HUMAN RESOURCE FOR RURAL HEALTH IN INDIA – A PRAGMATIC REALITY

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India with a population of 102.7 crores of people, out of whom majority (around 73%) lives in rural areas, needs to make gigantic efforts for significant improvement in its public health scenario. The prerequisite for it is the availability of adequate number of human resources with suitable skills and their appropriate deployment at different levels of health care system for providing an effective health care service for the population. According to Census 2001, there are around 2.2 million workforce for health in India out of which 60 per cent reside in urban areas making a ratio of 2.5 health workers per 10000 population whereas the international standard is very high. This shortage exists in all categories of human resources at different levels and especially in rural domain. Over and above bringing qualified health workers to rural, remote, and underserved areas is very challenging. Ensuring the availability of human resources for health in rural areas and building their capacity in public health are daunting tasks. A comprehensive & holistic national policy for developing & encouraging qualified human resources for health is needed to achieve universal health care in rural India.

Introduction

The Constitution of India provides for the right to health in the Directive Principles of State Policy (Article 42 and 47) making Health as a state subject and the State is responsible for the looking over the needs and the delivery of health services to its citizen. India’s health care system is characterized by a mixed ownership pattern practicing different system of medicines. There are two major groups in the provision of health care delivery services in India i.e. public sector and the private sector. Recent national surveys have shown that the maximum concentration of quality health service provider specially private sector is in urban areas thus leaving the rural population dependent on public health infrastructure for meeting their health care needs.

In the rural areas of the district, the public health infrastructure consist of Community Health Centers (CHC), Primary Health Centers (PHCs) and Sub Centers (SCs) provides various health services which lacks the confidence of the target population thus making ineffective & irresponsible health system of the country.

The prerequisite for building an effective and responsive health system of a country is the health workforce which includes physicians, nurses, public health workers, policy makers, administrators, educators, clerical staff, scientists, pharmacist and health managers and others. We are witnessing inadequate number of human resources with suitable skills and their appropriate deployment at different levels of health care system

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which are essential for providing an effective health care service for the population. Unfortunately, India, since independence, has a severe shortage of human resources for health. This shortage exists in all categories of human resources at different levels and especially in rural domain. Bringing qualified health workers to rural, remote, and underserved areas is very challenging. Maximum rural population receive care from unqualified providers. The migration of qualified health workforce is substantial and further strains the system. Nurses do not have much authority or say within the health system, and the resources to train them are still inadequate. Ensuring the availability of human resources for health in rural areas and building their capacity in public health are daunting tasks.

**Contextualizing Human Resources for Health (HRH)**

Human resources for health are defined as “the stock of all individuals engaged in the promotion, protection or improvement of population health”. This includes both private and public sectors and different domains of health systems, such as personal curative and preventive care etc. Human Resources for Health is characterized by diversity, multifaceted & its complexity and includes people from a wide range of occupational backgrounds. It encompass all of the men and women who work in the health field—not only physicians and nurses, but also public health workers, policy makers, health economist, educators, health managers, clerical staff, scientists and pharmacists, etc. The National Classification of Occupation used by the Census of India has the following categories of health workers in India:

1. Allopathic physicians/surgeons
2. Health professionals, except nursing
3. Dental specialists and assistants
4. Ayurvedic, unani, homeopathic physicians
5. Nursing professionals and associates
6. Sanitarians
7. Midwives
8. Pharmaceutical assistant
9. Medical assistants
10. Medical equipment operators
11. Dieticians and nutrition lists
12. Optometrists
13. Physiotherapists
14. Modern health associates
15. Traditional medicine practitioners (excluding ayurvedic and unani)
16. Faith healers
Information on India’s diverse health workforce is dispersed and, by and large, unreliable. Professional councils carry information only on certain categories of health workers such as doctors, dentists, nurses and pharmacist. Even here, attrition due to death, retirement or migration is not accounted for as live registers are inadequately maintained. This whole galaxy of human resource has acquired training from a variety of institutional setting. Appropriate deployment of this HRH with suitable skills at different levels of health care set-up is essential for providing an effective health care services for the people.

Throughout the countries, a large amount of public expenditure is absorb in the health. The developing and underdeveloped countries are expending 80 per cent and 60 per cent on the health needs of its citizen respectively.

