Modern HR Practices: (Under National Rural Health Mission, Government of Gujarat)

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Sometimes all of us think that one person can manage all the activities & process of management in Govt. system. This term is usually used or uses for Manpower. Meanwhile, one person will be able to do many works but it is not true because now the era of super specilaisation. Though, can we think or accept this term by any employer or any big industrialist and to-whom services (customers) are being provided in today's fast life? Definitely answer will be "No". Reason behind this is that, today's time has been changed, because customer (Patients) have become so much aware about Organization's services & about their quality of services, that they have become more and more educated, they know very well what they should get for which they are paying money. So now in nut-shell there will be the need of "Modern Manpower Practices as well as up-to-date practices". And if we want to do Modern HR Practices for that we must have specialized staff in the concern fieldor department. Therefore, in this paper, we will be discussing about the Organization (Government) who had recruited experts in the concern field and results found excellent.

Also, because the Govt. of India has spent a huge amount of money on NRHM to improve the quality of Healthcare services, this becomes even more important that the HR practices be critically evaluated. The Govt. of India have allocated huge fund for every state but the utilization of this fund only few state could do well for instance Govt. of Gujarat & other some states.

Keywords : Human Resources, National Rural Health Mission.

Introduction to NRHM

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district.

Health system and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and

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children.

The Vision of National Rural Health Mission (2005-12)

The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country. It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare. It seeks to revitalize local health traditions and mainstream AYUSH into the public health system. It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health. It seeks decentralization of programmes for district management of health. It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure. It shall define time-bound goals and report publicly on their progress. It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

Goals of NRHM:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR). Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition. Prevention and control of communicable and non-communicable diseases, including locally endemic diseases. Access to integrated comprehensive primary healthcare. Population stabilization, gender and demographic balance. Revitalize local health traditions and mainstream AYUSH. Promotion of healthy life styles.

Plan ofAction:

(a) Primary Strategies:

Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services. Promote access to improved healthcare at household level through the female health activist (ASHA). Health Plan for each village through Village Health Committee of the Panchayat. Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs). Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards). Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation &

hygiene and nutrition. Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels. Technical Support to National, State and District Health Missions, for Public Health Management. Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision. Formulation of transparent policies for deployment and career development of Manpowers for health. Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc. Promoting non-profit sector particularly in under served areas.

(b) Secondary Strategies:

Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost. Promotion of Public Private Partnerships for achieving public health goals. Mainstreaming AYUSH – revitalizing local health traditions. Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics. Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

Outputs and Outcomes

Recently by NABH after two long years of the make-over. This is the first PHC in the country to get NABH accredited. "The project is aimed at upgrading the standards of the health centres through focal points like patient's clinical safety, rights of the patients and improving the quality of care, to name just a few. Under the MoU, we will act as the technical advisors for the state Government for the entire project, by training their team through capacity building," says Giridhar Gyani, Secretary General, QCI.

The move of accrediting even PHCs emerged after Gujarat got 24 district level hospitals in the state registered for NABH. This was the first time that a state Government eagerly came forward to register its hospitals under a national accreditation. "After this, state Governments of Kerala and Tamil Nadu have been prompted to register their hospitals under NABH. They have received 60 and 12 accreditations so far," informs Gyani. Besides, Delhi has six, Madhya Pradesh five and Uttar Pradesh has one NABH accreditations to credit. "Gujarat has the commitment and passion to place Maternal, Newborn and Child Health (MNCH) at the centre of the development agenda and is testing innovative and evidence- based strategies," says Rita Teaotia, Principal Secretary, Health and Family Welfare Department, Gujarat.

Health programmes in the past have been beset with problems such as limited capacity, lack of programme standards and guidelines, and an obsession with quantified targets rather than client satisfaction. "The new quality parameters introduced by the state Government seek to address problems of poor sanitation and cleanliness in hospitals, staff shortage in every category, damaged and pathetic condition of the building and campus, poor signage system in hospitals, absence of patient satisfaction monitoring system, lack of a measurable parameter for patient safety and absence of legal compliances," shares Gyani. Hence, Total Quality Management (TQM) system was introduced to tackle all these problems, as also the issues of lack of accountability and planning in delivery of care to patients, lack of blood bank/ storage facility in some hospitals, and the absence of quality standards such as medical audit, management of medication, patient care, facility management and safety, information management system and infection control.

