Public Healthcare Delivery System: Contemporary HR Policies and Success

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According to an estimate by the World Health Organisation (WHO), healthcare sector is facing a shortage of about 4000000 health workers, and this single factor can be responsible for failing to attain the Millennium Development Goals (MDGs) within the defined timeframe. Addressing the same problem at National level, National Rural Health Mission (NRHM) was launched in the year 2005 by Govt. of India with an aim to improve the Public healthcare delivery system in India. Under NRHM, many new strategies have been devised to recruit, retain and increase the productivity of Human Resource (at all levels) in the public healthcare delivery system. The duration of first phase was 2005-2012. As, the first phase is already over, and we have substantial data to review the success of the contemporary policies w.r.t. Human Resource Management, so, this paper is an attempt to assess the validity of goals and strategies, which were publicized before launching this mission in the year 2005. It will also help in the evaluation of real success of this mission in terms of improvement of Health Indicators. For whichever indicators the data is available, comparison has been shown between the situations before the launch of NRHM and after the first phase of NRHM is over. Some suggestions have also been made to improve the situation.

Keywords : NRHM, Public Health Care Delivery System.

Introduction

This fact is very largely debated that health status of a community/region is directly proportional to the presence of trained healthcare professional in that area. We, in India have some of the Health Indicators which are even lower than countries like Bangladesh and Sri Lanka. This status can be clearly understood, once we analyze the difference between Government and Private sector. It is believed that one of the prime reasons for this is low presence and lower retention of medical staff. Inspite of the best efforts of the Government of India to improve attendance and retention of staff, especially doctors in Government hospitals, the results are not very encouraging.

This is a situation in a country where more than half of the population can afford treatment only in Government hospitals. According to a recent report by NRHM, Government of India, about 3/4th of Indian doctors prefer to stay and practice in urban area, serving only about 1/4th of population. According to World Health Statistics by WHO (2009), private expenditure on Health as % of total expenditure on Health is 75% (2006) and out of Pocket expenditure as % of private expenditure on Health is 91.4% (2006) in India. It means that, about 3/4th of the Indian population have to undertake treatment in private hospitals and out of that almost all of them have to make payment from their own pocket. Every year, 25% of the hospitalized Indians fall below poverty line just because of incurring expenditure on Healthcare/Hospitalization.

Along with other reasons for this issue, one of the key reasons is unavailability of doctors in Government

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hospitals. Also, as per another report by Ministry of Health and Family welfare, Government of India, even progressive states like Gujarat faces a severe shortfall of specialist doctors at CHC level, and this shortfall ranges from 98-100%.

Probable Causes for this Problem

The problems of recruitment and ultimately retention of the recruited staff have more or less the same causes, which can be underlined as follows:

- There are no standard guidelines for sanctioning the number of posts at all levels and all categories of healthcare staff.
- Due to limited financial resources, different states tend to develop their own norms which, though, satisfy the budgetary constraints, but may not satisfy the actual requirement.
- Unavailability of adequate fully equipped healthcare facilities at the Govt. level. It leads to an increased dominance of private players, which should solve the problem of availability of Quality Healthcare provider, but most of them are unqualified service providers, so the increase in Quality due to increased dominance of private sector seems to be questionable.
- The system has not been able to recruit and retain the service providers as per the sanctioned posts due to administrative failure or neglect or other unavoidable circumstances. E.g. when the states were facing a fiscal crisis in the 1990's, no new facilities were created. Even the replacement posts of superannuated staff were not filled.
- No major initiatives were taken by the Healthcare reforms in 1990's for improving the attraction and retaining the healthcare workforce or for improving the quality of performance. Inspite of repeated exposure to these issues, no attention was given as it was assumed that these problems are inherent part of the Public system/sector.

Standards and Scenario at International Level

The International standard reference figure is a minimum of about 2.28 skilled healthcare workers per 1000 population, so that a minimum of 80% deliveries or measles immunization could be conducted by trained professionals (Rock Feller Foundation 2006).

