Bridging the gap

Bottom Line: Govt. should sponsor preparatory plans to help fill faculty posts in Central institutions.

The gap in Affirmative Action:

1. A severe deficit in the number of OBC, SC, ST candidates recruited as faculty in Central institutes of higher education has been revealed drawing attention once again to the pallid state of reservation in some of India's elite institutions.
2. Some of the striking data show 62% unfilled vacancies for SC in the IIMs and 90% for OBC in the IISc, while vacant positions are on average about 38% to 52%, taking Central Universities, IISERs, IIT (non-faculty), IGNOU, and Sanskrit Central Universities into account.
3. The data confirm that the trend seen earlier in the IIT system extends to many more institutions, highlighting a serious mismatch between the government's equity-building goals and actual recruitment outcomes.
4. In the case of the IITs, an official committee suggested that the way out would be to exempt these institutions from the reservation, as provided for under the Central Educational Institutions (Reservation in Teachers' Cadre) Act, 2019, or to dereserve lower faculty positions after a year if suitable candidates from the beneficiary communities are not found.
5. This cannot obviously be a salutary course for official policy, when the reservation system, envisaged as an improvement on western ideals of affirmative action, is widely seen as the shortest path to equality and equity.
6. What could help bridge the gap is a better understanding of the lacunae in the education system, marked by a sea of deprived public schools and colleges, hyper-commercialised private universities and colleges and islands of elite institutions such as the IIMs.

Government-sponsored Preparatory Programmes

1. The failure of the Central higher education institutions to recruit faculty to all the reserved positions is usually attributed to the absence of enough qualified candidates, as the Education Ministry's committee for IITs did.

2. One of the forward-looking remedial measures suggested by the panel was to start government-sponsored preparatory programmes, which would both equip aspiring faculty, and create a pool of research talent.
3. This has merit in the context of management, science and other disciplines, and in the short term, could help qualified individuals overcome the deficiencies of their preparatory years.
4. Such courses would also make these institutions of higher learning more socially responsive, meeting the goal of addressing the historical deprivation of communities based on caste.
5. Yet, there are larger questions that need answers, and which continue to be agitated in courts. One of them is whether there should not be even greater attention devoted to the most marginalised within the reserved categories, such as SC since trickle-down quota benefits for them are scarce.
6. The egalitarian answer would be to continue expanding the pie of opportunity in the public realm, through ever greater funding of quality universal education at all levels and aiding the deprived through affirmative action on the road to equality.

We need to urgently invest in public health

Healthcare and public health

1. While the health-care capability in India ranks among the world's best, it is a different story when it comes to public health. We need to distinguish between the two.
2. Healthcare refers to the transaction between one caregiver and one sick person at a time – hence the client is the sick person and therapy is the mainstay.
3. For public health, the client is the community at large and the goal is disease prevention and control. Disease control is the deliberate, intervention-based and quantified reduction of disease burden. It has to be data-driven.
4. Data are required on baseline disease burden and real-time monitoring to track the control trajectory of all the highly prevalent infectious diseases.

5. Reliable data must be collected from all sources including every healthcare provider, for monitoring disease burden by diagnosis and outcomes; for this exercise, the total population is the denominator.

Experience of Polio and HIV

1. Data collection for HIV control is sample-based, under the unique Indian design of sentinel surveillance, established in 1986 and still continuing. It shows only the time trend of declining infection prevalence.
2. Counting of acute flaccid paralysis (AFP) and laboratory tests for polioviruses (including molecular methods distinguishing wild from vaccine viruses) were crucial for polio elimination in India.
3. The commonality between HIV/AIDS and polio programmes is the availability of denominator-based data. The denominator for polio elimination is the national total under-five population. So, we knew the total disease burden. And when it reached zero, we knew polio was eliminated.

Covering all diseases under data monitoring

Our health management does not have a way of prospectively collecting data on all diseases and deaths by diagnosis. That is precisely the task of public health. In short, we do not have a comprehensive and quantified profile of any disease in the entire population, including those under vertical programmes — tuberculosis, malaria, leprosy, AIDS.

Social vaccination

1. For COVID-19, there are non-pharmacological preventive interventions — face masks, hand hygiene, physical distancing — and pharmacological prevention by vaccination.
2. Where we fell short is timely and comprehensive public education with authoritative and authentic information communicated effectively to the public for self-motivated behaviour modification.
3. In other words, a 'social vaccine'. Social vaccination is another function of public health.

Social and Environmental Determinants

1. COVID-19 has strong social determinants of infection transmission — overcrowding, lack of cough/sneeze etiquette, and urban-rural divide in health awareness and education. These factors are common for influenza and TB too.
2. Typhoid, cholera, leptospirosis, scrub typhus, malaria, rabies, etc. have environmental determinants.
3. In countries where public health is given equal status with healthcare, public health addresses both social and environmental determinants and controls these diseases.
4. Public health personnel have jurisdiction over people in their homes and workplaces, food and water distribution chains, and over ecosystems — ranging from densities of arthropod vectors, rodent and canine populations, to flight ranges of fruit-eating bats.

Our government errs when it thinks that healthcare for people's felt need alone will suffice, without mitigating disease determinants through public health. India's style of mounting ad hoc responses only when there is a pandemic is no longer tenable. Currently, our healthcare institutions are cluttered with too many infectious diseases that are amenable to control if only we had public health. Imagine how much wealth is going down the drain for want of public health. Investment in public health will result in health, wealth and prosperity.