Impact of HR Reforms

Developed by

Swasti
10 YEARS OF EXCELLENCE

People for Health

This document is a product of the People for Health Project, and developed by Swasti, Health Resource Centre. The People for Health project is jointly implemented by Swasti Health Resource Centre and Public Health Foundation of India with financial support from the European Union.

Authors: Dr Angela Chaudhuri, Shiv Kumar

Year of Publication: 2013

Number of copies: 500

Acronyms

ANM	Auxiliary Nurse and Midwife
AP	Andhra Pradesh
ASHA	Accredited Social Health Activists
ANSWERS	Academy for Nursing Studies and Women's Empowerment Research Studies
AYUSH	Ayurveda, Unani, Siddha, and Homeopathy (Alternate systems of Medicine)
CHC	Community Health Centre
CDMO	Chief District Medical Officer
CMD	Chief Medical Director
CMP	Contract Medical Practioners
DHS	Director of Health Services
DMO	District Medical Officer
FBO	Faith Based Organisation
GNM	General Nursing and Midwifery
HR	Human Resources
HRA	Human Resource Allowance
HRC	Health Resource Centre
HRH	Human Resources for Health
HRMIS	Human Resource Management Information System
HRM	Human Resources Management
IPHS	Indian Public Health Standard
INC	Indian Nursing Council
KILA	Kerala Institute of Local Administration
MCI	Medical Council of India
MIS	Management Information System
MLOP	Mid Level Ophthalmic Personnel
MO	Medical Officer
NGO	Non-Governmental Organisation
NHSRC	National Health Systems Resource Centre
NMSU	Nursing Management Support Unit
NRHM	National Rural Health Mission
P4H	People for Health
PG	Post Graduate
PHFI	Public Health Foundation of India
PHC	Primary Health Centre
PSU	Public Sector Units
PEB	Professional Examination Board
SCC	Short Service Commission
SHSRC	State Health Systems Resource Centre
SOP	Standard Operating Procedure

1. Introduction

India's economic growth has not translated into commensurate improvements in its health indicators and the country continues to face difficulties in ensuring the effective delivery of health services to its people. One of the main obstacles is India's low health worker density. According to the World Health Organisation (WHO) there are less than seven physicians per 10,000 inhabitants.[i] The shortages of other health workers, including trained nursing and midwifery personnel, are equally severe. Human Resource for Health (HRH) is an important component for reforms which have not received much attention, despite the fact that WHO has been in the forefront of advocating for such measures for several years.[ii]

With the advent of the National Rural Health Mission (NRHM), huge investments have been made in the form of contractual staff especially in service delivery. Albeit, many states in the country still face huge shortage of HRH in rural areas. The improvements in the number for nurses and doctors are really impressive. The addition of nearly 850,000 Accredited Social Health Activists (ASHA) at village level provide much needed support for poor women and children to seek timely care. However, several studies reveal high attrition rates and lack of investments in training for these contractual staff. Furthermore in the absence of any career progression path, staff is not motivated.

Although the management of HRH is primarily a state responsibility, civil society organisations (CSOs) often play a supportive role in improving the functioning and outreach of public health systems, as well as helping strengthen HRH. They can make critical contributions towards shaping HRH policy, conducting analysis, providing evidence of practical applications as well as enhancing people's participation in health governance and oversight.

Core issues such as HRH planning continue to be weak in Indian states. There are issues related to numerical and distributional imbalance, inadequate training and technical skills, improper deployment, inefficient skill mix of health workforce often coupled with poor personnel management, non-existent career structures, inadequate staff supervision, lack of motivation, poor working environment, and lack of opportunities for personnel development. There is absence of a well-defined Human Resource Development (HRD) policy in states and even if it exists, it does not address the framework for key elements such as forecasting for HRH, deployment and career progression, compensation, and retention of health workers.

Despite the rapid expansion of medical colleges, dental colleges, and nursing schools and colleges in past decade, capacity building of HRH in India is a major issue. There are gaps in planning capacity building efforts and in utilising trained HR efficiently. The gaps include lack of need based training to different categories of staff, apathetic attitude towards training, inadequate training infrastructure and training skills, absence of induction training, and duplication of efforts by different agencies without much integration. Besides, there are 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 which calls for adequate attention.

It is in this context that NRHM and health sector reform programs in India have introduced several reforms to strengthen human resource management. As one of the pioneers in primary health care models, India has had a rich history of health service reforms, including reforms aimed at human resources. The last decade has been

significant in terms of the emphasis that has been brought back on HR reforms. Several policies have been articulated by state governments to make capable health HR available.