Indian Scenario

The nurse to population ratio in India is 1:1205 and in Europe is 1:100-150, whereas, nurse to doctor ratio in India is about 1.3:1 as compared to 3:1 in most developed countries (NCMH, 2005).

The health care infrastructure in rural areas has also been developed as a three tier system and is based on the following population norms:

(Table 1)

Centre	**Population Norms**	
	Plain Area	**Hilly/Tribal/Difficult Area**
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

(Rural Health Care System in India, IPHS)

Average Rural Population covered by: (Table 2)

	Norms	Present status
Sub centre	3000-5000	5089
PHC	20000-30000	31743
CHC	80000-120000	164632

(Rural Health Care System in India, IPHS)

Average Rural Area (Sq. Km) covered by: (Table 3)

Sub centre	21.37
PHC	133.31
CHC	691.42

(Rural Health Care System in India, IPHS)

Average Radial distance (Sq. Kms) covered by: (Table 4)

Sub centre	2.61
PHC	6.51
CHC	14.83

(Rural Health Care System in India, IPHS)

Average Number of Villages covered by: (Table 5)

Sub centre	4
PHC	27
CHC	142

(Rural Health Care System in India, IPHS)

These figures have been recommended by the IPHS. Indian Public Health Standard (IPHS) have been launched under National Rural Health Mission (NRHM), which have specified the staffing norms for the public healthcare facilities at all levels. These norms were actually laid down by the Planning Commission and later on these were known as standards.

Total number of doctors registered in the country up to 31st March 2008 is 695254 according to Medical Council of India (MCI) Annual Report 2008. It means that the doctor to population ratio in India is 1 per 1600 persons or 6 per 10,000 populations which is significantly lower than developed countries like Australia, Canada, UK and US (WHO, 2008). The population of doctors is not evenly distributed, inspite of these numbers. The rural areas are still unable to access the services of the allopathic graduate as 74% of these doctors live in urban areas, serving only 28% of the national population, while the rural population, which is 72%, still gets no benefit of their services.

NRHM

The Govt. of India has realized the importance of Health and in the development of the country. Keeping this view in mind, the Govt. has planned to launch the National Rural health Mission (NRHM). The main aim is to improve the basic structure and delivery of Healthcare services. This Mission has a very clear vision of improving the health through the improvement in significant health Indicators. Also, basic amenities like safe drinking water, nutrition, hygienic conditions have directly been linked with good health. Further, it intends to lay the foundation stone of improving healthcare infrastructure as well as Human Resource by fundamentals like Optimum utilization of available resources, Main streaming of AYUSH, utilizing the management and financial expertise in Healthcare. To quantify and measure the improvements Indian Public Health Standards (IPHS) have been developed for all category of Healthcare Organizations. The ultimate goal is to improve the accessibility, availability and affordability of Healthcare services in this country.

Goals Laid Down by 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

The efficiency and efficacy of any system or Organization is directly proportional to the Quality of Human Resource available to that system. Even more important than that is the Human Resource Management which ensures that the Quality Human Resource is utilized properly and its Quality is maintained for optimum utilization of the available resource. This applies equally well to the Healthcare delivery system. The healthcare delivery system in India can be subdivided to two categories: Public and Private. In a country of about 1.3 billion people, where more than 50% of the population can afford or receive healthcare facilities only through the Public healthcare delivery system, it becomes very important that the system is strengthened to meet the ever increasing demand.