Under the system, a policy framework for NABH and NABL accreditation of public hospitals and laboratories,

as approved by the state Government was launched, and empanelment of NABH and NABL consultants was undertaken in co-ordination with QCI. Appointment of Assistant Hospital Administrators (AHAs) for Government hospitals/medical colleges in a phased manner, and training at various levels, were among the key mechanisms of the TQM system, which also involved the development of quality steering committee for the state at all levels and nomination of district quality assurance officers.

Some of the practices implemented are patient satisfaction survey, employee satisfaction survey, clinical protocol, quality indicators, code blue alert (red for fire, yellow for external calamities, blue for cardiac arrest, black for bomb threat, pink for child abduction), disaster preparedness plan, basic infection control practices, fulfillment of patient rights, medication safety practices, facility management practices, incidence reporting system, safety inspection system, patient information, inventory management and quality control in diagnostics.

The Project Action Plan

To be initiated in a phased manner, public hospitals in Junagadh, Rajpipla, Godhra, Gandhinagar, Sola, Mehsana, Valsad and Kutch, and a medical college in Rajkot will be accreditated in the first phase. CHCs and PHCs often lack basic infrastructure and adequate staff. Accreditation, it is hoped, will do away with the disparities. Of the 273 CHCs and 1,073 PHCs in Gujarat, the health department has chosen 48 CHCs and 158 PHCs for the first phase of accreditation. The budget for the first phase is Rs 25 lakh for CHCs and Rs 10 lakh for PHCs. QCI together with district health officials will provide technical support in the accreditation process. The first phase of accreditation will be completed within a year. "The selection of centres has been on the basis of workload. One CHC and three PHCs in every district will undergo the process," says Dr JL Meena, State Quality Assurance Officer.

The standard of accreditation for these centres however, will be lower than Government and private hospitals. The training of staff has already begun. The health department is in the process of carrying out a baseline study of all PHCs and CHCs, are not up to the mark. The study will offer a clear picture of the extent of problems at health centres in rural areas.

In the second phase, eight district hospitals and the remaining five medical colleges would be standardized, followed by accreditation of the remaining nine district hospitals in the third phase. The process of accreditation for this PHC and all other hospitals is very methodically planned and targets are set in three phases.

After a thorough study of the on-ground situation and the formulation of various committees with specific role and responsibilities, the quality management team was developed. An assistant hospital administrator is appointed at the facility level and Quality Assurance Officers at the district level. An internal NABL training is administered to 25 members. The overall quality management is lead by a group of 40 team-leaders after getting trained by the QCI, out of which 19 are certified as NABH assessors. To introduce more quality personnel in the system, the Government has also introduced a post-graduate training course for additional directors, superintendents, and quality assurance officers. Fifty candidates have been already trained so far who make sure that the NABH guidelines are practiced.

Advantages of TQM

In a short period of its implementation since 2007, the TQM system has led to major positives and overhaul of the state's healthcare system. Patients have benefited immensely in terms of the quality of care, access to privileged medical staff, better safety conditions, safer transport and continuity of care. The benefits of TQM have not, however, been limited to patients. The hospital staff has also gained in terms of

their professional development, increased professional satisfaction, leadership and ownership, and a good working environment. For the community, this has translated into a quality revolution, marked by access to comparative database and disaster preparedness (epidemic and physical).

- Gandhinagar Civil Hospital is the first Govt. Hospital in India to be certified by NABH.
- Presently, Gujarat has 2 District Hospitals, 1 PHC, 1 Blood Bank, 2 Labs accredited by NABH and NABL
- FDCL Laboratory was accredited as per NABH (1st Government lab in India which was NABH accredited.)
- All six medical college laboratories are taken for NABL e.g. Surat, Jamnagar, Bhavnagar, Rajkot, Baroda & Ahmadabad in the first phase (year 2007-2008). (Bhavnagar Final Assessment completed 18-19 July 2009 and Ahmadabad Pre assessment completed on 30th July 2009)
- All mental hospitals are taken in the second phase year (2008-2009).
- All dental hospitals in the second phase year (2008-2009).
- Paraplegia Hospital, Ahmedabad in the second phase year 2008-2009.
- 47 CHCs & 170 PHCs in (2009-2010) (PHC Gadboriad Final assessment comp. on 10th Aug. 2009 first PHC in India accredited as per NABH standards).