Understanding the impact of health policy changes is complicated by a number of factors. First, health outcomes are determined by factors both inside and outside the health sector. Second, health status is a lagging indicator of health investments and policies. The impact of health policy changes on health outcomes will only manifest after some time even in the case of major policy changes. Third, self-reported health status indicators are often not independently reliable—they are determined partly by expectations and sensitivity to illness, which vary systematically with factors such as income. The poor are less likely to report sickness. The poor are not healthier than the rich, but they are more likely to underreport, partly because they are less able to do anything about it (Schultz and Tansel 1997; Strauss and Thomas 1998).[iii]

In the absence of evaluations which assess the outcomes of reforms, it is difficult to document the impact of HR reforms. This is compounded by the fact that reforms require several years of implementation before they are able to demonstrate impact. This paper therefore attempts to understand the early results of HR reforms in India. We hope that the documentation of experiences from India will perhaps inform state governments who are committed to strengthening Human Resource Management (HRM) as a means of reaching the Millennium Development Goals and improving overall health status of their populations.

2. The People for Health Project

Recognizing the importance of strengthening HRM in improving health outcomes, the European Union (EU), in 2009, launched a global Call for Proposals entitled 'Good health for all: Engaging civil society organisations to support national health workforce policies, strategies, capacity development, and skills transfer' under the thematic programme Investing in People (with an indicative budget of EUR 14.5 million globally). This Call was rather timely in India, as the country had just started preparations for the establishment of a National Council for HRH in order to address the country's HRH challenges. One of the projects selected under this Call is 'Improving the HRH policy, strategy, and practices in India' is being implemented by Swasti, an Indian health resource centre established in 2002. The project is being implemented in partnership with the Public Health Foundation of India (PFHI), an Indian network of institutions responding to India's public health challenges through education, training, research, communication, advocacy, and health systems support.

Recognising the link between health workers and health outcomes, this project is entirely focused on capacities. Its purpose is to address human resource issues in the health sector at national, state, and community level through knowledge mobilisation, capacity development and advocacy. The project looks at a wide range of HRH aspects including planning, recruitment, motivation, compensation and retention, performance management and work culture, capacity development methods and tools, and equity issues in HRH. It includes actions at the national level and pilot activities in two states:

Madhya Pradesh in central India and Kerala in the south.

A special 'Advocacy and Learning' component is included in the project, which includes support for HRH Expert Groups and Cells at the state and national level, as well as an online forum 'People for Health' which provides civil society and the private sector with an opportunity to advocate for enhanced HRH.

This paper is a product of the 'Knowledge Building' core area of the project.

3. What constitutes Human Resource Reforms in Health?

Reforms in health human resource management in India are better understood by analysing the HR barriers which deter the achievement of health outcomes. Literature review demonstrates that some of these core barriers exist in conjunction across India and perhaps in other developing countries. It is important to understand however that every state within India will have its own set of barriers depending upon the historical decisions and development they have experienced.

The core barriers to human resource management include:

- **Structure and architecture:** The organizational structures are mostly hierarchical, with limited horizontal communication and reporting. Communication is largely limited and lacks intra and inter-department co-ordination. Internal organization of departments of health generally lack key functions like Planning, Monitoring, Quality Assurance, Legal, and Human Resource Management or these are in very archaic state
- **Adequacy of workforce:** The allocated staffing norms are not as per the Indian Public Health Standard (IPHS) and this is further impacted by vacancies in key positions. One case in example is the staffing pattern of nurses in secondary and tertiary level hospitals
- **Recruitment:** The process of forecasting workforce needs and planning is generally missing in most states. Furthermore, workforce planning does not include the need for non-medical staff like MIS specialists, sociologists, and procurement managers
- **Rationalization of staff:** The available staff are not distributed as per needs and qualifications. Many specialists languish in facilities which do not allow them to practice their skills. In addition, several archaic cadres continue to be on rolls despite an absence of requirement.
- **Roles and responsibilities:** The workforce does not have well defined roles and responsibilities are in places ambiguous. In departments where job descriptions are articulated, they may not be available with the concerned staff
- **Career progression of key staff:** There are very few opportunities for career progression and there have been cases of people retiring in the same position. There are very few opportunities linked to performance and additional qualification. Lateral entry from Public Health to clinical or teaching careers and vice versa are not the norm
- **Training and capacity building:** States seldom invest in training their health workforce. Most training opportunities are driven by the centre and are vertical in nature. The training infrastructure is not nurtured and therefore cannot cater to the needs of the workforce