Certain significant issues regarding HR in Healthcare

- Every year around 30,000 medical graduates (MBBS) pass out of Medical colleges, still the entire rural health system for more than 750 million people has never more than 26,000 doctors.
- Retention of Medical workforce is still a challenge for the public healthcare delivery system in India.
- The huge pool of AYUSH graduates had remained unutilized by the Healthcare delivery system for a long time. This workforce can help to overcome the shortage of doctors at various levels.
- There is an acute shortage of specialist doctors at CHC and higher level. This shortage is upto the level of 90% in some states.
- Attrition of nursing staff is affecting Govt. system as well as private system equally. It is as vital as attrition of Doctors.
- World Bank funded Health systems projects have failed to address the issues of HRM, so it was one of the prominent reasons for special emphasis of HR issues under NRHM.
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- The nurse to population ratio in India is 1:1205 and in Europe is 1:100-150, whereas, nurse to doctor ratio in India is about 1.3:1 as compared to 3:1 in most developed countries (NCMH, 2005).
- No major initiatives were taken by the Healthcare reforms in 1990's for improving the attraction and retaining the healthcare workforce or for improving the quality of performance. Inspite of repeated exposure to these issues, no attention was given as it was assumed that these problems are inherent part of the Public system/sector.
- Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Union Budgetary allocation for health is 1.3% while the State's budgetary allocation is 5.5%.
- State Government's contribution to public health expenditure is 85% while Union Govt. contributes

about 15%.

Improvements Under NRHM

It is evident from the latest NRHM statistics, that Nearly 1.5 lakh skilled Human Resources have been added in the Public Health System in the last 6 years under NRHM. Of these, 41% are ANMs, 20% are staff nurses, and 14% are Medical Officers including Allopathic and AYUSH doctors. Management of programme has been improved by adding professionals like managers and accountants at State, District, Block and facility levels. Therefore, at present all the states have a SPMU (State level Programme Management Unit) and 636 districts have established full-fledged DPMU (District Programme Management Units). In the last 6 years, more than 15000 personnel have been added, overall, in the cadre of programme managers, accounts managers and data managers at the State, District, Block and Organizational levels.

With an increase in Quantity of Human resource, the Quality of Healthcare delivery has also shown a remarkable improvement:

Table 6

Action Point	Year	Number
Number of Institutional Deliveries	2005-06	10840036
	2006-07	11959064
	2007-08	14369678
	2008-09	14823481
	2009-10	16222201
	2010-11	16804718
	2011-12	17585434
Number of beneficiaries of JSY(As per division)	2005-06	734446
	2006-07	3154478
	2007-08	7308888
	2008-09	9077353
	2009-10	10067053
	2010-11	10696895
	2011-12	10937383

Number of Polio cases during (as per UIP division)	2006	676
	2007	874
	2008	559
	2009	741
	2010	42
	2011	1
	2012	0

(www.mohfw.nic.in)

Summary of Improvements

- More than 8 lakhs ASHAs have been selected, out of which more than one-fourth have been trained upto 5th module and about two-third have received drug kits in their villages.
- Addition of more than: 1,500 specialists, 8,600 MBBS doctors, 25,000 staff nurses, 17,000 paramedics, 46,000 ANMs, 8,000 AYUSH doctors, 3,000 AYUSH paramedics, 500 District Accounts managers, 500 District Data Managers, 550 District Programme Managers and other staff on contract, in the Healthcare Industry
- Restructuring of directorates to ensure optimum utilization of resources.
- Establishing IPHS standards to guide the stakeholders on how to improve a facility.
- Shifting of focus from employment guarantee to service guarantee.
- Reforms in managing cadre, transfer policy and promotion policy.
- Mainstreaming of AYUSH by revitalizing local health traditions.
- Concept of ASHA- to act as the interface between the community and the public health system.
- Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.
- Performance linked incentives and incentives for difficult areas.
- New cadre rules for posting of specialists at block level.
- Greater emphasis on continuing Medical and Nursing education.
- Strengthening of PRI.
- Contractual appointment of Medical and paramedical staff to combat the shortage.
- Training of MBBS graduates in emergency obstetrics and anesthesia.

New strategies regarding recruitment and retention of professionals in rural areas:

After the inset of NRHM, many new strategies have been in process to ensure the quality of healthcare provision by enhancing the recruitment and retention of professionals in difficult or rural areas. Some of these are:

- BRMS course has been planned keeping in view the reluctance of allopathic doctors to work in rural areas. It aims at training the students from rural background to practice in rural areas only. This is a 3 year course in medical science.
- Posting of AYUSH doctors to assist the allopathic doctors or to manage rural healthcare setup.

