INTENSIFICATION OF HUMAN RESOURCE PRACTICES IN HEALTHCARE IN INDIA: ISSUES AND CHALLENGES

Mr Sachin Pathak

Preamble
India has a historical background of absorbing managerial ideas and practices from around the world. The roots of management principles and prevalence of human resource practices can be traced to the world’s first management book, titled ‘Arthashastra’, written three millennia before Christ, which highlighted many aspects of human resource practices in ancient India. The socio-cultural roots of Indian heritage are diverse and have been drawn from multiple sources including ideas brought from other parts of the old world. Arthashastra written by the celebrated Indian scholar-practitioner Chanakya had three key tenets: 1) public Policy; 2) administration and utilisation of people; and 3) taxation and accounting principles. India has been in the forefront of various international movements in the health and population sectors. Overall, the Indian healthcare industry is going through a transition and the future is likely to see significant changes in the nature of provision of healthcare and the roles of various players in the industry. The healthcare service scenario in India is expected to evolve into a more developed stage. With this transition, management of human resources in health is a major challenge to health systems development in India. This includes planning for, Production, recruitment, and utilisation of health personnel. Although a number of measures have been instituted to meet this challenge, considerable gaps still remain.

Dr. Seema Rafique

RETROSPECT OF HUMAN RESOURCE IN HEALTH CARE
Since Independence, India has developed a vast public health infrastructure, which presently includes 144,988 Sub-centers, 22,669 Primary Health Centers (PHCs) and 3,910 Community Health Centers (CHCs), providing services to rural population. Besides, over 7663 sub-divisional and district hospitals and other specialized hospitals are also functioning in the public sector. (Deoki Nandan, 2007) The private sector plays a prominent role in the delivery of health care. According to NSSO–60th round, the proportion of population utilizing private health facilities for in-patient care is 58.3 percent in rural areas and 61.8 per cent in urban areas and for out-patients the proportions are 78 per cent and 81 per cent in rural and urban areas respectively. (Ramnath, 5 Things to know about India’s Healthcare System, 2014) A large number of practitioners of AYUSH (ayurveda, yoga and naturopathy, unani, siddha and homeopathy) are also working in the country. A huge training infrastructure is also available at national and state levels in both public and private sectors. India has a severe shortage of human resources for health. It has a shortage of qualified health workers and the workforce is concentrated in urban areas. Bringing qualified health workers to rural, remote, and underserved areas is very challenging. Many Indians, especially those living in rural areas, receive care from unqualified providers. The migration of qualified
allopathic doctors and nurses is substantial and further strains the system. Nurses do not have much authority or say within the health system, and the resources to train them are still inadequate. Little attention is paid during medical education to the medical and public health needs of the population, and the rapid privatisation of medical and nursing education has implications for its quality and governance. Such issues are a result of underinvestment in and poor governance of the health sector—two issues that the government urgently needs to address. A comprehensive national policy for human resources is needed to achieve universal health care in India. The public sector will need to redesign appropriate packages of monetary and non-monetary incentives to encourage qualified health workers to work in rural and remote areas. Such a policy might also encourage task-shifting and mainstreaming doctors and practitioners who practice traditional Indian medicine (ayurveda, yoga and naturopathy, unani, and siddha) and homoeopathy to work in these areas while adopting other innovative ways of augmenting human resources for health. At the same time, additional investments will be needed to improve the relevance, quantity, and quality of nursing, medical, and public health education in the country.

OBJECTIVE OF THE STUDY

The present paper aims to examine the problems and prospects of health services in India and role of human resources in order to overcome the problem. The specific objectives of the study are as under:

1. To reflect on the management of human resources and what challenges are faced.

2. To study the access of health services across economic strata and gender and to investigate the role of HR.

3. To examine the quality of health services in India; and

4. To suggest appropriate recommendations to revamp health policy and Institutional mechanisms to improve access and quality of health services Particularly for the excluded segments of society.

