EDITORIAL

# Augmentation of Human Resources for Health (HRH): A Critical Step for Achieving Universal Health Coverage (UHC) in India

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Abstract | Introduction | Methodology | Results | Conclusion | References | Citation | Tables / Figures

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In pursuance of the Bhore Committee (1946) recommendations, (1) India had established the norms for health human resources which have been revised several times since then. (2) After the launch of National Rural Health Mission (NRHM) in 2005, further revision of the norms was done. A second Auxiliary Nurse Midwife (ANM) was provided at sub-health centres (SHCs), nurses were deployed in the Primary Health Centres (PHCs) which opted to conduct deliveries, and Accredited Social Health Activists (ASHAs) have been organised in most of the villages.(3) However, shortage of human resources for health (HRH), especially in govt. health institutions, still remains a major issue in India as well as in most developing countries. Hence, World Health Assembly has called upon nations to strengthen health workforce.(4)

As a first step, World Health Organisation has supported countries to conduct a review of their human resources for health (HRH) situation. In India, an analysis of occupations from the census conducted in 2001 revealed that 20 health workers were available per 10,000 population.(5) Of these, 30% were allopathic doctors, 30.5% were nurses and midwifes, 9.6% were Ayurvedic, Unani, Sidha, & Homeopathy (AYUSH) practitioners, 1.2% were dentists and 28.8% were other categories of health workers which includes pharmacists, ancillary health professionals, and traditional and faith healers. In India, beside the census, district level household and facility surveys (6) and rural health statistics (7) also provide data on HRH periodically. HRH density varies not only across states but also within the states. It is lower in rural, tribal, desert, and hilly areas. Deficiency is not only of specialist or generalist doctors and nurses but pharmacists, laboratory technicians, health educators, health assistants, multipurpose workers, administrative and support service staff are also deficient.

Large populations in rural and urban slum areas have no option but to approach un-licenced private medical practitioners in a largely un-regulated healthcare market.(8) Qualified medical practitioners of modern system of medicine generally do not practice in villages and small towns, though some qualified Ayurvedic, Unani, Sidha, & Homeopathy (AYUSH) practitioners still exist in these areas. In most states in India, there is near absence of dental doctors and dental assistants in the govt. primary health care system. Due to huge deficiency of well-trained and well-equipped HRH in govt. sector, large section of Indian population incur substantial amount of health expenditure out of

their pockets,(9) which is increasingly becoming a cause of poverty.

Govt. of India has tried to strengthen the HRH in the last 10 years through the National Health Mission (NHM). However, the efforts were primarily focussed at improving maternal and child health related HRH in the rural area. Large number of medical, paramedical and community health workers, especially one million ASHAs, have been deployed on contract or on performance based incentives.(3) As a result, now govt. health sector dominates in the provision of MCH care. Maternal and child health indicators have also shown improvement. The decline in maternal and child mortality rates accelerated even in the north Indian states. The rate of rise of OOP expenditure was found to be less in govt. health institutions as compared to the private health institutions when data from 2014 round of NSSO is compared to 2004 round.(9) The NRHM policy of expanding HRH base in primary care has paid dividend. It indicates, that there is potential in govt. health system for advancing towards UHC in India at affordable cost provided HRH policies are aligned to the requirements of universal health coverage (UHC) after taking into consideration the rising burden of morbidity in various regions of the country.

In view of the ongoing epidemiological transition, the requirement of HRH has increased for meeting the needs of not only reproductive & child health and communicable diseases, but also for addressing the rising burden of non-communicable diseases which require repeated check-ups for long-term care. Therefore, based on the National Health Policy 2017, (10) Ministry of Health & Family Welfare should prepare an action plan for further augmentation of HRH. A mix of medical, paramedical, and community health workers can deliver comprehensive healthcare to achieve UHC if state and central govt. allocate sufficient financial resources for HRH.

In the last few decades, HRH production landscape has undergone a significant change in India. The capacity for training of medical and paramedical personnel has increased many folds. However, the HRH creation is now predominantly in the private sector where formal and informal capitation fee payment is quite common. This system is gradually reserving the occupations in the health field for the elite classes who generally seek employment in the comfortable environs of city hospitals where healthcare industry is looking outward to other wealthy countries to improve their profits. This type of market-oriented policies in healthcare are likely to drive the healthcare costs to higher level as has happened in the USA. These policies will further skew the distribution of HRH in favour of cities. If the HRH deployment capacity does not increase in govt. health system, then, in coming decades negative consequences of the policies pursued currently will become more apparent. Hence, reforms in HRH policies related to production, licensing, recruitment, placement, retention, remuneration, and management should to be carried out now. It is expected that National Medical Commission (NMC) would address some of these issues.

