

# HUMAN RESOURCES FOR HEALTH

THE KEY TO ACHIEVING UNIVERSAL HEALTH COVERAGE (UHC)

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India

The health sector in India is plagued by an acute shortage of human resources. Although, various initiatives were taken to address the issue, a comprehensive human resource policy, which lays down detailed guidelines for states to implement strategies to address the shortage of human resources for health, is always missing. It is now widely acknowledged that for achieving universal health coverage (UHC), health human resources is the key factor. Given the fact that India is committed to achieving UHC and also the Sustainable Development Goals (SDGs), it should develop and implement a proper human resource policy urgently.

Given the mixed success in achieving the Millennium Development Goals (MDGs), India has made commitment to achieve another set of ambitious targets laid down in the Sustainable Development Goals (SDGs). The SDGs calls for, among other things, an action to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (goal no. 3.8)”. This goal primarily urges for commitment to achieve UHC. As a member of the UN and the signatory to the SDGs, it is imperative that the Government of India reshapes its policies and implements these to achieve UHC. At the same time, the High Level Expert Group (HLEG) on UHC acknowledges that “India’s mandate for Universal Health Coverage (UHC) depends, to a great extent, on adequate and effective Human Resources for Health (HRH) providing care at primary, secondary and tertiary levels in both the public and private sectors”<sup>1</sup>.

As per the WHO estimates<sup>2</sup>, in 2006, India was one of the few countries to have a “critical” shortage of health workers and almost a decade later the situation is unchanged<sup>3</sup>. The critical shortage of human resources in health service delivery and its unequal geographical distribution is documented in many studies, viz., Hazarika (2013)<sup>4</sup>, Rao (2013)<sup>5</sup>, Garg (2012)<sup>6</sup>, and Rao et al (2011)<sup>7</sup>, among others. The total number of allopathic doctors, nurses, and midwives (11.9 per 10,000 people) was about half the World Health Organization (WHO) benchmark of 25.4 workers per 10,000 population<sup>8</sup>. When adjusted for qualification as prescribed by WHO, the number falls further to about a quarter of the WHO benchmark<sup>9</sup>.

Along with severe shortfalls in absolute number of HRH, unequal distribution is another area of concern. Health workers are unevenly distributed across states and across regions. Generally, the north-central states, which are some of the poorest in terms of economy and health, have low numbers of health workers. The numbers of health workers per 10,000 population in India range from 23.2 in Chandigarh to 2.5 in Meghalaya<sup>9</sup>. On the other hand, almost 69 per cent of India’s population lives in villages while only about 26 per cent of its doctors<sup>4</sup> serve there. Of these, the majority are in the private sector, which is economically beyond the reach of a large proportion of the population<sup>4</sup>. Bringing qualified health workers to rural, remote, and underserved areas is a daunting task. Huge level of international migration of qualified allopathic doctors and nurses further exacerbates the situation.

The inadequacy and uneven distribution of HRH

renders existing public health system ineffective leading to denial of services to the most vulnerable and needy. Reform of HRH will therefore be the key to universal health coverage reform in the country. Given this situation and drawing on existing research and policy debates, Oxfam India makes the following recommendations for improving the overall scenario of HRH and moving towards UHC.

### RECOMMENDATIONS:

- A comprehensive Human Resource Policy in healthcare should be developed.
- More investment should be made for augmenting the number of qualified doctors and other health workers and proper policy measures must be taken to fill up all the vacant positions.
- 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.
- Policy should be put in place to contain international migration to check the wastage of our scarce resources and address the problem of shortage of health workers.

**Recommendation 1:** A comprehensive Human Resource Policy in healthcare should be developed

Starting from 1946 Bhore Committee, several other committees/commissions made various recommendations for HRH. However, experts feels that there should be a comprehensive ‘Human Resource Policy’ which should lay down detailed guidelines for states to implement strategies to address the shortages of HRH. In the HRH policy, attention must be paid on human resource management tools which include in-service continued education and training. It should also incorporate the clear roadmap to bring transparency in promotions and transfers as these are critical factors for motivation of public sector workers.

