HRD AND HEALTHCARE

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ABSTRACT

As we are entering the New Year. We are witnessing the rapid changes in Healthcare division of India and its relationship towards Human Resource Development. Therefore the importance between the two is discussed in detail in this paper. The issues like Health Finances, Health Status and HR efficiency in Healthcare are discussed. The main four key HR issues in Healthcare sector reviewed in this paper include Improving efficiency in the use of HR, Improving equity in the distribution of HR, Improving staff motivation and performance and Improving HR strategic planning capacity in Ministries of Health. The issue of Healthcare is developing fast in India due to its population and the issues are needed to be addressed at the earliest. Qualifications and Skill with a blend of Experience must be given top priority for Healthcare. If Healthcare issues are ignored it will lead to many disasters in future. The need of the hour is Act now and Act fast. In short “Healthy India is Developing India”.

Keywords: Health Issues, Human Resource Development, Healthcare.

INTRODUCTION

Health and health care need to be distinguished from each other for no better reason than that the former is often incorrectly seen as a direct function of the latter. Health is clearly not the mere absence of disease. Good health confers on a person or group’s freedom from illness – and the ability to realize one’s potential. Health is therefore best understood as the indispensable basis for defining a person’s sense of well being. The health of populations is a distinct key issue in public policy discourse in every mature society often determining the deployment of huge society. They include its
cultural understanding of ill health and well-being, extent of socio-economic disparities, reach of health services and quality and costs of care and current bio-medical understanding about health and illness.

Health care covers not merely medical care but also all aspects pro preventive care too. Nor can it be limited to care rendered by or financed out of public expenditure within the government sector alone but must include incentives and disincentives for self care and care paid for by private citizens to get over ill health. Where, as in India, private out-of-pocket expenditure dominates the cost financing health care, the effects are bound to be regressive. Health care at its essential core is widely recognized to be a public good. Its demand and supply cannot therefore, be left to be regulated solely by the invisible had of the market. Nor can it be established on considerations of utility maximizing conduct alone.

**Forecasting in Health Sector**

In general predictions about future health – of individuals and populations – can be notoriously uncertain. However all projections of health care in India must in the end rest on the overall changes in its political economy – on progress made in poverty mitigation(health care to the poor) in reduction of inequalities(health inequalities affecting access/quality), in generation of employment/income streams (to facilitate capacity to pay and to accept individual responsibility for one’s health), in public information and development communication (to promote preventive self care and risk reduction by conducive life styles) and in personal life style changes (often directly resulting from social changes and global influences).

**Health Infrastructure in the Public Sector**

Issues in regard to public and private health infrastructure are different and both of them need attention but in different ways. Rural public infrastructure must remain in mainstay for wider access to health care for all without imposing undue burden on them. Side by side the existing set of public hospitals at district and sub-district levels must be supported by good management and with adequate funding and user fees and out contracting services, all as part of a functioning referral net work. This demands better routines more accountable staff and attention to promote quality. Many reputed public hospitals have suffered from lack of autonomy inadequate budgets for non- wage O&M leading to faltering and poorly motivated care. All these are being tackled in several states are part health sector reform, and will resuce the waste involved in simpler cases needlessly reaching tertiary hospitals direct. These, attempts must persist without any wavering or policy changes or periodic senigration of their past working. More autonomy to large hospitals and district public health authorities will enable them to plan and implement decentralized and flexible and locally controlled services and remove the dichotomy between hospital and primary care services. Some feasible steps in revitalizing existing infrastructure are examined below drawn from successful experiences and therefore feasible elsewhere.

**Feasible Steps for better performance**

The adoption of a ratio based approach tor creating facilities and other mpuls has led LO shortfalls estimated upto twenty percent. It functions well where ever there is diligent attention to supervised administrative routines such as orderly drugs procurement adequate O&M budgets and supplies and credible procedures for redressal of complaints.
The PHC approach as implemented seems to have strayed away from its key thrust in preventive and public health action. No system exists for purposeful community focused public information or seasonal alerts or advisories or community health information to be circulated among doctors in both private practice and in public sector. PHCs were meant to be local epidemiological information centers which could develop simple community.

The bulk of non-corporate private entities such as nursing homes are run by doctors and doctors – entrepreneurs and remain unregulated either in terms of facility of competence standards or quality and accountability of practice and sometimes operate without systematic medical records and audits. Medical education has become more expensive and with rapid technological advances in medicine, specialization has more attractive rewards.

Taking into account the size of the burden, the clinical and public health services cannot be shouldered for all by government alone. To a large extent this health sector reform in India at the state level confirms this trend. The distribution of the burden, between the two sectors would depend on the shape and size of the social pyramid in each society.