- Those students, who are interested and give commitment to work in rural area, may be given preference in admission in professional courses.
- More effective transfer policy to ensure that everyone gets a chance to work in rural or difficult areas.
- Financial and non-financial incentives to motivate employees.
- Mandatory rural posting for those who want to pursue PG courses in Govt. Institutes.

Initiative by MCI

India produces about 45,000 medical graduates every year, but most of them prefer to work in urban areas attracted by higher salaries. The Medical Council of India has recently proposed to the Ministry of Health, that the students of MBBS will have to complete six months of their Internship in rural area. Presently, the MBBS course is of total duration of four and a half year and 1 year of compulsory Internship. As per the proposal, out of the total duration of 1 year of Internship, six months service in PHC or CHC should be mandatory, rest 6 months of Internship can be completed in any urban area.

This initiative needs thorough interest from both the MCI and Ministry of Health. Also, the MCI believes that instead of forcing the student to complete whole duration of 1 year Internship in rural area, it'll be better to restrict this compulsion to 6 months. MCI has invariably agreed to this trend that, most of the MBBS students don't show any interest in working in rural area where the healthcare services are already dwindling and prefer to work in urban area, and those who start working in rural area are not so confident because of lack of exposure to the different demands and setup of rural area. So, this move will help the students to atleast have an idea about the rural setup and situation.

Public healthcare services in rural India is not in a very good condition. Infrastructural shortage is almost 20% and many of the hospitals and subcentres don't have basic amenities like water and electricity. There is a shortage of more than 70% doctors, almost 90% specialists, more than 50% nurses and about 80% technicians.

Conclusion

It can be concluded by having a glance at the above mentioned reports and data that though a lot has been done and being done to improve the situation of public healthcare delivery system in India, a lot still needs to be done to achieve the Millennium Development Goals (MDGs) and the goal of Universal goal of Health for all. It has been very lately decided by the Govt. that Human Resource or workforce is significantly vital in this Industry as well and that the Human Resource Management principles equally well here also. So, to increase productivity, efficiency, efficacy and quality of Healthcare services, it is more important first of all to improve the Quantity and Quality of Health workforce in this country. We have also learned a lot from the experience of other countries. So, how we are able to do justice to our system is yet to be seen.

References

http://mohfw.nic.in/NRHM.htm

http://mohfw.nic.in/NRHM/CRM/CRM_files/Introduction.htm

http://mohfw.nic.in/NRHM/Documents/Executive%20summary_March-2012.pdf

http://nhsrcindia.org/pdf_files/resources_thematic/Human_Resources_for_Health/NHSRC_Contribution/174.pdf

http://timesofindia.indiatimes.com/india/Six-month-rural-stint-may-soon-be-mandatory-for-MBBS-degree/articleshow/16226582.cms

http://www.indiannursingcouncil.org/anm-regulations-norms.asp

http://www.searo.who.int/

Indian approaches to retaining skilled health workers in rural areas: Thiagarajan Sundararaman A & Garima Gupta, Bulletin of the World Health Organization 2011:89:73-77. doi: 10.2471/ BLT.09.070862.

Indian Public Health Standards Indian Public Health Standards (IPHS) Revised 2012: Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India.

Mainstreaming of AYUSH Systems in the National Health Care Delivery System.

National Rural Health Mission (2005-12). Mission Document.

National Rural Health Mission: Meeting People's Health Needs in Partnership with states: The journey so far 2005-10, Ministry of Health and Family Welfare, Government of India.

NRHM- The progress so far.

Prasad, KM, Garima Gupta and T. Sundararaman (2009). *Documenting the 2nd ANM Training and Deployment of West Bengal*, New Delhi: National Health Systems Resource Centre.

World Health Organization (2009). Increasing Access to Health Workers in Remote and Rural Areas through Improved Retention, Background Paper.

World Health Organization (2006). Working Together for Health.

World Health Organization (2008). World Health Statistics.