Hurdles and ambiguities:

Big projects mean big money. Converting all the Government hospitals up to NABH level is a humongous task, to say the least. There are huge financial hurdles apart from Manpower management. The average additional expenditure per district hospital for NABH is a whopping Rs 3-4 crore. There are also logistic and operational hurdles like dearth of well qualified staff, old hospital architecture, upgrading a smaller facility to a larger one. There is also a high level of reluctance from the staff to understand and implement NABH standards.

Hence, a lot of time also goes in motivating and training the staff. Moreover, since most of the staff is at the contract level, it has resulted in high attrition rate, which means the QCI members have to repeatedly train the new staff.

But with the Government support in hand, the policy makers and implementers are optimistic to say the least, as things are going as per planned. Along the way, the state Government plans to extend its TQM system to the medical colleges, blood banks and laboratories across the state to accredit by NABH/ NABL. It also plans to work in close coordination with QCI to develop a sustainable and viable quality accreditation programme for CHCs and PHCs which can be replicated nationally, while managing workload with assured quality. After Gadhboriad, the waiting list includes 48 CHCs and 158 PHCs that are scheduled to undergo the accreditation process. This is not the end to it. We expect that we will be able to provide quality health service and many more CHCs and PHCs can get accreditation in future. We have retained some of the best quality assurance officers to monitor the services. Needless to say, a commitment has been made.

MANPOWER SUPPORT FOR THE MISSION

Some generalized problems related to manpower in Healthcare:

- Staff shortages of all key cadre - Doctor, Para Medics, ANM, Nurses, Lab Technicians, OT Assistants, etc.
- Irregular staff attendance and absenteeism especially in remote areas.
- Lack of opportunities for Continuing Education, skill up gradation and adoption of standard Protocols.
- Lack of a supportive system or a career plan to

provide adequate motivation to cadre.

- Lack of use of standard Protocols to promote quality affordable care and full utilization of Manpowers
- Dysfunctional procurement systems leading to under utilization of Manpowers. Non – availability of drugs and diagnostic tests at health facility leading to wastage of doctors' time and demotivation.
- Lack of orientation to needs of rural areas.
- Weak on non-existent accountability framework leading to powerlessness of local communities and Panchayat vis-a-vis the health system functionaries.
- Non-transparent transfer and posting policy leading to demoralization and corruption.
- Inadequate systems of incentive for difficult area postings.
- Lack of transparency in career progression leading to demotivation & corruption.
- Under-utilization of MBBS doctors and Specialists an account of two narrow a focus of health system around few vertical health programmes.

Managing MANPOWER shortage:

- Needs a clear state specific Manpower management policy and a strong political and administrative will to ensure transparency in management of cadres.
- Accept the need for engaging more Para-medics and doctors to meet the growing health care needs in rural areas.
- Compulsory rural postings / Rural Health Service.
- Develop incentives for difficult areas and system for career progression that categorizes postings into different grades.
- Accept accountability framework where local communities/Panchayats have a role. Devolve power and function to local health care institution- provides resource and flexibility to ensure service guarantees.
- Train bright young doctors as Managers of Health System and offer opportunities for training in IIMs etc. on condition that they return as District Health Manager and serve a minimum three-year term.
- Increase avenues for training and development so that standard treatment protocols can be operational zed.
- Provide resources, flexibility and powers to ensure that IPHS standards are achieved at CHCs. Develop similar standards for Sub Health Centers and PHCs.
- Revisit single doctor PHC idea- is it better to post doctors to Block/ CHC with mobility to do fixed day clinics or should we go for two doctor PHCs with adequate 94 staff nurses and ensuring a minimum OPD attendance and service provision to justify this investment
- Provide improved telephone linkages to SHCs, PHCs, for consultations.

