Planning for Human Resources in Health

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.

This document details the study and the findings of HR planning in public, private, and NGO-managed health sector and presents recommendations for improving HR planning in the public sector.

The Current Affairs of Human Resource Planning in the Indian Health Sector

A Study of the Indian Health Sector Managed by Government, Non-government, and Private Organisations

Acknowlegement

Introduction

Swasti, is a Health Resource Centre working in South and South East Asia. The Public Health Foundation of India (PHFI), is an Indian network of institutions responding to India's public health challenges through education, training, research, communication, and advocacy. Together, Swasti and PHFI are partnering to implement this initiative within a time frame of 2011–14, to advance Human Resources for Health in India, funded by the European Union. This initiative seeks to engage civil society organisations and other non-state actors (including the private sector), and networks to strengthen health workforce policies, strategies, and practices through effective knowledge management and capacity building at the national level and in two Indian states, Madhya Pradesh and Kerala.

This document details the study and the findings of HR planning in public, private, and NGO-managed health sector and presents recommendations for improving HR planning in the public sector.

Table of Contents

Acronyms

ANM	Auxiliary Nurse and Midwife
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
CME	Continuing Medical Education
CMD	Chief Medical Director
DHS	Director of Health Services
DMO	District Medical Officer
GOI	Government of India
GoMP	Government of Madhya Pradesh
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resource Management Information System
HRM	Human Resources Management
IMG	Institute of Management in Government
IPHS	Indian Public Health Standard
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCI	Medical Council of India
MIS	Management Information System
MLOP	Mid Level Ophthalmic Personnel
MO	Medical Officer
MP	Madhya Pradesh
MPHSRP	Madhya Pradesh Health Sector Reform Programme
MPPSC	Madhya Pradesh Public Service Commission
NABH	National Accreditation Board for Hospitals
NGO	Non-Governmental Organisation
NRHM	National Rural Health Mission
P4H	People for Health
PG	Post Graduate
PIP	Program Implementation Plan
PHC	Primary Health Centre
PSC	Public Service Commission
PEB	Professional Examination Board
SC	Scheduled Castes

1. Defining Health Human Resource (Workforce) Planning

Health Human Resource (HR) Planning is the process of articulating a strategy and evolving a specific action plan to meet human resource requirements of a health facility or a health department.

The formulation of national Human Resources for Health (HRH) policies and strategies require evidence-based planning in order to rationalise decisions and should include short-term and long-term targets and cost estimates. These will aid in scaling up education and training for health workers, reducing workforce imbalances, strengthening the performance of staff, improving staff retention, and adapting to any major health sector reforms (e.g., decentralisation). In addition, these targets and estimates will also align with broader strategies for social and economic development. However, these policies and strategies should address the human resources' development needs of priority health programmes and aim to integrate the same into a primary health care framework, based on epidemiological evidence.

The first critical step in workforce planning is establishing a comprehensive documentation of the HRH development situation in the country. Using the key findings from such a situational analysis, workforce projections can be constructed to inform the development of a recommended strategy and operational plan that includes both long- term and short-term actions. The other critical elements of an effective planning process include:

- Developing a consensus on the strategic plan with key stakeholders

- Having a formal political commitment

- A monitoring and evaluation system for health human resources

2. Health HR Planning in India

Health care systems in most countries have undergone reform processes with the intention to improve the efficiency, equity of access, and quality of public services in general. A critical ingredient for building an effective and responsive health system is the health workforce which includes the medical, paramedical, managerial, and administrative staff. The National Rural Health Mission (NRHM), a flagship programme of the Government of India, therefore underlines the importance of systemic reforms, especially those which improve governance and human resource management.

India's human resources in health have significant challenges in the areas of quantity, quality, skill sets, productivity, and motivation. HRH planning and management is largely limited to administrative functions of recruitment, posting, and transfers. Health workforce density in India is far below the WHO benchmark of 2.5/1000 population (2008) with inter-state variations. Furthermore, institutional mechanisms for HR planning do not include specialised HR departments or standard protocols to promote quality affordable care and full utilisation of human resources.

The vast institutional network and diverse human resources include physicians, AYUSH practitioners, dentists, nurses, midwives, pharmacists, technicians, and community health workers.