Health Resource Scenario at Macro Level
According to WHO’s World Health Report 2009, across the globe, out of 59.9 million health workers; 39.5 million (2/3rd) provide health services; and 19.8 million (1/3rd) are management and support workers. In many countries, including India information on HR is fragmented and difficult to obtain. Information in the private sector is scarce and very difficult to collect. Human Resource for Health is unevenly distributed among the regions, countries, and within countries. WHO (2006) recommends a minimum of 100 nurses and 20 physicians per 100,000 population. Many Sub-Saharan African countries have lesser than 50 nurses and 5 physicians per 100,000 population as against 222 physicians per 100,000 population in OECD countries. The ratio between nurses and doctors ranges from nearly 8:1 in the African Region to 1.5:1 in the Western Region. Approximately, there are four nurses per doctor in Canada and the United States of America while it is lesser than one nurse per doctor in Chile, Peru and Mexico. Besides, acute shortage of public health specialists and health care managers have been existing in many countries.

With reference to gender, it has been noted that more than 70 per cent of doctors are males and more than 70 per cent of nurses are females. About two-third of the workers are in the public sector and one third is in the private sector. 75 per cent of doctors, 60 per cent of nurses and 58 per cent of other workers live in urban areas while about 50 per cent of the population lives in urban areas. Skill mix and distributional imbalances; the skills of limited yet expensive professionals are not well matched to the local profile of health needs. Even density of human resources for health varies across sectors and regions special rural areas. Density of physicians and nurses in India (per 1000 population) is quite lower as compared to countries like China, Japan, U.K. and U.S.A.

According to WHO, Asia supplies over half of all migrating physicians. More than 100,000 doctors of Indian origin settled in the USA and UK alone.

Health Resource Scenario At Micro Level
According to Census 2001 estimates, there were approximately 2.17 million health workers in India in 2005 while at the time of independence, it was having a workforce
of 50,000 medical graduates and 25,000 nurses in the modern system of medicine to provide health care to the population. As per the Census 2001, India is a country of 102.70 crores of people, out of whom majority (around 73%) lives in rural areas. Since independence various government Committees were formed to strengthen the gigantic health system with special focus on rural domain and to provide recommendations for overcoming the loopholes and short comings of the programme and policies enacted by the government through its Five Year Plans with a special focus on rural areas. During these six decades, it has developed a vast public health infrastructure, which presently includes 145894 Sub-centres, 23391 Primary Health Centers (PHCs) and 4510 Community Health Centres (CHCs), providing services to rural population till March 2009. Besides, over 7663 sub-divisional and district hospitals and other specialized hospitals are also functioning in the public sector.

The benchmark set by the World Health Organisation (WHO) is one physician per 1000 population, while the world average has been estimated as 1.5 (World Bank 2009). India stands at about 0.6 per cent 1000 population. Compare this with other countries, Cuba has a doctor-to-population ratio of 1:165, United Kingdom 1:610, United States 1:358 and Italy 1:165 (UNDP, 2004). Further the nurse-to-physician ratio of about 4:1, which in India is about 2:1. Only about 40 per cent of the total population of registered nurses were said to be active because of wide reasons ranging from low recruitment, migration, to poor working conditions.

Among the different categories of health workers nurse and midwives constitute the largest percentage of the total health resources followed by allopathic physicians, Ayush physicians and pharmacists. Human resource estimate as per the Census 2001 is based on self reported occupation which may includes unqualified doctors as qualified doctors thus enhancing the percentage of doctors in total human resource for health. When the Census data were adjusted for health workers who may be unqualified based on NSSO, the density of health worker reduced to 8 per cent per 10000 population. Another astonishing estimates was provided by NSSO for Allopathic physicians, that only 37% were having adequate training.