Characteristics of a good HR policy:

- Induction of Management experts into the system, in District and State level Health Mission.
- Undertake cadre and institutional reviews to ensure best utilization of manpower and removal of constraints to decision making.
- Integrate field functionaries under various disease control programmes, AYUSH, etc. under a common frame of village, SHC, PHC, CHC/ Block structure. Break vertical systems and forge horizontal linkages.
- Make Para Medical Cadre a District specific cadre. Offer incentives for multi - skilling to improve outreach of diagnostic tests.
- Having a separate cadre of Sections i.e. Rural Health Service
- Re-orient medical education so that doctor is geared to rural to needs.

- Focus on key shortages of Anaesthetists, Gynecologists, Surgeons, Pediatricians, etc. alongside strengthening of diagnostic facilities.
- A policy of regular in service training that ensures that skills and motivation levels of all staff are periodically assessed and upgraded.
- Adequate training infrastructure to achieve the training goals outlined above.

Improving Manpower standards:

- Increasing density of health care providers per geographical area.
- Building referral chains of Medical Professionals and Habitation level health workers.
- Develop trust and partnership between the Medical Professional and the Community Health Worker.
- Develop credible accountability framework.
- Adopting professional management principle.

NRHM activities at three-tier level (State / District / Sub district level)

At Block Level

The success of decentralization experiment would depend on the strength of the pillars supporting the process. It is imperative that management capacities be built at each level. To attain the outcomes, the NRHM would provide management costs up to 6% of the total annual plan approved for a State/district as has been introduced under the RCH-II programme. Apart from medical and Para-medical staff, such services would include skills for financial management, improved community processes, procurement and logistics, improved collection and maintenance of data, the use of information technologies, management information system and improved monitoring and evaluation etc. The NRHM would also establish strong managerial capacity at the block level as 33 Blocks would be the link between the villages and the districts. At the district level the Mission would support and insist on developing health management capacities and introducing policies in a systematic manner so that over time all district programme officers and their leadership are professionally qualified public health managers. Management structures at all levels will be accountable to the Panchayati Raj institutions, the State Level Health Mission and the National Level Missions/Steering Group.

The amount available under the management cost could also be used for improving the work environment as such improvements directly lead to better outcomes. The management structure holds the key to the success of any programme and efforts to develop appropriate arrangements for effectively delivery of NRHM with detailing, will be a priority. Clarity of tasks, fund flows, powers, functions, account keeping, audit, etc. will be attempted at all levels.

Based on the outcomes expected in NRHM, the existing staff of Health Departments at SHC, PHC, CHC, Block, District, State and National levels are being carefully assessed to see how structures can be reoriented to deliver more efficiently and effectively. States will constantly undertake review of management structure and devolution of powers and functions to carry out any mid course correction. Block Level Pooling will be one of the priority activities under the NRHM. Keeping in view the time line needed to make all facilities fully functional, Specialists working in PHCs would be relocated at CHCs to facilitate their early conversion to FRUs. Outreach programmes are being organized with "block pooled" CHCs as the nodal point. NRHM will attempt to set up Block level managerial capacities as per need. Creation of a Block Chief Medical Officer's office to support the supervision of NRHM activities in the Block, would be a priority. Support to block level CHCs will also aim at improving the mobility and connectivity of health functionaries with support for Ambulances, telephones, computers, electric connection, etc.

Manpower for rural areas:

Improvement in the health outcomes in the rural areas is directly related to the availability of the trained Manpower there. The Mission aims to increase the availability through provision of more than 4 lakh trained women as ASHAs / Community Health Workers (resident of the same village/hamlet for which they are appointed as 34 ASHA). The Mission also seeks to provide minimum two Auxiliary Nurse Mid-wives (ANMs) (against one at present) at each Sub Health Centre (SHC) to be fully supported by the Government of India. Similarly against the availability of one staff nurse at the PHC, it is proposed to provide three Staff Nurses to ensure round the clock services in every PHC. The Out-patient services would be strengthened through posting/ appoint on contract of AYUSH doctors over and above the Medical Officers posted there. It will be for the States to decide whether they would integrate AYUSH by collocation at PHC or by new contractual appointment. GOI support will be for all new contractual posts and not for existing vacancies that States have to fill up. The Mission seeks to bring the CHCs on a par with the Indian Public Health Standards (IPHS) to provide round the clock hospital-like services. As far as manpower is concerned, it would be achieved through provision of seven Specialists as against four at present and nine staff nurses in every CHC (against seven at present). A separate AYUSH set up would be provided in each CHC/PHC. Contractual appointment of AYUSH doctors will be provided for this purpose. This would be reflected in the State Plans as per their needs.