HEALTH FINANCING ISSUES

Public expenditure levels

Fair financing of the costs of health care is an issue in equity and it has two aspects how much is spent by Government on publicly funded health care and on what aspects? And secondly how huge does the burden of treatment fall on the poor seeking health care? Health spending in India at 6% of GDP is among the highest levels estimated for developing countries. In per capita terms it is higher than in China Indonesia and most African countries but lower than in Thailand. Even on PPP $ terms India has been a relatively high spender information sheets based on reporting from a network associating private doctors also as has been done successfully at CMC Vellore in their rural health projects or by the Khoj projects of the Voluntary Health Association of India. It is only through such community based approach that revitalization of indigenous medicines can be done and people trained in self care and accept responsibility for their own health.

With the recent opening up of the general Insurance sector to foreign companies, there is the prospect of two trends. New insurance product will be put out so expand business more be deepening then widening risk covered. The second trend would be to concentrate on urban middle and upper classes and settled jobholders with capacity to pay and with a perceived interest in good health of the family. Both trends make sound business sense in a vast growth market and would increase extensive hospital use and protection against huge hospitalization expenses, and promoted by urban private hospitals since their clientele will increase.

Insurance is a welcome necessary step and must doubtless expand to help in facilitating equitable health care to shift to sections for which government is responsible. Indeed for those not able to access insurance it is government that will have to continue to provide the minimum services, and intervene against market failures including denial through adverse selection or moral hazard. Indeed in the long run the degree of inequity in health care after insurance systems are set up will depend ironically on the strength and delivery of the public system as a counterpoise in holding costs and relevance in technology.
Health Status issues

The difference between rural and urban indicators of health status and the wide interstate disparity in health status are well known. Clearly the urban rural differentials are substantial and range from childhood and go on increasing the gap as one grows up to 5 years. Sheer survival apart there is also the well known under provision in rural areas in practically all social sector services.

In spite of overall achievement it is a mixed record of social development specially failing in involving people in imaginative ways. Even the averaged out good performance ideas wide variations by social class or gender or region or State. The classes in may States have had to suffer the most due to lack of access or denial of access or social exclusion or all of them. This is clear from the fact that compared to the riches quintile; the poorest had 2.5 times more IMR and child mortality, TFR at double the rates and nearly 75% malnutrition – particularly during the nineties.

A Review of Human Resource Issues in the Health Sector

Although it is widely recognized that improved management of human resources is key to providing more effective, efficient and quality health services, few developing countries have made significant progress in this area in recent years:

- There is still an over focus on quantities – producing (and often overproducing) health personnel without taking account of the sector’s needs resulting in limited resources being spread too thinly
- Productivity is low as health workers are underpaid and often turn to alternative (at times illegal) means of making ends meet
- Human resource issues have become detached from the broader mainstream policy. Staff plans often represent little more than wishful thinking, bearing no relation to resource availability, and key issues and problems such as reconciling strategic management (e.g. maintaining equity) with responding to local needs remain unresolved.

The four HR areas reviewed include:

1. Improving efficiency in the use of HR
2. Improving equity in the distribution of HR
3. Improving staff motivation and performance
4. Improving HR strategic planning capacity in Ministries of Health

Cutting staff numbers is often seen as one way of achieving this. Over recent decades increases in staff numbers combined with severe financial constraints have not only squeezed salaries but also essential non salary items of expenditure such as drugs and maintenance. Cutting staff numbers is never easy as such measures are unpopular and carry high political costs.

Changing the skill mix and reallocating tasks is another approach that offers potential but has been little tried outside highly industrialized countries. Greater use of nurse practitioners can reduce staffing costs without reducing quality. Although this area offers major potential there is still little evidence as to its cost effectiveness in a developing country context, particularly as the broader implications for training and continued professional development also need to be considered.
Flexibility in employment arrangements is another area which offers potential. In general, these attempt to relate work more closely to performance. This could involve time base approaches (changing shift patterns, working hours, etc) or contract based approaches (temporary staff, fixed term contracts or even contracting out services – usually ancillary services, sometimes clinical services and on occasion whole parts of the service may be contracted out to NGO, mission or even private providers).

Improving Equity in staff distribution

It is well recognized that providing access to cost effective primary health care services is the best way of improving health status of the population. There is little incentive however for health workers to do this. In terms of rewards and quality of life qualifies medical staff would often prefer to work overseas or, failing that, work as a private practitioner in an urban setting.

Central level planning has attempted to address this problem but largely failed. Incentives such as remote area allowances or subsidized housing are in themselves ineffective unless salary levels are also increased.

Since many of these providers has little previous experience in health care delivery, the government set up a tight regulatory framework specifying service coverage targets against which performance of providers (and whether they deserve payment) can be assessed.

