Editorial

Human Resources for Health in India: Urgent Need for Reforms

Human Resources for Health (HRH) are defined as "the stock of all individuals engaged in the promotion, protection or improvement of population health". This includes both public and private sectors and different domains of health systems, such as personal curative and preventive care, non-personal public health interventions, disease prevention, health promotion services, research, management and support services (WHO, 2007).[1] Like other developing countries, India faces manifold challenges in meeting the demand for HRH in the country. HRH is an important component for reforms which have not received much attention, despite the fact that WHO has been in the forefront of advocating for such measures for several years.

It is a very well known fact that human resource density is directly related to achievements in health outcomes such as Maternal Mortality Ratio MMR, Infant Mortality Rate IMR or coverage with preventive and promotive interventions. Despite some improvement in the deployment of HRH in India, particularly after the implementation of National Rural Health Mission (NRHM), yet many states in India, particularly the low performing states face huge shortage of HRH in rural areas. Huge investments have been made in NRHM over last 7 years to add contractual staff in service delivery and managerial positions. Number for nurses and doctors are really impressive. In addition one can claim that nearly 850,000 Accredited Social health Activists at village level also provide much needed support for poor women and children to seek timely care. However, several studies have informed high attrition rates and lack of investments in training for these contractual staff. Also in light of lack of any career progression path, staff is not motivated. In many instances they have formed unions to demand "permanent" jobs in the governments.

Other HRH issues in India deal with the planning for human resources. Health being a State Government subject they spend almost more than double the amount the Central Government spends on the health care. There are issues related to numerical and distributional imbalance, inadequate training and technical skills, improper deployment, inefficient skill mix of health workforce often coupled with poor personnel management, non-existent of career structures, inadequate staff supervision, lack of motivation, poor working environment and lack of opportunities for personnel development. There is absence of a well-defined Human Resource Development HRD policy in states and even if it exists, it does not address the framework for key elements such as forecasting for HRH, deployment and career progression, compensation and retention of health workers. The policies also do not address issues like continuous education and on the job skill development to retain the talent; yet, very few states can claim to have a dedicated unit to handle Human Resource HR functions. It is very difficult to get a real time data from states on number of doctors, vacancy positions, deployment status etc. We feel this is one important area of reform which has escaped attention of the policy managers and program planners. States should have a dedicated cell for HR planning, especially forecasting requirements, taking into consideration the changing disease profile, and population dynamics and composition. The cell should not limit itself to public systems only but also monitor HR available in private sector so that a more holistic view can be undertaken.

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Skilled HRH are critical to achieve health policy goals. There has been a rapid expansion of medical colleges, dental colleges and nursing schools and colleges in past decade. Several concerns have been articulated about poor quality of training due to non- availability of faculty, lack of clinical material and present environment in examination system. Due to limited exposure in skill based training even fresh postgraduates are not confident and competent enough to perform simple clinical procedures such as interval tubectomies. This is also true for other specialties such as neonatal procedures, writing research protocol and epidemiological investigation. Same can be said about poor quality of Auxillary Nurse Midwives ANMs and nursing training as very few have independently conducted a delivery during pre-service training. Reforms are needed in standardization and accreditation of educational institutions and empowering state level institutional mechanisms to monitor adherence with standards. Why can't state

medical and nursing councils can be strengthened to monitor quality of training? It appears that these councils are not fully equipped to handle the assigned responsibilities for ensuring standards in pre-service training. Faculty in these institutions also needs to undergo some kind of pedagogy training.

Capacity building of HRH in India is another issue which include lack of need based training to different categories of staff, apathetic attitude towards training, inadequate training infrastructure and training skills, absence of induction training and duplication of efforts by different agencies without much integration. Besides, there are many non-training issues like lack of mechanism for follow-up after training, mismatch between training and job profile and lack of system for monitoring performance related to training which calls for adequate attention. In many states one cannot have any access to data base of either trainers or trainees. Performance monitoring of trained work force is also a major issue.

There are also issues of skill mix to provide quality health care and task shifting in times of changing needs. While task shifting or task sharing, the requisite skill mix should be developed through continuous training and the roles can be redefined to meet pressing needs at community level. Multi-skill training of existing workforce should also supplement the efforts. Doctors of indigenous systems of medicine like AYUSH (Ayurveda, Yoga, Unani, Siddha and homeopathy) can be provided training on jobs performed by medical officers at Primary Health Centers PHCs including conducting deliveries. Task shifting should not be seen as mantra for all HR problems in the sector. Delegation of tasks to peripheral functionaries should be based on some kind of evidence base generated through properly designed research studies. For example, if we wish to use AYUSH practitioners for Intra Uterine Contraceptive Device IUCD insertions, well designed trials should be commissioned to assess feasibility of this approach. Recruitment and selection of human resources are usually centralized, and do not bring as many local or locally trained personnel as would lead to greater stability and ownership. Decentralization in recruitment, selection and deployment of HRH is of utmost importance in countries like India, where majority of primary health institutions are located in rural areas. There is a need to have local cadres and link development of HRH with area specific requirements.[2]

The Bajaj Committee (1986)[3] had recommended for the establishment of University of Health Sciences in states and group of Union Territories to award degrees and diplomas in health sciences. A few states have already established University of Health Sciences (Tamil Nadu, Karnataka, Maharashtra etc.). There is an urgent need for establishment of health sciences in all states, especially in High Focus states that will ensure uniformity in admission, curricula and accreditation for all degrees in medical, nursing, and other paramedical courses. All colleges offering Diploma in nursing and other paramedical professionals can be affiliated to these Universities. Besides courses on public health and related fields such as health economics, epidemiology, health management, health informatics etc., should be offered through these Universities.

Management of HRH in India calls for flexibility and new ways of addressing emerging challenges. It is emphasized that the proposed National Council for HRH should address all issues comprehensively in terms of policy guidance and mechanisms. The human resource development plans (both at center and states) should address the critical shortages and specific competencies of human resources, ensure enabling environment required for providing basic primary health care are fully developed and implemented, and they are adequately financed to address the number, quality training, distribution, motivation and retention in rural areas.

Given the shortage of supply of qualified HRH as well as various demand-side barriers faced by the poor to reach the formal health system, there is imminent need to accelerate implementation of evidence based and sustainable strategies to increase access to primary health services and continue documenting innovative and complementary approaches such as task shifting sharing of tasks, fostering a team approach, including non-clinical and community health volunteers.

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