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COMMENTARY

Unjust discipline-based wage differentials in public health in India: a call to action

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Abstract

Public health professionals and researchers in India with allied health and non-health backgrounds are routinely undercompensated and not treated on par with their counterparts from a medical background. In this article, we use the practice of discipline-based wage differentials in public health as an entry point to examine the underlying structures, priorities, and prevailing perception of public health norms and professional image, along with the ethical implications these issues pose for equity and justice in public health in India. The unfair remuneration practices for professionals and researchers in the public health field are symptomatic of deeply embedded structural distortions, including the persistent conflation of disciplines, a colonial and biomedical legacy, a research funding ecosystem that systematically privileges certain epistemologies over others and market-driven inequities. Ensuring pay parity for professionals and researchers in public health is a matter of social justice and a critical step towards realising diversity, equity, and inclusiveness in the field.

Keywords: *public health, pay parity, India*

Introduction

The gender pay gap in the health sector is increasingly recognised, problematised, and some progressive steps are being taken in many countries, including India [1]. But wage differences based on factors such as a professional degree in public health practice, education and research have not received similar attention. For instance, an individual who completes an MBBS, followed by a Master's in Public Health (MPH) and a doctorate (PhD), continues to benefit professionally from having an MBBS as their foundational qualification. In contrast, an individual with a Bachelor of Science (BSc), MPH, and PhD may not receive the same level of remuneration or access to opportunities in the public health field in India. This distinction highlights that, in public health practice, education and research, one's primary educational background, particularly the possession of a medical professional degree, such as an MBBS, plays a significant role in determining market value and career advancement. The situation is similar or even worse in the public health research sector, which is already small and shrinking due to limited funding opportunities for research. An example of such a differential is the case of clinical and public health research fellowships offered by the Department of Biotechnology (DBT)/ Wellcome Trust India Alliance [2], an independent, dynamic public institution that funds research in health and biomedical sciences in India. As part of the fellowship, researchers with a medical degree (ie, in the western system of medicine) are referred to as "clinician scientists" and researchers with a non-medical degree are referred to as "basic scientists". For a *public health research fellowship,* clinician scientists are likely to be paid a 21 to 30% higher salary than basic scientists [3]. This excess payment to clinician scientists in the DBT/Wellcome Trust India Alliance-sponsored public health fellowships is justified as a non-practising allowance during the fellowship period. However, it may be noted that other cadres of health professionals, such as nurses, if selected for public health fellowships, are not provided with the non-practising allowance, and are considered as basic scientists during the fellowship period [3]. This points to a hierarchy not only between medical and non-medical degrees, but also within the medical field.

Another example is the salary structure for scientific staff engaged in the public health research projects of the Indian Council of Medical Research (ICMR), an apex research body in India that funds health research. Here again, a non-medical scientist is paid less than a medical scientist of equal cadre. On examining the job recruitment notifications from ICMR, we observed that a researcher in the non-medical scientist cadre is always paid less than a researcher in the medical scientist cadre [4]. One study, which examined several countries, including India, demonstrated that faculty with medical (clinical) backgrounds tend to be paid more than faculty with non-medical backgrounds in analogous academic roles in public health or related fields [5]. No single discipline is superior or inferior to the other in the field of public health [6]. However, public health professionals and researchers in India with allied health and non-health backgrounds continue to be routinely undercompensated and not treated on par with their counterparts with a medical background. In this article, the authors use the practice of discipline-based wage differentials in public health as an entry point to examine the underlying structures, priorities, and prevailing identity, that is, the dominant self-image and perceptions of the public health field through shared norms and assumptions. This approach includes questioning which disciplines are seen as core to public health, whose expertise is recognised or marginalised, what types of problems are considered "real" public health problems, which methods and forms of evidence are valued, and which roles are seen as legitimate in public health. In this commentary, the authors further explore the ethical implications of these issues for equity and justice.

The authors' perspectives on pay inequities in public health are shaped by their diverse social and professional locations. VRK, a medical doctor, teacher, and researcher trained in community medicine, applies social science approaches and brings insights from working across multidisciplinary teams and advocating for equity. MP, a nurse and health governance researcher, grounds this reflection in her own experience of pay disparities during a research fellowship, highlighting how gendered and professional hierarchies operate. SKU and DS, both non-medical public health researchers, with DS also co-founding Women in Global Health in India, offer critical perspectives that challenge medical dominance and foreground feminist and justice-oriented analyses. Together, their positionalities as medical, nursing, and non-medical professionals, as researchers and practitioners, and as individuals embedded in different hierarchies of gender, profession, and discipline, enable them to see pay disparities not as isolated experiences but as symptoms of deeper structural inequities in Indian public health.