Many countries have experienced a rapidly expanding and unregulated private sector yet governments have continued to target efforts at areas where the private sector (India) or social security health services (Latin America) are well established. Such duplication can be extremely inefficient and there is major scope for public/private partnerships to address this situation taking steps to ensure there is adequate protection for the poor.

Basic training of health personnel

As important as deploying sufficient numbers of health staff is to ensure they are able to do the right things. It is at the primary level of care that the main problems are experienced since training of many health professionals, particularly doctors and nurses remains hospital based and generally ill suited to the needs of primary care facilities. There are two main approaches to improve basic training (referring specifically to doctors and nurses). The first involves reviewing and adapting training curricula following better appraisal of service needs. A second approach has been to create primary care specific professionals.

Improving Staff Performance

Individual staff performance is a key element in overall system performance. This, in turn, is governed mainly by the network of incentives, of which an adequate reward package, including a competitive salary is an essential pre-requisite not found in many developing countries. A second pre-requisite is for staff to have the means to do their work, especially drugs, transportation and communications, three elements often missing in many health facilities based in rural areas. There is increasing evidence from recent research that attempts to improve the performance of staff when these prerequisites are not in place will not work and can be counter-productive.

Incentives for good performance are very weak. Although systems such as staff appraisal are often in place they are rarely enforced. Health service managers (typically clinicians) usually lack the necessary HR management skills to establish good systems. In addition, it is extremely difficult to measure performance unless specific, tailor-made outputs and indicators are defined for individual
staff or units against which performance is measured. Finally, because staffs seldom work along clear, individual objectives judgments on performance are often made on personal or political grounds rather than objective, technical criteria. Health workers must also possess the requisite skills. A common finding emerging from best performing health systems is that the gaps identified during staff appraisal must be addressed speedily enough for the worker to have a chance of performing better. In many developing countries this is hardly ever the case for various reasons. First, training budgets are often centralized and training provided is often programming specific and unrelated to the specific needs of staff.

**Development of HR Policy and Planning Capacity – The Challenge of Health Care Reforms**

Human resources are often mistakenly equated largely with training. Whilst training is certainly an important component of HR management, without strategic HR planning, HR policy development and HR management, good performance in the health system will not be achieved. As with other management functions in the health sector, reforms are likely to require HR management to move from the personnel administration function that usually does some simple human resource planning, to a function with a much more strategic approach. The monitoring of the staffing situation, but will also demand the development of strategic choices based on information from the monitoring process.

**EMERGING SCENARIO IN HEALTH SECTOR**

An optimistic scenario will be premised on an average 8% rate of economic growth during this decade and 10% per annum thereafter- If so, what would be the major fall out in terms of results on the health scene? In the first place, longevity estimates can be considered along the following lines. China in 2000 had a life- expectancy at birth of 69 years (M) and 73(F) whereas India had respectively 60 (M) and 63 (F). More importantly, healthy life expectancy at birth in China was estimated in the World Health Report 2001 at 61 (M) and 63.3 (F) whereas in Indian figures were 53 (M) and 51.7 (F). If we look at the percentage of life expectancy years lost as a result of the disease burden and effectiveness of health care systems. Clearly, an integrated approach is necessary to deal with avoidable mortality and morbidity and preventive steps in public health are needed to bridge the gaps, especially in regard to the Indian women. This leads us to the second question of the remaining disease burden in communicable and non-communicable diseases, the effective of interventions, such as, immunization and maternal care and the extent of vulnerability among some groups.

As regards TB it is possible to arrest further growth in absolute numbers by 2010 and thereafter to bring it to less than an million within internationally accepted limits by 2020. Taking the third aspect viz fairness in financing of health care and reformed structure of health services, an optimistic forecast would be based on the fact that the full potential of the vast public health infrastructure would be fully realized by 2010. Finally it is proper to remember that health is at bottom an issue in justice. It is in this context that we should ask the question as to how far and in what way has politics been engaged in health care? The record is disappointing. Most health sector issues figuring in political debate are those that affect interest groups and seldom central to choices in health care policy.
CONCLUSION

The task of ensuring the availability of MBBS doctors and specialists and to build capacity for rural health care in India is huge, but doable. The challenges include shortages, imbalances and low productivity, compounded by insufficient investment, inadequate pre-service training, migration, work overload, freeze in salaries and work environment issues (infrastructure, technical safety and community support). The overall shortages are aggravated by skewed distribution within the country, and even within the states, and movement of health personnel from rural to urban areas, from public sector to private sector, or to jobs outside the health sector or overseas. The gaps within the existing infrastructure and the services both within and outside the public sector need to be addressed. However, just having the requisite numbers of health personnel is not enough.

REFERENCES