- **Performance management:** Measuring the efficiency in healthcare delivery is very complex and difficult. Health departments have traditionally failed to establish any systematic effort of measuring consistent and methodical changes in health care service delivery either at the facility or individual level. Currently, the performance appraisal is done through ACR (Annual Confidential Reports) process with the help of two types of Self Appraisal Forms. The performance is neither linked to incentives nor to disincentives
- **Promotions/posting and transfers:** The system is not transparent in most states and amenable to external influence, further skewing the availability of adequate and capable staff at critical positions
- **Monitoring HRM including employee information data base:** Despite the department being highly personnel intensive, there is no central data of personnel or structures to monitor HRM needs. As for other departments, HRM is under the General Administrative Departments and this does not necessarily address the specific nature of workforce within the health sector. Without a robust HR MIS, planning for workforce management remains inefficient
- **Employee grievance redressal:** Reviews show that the senior management of health departments spent 80% of their time in HR related issues. This is primarily because of non-availability of structures to address employee grievances
- **Private Public Partnerships (PPPs):** While India, under the NRHM, has been exploring PPPs for making workforce available; there is a need for a strong PPP framework which is both relevant and regulated

In conclusion, therefore, systemic and systematic efforts to address these barriers constitute reforms in health human resources.

4. History of HRH Reforms in India

The situation of health human resources was dismal in India at the time of Independence. There were merely 1.6 doctors and 0.23 nurses for every 10,000 people. Of the available doctors more than two thirds had not undergone the requisite five and a half years of allopathic course and most of these doctors practised in the urban areas, leaving unqualified doctors to cater to the rural population.[v]

The Bhore Committee (set up in 1943) noted the lack of training infrastructure to generate health workforce (doctors and nurses) and the absence of working conditions necessary to attract health workforce into the public system.[vi] Based on the recommendations of the Bhore Committee and other committees,[vii] the Government of India designed India's public health system. With a focus on primary health care GoI created a cadre of basic doctors trained in clinical skills and public health.

Medical courses which did not administer the five and a half year allopathic curriculum were abolished, bringing an end to rural practitioners (trained in three years courses) and doctors trained in Indian System of Medicines.[viii] This was done despite contrary recommendations from the Chopra Committee (1948). Similarly, nursing education was standardised and invested in training public health nurses and midwives. However since the design of the public system was centred around the doctor, the development of nursing and other cadres suffered continued inadequacies in budgetary allocations and therefore neglect.[ix]

Health became a state responsibility (which included providing and developing HRH) with the central government exercising limited role. Public health was relegated to medical colleges in the form of Preventive and Social Medicine and medical school curricula

emphasised clinical education and practice rather than public health education.

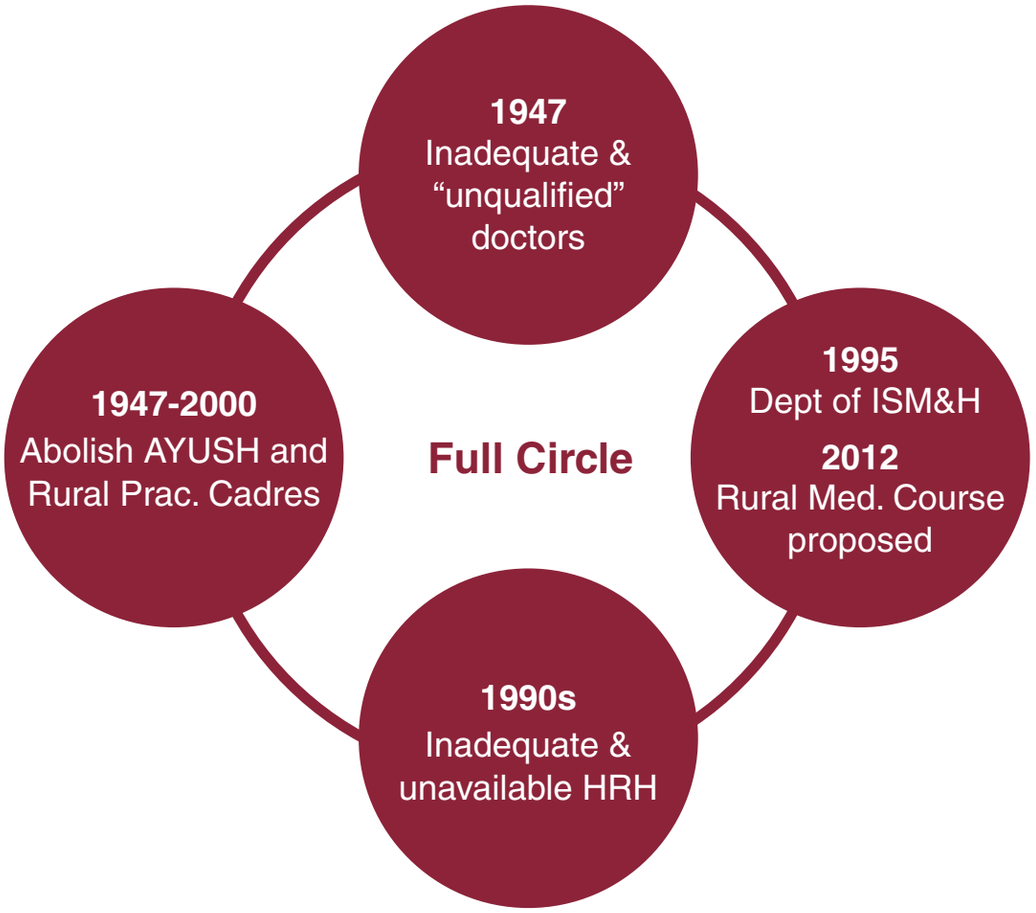
Despite the increasing infrastructure for generating health workforce, India continued to face shortages. In 1975, the Srivastava Committee recommended the recruitment of part-time health workers from the community.[x] The national Community Health Volunteer programme was launched in 1978. However it was found to be working suboptimal by 1988 owing to inadequate ground level support and opposition from doctors.[xi]

