Human Resources in Health

Timely Recommendations, Some Lacunae and What about Implementation?

GEORGE THOMAS

A close look at the major recommendations on human resources in the report of the High Level Expert Group on Universal Health Coverage for India shows that most of them are timely and have been made in the right spirit. Some lacunae do exist, especially on medical education and specialisation. But the most important issue is whether the recommendations can and will be efficiently implemented to give shape to a non-competitive, high quality medical system that provides all possible preventive and curative services to every citizen in the country.

George Thomas (*george.s.thomas@gmail.com*) is an orthopaedist at St Isabel's Hospital, Chennai and was formerly editor of *Indian Journal of Medical Ethics*.

Healthcare is labour-intensive. It is appropriate that the report of the High Level Expert Group (HLEG), chaired by Srinath Reddy, on Universal Health Coverage (UHC) for India has devoted an entire subsection to human resources in health, perhaps the most important component to achieving universal healthcare. As summarised in the report, right from the Joseph Bhore Committee in 1946 to the Planning Commission task force on planning for human resources in the health sector in the Eleventh Five-Year Plan (2007-12), many recommendations have been made on the subject. Yet, by the norms of the World Health Organisation (WHO) and other institutions, the human resources for health are inadequate, perhaps even grossly so, in India and the available resources are unevenly distributed with some areas of the country very poorly served. A clear understanding of the present situation is necessary to change it. The figures given in the report capture the starkness of the situation, but how did this state of affairs come about and what are the systemic factors responsible for keeping it that way?

The HLEG report states that the existing deficits in human resources for the health system are lack of data, skewed production of human resources, uneven deployment of resources and disconnected education and training. This is a fair analysis. All previous expert committees have remarked on the same factors and suggested remedies, which do not seem to have worked very well. Why did the remedies not work?

The early post-independence years were marked by the central government establishing the All-India Institute of Medical Sciences in New Delhi, the Postgraduate Institute of Medical Education and Research in Chandigarh and the Jawaharlal Institute of Postgraduate Medical Education and Research in what was then the union territory of Pondicherry to provide leadership in healthcare research and training personnel for the health sector. Unfortunately, in the absence of a supporting environment, the leadership role of the central institutions failed to become a reality, a large number of students left the country and the institutions gradually drifted into being one among many other medical colleges and hospitals. I emphasise this because an attempt at piecemeal implementation of the HLEG report will lead to another cycle of failure. The report is a composite piece and each component is an essential part.

State Responsibility

Healthcare being on the concurrent list, it was left largely to the states to expand the health network. This has resulted in huge imbalances in the distribution of all health resources, in general, and of human resources, in particular. At present more than 50% of India's medical colleges, dental and nursing colleges and other ancillary medical educational institutions are in the southern states and Maharashtra.

Up to the 1980s, most healthcare activities, both preventive and curative, were provided by the state. A network of primary health centres dispensed basic care, taluk and district hospitals delivered secondary-level care and medical college hospitals provided tertiary-level care. Curative care in the private sector was mostly primary. Nursing homes provided elective surgery. For all emergency care and tertiary-level care – the stuff of television dramas today – everyone had to go to a state-funded institution. A major shift occurred in the 1980s. On the one hand, there was a rapid development of medical technology in the world. On the other, there was a shift in economic policy in India with the emphasis shifting from the state to the private sector. In the two decades since, we have seen a split of service provision – preventive care, otherwise called public health, has remained largely a service provided by the state, while curative care, especially expensive (and profitable)

tertiary care, is now provided mainly by large private hospitals.

Such a split is not seen in any of the countries (mostly in Europe) whose healthcare systems are considered role models. Unfortunately, previous committees seem to have considered this split inevitable due to resource constraints. From the A L Mudaliar Committee (1962) onwards, there has been no clear road map to establishing a high quality healthcare system available to all citizens. Instead it has been an acceptance of two systems – the public health system for the poor and a private system for the rich. The HLEG is to be commended for attempting to reconcile this split and strengthen and expand the services provided by the state, while co-opting the resources of the private sector in a composite system.

Recommendations for Exponential Growth

On human resources, the HLEG emphasises increasing numbers exponentially. Its first proposal is adding more community health workers (CHWs) at the village level so that there is one for every 500 people in rural areas. In urban areas, the recommendation is one for every 1,000 people. A major step is the guideline that CHWs be from the area served. This is important because government jobs are much valued at the lower levels and a large number apply for them. They are unable to meet their obligations if they have to travel long distances to their workplace. Absenteeism is one of the major problems of state-sponsored healthcare and brings the system into disrepute.