METHODOLOGY

The research methodology is purely based on the secondary data.

INDIAN SCENARIO

At the time of independence in India, there were about 50,000 medical graduates and 25,000 nurses in the modern system of medicine to provide health care to the population. During the Plan periods, concerted efforts were made to address the shortages of human resources for health. However, it is a matter of concern that there are huge gaps in critical health manpower in government institutions that provide health care to the poorer segments of population living in urban slums, remote rural and tribal areas. In keeping with the growth of health infrastructure and expanding scope of the health care services, human resource needs have been increasing. In view of the shortage of medical personnel in less-developed and rural areas, the National Health Policy (2002) suggested to examine the possibility of entrusting some limited public health functions with nurses, paramedics and other personnel from the extended health sector by providing adequate training to them. The changing scenario of health services and strategies, especially the National Rural Health Mission, has led to an urgent need to develop new competencies and skills among the public health personnel. The norms for health care infrastructure and manpower were laid down for the first time by the
Bhore Committee (1946) and subsequently modified by the Mudaliar Committee (1961) followed by the Bajaj Committee (1987). The 9th Five-Year Plan had emphasized on health manpower planning taking into consideration, the district specific assessment of available manpower and health care facilities and the demand for health care services. Efforts were made by the Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, to obtain reliable and accurate district-wise data on the number of medical, dental, ISM&H professionals and nursing and para-professionals. However, there has been a very little progress in this effort and in the 10th Plan it was again expected to create a data-base to decentralize district-based health manpower planning to meet the needs.

THE IMPORTANCE OF HR TOWARDS HEALTH CARE

In the World health report 2000, Human resources for health are defined as "The stock of all individuals engaged in the promotion, protection or improvement of population health". This includes both private and public sectors and different domains of health systems, such as personal curative and preventive care, nonpersonal public health interventions, disease prevention, health promotion services, and research, management and support services. The classification of human resources is based on the primary intent of professional education and training. Human resources actually engaged in the health system can be referred to as the health system workforce or health work force. Four main arguments can be made for giving special attention to the health workforce and associated policy options. Constraints to scaling up Human resources for health are central to managing and delivering health services. Health services are labor-intensive and personal in nature. As additional funds become available from the Global Fund to Fight AIDS, Tuberculosis and Malaria or through the debt alleviation process (Highly Indebted Poor Countries initiative) and other processes, a country's ability to absorb them will be constrained without appropriate human resources. But even in difficult situations, there are examples of health interventions that work adequately at a pilot level. (Health human resources, 2014) These can be used as demonstration sites and expanded country-wide. The central role of the workforce in the health sector should be considered. The performance of any organization depends on the availability, effort and skill mix of the workforce. Human resources for health are therefore a strategic capital. It is human resources for health (i.e. the various clinical personnel, managers, auxiliary staff and others) who enable each health intervention to be performed. It is also they who diagnose problems and determine which services will be provided and when, where and how. Each health intervention is knowledge-based: health workers are the stewards and users of this knowledge. If appropriate skills and knowledge are not present in a country, the delivery of critical health interventions will be negatively affected. It is therefore necessary to understand the extent and nature of the constraints on the health workforce and more specifically, the impact of poor distribution on access to services. Human resources for health account for a high proportion of budgets assigned to the health sector. The health sector is a major employer in all countries. The International Labor Organization estimates that 35 million persons are currently employed in the health sector health sector. The quality of health services, their effectiveness, efficiency, accessibility and viability depend in the final analysis on the performance of those who deliver the services. The performance of these providers is, in turn, determined by the policies.
and practices directed towards guaranteeing that an adequate number of appropriately qualified and motivated staff are in the right place at the right time, at an affordable cost. Critical choices must therefore be made as to the number of personnel to be trained; their mix and their allocation, deployment and management to ensure the productivity of personnel; technical and sociocultural quality of services; and organizational stability. Inappropriate choices at these levels can result in inefficiencies in the functioning of health services and consequently in the ability of these services to contribute to achieving health policy objectives.