However, signs of improvement have been visible in the implementation of NRHM in the last five years. The commitment by NRHM to provide funds needed to close the gaps between posts sanctioned by state governments and posts required to meet NRHM norms, dramatically changed the situation. While the progress in health HR reforms has been slow, there exist many good examples from civil society, corporate organisations, faith-based organisations, and other public sector entities that manage health programmes and facilities effectively and efficiently.

Problems in the Indian Public Health System

- Loss of personnel to private sector
- Lack of strong MIS systems
- Imbalances
- High staff turnover
- Low productivity of personnel
- Shortages
- Migration of health workers
- Mis-distribution
- Poor work environments
- Sparse, fragmented and limited data
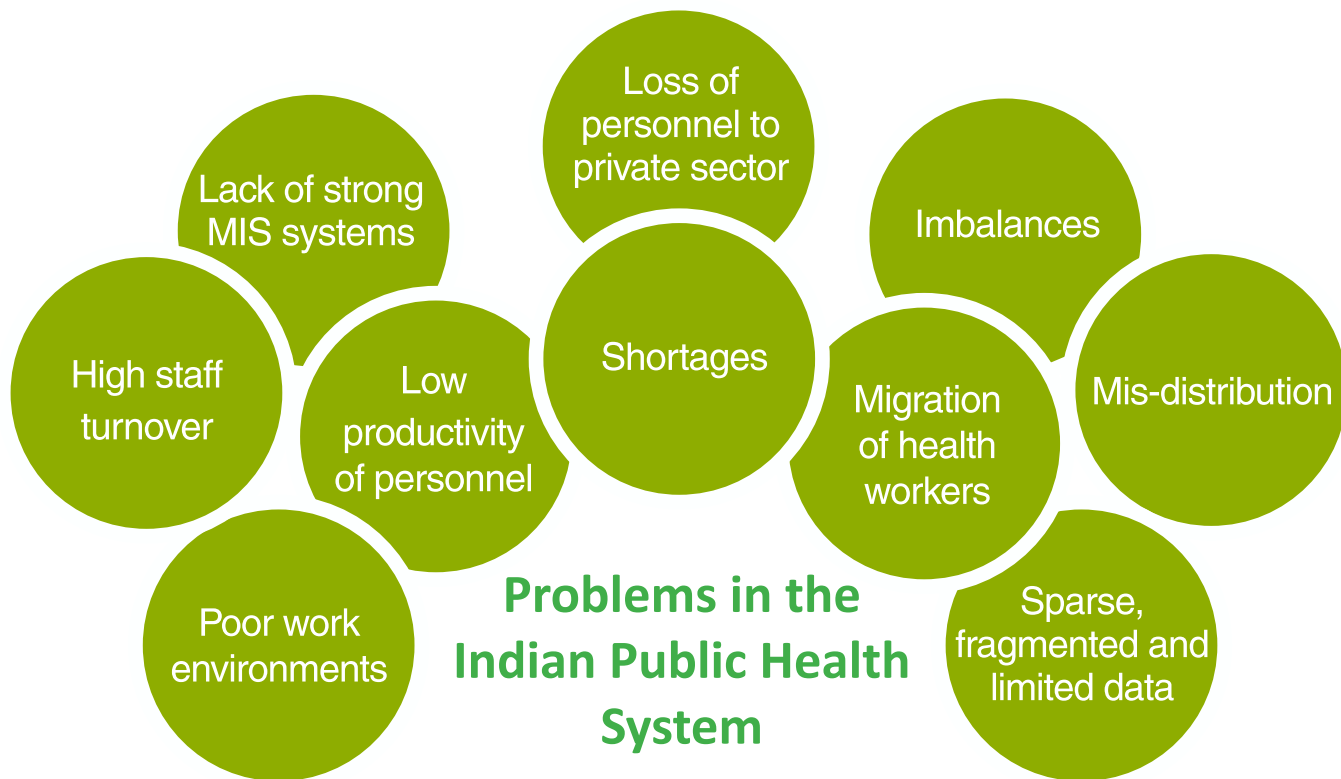
3. The People for Health Project

The People for Health Project, implemented by Swasti and its partners, aims to build an evidence base of good HR practices and systems from the different sectors, from different Indian states. This knowledge will be used to build capacities of health managers, advocate management systems and practices at national and state levels.