During the X & XI Plan periods, concerted efforts were made to address the shortages of human resources for health. However, it is a matter of concern that there are huge gaps in critical health manpower in government institutions that provide health care to the poorer segments of population living in urban slums, remote rural and tribal areas. In keeping with the growth of health infrastructure and expanding scope of the health care services, human resource needs have been increasing. In view of the shortage of medical personnel in less-developed and rural areas, the National Health Policy (2002) suggested to examine the possibility of entrusting some limited public health functions with nurses, paramedics and other personnel from the extended health sector by providing adequate training to them. The changing scenario of health services and strategies, especially the National Rural Health Mission (NRHM)-2005, has led to an urgent need to develop new competencies and skills among the public health personnel.
The edifice of health care infrastructure and manpower were first laid down by the Bhore Committee (1946) and subsequently modified by the Mudaliar Committee (1961) followed by the Bajaj Committee (1987). The 9th Five-Year Plan had emphasized on health manpower planning taking into consideration, the district specific assessment of available manpower and health care facilities and the demand for health care services. Efforts were made by the Central and State Concerned bodies, however, there has been a very little progress were made in this effort and in the 10th Plan it was again expected to create a data-base to decentralize district-based health manpower planning to meet the needs. The National Commission on Macro Economics and Health has also highlighted the requirement of the public health system in terms of both medical and para-medical personnel.

Current Status

The problem of inadequacy of health delivery system is compounded by the uneven geographical distribution of human resources for health. For example some states like Punjab and Goa have allopathic doctors density upto 3 or 4 times in compare to BIMARU states. Such disparity exists between rural and urban areas as well. Almost all types of human resources in health have greater density in urban areas.

Currently, there has been a shortage of all key cadre including doctors, nurses and paramedics, particularly in rural areas. Irregular attendance/absenteeism in rural/remote areas, inadequate system of incentives for postings in difficult areas, lack of opportunities for continuing medical education (CME), skill upgradation, lack of orientation to needs of rural areas, lack of supportive system for career development, non-transparent transfer and posting policy and lack of transparency in career progression are the major issues need policy attention.

The number of registered doctors and population coverage per doctor varies across States. The current rate of production and severe shortfall in the production of specialists are major issues for achieving the health goals in the country. At present, the country has got 725,190 allopathic doctors, registered with State Medical Councils (till December, 2008), 751,926 AYUSH practitioners (till January, 2008), registered with their respective councils and 73,057 dental surgeons, registered with Dental Council of India (till December, 2007) (CBHI, 2008) making a ration of 6.3, 6.6., and 0.6 per 10000 population respectively. It is very clear that there is an acute shortage of dental surgeons in the country as compared to other disciplines. As per the norms of 1 dentist for 4000 population as recommended by the Bhore Committee, the total number of dental surgeons actually required is about 2.82 lakh in 2007, which is four times of the current production. As on 31 December 2006, 5,78,179 pharmacists were registered with the Pharmacy Council of India. The ratio of one pharmacist per 1923 population in India (2006) is quite comparable with developed countries; however, variations across the States are observed.

The combined strength of doctors in allopathic and AYUSH systems make a doctor population ratio of 1:775 in 2008 where as in 2006 it was 1:798 which is a decreasing
trend may be due to increasing population and decreasing human resource in health. The total number of registered doctors (allopathic, AYUSH and dentists) also varies considerably across different states.

Nurses and Midwives are the key health care providers. As on December 2006, 9,08,962 nurses had registered with Indian Nursing Council in the country (GOI, 2007). The ratio between nurse and population in India was 1:1205 as against 1: 100-150 in Europe. Overall, a huge shortage of nurses and midwives exist in India. Also, a vast difference in the availability of nurses in various States has been found.

**Human Resources for Health in Rural India**

Improvement in health outcomes in rural areas is mainly depends on the availability of trained human resources. In the rural areas of the district, the public health infrastructure consist of Community Health Centers (CHCs), Primary Health Centers (PHCs) and Sub Centers (SCs) providing health services and out reach services. Each CHC, generally located at the Block Headquarters covers a population of 1,20,000 in general and 80,000 population in tribal areas and provides 30 inpatient beds facility. By norms, a CHC is to provide referral back upto about 4 PHCs and about 20 health Sub-Centers. Each CHC is to provide mainly specialized curative services in different domains of medicine. The staffing pattern of the CHC contains 4 specialists, 3 general duty medical officers along with 1 X-ray technician, extension educator, ophthalmic technician, statistical assistant, 16 ward staff and 10 supporting staff.

The second on the tier is PHC having a norm to cover 30,000 population in rural areas or 20,000 population in tribal areas with atleast 6 inpatient beds facility. The health team of PHC consist of 2-3 physicians including the Medical Officer as overall incharge of the PHC along with 1 physician trained in an Indian system of medicine, one health assistant, and one female health assistant/Auxiliary Nurse Midwives (ANMs), a laboratory assistant, a computer operator, other ancillary staff and attendents. The PHC is the referral point for emergency cases and complications at rural level.