Unpacking the roots of unfair remuneration practices

The public health–community medicine confusion

Unfair remuneration practices in public health are symptomatic of deeper structural issues rooted in how the field has been institutionally organised and epistemologically defined in India. One foundational problem is the persistent conflation of public health with community medicine. While these fields overlap in practice, they differ significantly in philosophical orientation, scope, and methodology [6]. Public health is inherently multidisciplinary, focusing on population-level, systems-oriented approaches and emphasising upstream determinants, such as socioeconomic position, policy, and political forces. Informed by social justice frameworks, it seeks structural reform, policy and public engagement [6,7]. In contrast, community medicine in India was developed as a medical speciality with a biomedical, epidemiological and programmatic focus on disease prevention, health education, and health service delivery. Though it engages with social determinants, the approach remains largely medical, operational and confined to service implementation and programme management. The widespread interchangeable use of "public health" and "community medicine," especially within medical institutions where most public health programmes are housed and led by clinicians [8,9], has undermined the inherently interdisciplinary nature of public health education, research, and practice. Thus, the way public health is organised and conducted through formal State structures reflects how public health work is defined, who is appointed to leadership positions, and which kinds of expertise are given authority. It is the politics of public health organisation in India that strengthens the focus on curative requirements and implementation of State-sponsored programmes as core public health functions. Public health research is not recognised as a core function. At best, only public health surveillance is. This dynamic reflects Foucault's concept of *biopower,* where medical and institutional systems regulate populations by defining what counts as legitimate knowledge [10,11]. Through this process, the State shapes public health policy using biomedical logic, often sidelining broader, community-based and social science perspectives. Medicalisation thus reduces public health to technical management, marginalising more holistic and socially grounded approaches. Despite the broader expertise public health requires, from clinical to social and policy domains, there remains a strong bias in favour of medical professionals, particularly those with a background in the western system of medicine. This is evident in hiring patterns, institutional hierarchies, and most notably, policies on remuneration practices.

Colonial legacy

A second structural issue is rooted in the historical evolution of public health in India. Under colonial rule, public health was primarily designed to safeguard British personnel, with a narrow focus on sanitation and epidemic disease control, supported by institutions like the Indian Medical Service and laws such as the Epidemic Diseases Act of 1897. After independence, the Indian constitution mandated healthcare to be largely a "state subject" in the federal governance structure. However, the union government continued to influence public health through the implementation of vertical national health programmes and health systems strengthening initiatives. Before 2000, there were hardly any MPH courses in India and thus, community medicine shaped the early development of the public health field by integrating preventive and promotive care into medical curricula and facilitating national health programmes [12]. Across India, a common practice is that MPH graduates from non-medical backgrounds are typically hired under various national health programmes, but at significantly lower salaries compared to their MBBS counterparts. For example, in one of the job recruitment calls released by the National Health Mission (NHM), Karnataka in 2025, consultants for maternal health with an MBBS background are offered a salary of ₹80,000, while professionals without an MBBS degree are paid between ₹50,000 and ₹60,000; and the same difference in remuneration is shown for the position of State Leprosy Consultant [13]. When the nature of the public health work remains the same, such differential treatment raises an important question: why should this disparity exist at all? The medicalised foundation of public health reinforced a narrow biomedical orientation, the legacy of which persists today. According to Foucault, this represents the continuation of colonial biopolitical governance where the State assumes responsibility for the "health" of populations, but only through disciplinary regimes embedded in medical institutions [11]. The continued appointment of doctors trained in the western system of medicine to public health administrative/leadership roles at district, state, and national levels exemplifies how this legacy restricts the inclusion of professionals from diverse, non-medical backgrounds, thereby stifling the interdisciplinary

evolution of the public health system. The emergence of public health courses, such as an MPH in India, and other related courses in political science, public policy, behavioural sciences, and public health nutrition has opened doors to public health training for a diverse range of professionals [14]. However, despite the expansion of courses related to public health, public health postgraduates with a prior degree in medicine generally get higher remuneration in the field.

Biomedical dominance in health research funding

Thirdly, biomedical dominance is further entrenched in health research funding. Public health research, particularly studies that explore health governance reforms, political economy of health, structural inequities, or system-level solutions, continues to be underfunded [15]. These issues required research focused deeply on the social sciences, economics and other disciplines. While agencies such as the ICMR and the DBT/ Wellcome Trust India Alliance have begun funding macro-level, policy-oriented research, their portfolios remain predominantly focused on biomedical and clinical sciences. This reflects an enduring epistemological hegemony of biomedical-oriented public health. This further illustrates how *biopower* [11], with a predominantly positivist paradigm, functions through institutional funding mechanisms that reward knowledge systems that can be quantified, controlled, and technocratically managed. As a result, disease-specific, laboratory-based studies receive disproportionately high attention and funding, while interdisciplinary, community-based, and real-world research is marginalised. For instance, among the 115 research projects shortlisted for ICMR's intermediate grants in 2025, only 33 are non-medical intervention-based, or community-based, or health-systems/ social-science–oriented projects [16]. This bias in research funding not only distorts the national public health research agenda but also reinforces professional hierarchies and deep-rooted structural inequities that continue to undervalue non-medical expertise and approaches critical to public health policy and practice.