With the economic growth of India, the private health sector flourished and the workforce which was predominantly urban in the pre-independence era became distributed predominantly in the private sector and in the urban areas. The migration of doctors and nurses internationally began to emerge as an important challenge in the early 90s. A study carried out on graduates of a leading medical college between 1989 and 2000 showed that 54% migrated to the USA.[xii]

The Planning Commission acknowledged emigration as one of the reasons for shortages of nursing staff members.[xiii] Another study found that nurses who emigrate are better qualified and have more experience, resulting in a shortage of competent nursing personnel in hospitals.[xiv]

In the more recent years, the GOI acknowledged the need for strengthening infrastructure and human resources through the conception of NRHM. While the NRHM makes a serious effort through its provision for the ASHA, to create a cadre of community health volunteers, the GoI is yet to develop a comprehensive human resource policy for the health sector.

NRHM however has contributed hugely by providing the financial support, which have been translated as innovative solutions to HRH challenges, designed by several states in India. Many states have begun to articulate comprehensive HRH policies and have undertaken medium term measures to plan, develop, and nurture health workforce in the public sector.



5. HRH Reforms in the Last Decade

Since the advent of NRHM, several health sector reforms have been implemented by the Indian states. These include reforms and interventions to address the challenge of HR adequacy, distribution, capacities, and performance.

Table 1 Examples of Recent HRH Reforms in Indian States

HR Challenges	Reforms Introduced	States
Adequacy		
51% of the medical colleges are concentrated in four states, namely, Maharashtra, Karnataka Andhra Pradesh, and Tamil Nadu.[xv]	• National Health Policy envisages the setting up of a Medical Grants Commission for funding new Government Medical and Dental Colleges in different parts of the country.[xvi] PPP options include use of district hospitals for training private nurses and doctors, telemedicine and using private hospitals for multi-skilling public providers. • Increased number of medical seats • Relaxed rules for establishment of private medical colleges • Multi-skilling • Introduction of three-year Rural Practitioner course	Proposed Odisha Madhya Pradesh (MP) Several states
The four southern states have two-third of the nursing schools and 70% of the M.Sc. Nursing Institutions.[xvii]	• Central Government has taken a recent initiative in supporting 240 nursing schools and in setting up one National and eight Regional Institutes of Para-medical Services (2011). • PPPs for expanding nursing education; setting up of 8 GNM schools	EAG states Odisha
Public sector jobs have lower remuneration, tedious recruitment processes, and are unattractive options	• Increased remuneration for medical faculty • Increased remuneration for nurses • Walk-in recruitment, recruitment melas, lowering entry level barriers • Recruitment portals • Delinking recruitment from Public Service Commissions • Increasing age of retirement from 60 to 62 years	Andhra Pradesh(AP) Odisha MP & Assam Punjab Haryana Madhya Pradesh Tamil Nadu

HR Challenges	Reforms Introduced	States
	• Incentive packages – PG seats, regularization • Partnership with civil society organization for recruitment • Placements in preferred location – based on feasibility • Financial support for nursing education • Contractual recruitment • Contracting out services	Kerala Harayana MP Several states Several states
Weak HR Planning	• Establishment of HR Cells to manage HRM functions • Diagnostic studies • HR databases	Odisha Andhra Pradesh West Bengal (WB) Odisha and others
Distribution		
Workforce reluctant to serve in rural environments and resort to corrupt practices to be transferred out	• Mandatory rural posting; transfer requests not allowed for three years • Post graduate seats to those serving in rural/ remote areas • Financial incentives • Accommodation and transport allowances • Decentralized cadres – district cadres • Rationalization of staff	Several states Several states More than 20 states Assam Odisha AP, MP
Capacities		
Inability of fresh recruits to function optimally	• Induction training • Financial management training	Several states Andhra Pradesh
Lack of public health leadership; preponderance of clinical skills	• Public Health Cadres • Public Health and Management Training • Public Health Resource Network • Nursing Directorate	AP, Odisha Eastern and North East (NE) states Odisha and WB