Objectives of the People for Health Project:

- Construct a comprehensive knowledge base on key human resource issues
- Build capacities of key stakeholders to advocate, absorb, and learn from each other
- Build and operate cross-learning platforms

The Project specifically targets:

- Government: National Ministry of Health, GOI, two State Governments — Madhya Pradesh and Kerala
- Civil Society Organisations
- Other non-state actors (private for profit and not-for-profit)

4. Scope of the Current Study

An in-depth study of the HR planning processes was carried out in the government, private, and NGO sectors and the state health departments of Madhya Pradesh and Kerala were selected, as these are the focus states for the European Commission programmes, for the study. In addition, the Indian Railways was also included to understand the Central Government HR practices.

- This report highlights the experiences and practices pertaining to health HR planning in the government sector departments, civil society organisations, and private organisations

- The report lists the current practices being followed by these organisations and concludes with a set of recommendations on improving HR planning

- The report also critically analyses the HR Planning System in the following private and NGO-managed hospitals:

Private Sector Hospitals

- Chirayu Medical College and Hospital, Bhopal
- Jawaharlal Nehru Cancer Hospital & Research Centre, Bhopal

NGO Sector Hospitals

- Lourdes Hospital, Kerala
- Aravind Eye Care System, Tamil Nadu
- Karuna Trust, Karnataka

This study explored the following aspects of the HR planning process:

Planning Processes

- At what level of the organisation is the planning done?
- Who is involved in developing the strategic and operational plans?
- What is the planning cycle for both strategic and operational plans?
- What is the approach to planning — top-down or bottom-up?

Basis of Planning

- What type and source of data is used for developing the plan?
- What are the tools that are commonly employed in the planning process?

Micro Planning

- How are HR needs of the health facility/department estimated (staff and skill sets)?
- How are requirements of special cadres estimated?
- How is planning done for different geographies?
- Are change management plans adopted?
- What is the budgeting process of the HR department?

Challenges

- What are the challenges faced in developing and implementing the plan?
- What are the steps introduced to address these challenges?

Details of methodology are presented in Annexure 1.

5. Findings From the Government sector

The state health departments of Madhya Pradesh and Kerala along with the Indian Railways as a representative of the Central Government's HR practices were included in the study sample.

5.1 Madhya Pradesh Health Department

Madhya Pradesh (MP) is one of the poorest states in India with a total population of 60 million. MP is a large state and is divided into 50 districts. Each district has a district hospital with capacities ranging from 100 to more than 300 beds. The districts are further divided into 313 administrative units — the blocks. Each block has a Community Health Centre (CHC) with a capacity of 30 beds. In addition, the State has over 1,400 Primary Health Centres (PHC), each with a capacity ranging from 6–10 beds. The state also has 65 civil hospitals with approximately 100 beds in each. Hence, planning health HR in MP is a humungous task.

Population above poverty line 63%

Population below poverty line 37%

Total Population: 60 million

Others 65%

SC/ST 35%

SC/ST Population: 21 million (35%)

SC/ST 60%

Others 40%

Poor Population Breakdown: 36 million SC/ST (60%)
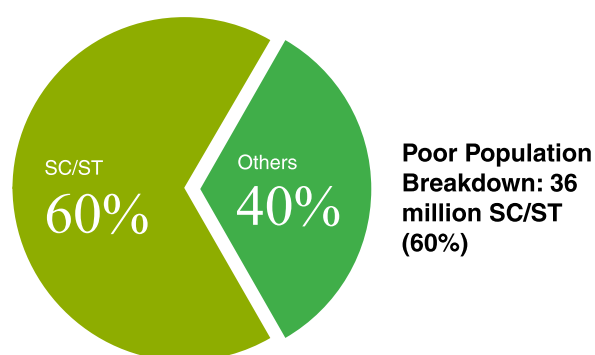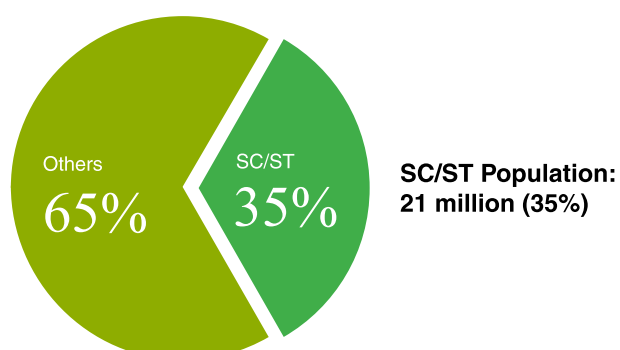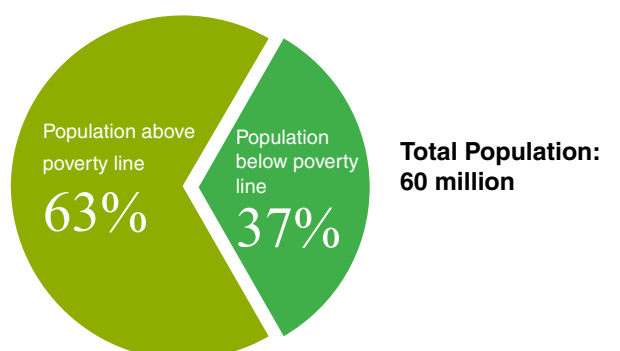
The performance of the public health delivery system in MP has faces several constraints which include:

- Staff vacancies and infrastructure gaps, particularly in the poorest 10 districts and tribal areas

- Lack of drugs and other essential supplies at local levels

- Weak implementation and monitoring systems

- Poor accountability of staff and low staff motivation

- Low management capacity

The ongoing Madhya Pradesh Health Sector Reform Programme (MPHSRP) supports, among other things, reforms to improve equitable access to quality public healthcare services, accountability of staff, organisational development, and human resource management. The Government of Madhya Pradesh (GoMP) has taken a number of steps in the recent past to improve the functioning of the health system and facilities through increasing public expenditure on health, decentralisation, and community participation, providing funding for community level health workers, and granting functional autonomy to local health facilities.

5.1 a. Planning Process

Traditionally, health HR planning in MP was done at the state level. However, following renewed commitment to decentralisation, districts are now involved in the HR planning process as well. The State Health Department does not have a distinct HR cell to plan and manage HR processes. The HR functions are led by Dr. Srivastav, Deputy Director, who holds additional charges of Quality Assurance and Human Resource Management Information System HMIS.

The HR planning processes of the health department are supported by the HR and Planning Department of the GoMP. The HR plan is developed annually during the development of the state's National Rural Health Mission (NRHM) Programme Implementation Plan (PIP). The HR requirements are estimated at the district level and fed into the State HR plan. In addition to allocating for Human Resources under the NRHM funds, the State carries out special allocations of human resources as it did to establish the Sick New Born Care Units (SNBCUs) in 2008–09. Details of this comprehensive HR planning are described in later sections.

To summarise, HR planning in the Health Department occurs at both the state and district level. Health leadership at district and state levels is involved in the planning process along with receiving support from the HR and Planning Department at the state level. The cycle of planning is annual; however, special needs are met with special planning inputs.

5.1 b. Basis of Planning

Currently, the Health Department does not have a dedicated HR Management Information Software (MIS). However, a software-based HR information system is expected to be implemented this year under the MPHSRP programme. In addition, a database of all doctors has been created in the recent past and is being utilised to understand the vacancy situation . A pilot for developing a similar database for the paramedical staff is underway. HR planning is carried out on the basis of the programme

data and HR requirements are collated from the districts. Sanctioned HR posts are juxtaposed against vacancies arising from retirements and resignation/voluntary retirements, every year, to calculate the needs of the health department.

There are no other specific tools employed to estimate and forecast HR. However, the State uses national and state articulated norms for recruiting and deploying various cadres of health workers. These are described in the ensuing section.

5.1 c. Micro planning

Estimating HR Needs (Number and Skill Set)

The State Government has articulated a set of 'Cadre and Recruitment Norms' in the State Gazetteer. These norms are employed to determine HR needs by the Health Department as well. In addition, the Indian Public Health Standard (IPHS) and the National Accreditation Board for Hospitals (NABH) norms are employed to determine the creation and sanction of HR positions for the hospitals.

The specialist doctors and medical officers are posted and reallocated based on norms articulated in the 'Pink Book'. This document, containing criteria for posting specialised doctors and medical officers based on the bed capacity of a hospital, is disseminated by the State Ministry of Health and Family Welfare. The number of departments and the staffing pattern under the NRHM funded national programmes is fixed. The number of staff required is decided upon and requested after taking the workload into account.