**APPROACHES TO UNDERSTAND HUMAN RESOURCES**

There are two ways to look at the human resources by political ways and also through economic ways. The recourses should be generated in the different ways to meet the needs of the public in the health care system. The development of a comprehensive analytical framework of health systems is a further step towards a strengthened WHO leadership role in global health policy formation. The performance of the system centers on three main goals: Improving health; Enhancing responsiveness to the expectations of the population; and Assuring fairness in the level and distribution of financial contributions. The absence of adequate HRH (Human Resource Health Policies) policies has been shown as being responsible, in many countries, for a chronic staffing imbalance with different effects on the health workforce and the health system in general: quantitative mismatch, qualitative disparity, unequal distribution and a lack of coordination between population needs and the management of the human resources available. Putting human resources issues on the political agenda would enable these disparities to be addressed. But any such action must allow for the distinctive features of human resources for health: that HRH issues are intersectional; the relatively long interval between decision-making and outcome; that the health sector is dominated by the professions ; the mutual dependencies and hierarchical relations between certain professional categories; in many countries the role played by the State as principal employer; the high proportion of women employed in the sector; and the deficiencies of the market in the sector.

**BASIC NECESSITIES FOR INDIA’S HEALTH CARE**

1. **Rural versus Urban Divide:** While the opportunity to enter the market is very ripe, A staggering 70% of the population still lives in rural areas and has no or limited access to hospitals and clinics. Consequently, the rural population mostly relies on alternative medicine and government programmes in rural health clinics. One such government programme is the National Urban Health Mission which pays individuals for healthcare premiums, in partnership with various local private partners, which have proven ineffective to date. In contrast, the urban centers have numerous private hospitals and clinics which provide quality healthcare. These centers have better doctors, access to preventive medicine, and quality clinics which are a result of better profitability for investors compared to the not-so-profitable rural areas.

2. **Basic Primary Healthcare and Infrastructure:** India faces a growing need to fix its basic health concerns in the areas of HIV, malaria, tuberculosis, and diarrhea. Sadly, only a small percentage of the population has access to quality sanitation, which further exacerbates some key concerns above. For primary healthcare, the Indian government spends only about 30% of the country’s total healthcare budget. This is just a fraction of what the US and the
UK spend every year. One way to solve this problem is to address the infrastructure issue... by standardizing diagnostic procedures, building rural clinics, and developing streamlined health IT systems, and improving efficiency. The need for skilled medical graduates continues to grow, especially in rural areas which fail to attract new graduates because of financial reasons.

3. Growing Pharmaceutical Sector: According to the Indian Brand Equity Foundation (IBEF), India is the third-largest exporter of pharmaceutical products in terms of volume. Around 80% of the market is composed of generic low-cost drugs which seem to be the major driver of this industry. The increase in the ageing population, rising incomes of the middle class, and the development of primary care facilities are expected to shape the Pharmaceutical industry in future. The government has already taken some liberal measures by allowing foreign direct investment in this area which has been a key driving force behind the growth of Indian pharmacy.

4. Underdeveloped Medical Devices Sector: The medical devices sector is the smallest piece of India’s healthcare pie. However, it is one of the fastest-growing sectors in the country like the health insurance marketplace. Till date, the industry has faced a number of regulatory challenges which has prevented its growth and development. Recently, the government has been positive on clearing regulatory hurdles related to the import-export of medical devices, and has set a few standards around clinical trials. According to The Economic Times, the medical devices sector is seen as the most promising area for future development by foreign and regional investors; they are highly profitable and always in demand in other countries.