Moving on to health sub-centres, which cover 3,000 to 5,000 people, the HLEG report recommends that each of them have a mid-level bachelor of rural healthcare (BRHC) graduate, two auxiliary nurse midwives and one male health worker. In urban areas, the BRHC graduate is to be replaced with a trained and qualified nurse practitioner. There is no doubt that this recommendation will be opposed by associations of medical practitioners on the ground that BRHC graduates and nurse practitioners will be underqualified, if not dangerous. This criticism is only valid if these personnel attempt to do what better qualified staff is supposed to do. This only happens when medical personnel compete for patients, and such competition should be eliminated by a universal healthcare system. It is important to emphasise that all the HLEG report's recommendations are based on the premise that there will be no competitive market in healthcare.

Intermediate-level medical personnel are an essential part of many health systems. For example, in the UK, much obstetric care is provided by qualified midwives. It is hoped that the government will implement this recommendation in the spirit in which it has been made; that is, as part of a comprehensive universal healthcare system. The HLEG has stated that BRHC graduates should be mandated to serve only in a notified area. If, on the other hand, these graduates are left to fend for themselves in private practice, it will be bad for them as well as their patients because they will have to inevitably compete for the same pool of fee-paying patients. The HLEG has taken note of the human aspiration for advancement by suggesting means for their career progression. Indeed, it has done this for every level of worker.

The third recommendation is increasing the number of health workers to 23 per 10,000 people in line with WHO guidelines by 2027. This would include one doctor for every 1,000 people and three nurses and midwives for every doctor. These numbers are based on studies that have looked into working patterns and the requirements of patients and medical personnel. To achieve this goal, the HLEG has recommended increased financial allocations and expansion of educational centres to train midwives, nurses and doctors in areas of the country that have severe shortages.

Nurses and Midwives

The HLEG's fourth and fifth recommendations are related to the third. They outline the path to increase the number of midwives and nurses in the country and this is to be done in four phases from 2012 to 2022. The report remarks, "In many states the National Rural Health Mission had to appoint far fewer nurses than required due to non-availability." It is important to find out why there are so few nurses in some parts of the country. Is it because there are no nursing colleges? Or is it because nursing is seen as an undesirable profession among certain ethnic groups? The HLEG's good intention should not be frustrated by unexpected social resistance, and research in this area would be helpful.

In government hospitals, many tasks considered as a part of nursing in other countries, such as helping patients with bedpans and urinals or sponging them, are delegated to sanitary workers. A mere increase in numbers will not improve nursing care in India. A change in attitude among nurses and the way society views nursing will have to be brought about. The example of Florence Nightingale – a rich, upper class woman caring for thousands of wounded and infected soldiers during the Crimean War – did much to elevate the status of nursing as a profession in Europe.

The sixth recommendation is raising the number of allopathic doctors to one per 1,000 people. This is to be done by increasing the number of medical colleges in underserved areas, increasing the number of seats in government medical colleges and reserving 50% of the seats in private medical colleges for local candidates. I must confess that this recommendation causes me much unease. The existence of private medical colleges that admit students for large sums of money will always be detrimental to creating an equitable healthcare system. Where will the doctors who have paid a fortune for medical education recoup their investment? It seems a foregone conclusion that these powerful people will ensure the existence of an expensive and profitable private sector. This will have a very bad effect on the psyche of health workers as this high-reward sector will be seen as the acme of success, the goal to be aspired for. The universal healthcare at the primary and secondary levels will be for less-powerful doctors, the tertiary level for the tie-wearing elite (unhygienic or not, a tie is still the mark of a corporate doctor).

Public and Private Facilities

It is also commonly believed, though not proved, that various castes have established their hegemony in medical

education through unfair means. That the prime minister and the queen in the UK and the president in the US utilise the services of public hospitals has had enormous value in creating public trust in the state health system in these countries. In India, the rich and powerful in both the private and public sector use private corporate hospitals or go abroad for treatment. This conveys the message that public-sector hospitals, including the so-called centres of excellence such as the All-India Institute of Medical Sciences and the postgraduate institutes in Chandigarh and Puducherry, are not really excellent. The HLEG should have tried to ensure that this sad history is not repeated. In an otherwise path-breaking report, it is strange that the recommendations for the education of doctors, who are right at the top of the pyramid, should be out of line with the rest of the document. The power of a small but powerful group among doctors to protect their own high incomes should not be underestimated.

