

Discussion Inputs from cross- cutting theme of Human Resources for Health

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**TO STEERING COMMITTEE FOR 12TH FIVE
YEAR PLAN,**

Reference Pages:

- Approach to the 12th Five year Plan, para 9.23, page 121 to 123. 9.26 to 9.33
- Background Paper for Steering Committee on Health for the 12th Five Year Plan- Pg 3, para 4.6. pg 5,
- HLEG Report on UHC: Exec. Sum. pg 21 to 27. **Vol. II**, pg 155 to 192
- Working Group on National Rural Health Mission in the 12th Five Year Plan pg. 28-33; 34 to 37; 76 to 80.
- Working Groups on Non-Communicable diseases: Human resource requirements are distributed across specific existing and proposed disease control programmes. Need to be consolidated.
- Working Group report on Communicable disease- pg 117 to 119 ; paras 5.1.
- Working Group on Tertiary Care Institutions for the 12th Five year Plan. Chapter 2, pg. 26 to 46. (20)
- Working Group on Drugs and Food Regulation 12th Five Year Plan, Recommendation : Drugs A. B. & Food C.E.
- Working Group on AYUSH in the 12th Five Year Plan Pg 18, para 4, (29)
- Working Group Health Research in 12th Plan pg.15- 16.pg. 20 para vi; Pg 28,

Sub- Themes covered:

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- 1. Norms for Human Resources for facilities. Also their financing- center or state- contractual or regular!!**
- 2. Improved workforce management & governance- including attraction/retention in rural/remote areas.**
- 3. Expansion of medical, nursing and paramedical education: at terms of meeting public health goals.**
- 4. Creating new skilled health worker categories.**
- 5. In-service Skill Development Programmes.**
- 6. Needs for Programme Management and for Institutional Development.**

Norms for Staff per facility.....

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HLEG Report

- Two Female Health Workers
- One Male Health Worker
- One Bachelors in Rural health care:
- Two CHWs(ASHAs) per 500 (20 in a sub-center area)

3 lac FHWs, 1.5 lac MHWs,
1 lac BRHCs, 20 plus lac ASHAs

Working Group Suggestions

- One Female and one male health worker
- Second FHW in sub-center- delivery points (about 10%)
- One BRHC- in lieu of or in addition to male health worker
- One ASHA per 1000 (5 in a sub-center area)

1.7 lac FHWs, 1.5 lac MHWs,
1 lac BRHCs, 9 plus lac ASHAs

Bridging the gap- understanding the concerns:

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The HLEG suggestion

- Based on estimation of work time needed if universal health care is to be achieved.
- Suggests that center would need to absorb a greater human resource cost- but on regular basis.
- Needs to factor in differing work patterns in sub-centers of different states.

The working group suggestion:

Based on current work patterns. Many States even first ANM needs full working day. Most ANMs not into midwifery.

- Center pays for M& F HW + 10% of second ANM. State takes on additional ANM costs. BRHC?
- Need to factor work time requirements of its commitments under NCDs.

Need for differential norm- keeping working group position as minimum and HLEG as maximum- and adding on staff at state costs or shared costs- in proportion to package of care delivered –as proposed for second ANM.

Similar Approach to staffing of PHCs/CHCs and DH. Norms are indicative, actual delivery of services is what is definitive

Second ASHA for NCD ? : Ifs and Buts:

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- Rest of the system – from DH and SC has taken on NCDs. Developing the ASHA in case detection roles, before ability to manage referrals . Balance between referral roles and care provider roles.
- Need to be sure that sub-center strengthened by a BRHC and perhaps two or three health workers cannot handle this requirement.
- In some states, first ASHA herself can be assigned these roles: eg Kerala, TN, Punjab, Himachal, (RCH tasks of the first ASHA are limited)
- System has put in place institutional capacity required to train and support the first ASHA. In the high fertility and high communicable disease states, the first priority should be to make the first ASHA fully skilled and equipped for critical issues of neonatal and child survival and care in pregnancy and issues like malnutrition, family planning and adolescent health- before moving into the second ASHA.
- Career path and long term HR strategy in place - with options for different choices.

The second ASHA proposal could be a state specific decision and not a national norm to be adopted at this stage. Though it is the direction for the future- esp. if concerns like mental health and geriatric care come of age.

Workforce Management Issues

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- **Reiterating the role of Good Governance:** 1. Sanctioning the required posts- not depending on ad hoc arrangements and contractual terms for service providers; 2. Efficient and innovative recruitments- eg campus placement 3. fair and rational transfers and postings, 4. promotions and career-paths 5. remunerations- *How to move on this-* Making minimum standards of workforce management a MOU condition for financial transfers.
- **Packaging Measures for Attracting/Retaining Skilled Staff in rural and remote areas-** *difficult, most difficult, inaccessible:* 1. locality based preference for admission into educational institutions and for selection/posting; 2. Financial Incentives, 3. Non- Financial Incentives, 4. Measures to address professional and social isolation- positive practice environments.