CHALLENGES IN HEALTH CARE

The three greatest challenges facing India's healthcare system are accessibility, availability and affordability. Cumulatively, they lead to very high out-of-pocket medical expenses. Nearly 78 per cent of all expenditures on healthcare are out-of-pocket, with a high 72 per cent of it on medicines alone. While the private medical sector remains the primary source of healthcare for the majority of households in both urban and rural areas, there is huge variation across states and across the socioeconomic divide as is evident from The Annual Health Survey (2010-11). (Chatterjee, 2013). The other major challenge is about the infrastructure, India is lacking in the case of good hospitals which includes the referral units also. People have to face many problems when diseases hit the large population. The beds and the medicines are not available and indirectly they have to face out of pocket expenses occur. This happens because the existing resources are enough for the population and always is struggling is going on. The rich class have various advantage due to money where as the poor suffers. The situation keeps on persisting. The resources should be divided in such a manner so that inequalities should be reduced. A well functioning and an effective system should be there to manage the service providers in the country. The public private collaboration in the country should be scaled up so that the management of the resources can be done in an effective manner. Even in the government programmes, large population of the country remains uncovered due to several reasons like illiteracy, lack of transparency etc. such section of people do not get any benefit from the government and remains without any help. So there is a need to identify them and try to fulfill their needs. The public health system has a shortage of medical and paramedical personnel. Government estimates (based on vacancies in
sanctioned posts) indicate that 18% of primary health centers are without a doctor, about 38% are without laboratory technician, and 16% are without a pharmacist. Specialist allopathic doctors are in very short supply in the public sector; 52% of sanctioned posts for specialists at community health centers are vacant. Of these vacant posts, 55% are for surgeons, 48% are for obstetricians and gynecologists, 55% are for physicians, and about 47% are for pediatricians. Many nursing posts are vacant—18% of posts for staff nurses and auxiliary nurse midwives at primary and community health centers are vacant. The number of primary and community health centers without adequate staff is substantially higher if high health-worker absenteeism is taken into consideration. In the public sector, shortages of laboratory technicians and pharmacist sso exist. Similarly, the private sector has a lack of qualified health-care providers. Many unqualified health care providers work in the private sector, particularly in rural areas and the slums in urban areas. Although little documented evidence exists, this problem might even affect private hospitals, which are unregulated; a court in Delhi has ordered the Delhi Medical Council to investigate the hiring of unregistered doctors by private hospitals. A consequence of the shortage of health workers is that many people in rural areas and those who are poor in urban areas receive inappropriate or no health care.

CONCLUSION
A long-term effort is now required to rebuild the public health workforce; this will require major support from national and a wide variety of international agencies. A strengthened public health workforce will be in a better position to ensure that evidence on the effectiveness of health interventions and the new resources coming into the health sector lead to improvement of the health of all populations. The delivery of National Health Programmes and the activities related to it should be given to state bodies for a better management perspective. Allocation of funds should be properly done in both public and private hospitals, so that human resource can be managed in proper manner. The public health services should be extended. Education of healthcare professionals should be developed for medical colleges. In the urban areas government hospitals (PHC, Primary health Centre and CHC, Community Health Centre) should be promoted equally. Nongovernmental organizations can be used as a medium to serve people in case of health care. The solution for meeting the challenges inhuman resources for health include strategic planning for human resource for public health at state/national level. State specific human resource development and training policy, reorientation of medical and paramedical education, ensuring proper utilization of the trained manpower and standardization of trainings, effective human resource management information systems are also important. Professionals and policy-makers in the fields of public health, foreign policy and national security should maintain open dialogue on endemic diseases and practices that pose personal health threats, including HIV/AIDS, which also have the potential to threaten national and international health security. Although the subject of The World Health Report 2007 has taken a global approach to public health, WHO is not neglecting the fact that all individuals – women, men and children – are affected by the common threats to health. It is vital not to lose sight of the personal consequences of global health challenges. This was the inspiration that led to the “health for all” commitment towards primary health care in 1978. That commitment and the principles supporting it remain un tarnished and as essential as
ever. Human resource in India should be very strong to deliver better services in the country.

REFERENCES


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