Each PHC has a network of SCs serving a population of 5,000 in general and 3,000 in tribal areas manned by a team of one male and one female Multi Purpose Worker(MPW) providing the basic maternal and child health services playing important role in defining the health status of any country. The MPW (M) is often simply referred to as the MPW and the MPW (F) is often referred to as the ANM, i.e. auxiliary nurse midwife. Under each SC for a population of 1000 there is Community Health Volunteer (CHV) generally known as Accredited Social Health Activist (ASHA) according to NRHM norms. ASHA is a women choosen by the community from the community who have completed middle school. Thus NRHM created a new largest cadre of Health delivery system i.e. ASHA with different pros and cons.

As on today, a significant proportion of positions are lying vacant at various levels; including shortfalls. The major shortfall at sub-centre level is of health worker (male)
resulting in overburdening of ANMs. According to a Bulletin on Rural Health Statistics (GOI), 7.5 per cent of PHCs were functioning without a doctor, 38.9 per cent without a lab technician and 17.7 per cent without a pharmacist while in CHCs, 54.5 per cent of the sanctioned posts of specialists were lying vacant as on March, 2006. Shortages of 9413 specialists at CHC level and 18,318 MPW(F)/ANM, 74,721 MPW (M), 5941 Health Assistant (female)/LHV and 7169 Health Assistant (Male) at PHC/Sub-centre levels have been observed. In most of the states the post of the MPW(M) lies vacant and there have been no recruitment over year. The male worker is paid for by the state, while the female worker is paid for by the central governmnet. Even there is a wide variation among states in number of persons served by a specialist in rural areas.

HRH Challenges
A shortage of all categories of health personnel in the public health system has been well recognized in the country and this needs to be tackled on priority basis. In order to ensure the availability of health professionals in rural areas on a regular basis, the country still has to train a large number of health professionals to meet the health care needs of the growing population and increasing disease burden.

The Overall Shortage of Skilled Human Resource for Health
It is increasingly clear that government in facing an acute shortage of skilled public sector health workers, and that this is getting worse, not better. The manifestations are obvious: vacant posts; unstaffed facilities; long waiting times; and a rapidly growing private sector. In most cases several factors have combined to produce this crisis but the causes boil down to four basic problems:

- there are not enough health workers entering the public sector
- there are too many health workers leaving the public sector
- demands on the public sector are growing; and
- human resource capacity in the public sector is shrinking.

Why Shortage in the Public Sector?
There has obviously not been sufficient pre-service training of human resources in health to meet the needs of the health sector. Partly this is because planners were not prepared for the increasing rate of loss, and increasing demands upon the health service delivery systems but this is not the full story. Government funding for pre-service training has been stagnant or falling over the past two decades: slow economic growth and demands for fiscal stringency did not allow increased budget allocations to training, while resources that were available tended to go into basic education and in-service training. Secondary school education has also failed to produce the number and quality of candidates for some health careers, but perhaps the most important factor has been general reluctance among donors to provide support for pre-service training of health workers.
The trainers of health workers have been hit by the same factors causing losses among other health sector human resources: poor pay and working conditions; and more attractive options in the private sector and abroad. Students struggle to pass their courses under such conditions when taught by ill and unmotivated teachers.

Other factors should also be highlighted: there has been a bias, often actively promoted by professional interest groups, towards the training of small numbers of high cost exportable professionals rather than less trained cadres such as enrolled nurses, clinical assistants, community health volunteers etc.

Careers in health may also be becoming less attractive to secondary school leavers as business, engineering and commerce degrees offer quicker routes to better earnings. Again, budgetary constraints have affected the salaries and financial incentives that health professionals receive once they graduate. On the other hand, the overall shortage of doctors and nurses, and the opportunities that these careers offer for migration (where health professions remain relatively well paid), should still make them relatively attractive options.

There are difficulties even once a student graduates into a health profession. Recruitment processes are lengthy, bureaucratic and costly. The latter is especially true if the posting is in a distant district.

**Why Human Resource in Health Leaving the Public Sector?**

The huge losses of human resources in most developing countries can be attributed to a combination of death, migration, movement to the private health sector, and movement outside the health sector altogether. For all but the first of these there are both ‘push’ factors which drive workers away, and ‘pull’ factors, which attract them to other options.