Given the current problems of availability of both medical as well as paramedical staff in the rural areas, the NRHM seeks to try a range of innovations and experiments to improve the position. These include incentives for compulsory rural posting of Doctors, a fair, transparent transfer policy, involvement of Medical Colleges, improved career progression for Medical / Para Medical staff, skill up gradation and multi-skilling of the existing Medical Officers, ANMs and other Para Medical staff, strengthening of nursing / ANM training schools and colleges to produce more paramedical staff, and partnership with non governmental stakeholders to widen the pool of institutions. The Ministry has already initiated the process for the up gradation of ANMs into Skilled Birth Attendants (SBA) and for providing six month anesthesia course to the Medical Officers. Convergence of various schemes under NRHM including the disease control programmes, the RCH-II, NACO, disease surveillance programme, would also provide for optimum / efficient utilization of all paramedical staff and help to bring down the operational costs.

Resource Centers at Central and State level for capacity development: Decentralized Planning, preparation of District Plans, community ownership of the health delivery system and inter-sectoral convergence are the pillars on which the super-structure of the NRHM would be built. The implementation teams particularly at district and state levels would require development of specific skills. Even at the Central level, the program management unit within the MOHFW would need technical and management support from established professionals in the field. The institutions like National and State Institutes for Health and Family Welfare which were primarily conceived as research and training organizations may not fit the bill for this purpose. The National Health System Resource Centre (NHSRC), which is envisaged as an agency to pool the technical assistance from all the Development Partners, would be ideal for this purpose. Mandated as a single window for consultancy support, the NHSRC would quickly respond to the requests of the Centre/ States /Districts for providing technical assistance for capacity building not only for NRHM but for improving service delivery in the health sector in general. It is proposed to have

one NHSRC at the national level and another Regional Centre for the North Eastern region. State level Resource Centers will be provided for EAG States on a priority to enable innovations and new technical skills to develop in the health system. In addition to the above a number of already existing reputed bodies with national caliber may be strengthened and facilitated to mentor state health resource centers and district resource groups so that they are able to support the state level planning efforts.

The NRHM would also require a comprehensive plan for training at all levels. While efforts are being made to strengthen the NIHFW, the States have been asked to closely examine the training infrastructure available within the state including State Health & Family Welfare Institute, ANM Training Centers, Medical Colleges, and Nursing Colleges etc. and identify the investment required in them to successfully carry out the training/ sensitization programmes. Comprehensive training policy is being developed to provide support for capacity building at all levels including PRIs/Community. NRHM will particularly encourage involvement of Medical Colleges and Hospitals to strengthen systems of capacity building in the rural health care set up.

Limitations:

- Low retention of Human-Resource at various levels, due to the policy mismatch.
- Lack of support from Govt. doctors while implementing SOPs and procedures and protocols, which are necessary for smooth running of the Administration.
- Job-insecurity of In-service Manpower
- Lack of Proactiveness in Govt. system for execution of work.

Conclusion:

Therefore, in the continuation of better healthcare system we need to create good post and provision for their appropriate Management. Because we all know that health is a national subject, it is everyone right to have good & quality care of services as Govt. of Gujarat have taken a excellent initiative. A commitment to continuous training of personnel to imbibe quality as a culture among its people. A commitment to strictly adhere to the quality manual in all its operations. A commitment to be abreast of the latest technology to become innovative. A commitment to be the best. With the guidelines and resources provided by NRHM, Many Govt. systems like Govt. of MP , Gujarat, Rajasthan, Assam, Orissa, Punjab etc. have realized the potential of Management experts in the Healthcare Industry and they have done a commendable job in this sector. Further, a lot needs to be done to completely overhaul the system. Moreover our system must utilized the hospital & healthcare management Experts including Young & dynamic professional.

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