Specialisation

Another lacuna in this recommendation is the absence of a plan for specialist doctors. At present, the number of places available for training at the postgraduate level in India is not based on any scientific analysis of the need for services. With increasing sophistication of technology, it has become impossible for a doctor to be skilful in all possible medical techniques. The perception that super-specialisation dehumanises medical practice and "atomises" the human body is more an opinion among medical professionals than a real argument against specialisation. Many medical procedures are so complex that they take years of practice to master. Super-specialisation will continue to grow and doctors' attitudes can be changed so that their skill level does not make them arrogant. It is very important to have an idea of how many specialists are needed in each area and make plans to train them so that the universal healthcare system does not end up as a substandard one.

The laissez-faire approach to medical education has meant that the maximum degree of specialisation has occurred in fields where the financial rewards are the greatest. It is no coincidence that the most sought after specialisation in India now is radiodiagnosis and scan centres are opening everywhere. It is not clear whether we need so many centres because we lack epidemiological data (as the HLEG report has pointed out). However, an indirect indicator that all is not well is that many of these centres offer bribes to doctors to refer patients to them. The need to attract patients has thus led to all kinds of dubious practices. In India, we have, on one side, the absence of even the most basic medical care for large sections of the population, and, on the other, medical personnel with all kinds of specialised skills but not enough patients. Human resource planning needs to be based on the kinds and numbers of personnel required and afford opportunities to trained personnel to work at centres where there are a sufficient number of patients. This can only come about if there is more organised healthcare delivery. The HLEG seems to have been well aware of this dilemma though it has not been bold enough to state it upfront.

The seventh recommendation is that doctors trained in ayurveda, unani, siddha and homeopathy (AYUSH) undergo a bridge course for three to six months and their services then be utilised in primary health centres, community health centres and district hospitals. This is a truly innovative proposal. There is an unhealthy rivalry between practitioners of different schools of medicine in India. Traditional systems of medicine seem to have a high degree of acceptance among the public for certain ailments, while so-called "English" medicine is seen as good in emergencies and for surgical problems. It would be wise to study and integrate all effective therapeutic techniques and finally create one system of medicine so as to eliminate competition among practitioners, which only confuses patients.

The eighth recommendation is standardising the training of allied health professionals such as radiographers, laboratory technicians and pharmacists and the ninth is creating district health knowledge institutes. These are expected to provide continuing education to health personnel at regular intervals. It is extremely important that there be systematic retraining of health professionals other than doctors. At present, although there are a large number of continuing education programmes for doctors, there are very few for other health professionals. The 10th recommendation is improving human resource management in the health sector by supporting postgraduate courses in public health and hospital management.

Strengthening the existing state and regional institutes of health and family welfare and developing regional faculty development centres are the focus of the 11th recommendation. It is well known that obstetric services in India are unsatisfactory and poorly dispersed across the country. However, it would be better that these services are improved as part of a general improvement of medical services. It is not clear why this sector alone has been singled out for special attention. It will give rise to pressures from other interest groups who view, for example, tuberculosis as a great threat, and so on. Years of "targeting" in India have led to a diversion of resources into one or other thrust sectors without much noticeable improvement in overall health outcomes.

The 12th recommendation is improving the quality of health education to produce professionals appropriate to the needs of the country. This has been recommended in every report on healthcare in India. It has never happened primarily because the private health sector, in which more than 85% of health professionals now work, can only be urban, specialist and high cost if it has to realise the profits for which it has been established. If the Government of India is truly serious about providing universal, high-quality healthcare and creating a cadre of health professionals for whom personal success is subservient to the welfare of society, it must give shape to one system of healthcare for all. A private, for-profit health system cannot coexist with a state health system. The private system will inevitably cannibalise a large number, if not the majority, of the most effective personnel from the state

system, and the state system will always be seen as second class.

Developing human resource management systems is the 13th recommendation's concern and it deals in fair detail with the career paths of health professionals. It is important to ensure opportunities for career advancement so that suitable people will apply for jobs in the health sector. The 14th recommendation stresses developing the capacity for health sciences research appropriate to the country.

Finally, one must ask, what could possibly be an ideal health system? It would provide all possible preventive and curative services to every citizen by personnel who are seen by patients as friendly and helpful. In other words, the care would be comprehensive and caring. To achieve this, we not only need enough personnel, but also the right kind of personnel. The HLEG report has made a brave effort to address the issue of numbers. Quality, responsiveness and accountability, all attributes generally believed to be absent in state-sponsored health services, will also hopefully be given importance so that India will have a high quality, egalitarian healthcare system, a basic service in every civilised country.