**Push Factors**

Perhaps the most important ‘push’ is the low morale among health workers. Poor (and often late) pay is a major contributor to this low morale. Pay rates have been eroded by years of slow economic growth and inflation. In addition, career paths are unattractive, especially since promotion is rarely linked to performance, as are working conditions generally, including housing, workloads (either too high or too low) and on-the-job safety (protection from contracting AIDS for example). Supervision is infrequent and when it does take place, is often not constructive. One of the pushes has come from the state itself in the form of downsizing schemes, including early retirement like VRS scheme.

**Pull Factors**

The ‘pull’ factors are primarily the better opportunities and conditions that HRH can obtain in other countries, in NGOs, in the for-profit private health sector, and outside the health sector altogether. Ironically, growth in health sector external assistance may be exacerbating the problem in the public sector by drawing scarce human resources
Migration
Migration is itself partly driven by human resource crises in the richer countries. Growth in demand for health services is outstripping growth in the training of the health workers needed to provide these services. This has created a ‘carousel’ effect where there is a flow of health professionals from poor developing countries to middle-income developing countries, then to developed countries with many eventually returning to retire in their countries of origin.

The Increasing Demands on Health Worker’s Time
While the pool of human resources in health is shrinking, the need and demands made of them continues to grow. The TB malaria, diarrhoea epidemics and its proper documentation has been a major factor, absorbs a lot of the system’s human resource capacity, but also increases in the burden of chronic conditions (cardiovascular disease) and resurgent communicable diseases (TB and malaria). New technologies and health care practices are being introduced to address these and other problems (e.g. DOTS, PMTCT, VCT, syndromic management of STIs, Integrated Management of Neonate & Childhood Illnesses (IMNCI), etc.). All imply additional staff training and they are normally more labor-intensive than the practices that they replace.

Diminishing Quality & Decreasing Number of Medical Institutions
There was a rapid growth of medical colleges from 25 in 1947 to 106 in 1981 and more recently 272 in 2008. Of these 127 colleges are in the public sector. There is a demographic disparity in its distribution also i.e. poorer states having a lesser number. This differential coverage has wide implications, quite apart from the production of physicians. The attached hospital of a medical college makes available a high quality of medical care to the local population. Distribution of medical colleges thus provides an important indicator of disparities in terms of health institutions and HRH.

The number of trained doctors increased from 65000 in the first five year plan period to 300000 in the sixth plan and more than 700000 in 2008. It is estimated by CII-McKinsey & Company (2002) that if India were to meet a target of 1 allopathic physician per 1000 population by 2012, the number of students in medical colleges will have to double and even then it will be difficult to attain the target.

Due to limited resources, the government is unable to open new medical colleges as per the demand of the growing population thus providing affiliation to different societies/trust to open medical colleges in different states according to the norms of the medical council. But unfortunately these colleges are growing as an industries for procuring sub standard degrees to became a part of the HRH thus affecting the quality of service delivery and hampering the life of the citizens too.
Lack of Supportive Supervision to Nurses and Para-medical Staff

As on March 2006 there were 1,312 institutions available for training of General Nursing Midwives in India, with an admission capacity of 50,628. The quality of Nurses training is affected by a number of constraints such as lack of teachers, infrastructure and non-adherence to the Indian Nursing Council teacher student norm, budget, etc. With globalization and growth of private health sector, the country needs more nurses.

As on March 2006, a total number of 336 ANM/MPW (female) schools with an admission capacity of 13,000 and 42 promotional training schools for LHV/Health assistant (female) with an admission capacity of 2,600 and 56 training centers for training of health worker (male) were established which were not sufficient to provide the appropriate number of HRH.

HRH Strategies

Strategies for augmenting the number of active HRH should be broadly focus on four dimensions:

- Augmenting the production of new Human Resource for Health
- Improving retention rates
- Harnessing unemployed, inactive or retired health workers and
- If possible importing health workers.

These should be complemented by different efforts made by the government to enhance performance and productivity by carving out necessary procedures & policies.

Measures to Reduce Outflows of Human Resources

Improving Income

Providing training is the obvious way to increase human resource inflows, improving pay rates is the obvious way to reduce outflows. Pay rises should of course target the cadre with the highest net outflow rates. But raising pay is more complicated because these include government department related to salary payments, potential differences due to increases in pay in the health sector might with other sectors (e.g. professors and civil servants), delatory attitude of state governments in implementation of recommendations, and other fiscal constraints.