HR Challenges	Reforms Introduced	States
Dismal training infrastructure, training/trainer quality	• Strengthening of training centres • Establishment of Public Health Schools • PPP – nominations for training in private academic institutions	Several states Nationally driven Several states
Performance		
	• Cadre reviews • Defining roles and responsibilities • Awards and recognition for ASHAs • Non-practice allowance • Service and duty allowance • Performance awards • Career paths for nurses • Key performance indicators for facilities and prioritized cadres • Decentralizing HRM management to PRIs • Structural changes decentralizing M&E	AP, Odisha, WB Tamil Nadu Assam Gujarat Several states Bihar, J&K, Karnataka Odisha Andhra Pradesh Kerala Andhra Pradesh

Comprehensive Health Sector Reforms and their Impact on HRM

Several donor agencies in India have been supporting sector wide reforms and in the forefront is Department for International Development (DFID), UK, which has invested in health sector reforms in five Indian states. USAID and World Bank have initiated health sector reforms as well. One such state is Andhra Pradesh, where major HR reforms have been initiated and have culminated in a comprehensive HR policy which addressed performance management through key performance indicators, architectural corrections, training policy, cadres review, recruitment and retention, transfers, promotions/postings, incentives, and redefined roles.

The HR reforms were concomitant with reforms in financial management, which was appreciated widely by clinically trained managers of health facilities. Similarly procurement reforms resulted in door step delivery of medicines and supplies providing the opportunity to perform. The architectural reconfiguration decentralized monitoring and evaluation while providing additional tier for promotion to the medical cadres. The establishment of a comprehensive IT based M&E system, complemented by key performance indicators is expected to provide evidence to support decision making.

Similar sector wide reforms in Odisha and West Bengal provided an opportunity for HR interventions to be supported by improvements in other sub-systems of the health sector. The outcomes of the health sector reforms in Madhya Pradesh are much anticipated as they include reforms in water and sanitation as well as the nutrition sector.

Results of HR Reforms

In a nutshell, the initiatives under the NRHM include an increase in sanctioned posts for public health facilities, incentives, workforce management policies, locality-specific recruitment, and the creation of a new service cadre specifically for public sector employment. As a result, the National Rural Health Mission has added more than 82,343 skilled health workers to the public health workforce (2011).[xviii] The challenge to make physicians available in rural areas or multi-skilling nurses to act as nurse practitioners however, continues.[xix] While some of these reforms have been initiated across India, many remain as anecdotal efforts limited to few states.

Hugely missing from these set of reforms are:

- The effort to develop and articulate comprehensive HR policies
- Evidence based HR planning
- Capable HR management through HR professionals
- Transparent transfer and promotion policies linked to performance
- Improvements in working environment
- The inculcation of public service spirit and loyalty
- Employee grievance redressal
- Efforts to address gender equity
- Efforts to shift tasks - from doctor-centric to nurse-centric delivery system

6. Measuring the Impact of HRH Reforms

It is clear from the previous sections that HRH reforms are at the core of the new ways of functioning of the public sector in India. Although the country is yet to introduce comprehensive reforms to address several critical barriers to HRH management, the few which have been implemented are being perceived to have improved health outcomes. This reiterates the question whether the country needs a more structured understanding of the links between HR reforms and their impact on improved health services and outcomes.

Policy makers will need a categorical response to whether incentives lead to actual availability, wherein the doctor's presence leads to improvements in service provision. Anecdotal field experiences reveal that several fresh graduate doctors agree to rural posting in lieu of a preferential treatment in postgraduate examinations and spend their mandatory posting preparing for the exam and not providing services. Does improved availability lead to decreasing out of pocket expenditure on health care? Does provision of better working environment lead to improved accountability? Will the presence of a HRMIS lead to better management of HRH? Will a trained health worker offer better services? Several such questions remain currently unanswered in the Indian context.

Impact evaluations in Latin America, where several countries implemented large scale HR reforms reveal how despite twenty years of reforms, the capacity to carry out HRM was still weak and how the utilisation of HRMIS was limited to payroll. The evaluation while highlighting the success of reforms in improving health outcomes also identifies gaps in primary health care, continued gaps in quality, reliance on out-of-pocket expenditure and a growing public dissatisfaction with public sector services.[xx]

The impact data in India is limited to the proportion of vacancies filled and general improvements in health outcomes. Reliance on the latter masks the influence of the generalised socio-economic development that the populace experience. For example, three fourths of the pregnant women in Andhra Pradesh have institutional deliveries, but two thirds of these are done in private facilities.