Disciplinary hierarchies and gender bias

Fourthly, the wage differentials in public health are probably a reflection of wider inequality within the healthcare delivery systems, where professions such as nursing, social work, and other allied health services have historically been undervalued in comparison to the medical profession, which often receives greater political and administrative attention and resources [17,18, 19, 20, 21]. This neglect is frequently compounded by gendered dynamics: allied health and care professions, particularly nursing, tend to have a higher proportion of female workers; thus, reflecting broader patterns of gender-based segregation of labour towards the lowest levels in the hierarchy, and consequently are undervalued and underpaid [19, 20, 21]. These disparities are not merely economic but are deeply rooted in social and institutional biases that often see their role in the health sector as an extension of unpaid care work from their homes.

Market-driven inequities

Fifthly, in a neoliberal economy, market forces drive compensation norms. One of the commonly cited justifications for higher compensation of medical professionals is the longer and more expensive nature of their training. This rationale requires critical scrutiny. The longer medical training period does not automatically ensure better public health competencies among medical graduates. In India, the high cost of medical education does not always reflect merit-based selection and quality of medical training [22, 23]. The widespread mushrooming of private medical colleges with astronomically high fee structures makes them affordable to only the privileged few and thus introduces inequity in access to medical education [22, 23, 24]. Further, paying high capitation fees to get into a private medical college reveals that this access is often governed by wealth rather than aptitude. This reinforces the elite status of the medical profession and limits the entry for historically marginalised and non-elite groups. If medical education were made more accessible and consistent in quality, it could enable a more socially representative and diverse medical workforce. Moreover, allied health professional education is also increasingly becoming expensive due to the rapid privatisation of educational institutions, which threatens the quality and equity in access to education [25]. Yet, the logic that expensive education necessitates higher compensation is applied inconsistently and in ways that disproportionately favour professionals from the medical stream. In the context of public health, a field inherently interdisciplinary in nature, such elitism is deeply problematic. Professionals from diverse academic and practice backgrounds, including medicine, social sciences, and allied health, contribute valuable perspectives. Treating only the medical fraternity as central within public health is not only unjust but also contrary to the equity and collaborative ethos that defines the field. Standardising compensation is complicated by the heterogeneity of roles and varied certification requirements within the health sector [26]. Medical power through professional associations further influences bargaining power: physicians typically have greater access to financial, political, technical and policy resources, while allied health professionals tend to be more context-bound in their roles and function with limited resources [27, 28]. Additionally, labour market conditions, including regional supply-demand mismatches and workforce shortages, create uneven wage pressures across sectors [29]. Career pathways to public health are also shaped by a mix of push factors (eg, job insecurity) and pull factors (eg, prestige, incentives), which influence not only who enters the field but also how different professions are valued within it [30]. Foucault's lens reminds us that these seemingly neutral market forces are also embedded within broader regimes of governance that define the value of work through institutionalised discourses [11, 31]. A more equitable approach to workforce planning must recognise and address these intersecting influences, educational

access, career mobility, and socio-economic stratification, if structural disparities in public health are to be meaningfully resolved.

Ethical implications of unfair remuneration practices in the public health field

The ethical implications of pay disparity in public health, driven by medical dominance, are significant and troubling. When professionals with medical degrees are consistently paid more than those from disciplines such as allied health and social sciences for similar public health roles, it reinforces a hierarchy that privileges biomedical knowledge over equally essential non-clinical perspectives and expertise for public health [32]. This phenomenon also reflects what Miranda Fricker [33] conceptualises as epistemic injustice, where certain knowers and knowledge systems are systematically discredited within dominant institutions.

The non-medical professionals in public health are subjected to *testimonial injustice,* where their contributions are accorded less credibility or authority, solely based on their disciplinary identity. Their insights, often grounded in social theory, lived experiences, and community engagement, are frequently overshadowed by biomedical framings that are institutionally privileged historically. This disparity not only violates principles of fairness and equity but also undermines interdisciplinary collaboration, which is crucial for addressing complex public health issues [34]. It can marginalise non-clinical professionals, deter diversity, and skew research agendas toward clinical interventions rather than addressing broader social determinants of health [35].

