban and rural areas. Such problems are compounded by declining morale among the doctors (notably those practising western medicine) and likely defensiveness towards further change (including leadership). Finally is the question of incentives with low pay and the kickback culture potentially interfering with efforts to persuade doctors to focus more on leadership.

To conclude, it is evident that significant medical leadership competency gaps exist in India. For medical leadership to succeed, the key strategies would be:

i. Introducing substantial reforms to address challenges of workforce shortages and skills. This also means looking at incentives for doctors especially for those in public sector to engage in leadership roles.

ii. Creating a national mandate for medical leadership development. Considering the size and complexity of Indian healthcare, medical institutions and professional bodies need to be active and granted adequate autonomy and funding for leadership development at all levels of the healthcare system.

iii. Developing its own model/framework of medical leadership competencies along the lines of NHS-MLCF and CanMEDS.

iv. Establishing a forum similar to the Faculty of Medical Leadership and Management of the UK (www.fmlm.ac.uk) to propagate the concept of medical leadership and provide practical support in terms of training and access to relevant networks.

Contributors KG conducted the primary review of sources relating to medical leadership in India and initial drafting. IK assisted with the framing of the paper and final drafting.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data sharing not applicable as no datasets generated and/or analysed for this research paper. The paper draws on a review of available secondary sources including published journal articles in the academic and grey literature, reports published by the Indian government, research bodies and transnational organisations.

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