India, while drawing from global evidence, has to constantly monitor the results of the reforms which are being implemented and evaluate its impact on quality of health services and improvements in health outcomes. There is an urgent need to understand the impact of NRHM investments in making health workers available at the primary healthcare level. This would require client satisfaction surveys, an understanding of service utilisation patters, and a measure for quality of services to begin with.

7. Discussion

The literature clearly indicates India's urgency to address HR for health. It also indicates the myriads of efforts being implemented to address the immediate needs of adequacy and distribution. However, despite comprehensive recommendations which have been offered at a national and state level through situational analysis exercises, the policy makers have implemented a limited set of reforms—more as emergency measures or driven by political commitments. Furthermore, the impetus provided by NRHM has been utilised to address the inadequacies of doctors and to some extent ANMs.

The primary challenge in the HR reforms in a public sector context remains the need to satisfy the concerns of the various interest groups, especially in the health sector. In the absence of an effort to generate consensus among key stakeholders and interest groups, the reforms will continue to be restricted at the input level interventions.

The other major challenge that faces reforms for HRH is the across-the-board dearth of HR data. Many states cannot produce information on who is posted where, how many specialists are available, and who has been trained in a particular domain. Since HR matters within health are ruled by General Administrative Departments of the state government, specific requirements of the health department are often difficult to implement—opposed by the argument that the benefits or rules for the HR of one department needs to mirror that of the others in the government.

Given these complexities and the fact that historically HR and financial reforms have been the most difficult to initiate and implement, it is no surprise that states have not gone ahead with efforts which offer the HRH career paths, performance linked remunerations, or transparent transfer and posting criteria.

Anecdotal experiences in Andhra Pradesh (AP) and Kerala can offer a solution to this conundrum perhaps. These two states undertook analysis of service delivery priorities and are attempting to address HRH within the context of improvements in health outcomes. To a certain extent, the attempt of Madhya Pradesh to improve neonatal mortality through introduction of a special cadre of HR to manage and implement Sick Newborn Care Units

can be considered a similar effort. Tamil Nadu's example of utilising NRHM funds to reinvigorate its primary health centers is another example in how the focus on service delivery is an effective way to improve HR situations.

It has to be mentioned here that AP and Kerala are yet to implement the solutions proffered by programme managers to address HR gaps for improving service delivery. However, this certainly seems like a pragmatic first step to approaching the complex HR reforms.

The vector borne disease control programme in AP identified the vacant positions of lab technicians and inadequate utilisation of existing lab technicians as one of the barriers to reducing annual parasitic rates to below two in 323 *Mandals* of the state.[xxi] The programme managers offered the following solutions to overcome the barrier posed by vacancies:

- Multi-skill and effectively engage LTs working under different programmes to screen malaria, TB, and HIV
- Develop curriculum and facilitate training
- Train ASHAs to draw blood smears and conduct rapid tests

Similar exercises carried out by various sub-departments in the department of health resulted in the realisation that strengthening the cadre of lab technicians could lead to significant improvements in critical health outcomes. Career pathways were designed and efforts to multi-skill them were articulated. A separate HR initiative assessed training needs among LTs and these combined findings were presented as policy considerations to the government.

Similarly in Kerala, a recent effort under the EU-funded P4H Project undertook the service delivery approach to improvements in HR and found doable, practical solutions to the HRM crisis. The deliberations resulted in some critical insights for the government including[xxii]

- Regardless of the disease or disease programme, HR for health challenges is similar and cut across
- Actions which are prioritised as short, medium, and long term should include all cadres and not just the doctors and complemented by systemic strengthening

UNICEF with its focus on maternal and child health acknowledges the role HR barriers present to achieving improved outcomes. It has recently funded the development of operational guidelines for state governments interested in approaching HRH reforms in a phased manner by prioritising not only programmatic needs but also current capabilities of the states to introduce and sustain reforms.[xxiii]

The first step while approaching comprehensive, albeit phased HR reforms to improve outcomes is to establish a HR team/unit/cell which comprises dedicated HR experts, both internal and external, followed by systematic diagnostics. This needs to be followed by prioritisation and implementation of interventions, which are monitored constantly and evaluated at each turn for effectiveness and results.

The other critical element to build into HR reforms is the need for rigorous monitoring and evaluations of the reforms. While increasing numbers is a legitimate focus of policies at the national level, institutional weaknesses plague their successful implementation. Anecdotal reports of doctors utilising their rural postings to prepare for post graduate exams, absenteeism, inaccurate reporting of data, indicate that the numbers do not necessarily translate to improved services. Studies show that all the HRH interventions which were implemented individually or in combination had a positive impact on the maternal mortality and significantly decreased crude fatality rate in many countries.[xxiv] It can be conjectured from the mortality and morbidity data that the Indian states which leveraged NRHM funds efficiently, innovated appropriately, and implemented effectively have shown amplified health outcomes in the past decade.