Creating & enhancing allowances is another strategy to increase their figure of income but this has the disadvantage that this income does not count towards pensions & other retirement benefits. Previously these allowances were in fringe benefits which was not taxed but now the Finance Ministry covered these allowances also in the perview of Income Tax. Allowances can also have perverse effects. Allowances for attending workshops, for example, make a significant contribution to many health worker’s income, but encourage them to spend less time in the work place.
Another strategy could be allowing clinical and nursing staff to conduct private practice and thereby improve their overall income. In many cases this would merely institutionalize existing practice. If not implemented carefully, however, this measure can have negative consequences (e.g. neglect of public sector duties; discouraging rural postings where potential earning from private practice are small), and may produce a political backlash as public sector patients complain about the development of two tiers of service.

Another possibility is to use income from user charges to pay for salary ‘top-ups’. Finally, it must be emphasized that pay increases could be achieved by combining these with improvements in working conditions.

**Improving Working Conditions**

Of course increasing pay is not the only way to improve working conditions. Providing better housing, reducing occupational risks, lowering workloads, improving supervision, making it easier for people to remain in employment whilst following their spouses postings or bringing up a young family, and a range of other measures can often be put in place at little or no additional cost to the government.

**Creating more Attractive Career Structures and Opportunities for Promotion**

Retaining health workers is not just about providing acceptable working conditions with handsome amount in hand. It is also about offering staff the possibility to develop in their professions, acquiring quality experiences and greater levels of competence, and receiving recognition. To make career structures work in this way, a formal appraisal systems need to be developed to ensure that promotions are related to performance and sacrifice, rather than political or personal favourism.

**Developing More Attractive Retirement Packages**

This can serve as a strong disincentive for health workers to leave the current public sector on the cost of the sustainable golden post-retirement period. On the other hand the government could also think about raising the retirement age of the doctors from 60 to 65 & could also grant permission for establishing private practice/pay clinics/evening clinics, posting spouses at same place specific in tribal and rural areas postings.

**Sustaining Voluntary Community Health Worker Schemes Like ASHA**

Some have described community health workers as the backbone of the rural primary health care. Unfortunately they often have a low status and are given a low priority in government budgets. This is a pity because with a relatively small (additional) investment the governmnet could do much to reduce the high turnover of volunteers and retain higher numbers. Among the possibilities are performance-based awards, supplying volunteers with appropriate inputs (e.g. family planning, replenishing first aid kit and basic medicines), and offering preferential entry into formal health worker payroll. It remains debatable however, whether these volunteers can significantly
alleviate shortages if made permanent & formal part of health care delivery service. To maintain the motivation of these health workers, regular supportive supervision should also be provided to them with the help of different non-profit based organisations like UNICEF etc.

**Mandatory Government Service for Newly Medical Graduates**

Formal bonding schemes or compulsory social service of health professionals may be bestowed on the newly medical graduates and this scheme is being implemented by the Government of India but this scheme lacks graduate's motivation towards work and opportunity. These schemes should be attached with other arrangements to retain new graduates with motivation and commitment and to provide services in areas where it would otherwise be difficult to fill posts. A number of measures can be taken to ensure compliance such as withholding full registration until obligations are completed. The media could also be used to place social pressure on graduates to ‘give back’ the country’s investment on them.

**International Agreements to Manage Out Migration of Health Workers**

The gigantic problem was created to developing countries by wealthier countries i.e. ‘poaching’ their health workers and hijacking the health talents of other countries specially developing countries. We must establish codes of conduct for the ethical recruitment of health workers to abroad through migration department. In the longer term developed countries need to be discouraged to recruit our health professional and should make a commitment to train their own health professionals.

**HRH Strategies under NRHM-2005**

Under the NRHM, the government aims to increase the availability and accessibility to health care by providing a health cadre consisting of over four lakh female Accredited Social Health Activists (ASHAs) in 18 high focus states with poor health indicators and weak public health infrastructure. The formulation of transparent policies for deployment and career development of human resources for health, strengthening capacity for data collection, assessment and review of evidence based planning, monitoring and supervision and technical support to national, state and district health missions for public health management are part of the core strategy of the mission. In order to develop a coordinated approach to the issue of greater public health focus in the country, a task force on public health under the chairmanship of Director General of Health Services, has been constituted by the government under NRHM.