Recently announced Health & Wellness Centres and National Health Protection Scheme is expected to contribute to improvements in the UHC. However, sufficient budgetary outlays and adequate supply of HRH, drugs & diagnostics in the govt. sector will be critical to contain the health care costs of UHC. Supply side and demand side issues would need to be balanced to achieve the stated objectives in the short and long term keeping in view the available fiscal space. The upgradation of the sub-health centres to health and wellness centres (HWC) – a kind of community clinic/dispensary – under the charge of a Mid-Level Healthcare Provider, who has basic clinical & diagnostic skills, can potentially enhance access to primary care. However, to have better outcomes, the HWC initiative should be backed by additional human resources to establish a village health post (Gram Arogya Kendra) in each village served by it as well as at the PHC to which it is attached. Each HWC should also have a Health Promoter – Multi-Purpose Health Worker with diploma in health promotion and education in addition to the Nurse Practitioner. Alongside the ASHA, each village with 1000 population should have one more community health worker (CHW) who is trained in home-based care as 8% of old people may require homecare as per NSSO 2014, (9) and the need for homecare is likely to increase over time. Health & Wellness centre should be within half an hour walking distance from the households which it intends to serve, and HWCs should function on the spoke and wheel model with PHC occupying a central place for health action in rural as well as urban area. PHC doctors should have mobility support so that they can conduct once-a-week outreach clinic in the HWCs attached with it on a fixed day, and ANMs from HWCs should conduct outreach clinics in every

Village Health Centre (Gram Arogya Kendra) once-a-week.

According to Indian Public Health Standards (IPHS), (11) each 24X7 PHC is supposed to have at least two doctors, a third doctor is placed in the desirable category, beside the three nurses, one laboratory technician and one pharmacist. However, at present 7.9% PHCs do not have even one doctor, 35.8% do not have a laboratory technician and 18.4% do not have a pharmacist, and 61.2% PHCs function with only one doctor. (8) Ideally all PHCs should provide services round the clock. At present, only about 30% PHCs provide services round the clock. According to NSSO about 3.5% and 4.4% of the urban and rural population respectively requires hospitalization every year, and about 8.9% and 11.8% people have illness in last 15 days in rural and urban areas respectively; about half of the illnesses are chronic in nature. (9) Beside the treatment of morbidity, healthcare involves health check-up, immunization, antenatal care, postnatal care and hospitalization for childbirth etc. To handle this large case load, ideally each PHC should have at least 4 medical doctors, 1 dental doctor, 1 dental assistant, 6 nurses, 2 laboratory technicians, 1 ophthalmic assistant, 2 pharmacists, 2 technical assistants, and about 15 support staff and 10 beds so that it can take care of most of the health needs of the population attached with it. Only those referred by PHC should have treatment in the hospital. Essential emergency healthcare needs should be available within half an hour travel distance by ambulance.

Since PHCs are required to provide comprehensive health services (public health, preventive, promotive, curative, and rehabilitative services) to about 30,000 population. Ideally, every PHC should also have a Community Physician (CP) as head of the PHC team who should be assisted by one Public Health Officer (PHO) so as to take care of all health programs using multi-sectoral approach. As a short-term measure, CP and PHO can be placed initially at Community Development Block. The capacity of the Community Health Centres (CHC) should also be enhanced by placement of about 5 general duty medical officers and 5 specialist doctors trained in Family Medicine and adequate number of paramedics to provide in-patient services round the clock to referrals from the PHCs.

The primary health care system should also have adequate backing of the secondary care system at sub-district level and tertiary care system at the district level. Hence, in the short-term, number of hospital beds need substantial increase (at least 1 bed per 1000 population in govt. sector) with commensurate increase in the HRH in the sub-district and district hospitals. In the long-term, the policy to have a govt. medical college in each district could create basic infrastructure required for National Health Protection Scheme which is expected to finance the secondary and tertiary care for about 50 crore people initially but eventually this scheme should cover every citizen, as the aim is UHC – everyone, everywhere. In the short-term, due to shortage of specialist and super-specialist in the govt. health services, strategic purchase of tertiary care service from private sector can be explored as an alternative.

To operationalize strategic purchase of services, district health authority would require a 'district health fund' and a team which has expertise in designing and monitoring contracts with private and public sector for treatment of cases and for planning and managing health promotion programs in the district. A single payer/purchaser system for all kinds of healthcare for everyone would be a better option under constitutional guarantees. IT systems would also need to be set up for monitoring the performance of HRH in terms of quantity and quality by the District Health Authorities. Hence, an Integrated Health Information System for Primary Health Care (IHIS4PHC) catering to all national and state health programmes related to MCH, CD or NCD including personal health records need to be developed on open source and free IT platform. The data should also be accessible to civil society for accountability assessment. Adequately staffed and financed District Health Office would be necessary to manage health services in a decentralized manner as per the local needs.

In conclusion, substantial augmentation of HRH is required to achieve UHC; at least 42 health workers including medical and paramedical staff per 10,000 population are needed. Additional physical infrastructure in terms of hospital beds, clinic space & staff quarters, regular supply of drugs and other consumables would also be required so that HRH can perform their assigned functions. Central and State governments would need to spend at least 5% of their GDP on health in an efficient manner to achieve UHC. Indian Public Health Standards also needs to be re-visited in order to create sufficient health infrastructure at various levels. As health service is

human resource intensive activity; it can provide employment to large number of our youth, who will in turn be instrumental in achieving universal health coverage by 2030.

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