There is a dearth of research on impact of reforms, especially HR reforms. States report on increased numbers, whether they result in improved and expanded services cannot be ascertained without further study. In addition, there is insufficient, inadequate systematic documentation and analysis of the various aspects of reform. It is essential to assess both progress and problems in the implementation of reforms in each state and to

appropriately modify the content and pace of implementation. Information on health workforce is sparse and available data are fragmentary.[xxv] Strong MIS system and mechanisms for health workforce planning and management is lacking in most of the states.[xxvi] A framework of HRH indicators therefore needs to be applied for monitoring and evaluating the country health workforce system and regional progress in health workforce development.[xxvii]

Based on the various recommendations that have been put forth by research in India, this document presents a framework for measuring the impact of HRH reforms.

HEALTH HUMAN RESOURCE REFORMS

Inputs	**HR Reforms**	**Reform Outcome**	**Reform Impact**
HR Cell/Unit	Recruit	Improved HW performance	Improved utilisation of services
HRM Team/ Expertise	Remunerate	Improved accountability	Improved health indicators
HR data	Distribute	Improved quality of Services	Decreased morbidity and mortality
Budgets	Motivate		
Policies and Guidelines	Train		
	Improve Work Environment		
	Balance gender issues		
Systemic level measures	**HW level measures**	**Service delivery level measures**	**Community Level measures**

Some examples of impact indicators are:

- Percentage change in vacancy status for critical cadres
- Proportion change which can be attributed to a particular reform (for eg, new recruitment policy)
- Sustainability of adequacy: Proportion of contractual staff in critical cadres
- Levels of capacity in critical functional domains through regular capacity needs assessments, included as a part of annual performance appraisals
- Proportion of employees satisfied with work and service conditions to understand parameters of performance, commitment, and morale
- Changes in client perceptions: Feedback from client satisfaction surveys for availability of critical cadres, especially in marginalised areas to assess distribution
- Percentage changes in critical service coverage by health care facilities

8. Key Messages

India has made a conscious start in addressing health HR reforms. It will be prudent for the country to implement the reforms that are accompanied by clarity on intended outcomes. When the approach to reforms is evidence-based, the progress is likely to be accelerated and responsive.

Reforms to strengthen health HR are critical and urgent. However, it is more critical that such reforms are evidence based and result in measurable outcomes that are required by the health system

Health departments are HR intense and often are complex. The structures and functions are not uniform across the country and are more often state specific. It is very important to understand and document the complexities of the HR systems before initiating the reforms. The availability of such analyses helps governments to quickly identify areas of gap and prioritise the key HR reform areas. Collating and utilising HR information is a crucial first step in HR reforms. It is imperative to match the identified gaps and felt needs with the current capacities within the government and preparedness for carrying out HR reforms as these need to be led internally. Prioritising based on preparedness or non-negotiable issues such as making workforce available in remote corners of the state allows for structured effort

Analyses of the baseline situation further ensures that reform designs take into account both intended and unintended outcomes. Governments should take into cognizance the fact that systemic reforms have an outcome on health workers and their environment. For example, incentives in the absence of accountability measures perhaps do little to improve availability of health workers to the population. Similarly, contracting-in of staff to improve adequacy may influence the work environment of both regular and contracted staff members. Reforms such as contracting are also fraught with potential legal debacles which are currently not safe-guarded

Multiple and complementary reforms are a possible solution to counter unintended outcomes. Functional reforms when accompanied by structural reforms help rationalising the workforce and therefore perhaps bolster sustainable availability of workforce in remote corners of the country. Furthermore, involving key stakeholders (various pressure groups and lobby groups) in the design process will facilitate key reforms prevent legal hurdles

The reform design should delineate the theory of change leading to the expected outcome and include a robust monitoring and evaluation framework that will enable mid-course corrections. There is an urgent need for the government and the donors to shift the HR evaluation paradigm from adequacy and distribution to actual improvements in services and decreases in morbidity and mortality

A phased approach to carrying out HR reforms in the context of desired impact could be attempted, especially in resource constrained environments

Identify gaps in the health systems as well as felt needs by the department. Then, match these with the preparedness of the department and its current capacities so that the reforms can be prioritised

Instead of overhauling the entire health system, prioritise reforms so that they are focused on key areas

Develop mechanisms to identify reform champions, assign them responsibilities, and empower them to carry forward the reform agenda

Develop demonstrable evidence on the effectiveness of reforms and promote cross learning. Disseminate the evidence to stakeholders

Develop a strong network of local, regional, national, and international institutions to provide technical support. Availability of such a network helps provide the government with policy level inputs and familiarise them with global best practices