New Professional boundaries/skill sets/educational qualifications: *Getting the right person in the right place:*

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1. The Bachelors in Rural Health Care.
 2. AYUSH doctors trained to play medical officer roles.
 3. Nurse Midwifery Practitioner.
 4. Multi-skilled paramedical health workers providing supporting functions at peripheral institutions.
 5. The Family Medicine course as a basic specialist:
 6. Multi-skilled Medical officers providing speciality care in select areas-like obstetrics, anesthesia, psychiatry, paediatrics including neonatology, trauma care etc.
 7. Male Multipurpose worker- need to define tasks, competencies, training institutions.
 8. Bridge courses- for ASHAs to move to ANMs, for ANMs to move to GNMs and B.Sc nursing, for nurses to move to nurse practitioners etc:
 9. Diplomas in public health management, epidemiology, medical entomology etc, etc.....
- ***There is a need for institutional arrangements that can lead and guide these changes:***

Human Resource Development

Professional and Technical education:

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57 new medical colleges- 269 new nursing schools, 149 medical college based paramedical institutions and 26 state/ 8 regional and one national paramedical institutions; also more seats in existing institutions with faculty expansion: aim- double the number of doctors and specialists produced and even higher level of nurses;

Continue with development of 10 AIIMS like institutions-and strengthening existing ones.

Publicly financed with affirmative action to balance out current inequity in development.

Faculty development plans , centers of excellence, more appropriate norms to facilitate development. (extending retirement age, in-service PG seats, DNB- equivalence to MD)

Using district hospitals for medical, nursing and paramedical - and even CHCs for the latter.

In-service Skill development:

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- 1.** Innovative and scaled up use of telemedicine- and the national knowledge network for continuing medical and nursing education.
- 2.** Strengthening NIHFWS and the NCDC as lead centers of in-service skill development and the institutional base at state and district level.
- 3.** Planned nationally coordinated programme to deploy nationally recruited trainers in high focus districts to build capacities in their training and supervisory institutions.
- 4.** Strengthening district hospitals to act as sites of in-service and pre-service clinical training and as hubs of health systems and programme management capacity.

Public Health Management Functions

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- A.** Expansion of training in public health management.
- B.** The development of a public health cadre.
- C.** Mid-level managers with specific technical skills- epidemiologists, disease control programme managers, HMIS managers, finance managers, hospital managers, logistics and supply chains, food inspectors, drug inspectors, laboratory networks, Need to combine- A & B with in-service programmes.
- D.** Knowledge Management Institutions and skills: Pharmaceutical policy, patents, support to innovation, technology assessment, managing PPPs, insurance and insurance like arrangements, data management and analysis, quality management systems, guiding community processes, supporting decentralised planning.

On Public Health Schools

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- Regulation to improve quality of existing public health schools.
- Expand the number of institutions graduating public health students and hospital managers - let these be outside of purview of MCI.
- Enable AYUSH, nurses, microbiologists, vets, public health engineers, other relevant disciplines to enter schools of public health.
- Strengthen managerial skills of doctors- periodic training in programme management for doctors in administrative positions

Institutional frameworks and Capacity:

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- Large number of institutions proposed in the working group papers and in the HLEG report.
- Need to develop skills and institutional governance frameworks for developing and managing these institutions- best practices in degree of autonomy, control and performance orientation.
- There is also a need for institutions that cater to knowledge management and programme management of new programmes and old programmes that are being scaled up- and the proposed institutions need to be aligned to these needs.
- Do we have cadre policies and institutional governance framework wherein we can recruit and deploy the necessary senior professionals and provide them with the autonomy needed to meet these needs ?

AYUSH mainstreaming:

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- **Cross learning between AYUSH and allopathic streams- training AYUSH docs in programme management, and vice versa,**
- **Legal and administrative support for use of AYUSH qualified doctors with multi- skilling for other clinical services of public health importance.**
- **Include training of ASHA and ANM in AYUSH**
- **Set up a Natl. Comm. For HR in AYUSH**

HRH and Disabilities

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- **Include sensitization for disability : across cadres of providers and across spectrum of needs- from disability rights to disability services.**
- **Increased access to disabled (beyond motor/ortho) in medical/paramedical/nursing courses**
- **Make facilities user friendly- disability friendly**
- **Community level care important to enable reach to all disabled- improves access to care at all levels**
- **Role of care givers in community and facilities to prevent secondary impairment**

- **Thank You.**