**Recommendation 2:** More investment must be made for augmenting the number of qualified doctors and other health workers and proper policy measures must be taken to fill up all the vacant positions.

It is so far evident from the introductory discussion that there is an overall acute shortage of human resources. Wide differences are evident across states if we get into the details. For example, the numbers of allopathic doctors per 10,000 people in states such as Goa (41.6)

and Kerala (38.4) are up to three times higher than in states such as Odisha (19.7) and Chhattisgarh (15.8)<sup>10</sup>.

However, irrespective of the socio-economic status of the states, doctors and other health workers are concentrated in urban areas and consequently, urban areas are better served compared to the rural areas. The National Health Policy 2015 also acknowledges that “currently, most human resources created, crowd into urban areas, creating a highly competitive market for clients who can pay.” The number of health workers per 10,000 population in urban areas (42.0) is more than four times that in rural areas (11.8). The number of allopathic doctors per 10,000 people is more than three times larger in urban areas (13.3) than in rural areas (3.9). The number of nurses and midwives, who are the backbone to provide basic healthcare in rural areas, is also four times lower compared to urban areas (15.9 in urban areas vs 4.1 in rural areas)<sup>11</sup>. Even more ayurveda, yoga and naturopathy, unani, siddha, and homoeopathy practitioners work in urban areas (3.6 per 10,000 population) than in rural areas (1.0 per 10,000 population).

On the contrary, with only about 44,000 doctors for over 833 million people (as per the Rural Health Statistics 2014), the shortage of doctors in the public sector in rural regions is so severe that each doctor here serves a community averaging close to 19,000 people<sup>4</sup>. The National Rural Health Mission (NRHM), launched in 2005, somewhat improved rural health care infrastructure, introduced village level Social mobilisers in the form of Accredited Social Health Activists (ASHAs). But, due to the dearth of health workers in rural facilities (i.e., Sub-centres, Primary Health Centres and Community Health Centres) even basic healthcare is still a distant goal for a large section of rural masses.

The Rural Health Statistics 2015 indicates that as on 31 March 2015, shortfall<sup>11</sup> (based on required number of posts vis-à-vis in position) of health assistants (female)/ Lady Health Visitor (LHV) at PHCs was 49 per cent and for health assistant (male) and doctors the shortfall was 61% and 12% respectively. Out of the all functioning PHCs, 8% were running without a doctor. Proportions of functioning PHCs without laboratory technicians and pharmacists are 38% and 22% respectively. Specialist allopathic doctors are in very short supply in the public sector. At the CHC level, there was shortfall of 81 %, if ‘specialist doctors in position’ are compared to ‘requirement<sup>12</sup> of doctors’. Out of these specialists, shortfall of surgeons and physicians were 83% followed by pediatricians with 82% and for obstetricians and gynecologists this shortfall was 76%. Around 21% of posts for nursing staffs at primary and community health centres are vacant. The National Health Policy 2015 also states

to expand number of specialists, government shall invest in states with larger human resource deficits by strengthening 58 existing medical colleges and further converting 58 district hospitals to new medical colleges. In absolute terms, reversal of the country’s shortfall in health workers was estimated to require an investment of almost USD 2 billion<sup>3</sup> per year by 2015. Given this situation, it is imperative that governments must invest as per the requirement in producing adequate number of doctors and other health workers to eliminate the human resource gap in a time bound manner. Immediate initiatives must be taken to fill up all the vacant positions especially in rural areas.