The President of India also established a National Council of Human Resources in Health (NCHRH) as an overarching regulatory body for health sector to reform the current regulatory framework and enhance supply of skilled personnel. Consequently, a Task Force was also constituted to deliberate upon the issue of setting up of the proposed National Council.
These organisations were bestowed the function of coordinating all aspects of medical, dental, nursing, pharmacy & paramedical education, will in itself consist of senior professionals and experts of known integrity and social commitment, selected/nominated by the most stringent standard. Accordingly, the following three bodies have been proposed to be formed under the ambit of NCHRH – National Board for Health Education, National Evaluation, Assessment & Accreditation Committee and National Councils. These affirmative actions will enhance the coordination among the systems & sub systems realetd to health and quality of health delivery system.

**Medical, Nursing and Para-Medical Education**

As far as medical education is concerned, at present the country has got 271 medical colleges, of which, 138 are government owned (MCI). The admission capacity in undergraduate colleges is about 31,172 students per year. State-wise distribution of medical colleges in the country clearly reveals the shortages of medical colleges in States like Uttar Pradesh, Rajasthan, Madhya Pradesh, Orissa and Chhattisgarh. Nearly 60 per cent of medical colleges in India are located in six States namely; Andhra Pradesh, Karnataka, Tamil Nadu, Kerala, Maharashtra and Puducherry. Acute shortage of teachers in medical colleges has an adverse impact on the quality of education. Problems like procedural delays in appointment of faculty, low pay scale structure and lack of uniform standards of medical education, at both graduate and post-graduate levels, hamper the quality of education. The content of teaching/training also varies from state to state; and between government and private institutions. National and state level guidelines are not available for teachers and as a result they are not exposed to recent changes in policies and programmes. The quality of research in medical colleges is poor and research findings do not feed training. The problem in the government owned institutions has become more severe as the private institutions pay more for the medical doctors. Of course, the candidates opting for public health and community medicine subjects are gradually declining as compared to potentially lucrative & attractive clinical and diagnostic specialties.

At present, the country has got 461 AYUSH colleges with admission capacity of 25,555 students with disparity in the availability of AYUSH colleges in different States, for example, Maharashtra has got as high as 107 AYUSH colleges while Himachal Pradesh has got only two. The country has in all 240 BDS colleges with admission capacity of 18,180 (2006-07), with regional imbalance in the establishment of dental colleges, among major states, maximum in Karnataka (43) and minimum in West Bengal.

**Capacity Building**

Lack of need based training to different categories of staff, absence of a well defined HRD policy, apathetic attitude towards training, inadequate training infrastructure and training skills, absence of pre-service and induction training and duplication of efforts by different agencies without much integration are some of the major challenges for capacity building. Other problems like unwillingness of doctors to serve in rural areas, charisma of post-graduation and private practice, incorrect/incomplete/
inconsistent data and lack of appropriate system for validation of data also pose a challenge for capacity building. Apart from these, many non-training issues like lack of mechanism for follow-up after training, mismatch between training and job profile and lack of system for monitoring performance related to training are also to be given adequate attention for capacity building.

Conclusion

In the context of the country’s health needs and demands, ensuring the availability of human resources for health, their capacity building and sustaining their motivation to work in rural areas is a real challenge. The overall shortage of human resources are aggravated by skewed distribution within the country, even within the states, movement of personnel from rural to urban areas, from public sectors to private sectors and from developing countries to developed countries. The solution for meeting the challenges in human resources for health include strategic planning for human resource for public health at state/national level. A comprehensive national policy for human resources is needed to achieve universal health care in India. 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. Such a policy might also encourage task-shifting and mainstreaming doctors and practitioners who practice traditional Indian medicine (ayurveda, yoga and naturopathy, unani, and siddha) and homoeopathy to work in these areas while adopting other innovative ways of augmenting human resources for health. 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. State specific human resource development and training policy, reorientation of medical and paramedical education, ensuring proper utilization of the trained manpower and standardization of trainings, effective human resource management information systems are also important. It is also essential to establish appropriate and positive link between HRH and NRHM in addressing human resource issues.

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