links with potential public and private employers; and modifications to existing policy guidelines on recruitment and staffing in public health facilities.

⇒ A mature faculty development programme, as observed in the international arena, has several components, with mentorship, research and continuous professional self-development standards being integral components. In India, however, the shortage of both quality and quantity of faculty is a major impediment to the capacity building of faculty in allied health.

⇒ Budgetary allocations towards each of the issues listed above, along with flexibility to hire the number and type of allied health staff as required by each level of the public health system, would go a long way in spreading the existing best practices in allied health.

⇒ Unlike medical or nursing professionals, allied health staff constitutes a wide variety of professionals (as evident from Chapter 2) that completes the clinical team along with doctors and nurses. When standardising inputs, curriculum, and practice guidelines, the vast differences between each of these numerous cadres have to be kept in mind, and guidelines customised for each group using subject experts in the area. It is also critical to plan for increases in each cadre based on the epidemiological need in the respective region. Factors to consider for this purpose are the population, including geographical and other access issues, the time it will take to upgrade the existing staff to requisite levels of knowledge and skills, and the private sector hospitals and outpatient centres that would also require these services.

7.3 Conclusion

Paramedics or AHPs constitute a vital part of health system delivery, both nationally and internationally. In the Indian context, however, their significance and role has been marginalized due to the prevalent culture of medical dominance as well as the fact that there is no statutory body to highlight their contributions or concerns. As the Government of India's MoHFW gets ready to undertake a facelift for the entire allied

health workforce by establishing national and regional institutes of excellence, the time is opportune to study this provider group in detail; review existing inputs, processes and outputs; standardize institutions, educational tools and methods; revisit career paths and progression; and re-introduce these professionals into the public system to reap much-awaited rewards in the form of developing educational and training institutes of excellence which provide a regulatory framework.

Regulation is limited in what it can accomplish and not a solution to the various problems. As seen in the case of recent developments in the MoHFW wherein due to nexus between corruption in MCI and politics, the senior most executive in the Ministry has been removed. Therefore when due to such nexus, regulations remain unenforced or lacking in action, then they count for little. It is therefore equally important to develop the capacity in the sector itself for self-regulation and a social consent in public to enforce them.

Nevertheless, given the gaping holes in our nation's health workforce, particularly the severe shortage of physicians and specialists, it would be a most appropriate to utilize the capacities of this vast and varied resource of AHPs in meeting several basic preventive, promotive, curative, and rehabilitative needs of the population. Para-medical /Allied health workers can reduce costs and augment the quality of care. They also reduce dependence on expensive expert time and resources. Both primary and allied health workers need to form the base of the healthcare pyramid. A composite whole can only be improved if human resources for nursing and allied health services are developed, nurtured and enhanced in a systematic and planned manner with a reliable data base.