Along with the shortage of health staff, higher employment in private sector also impedes universal access to healthcare because of the high burden of out-of-pocket payments for healthcare services. NSSO shows that at present, larger proportion, around 70%, of all health workers are employed in the private sector. Around 80% of allopathic doctors and practitioners of ayurveda, yoga and naturopathy, unani, siddha, and homoeopathy are engaged in the private sector, whereas 90% of dentists are employed in the private sector. On the contrary, lower proportion of nurses and midwives, around 50%, are employed in the private sector<sup>6</sup>. It is worthwhile to note here that it is widely recognised that much of basic primary healthcare does not require doctors to deliver. Evidence across the globe suggest that technology enabled frontline health workers (community health workers, nurse practitioners, midlevel community health assistants and other allied health professionals) can competently provide many needed services, assisted by point of care diagnostics and decision support systems located on handheld tablets, telemedicine and intermittent physician visits<sup>13</sup>. But, presently, India has roughly one ‘nurse and nurse-midwife’ per allopathic doctor, which is considered as very low and if the WHO standard is followed, the qualification adjusted ratio falls further to 0.6 nurses per doctor<sup>8</sup>. Although, there is no fixed nurse-doctor ratio, a higher ratio is desirable because nurses can deliver basic clinical care and public health services at a lower cost than doctors<sup>8</sup>. The 1993 World Development Report<sup>14</sup> recommended that the ratio of nurses to doctors should exceed 2:1 as a minimum, or 4:1 and above. This is considered best for cost-effective quality care. Keeping in mind the fact that higher proportion of nursing staff are amenable to the public sector and they can deliver basic healthcare services in a cost effective manner, vacancies for nursing staff must be filled up on a priority basis along with investing for producing more nursing staff.

To meet the ever increasing demand for qualified health workers, more investment should be made for medical education given the present situation in India. In the



post-independence era, there has been considerable improvement in strengthening health workforce. The number of medical schools has increased from 19 at the time of independence to roughly 270 at present and number of doctors who graduate<sup>15</sup> every year has increased to 28,158 from only 1,200 graduates per year at the time of independence. Private medical institutions have significant role in this rapid increase in medical education<sup>16</sup>. The percentage of privately operated medical schools has been increased to 57% at present from 33% in 1990. Due to our constitutional obligation, government medical colleges are mostly funded by state governments and municipal corporations and only a few are supported by the Central government. However, it is observed that the rapid increase in the number of medical colleges has also created the problem of poor quality of medical education. A Planning Commission task force for planning on human resources in health sector also observed that many medical colleges have been set up because of political pressure, with grossly inadequate facilities, acute shortage of faculty, and poor quality training<sup>17</sup>. So, along with augmenting the number of educational institutions, quality of education and training should be ensured.

Additionally, many experts feel that, at present, education and training of health workers, particularly doctors and nurses, is not public health oriented. Changes in faculty development programmes for more relevant curricula and teaching-learning programmes is required for proper training of health workers to work in underserved areas. 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<sup>8</sup>.

**Recommendation 3:** The public sector will need to redesign appropriate packages of monetary and non-monetary incentives to attract qualified health workers and encourage to work in rural and remote areas.

The shortage of health workers manifests in public health sector especially in rural areas. This is because of the disinclination of qualified private providers to work there and the inability of the public sector to attract and adequately staff rural health facilities. It is documented that preference of doctors/ health workers of private sector over public sector and urban areas over rural areas is attributable to several factors, viz., better income, better infrastructure, good working and living environments, and also better education opportunities for their children. Evidence also suggests that many medical graduates abstain from entering the job market and from taking posts in the public sector in rural areas due to their desire for postgraduate specialisation<sup>18</sup>. Nurses are more amenable to public

sector employment than are doctors<sup>9</sup>. Therefore, to attract and retain health workers in public sector as well as in the rural areas several issues should be addressed simultaneously.

As health is a state subject, a wide range of policies are already in practice across states to address the shortage of human resources in the public sector. Several policies viz., providing educational incentives, financial incentives, compulsory rural service when graduating from a government medical college, personal and professional support etc. are in place and adopted by states. Best practice of one state should be replicated in other states. Additionally, a system of scheduled transfers is important so that public sector health workers only work in rural areas for a finite time, which could increase their willingness to take such roles. All health workers, including accredited social health activists, should have clear avenues for promotion. Incentives that focus health worker attention on select activities or programmes are counterproductive and not desirable. Efforts to build positive practice environments and support to reduce professional and social isolation would also help. Most importantly, to address India's crisis in human health resources, increased emphasis on recruiting candidates from these very underserved disciplines, training them as close to their homes as technically feasible, and enabling them to work in these areas would be very beneficial.