Frequently assess reforms for achievement of results and introduce corrections as required

9. Reference

[i]WHO. Not Enough Here Too many There, Health Workforce in India. India: WHO, Country Office; 2007

[ii]Nandan D, Agarwal D. Human Resources for Health in India: Urgent Need for Reforms. Indian J Community Med [serial online] 2012 [cited 2013 Sep 10];37:205-6. Available from: http://www.ijcm.org.in/text.asp?2012/37/4/205/103464

[iii]M Lundberg, L Wang, A Coudouel. Impact of reforms, 2006 - siteresources.worldbank.org

[iv]Government of India. Report on the health survey and development committee survey: volume 1. Delhi: Manager of Publications, 1946.

[v]Rao M. History of medicine in India and Burma. Med Hist 1968; 12: 52–61.

[vi]Raha S, Berman P, Bhatnagar A. Career preferences of medical and nursing students in Uttar Pradesh. In: La Forgia J, Rao K, eds. India Health Beat. New Delhi: World Bank, New Delhi and Public Health Foundation of India, 2009.

[vii]Government of India. Compendium of recommendations of various committees on health development 1943–1975. New Delhi: Central Bureau of Health Intelligence, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, 1985

[viii]Gautham M, Shyamprasad KM. Needed: 'basic' doctors of modern medicine. The Hindu (Madras), Nov 5, 2009.

[ix]Healey M. 'I'm the gal that can do it if they let me': International Nurse Advisers and Notions of Professionalism in Indian Nursing, 1947-1965. http://coombs.anu.edu.au/SpecialProj/ASAA/biennialconference/2006/Healey-Madelaine-ASAA2006.pdf (accessed Nov 16, 2010).

[x]Government of India. Health services and medical education: a programme for immediate action: report of the group on medical education and support manpower—Ministry of Health and Family Welfare. New Delhi: Allied Publishers, 1975.

[xi]Sundararaman T. Community health-workers: scaling up programmes. Lancet 2007; 369: 2058–59

[xii]Kaushik M, Jaiswal A, Shah N, Mahal A. High-end physician migration from India. Bull World Health Organ 2008; 86: 40–45

[xiii]Government of India. Task force for planning on human resources in health sector. Planning Commission, Government of India, 2006

[xiv]Kingma M. Nurses on the move: a global overview. Health Serv Res 2007; 42: 1281–98.

[xv]Presentation on Medical Education – Proposed Amendments in MCI Regulations (PPT), Debasish Panda, Joint Secretary, Ministry of Health & FW, GOI

[xvi]National Health Policy 2002 India, Source: http://mohfw.nic.in/

[xvii]Growth, Decline and Revival of Nursing and Midwifery in India – Role of Private Nursing Institutions, PPT by Dr. M. Prakasamma Director, ANSWERS

[xviii]Indian approaches to retaining skilled health workers in rural areas, Thiagarajan Sundararaman & Garima Gupta

[xix]Career preference of medical and nursing students in Uttar Pradesh by: ShomikhoRaha, Peter Berman, AarushiBhatnagar

[xx]Michele Gragnolati, Magnus Lindelow, and Bernard Couttolenc; Twenty years of health system reforms in Brazil, An assessment of Sistema Unico De Saude; World Bank, 2013

[xxi]Sub-Department Action Plans, Directorate of Health Services, GoAP; AP Health Sector Reform Program submitted to DFID by FHI360, 2008

[xxii]HRH Prioritization Workshop Report, Department of Health and Family Welfare Kerala and SWASTI, health Resource Center – 2013

[xxiii]Developing Comprehensive Human Resource Policy in Indian States: Operational Guidelines and Resources; UNICEF, FHI 360, January 2013

[xxiv]Systematic Review on Human Resources for Health Interventions to Improve Maternal Health Outcomes: Evidence from Developing Countries: Zulfiqar A. Bhutta, Zohra S. Lassi, Nadia Mansoor Division of Women & Child Health, The Aga Khan University, Karachi, Pakistan

[xxv]Human Resources for Health in India's National Rural Health Mission: Dimension and Challenges, S K Satpathy and S VenkateshRegional Health Forum – Volume 10, Number 1, 2006

[xxvi]Managing Human Resources for Health in India, Central Bureau of Health Intelligence, Directorate General of Health Service , MoHFW, GOI, In collaboration with World Health Organisation - India Country Office, October 2007. A case study of Gujarat & Madhya Pradesh

[xxvii]Development of Regional HRH Indicators and Monitoring Template, Progress Report Submitted to Asian Action Alliance for HRH Development

Swasti
10 YEARS OF EXCELLENCE

KNOWLEDGE TO ACTION
phfi
PUBLIC
HEALTH
FOUNDATION
OF INDIA