Hermeneutical injustice, which occurs when some social groups are not fully heard or valued, is also evident in how institutional frameworks in public health fail to recognise or accommodate the conceptual contributions of non-clinical disciplines. For example, researchers who critically engage with political economy, caste, gender, or structural determinants of health often find their work less fundable, less publishable in high-impact medical journals, and undervalued in policymaking circles [33,36]. Such inequities raise ethical concerns around justice, recognition, and the responsible stewardship of research funding, particularly in settings where power asymmetries are stark.

Medical dominance in public health research harms the advancement of science and scientists with non-medical backgrounds in India. The pay disparity between medical and non-medical researchers/professionals is not just a reflection of institutional norms but an active reproduction of societal inequalities. Further, scholars have empirically demonstrated that individuals belonging to higher social classes tend to be paid more than other individuals with less privileged backgrounds [37, 38]. Medical practitioners of the western system of medicine continue to be a socially elite group, possessing significant power and influence in health policy-making processes [27, 39, 40, 41, 42]. Wage inequality is instrumental in maintaining the status quo, where certain knowledge forms and expertise are valued over others [37, 38]. Another critical issue is whether the current model of professionalisation in India undermines efforts to address social determinants of health. Increasingly, professionalisation emphasises university level degrees and technocratic specialisation, often reinforcing biomedical hierarchies and privileging elite institutions [41, 43, 44, 45]. This trend risks sidelining the lived experiences of people, interdisciplinary approaches, and professionals from non-elite backgrounds, precisely those needed to engage meaningfully with the social, economic, and environmental drivers of health [32]. As a result, public health in India may become overly narrow in focus, distancing itself from equity-oriented goals and weakening its capacity to serve marginalised populations effectively.

When researchers and public health professionals, regardless of medical or non-medical background, perform comparable duties, the similarity in their job functions should justify equitable compensation practices. We are not asking for equating the salaries of frontline health workers with those of MBBS doctors. We are demanding equity in positions that involve comparable responsibilities and work. For instance, a programme officer appointed at the state/district level or a faculty member in a public health school, or a public health researcher should receive equal pay regardless of whether they come from a medical or non-medical background. The principle of "equal pay for equal work" should be applied in public health institutions, yet current salary guidelines and recruitment practices consistently privilege medical professionals, even when non-medical professionals perform the same functions with equal competence. This structural bias undermines the interdisciplinary character of public health and perpetuates unnecessary hierarchies that weaken public health practice, education and research.

Any form of discriminatory practice in the workplace affects productivity, morale, culture, and can stifle the collaborative spirit necessary for effective trans/multi/inter/intra-disciplinary public health work [46]. Pay gaps take a heavy toll on the mental health of non-medical public health professionals. Most importantly, such a discriminatory practice goes against the values of diversity, equity, and inclusiveness in science. Any kind of bias is a threat to scientific advancement in public health because it deters the development of conceptual frameworks, perspectives, methods, and approaches to tackle the complex public health issues of our real world. Pay disparity in public health only bolsters the epistemic and normative powers of medical professionals and denies the equality principle endorsed by Article 14 of the Indian Constitution to public health researchers/professionals with allied health and non-medical professional degrees.

A call to action

The unfair remuneration practices in public health are not isolated anomalies but symptoms of deeply embedded

structural distortion, including the persistent conflation of disciplines, a colonial and biomedical legacy, a research funding ecosystem that systematically privileges certain professionals over others and market-driven inequities. These dynamics highlight how biomedical systems are entangled with political and economic structures that sustain professional hierarchies, marginalise social determinants of health, and valorise technical knowledge over relational knowledge [10, 32, 33, 34, 35]. Addressing these inequities requires a fundamental reimagining of what constitutes public health and who is recognised and rewarded within it. Within the Sustainable Development Goals framework, target 8.5 includes equal pay for work of equal value [47]. Yet, in public health in India, this principle is routinely violated through remuneration practices that elevate clinicians with a western system of medicine background, while undervaluing allied health and non-medical professionals, despite their equivalent contributions.

It is time for public health organisations, academia, funders, and governments to eliminate the categorisation of researchers and professionals in public health as medical, allied health, and non-health researchers. Such categorisation not only lacks conceptual validity in an inherently interdisciplinary field but also reflects a biomedical worldview that is critiqued for its inability to address the structural causes of illness, such as poverty, caste, gender inequity, and environmental injustice [48, 49]. All public health researchers and professionals, regardless of disciplinary training, are to engage in knowledge production, policy engagement, and community-based practice that are vital to improving population health.

Ensuring pay parity in public health is a matter of social justice and a critical step towards realising diversity, equity, and inclusiveness in the field. It is also a concrete step towards tackling biomedical hegemony that undermines social determinants of health and healthcare systems. To create a vibrant public health ecosystem with transformational value, we must ensure pay parity for public health scholars, regardless of their discipline. That way, we can change the patterns of practice that reinforce structures of medical power in public health in India.

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