It would be worthwhile to mention here that across states attempts have been made to address the shortage of human resources. But, in absence of a comprehensive HRH policy, and other drawbacks, such initiatives could fail. For example, the model of public private partnership (PPP) in Chhattisgarh for outsourcing of recruitment and management of human resources could be cited here. The main objective of this initiative was to fill the gap in HRH, especially in remote and conflict areas. Given the severity of the problem, and consequently, requirement of an urgent action, the initiative is praiseworthy. However, a recent study<sup>19</sup> of Oxfam points out that the government had not done enough to resolve the issue prior to outsourcing. The initiative led to increase in number of nurses, but huge gaps persisted in the number of medical officers and specialists. The study found that the government was unable to recruit adequate doctors due to gaps in the recruitment process and in this case too, the extra incentives under Chhattisgarh Rural Medical Corps (CRMC) were not well advertised to attract health professionals. As a viable option, the acute shortage of specialists could have been resolved through multiskilling and also through more broad based medical courses like the family physicians course. The study further reveals that adequate analysis regarding

available HRH and strategising how to make best use of them was not done prior to adopting that PPP initiative. The study also states that aggressive recruitment, publicity and awareness of CRMC benefits and the willingness of the government to recruit regular staff could have led to resolution of the issue to an extent. Against this backdrop and drawing upon various other findings, the study draws attention to implement a more robust and transparent system of recruitment, posting and transfer and aggressively recruiting health staff with prior publicity regarding the incentives under CRMC. But, above all, instead of adopting stop-gap arrangements like outsourcing of recruitment of HRH, a comprehensive HRH policy must be put in place for a more long-term and sustainable solution to this problem.

**Recommendation 4:** Policy should be put in place to contain international migration to check the wastage of our scarce resources and address the problem of shortage of health workers.

The country's shortage of health workers to some extent can be attributed to emigration of a large number of doctors, nurses and health technicians. Indian doctors constitute the largest number of foreign trained physicians in the USA (4.9% of physicians) and the UK (10.9% of physicians), the second largest in Australia (4.0% of physicians), and third largest in Canada (2.1% of physicians)<sup>20</sup>. The Planning Commission states that about 1,00,000 Indian doctors<sup>18</sup> work in the USA and the UK. A study<sup>21</sup> on migration of physicians found that during 1989 to 2000, from India's premier medical colleges, 54 per cent of graduates emigrated from India and most of them went to the USA. Developed countries are now increasingly dependent on foreign trained nurses and the presence of Indian nurses in developed countries is substantial and increasing<sup>21</sup>. The Planning Commission<sup>18</sup> rightly pointed out that shortage of nursing staff is worsened by migration of trained nurses to other countries. Medical and nursing schools are facing difficulty in filling teaching staff vacancies<sup>22</sup>. Nurses who emigrate are mostly better qualified and have more experience, consequently, it creates shortage of competent nursing staff in hospitals.

Although, Planning Commission acknowledges the negative consequence caused by emigration of huge number of health workers, Government of India, on the contrary, made an agreement<sup>8</sup> with the UK Department of Health. The purpose of the agreement is to recruit nurses from India. In 2003, the US Commission on Graduates of Foreign Nursing Schools opened a new examination centre in Kochi to enable Indian nurses to enter the US labour market and it has now four offices in India for recruitment purposes. So, the government's

attention to the shortage in the number of health workers and simultaneous promotion of health worker migration is contradictory. Given the paucity of resources in the health sector in India, the consequence of health worker migration is enormous; especially for those whose training is funded by the public. "The number of doctors and nurses leaving the country has important implications for the capacity and quality of health services, research, and faculty development for training future generations"<sup>8</sup>.

To address the huge human resource gap in the health sector, first and foremost, a comprehensive human resource policy, which entails a clear roadmap for producing adequate number of doctors, nurses and other health workers, providing a conducive environment for professional growth and creating proper incentive structures for retention must be developed. Finally, proper implementation of these policies is the prerequisite for eliminating the shortage of human resource.

## ENDNOTES

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