Recruitment and Deployment of Health HR

Recruitments are sanctioned through government orders and publicised through advertisements. Several reviews are held at the ministerial levels to ensure the regularity of the recruitment process. The State initiated re-deployment of the workforce in 2012 to address geographic disparities and 4,000 Auxiliary Nurse Midwifes (ANMs) have been re-deployed as a first step.

Body	Function
The Professional Examination Board (PEB), a government agency	Overall recruitment in Madhya Pradesh
Madhya Pradesh Public Service Commission (MPPSC)	Supports overall recruitment process, but is limited to recruitment
The Establishment Section, Health Department	Responsible for the postings and transfers of staff especially those pertaining to doctors
Nursing Section	The posting of nursing staff

Case Study

HR Planning for Operationalising Sick Newborn Care Units (SNBCU)

Madhya Pradesh identified the need for establishing SNBCUs at the district level to address the high rates of neonatal mortality. The first SNBCU was established in 2008–09 and has since been scaled up across the State. To overcome the non-availability of adequate number of paediatricians at the district level, the State recruited and trained graduate medical doctors, including existing government graduate doctors to manage the SNBCUs. A multi-skilling approach was adopted and specialised training was provided to develop a cadre of SNBCU specialists. The doctors were trained in a formal 40-day course in neonatology, specially designed by the senior doctors of Maulana Azad Medical College, New Delhi. Each such trained doctor received on-the-job capacity building training under the supervision of a paediatrician at each location. Furthermore they underwent a 6-day training on Standard Operating Procedures and operation of SNBCU equipment. This can be considered as an example of special planning effort for addressing an identified need.

Special Cadres

There is no formal system for understanding and estimating the emerging need for special cadres. However, several processes have been initiated to recruit and retain special cadres. For instance, there is a system in place for recruiting and retaining specialist doctors, though the need for programme managers or MIS specialists is yet to be identified. Similarly 'Feeding Demonstrators', medical and paramedical staff to manage the SNBCU and Nutrition Rehabilitation Centres, and family welfare counsellors are some of the new cadres included in the health service provider list of the state.

The government has implemented specific interventions to recruit specialists and make them available in rural areas. Recruitment is aided by lowering the entry level barriers (example: qualification, age, and duration of experience may be lowered), and special walk-in interviews are organised at the district level. To facilitate posting and retention in remote and hard to reach areas, a 'Difficult Area Allowance' is offered to all cadres and in addition a 'Performance Allowance' is made available to the doctors.

The Budgeting Process

The funds received from state and NRHM budgets are allocated by the State Health Department to recruit and retain Health HR. However, currently several staff positions are financially supported by development partners such as Technical Assistance Support Team of UKAID (United Kingdom AID) and UNICEF.

5.1 d. Challenges

As MP is a large state, recruiting, posting, and retaining doctors (both specialists and graduates), poses a big challenge to the other challenges include:

Gap between requirement and availability of doctors:

A large gap between the requirement and availability of doctors exists, and their willingness to work in the rural areas is waning. The few doctors, who opt for careers in the government sector for placement, either at the state or district level hospitals, use political clout. The Health Department has responded to this situation and taken steps to promote careers in the government sector with the following initiatives:

- The government permits doctors serving in government hospitals to maintain a private practice as well

- Special incentives have been created for serving in remote and hard to reach areas

- The GoMP has reiterated its commitment to improving Health HR in the government sector by introducing the re-allocation norms. This move aims to eliminate external and unethical influences to transfers and postings

Shortage of medical colleges:

The shortage of medical colleges, the source of future doctors, is yet another challenge. The State had five medical colleges and in the last two years, establishment of private medical colleges have been approved to improve future availability of doctors. The government has piloted various measures to address the adequacy of doctors, the key among them include:

- Posting of contractual doctors at higher remuneration to fill the rural vacancies through NRHM funds and organising walk-in interviews for them

- Increasing the retirement age for practicing doctors from 60 to 65 years

- Introducing two-year work bonds for graduating MBBS students to enable completion of internship

- Providing doctors in the government service preferential admission to post graduate courses

- Mandating six-month rural posting for all MBBS students as a requirement for completing graduation

- Posting AYUSH Doctors in rural health facilities to ensure availability of doctors and provision of basic health care in their respective systems of medicine

- Increasing the under and post graduate seats in the medical colleges

These measures have given mixed results as they were intended to be short-term strategies to overcome emergent needs. The Health Department does not have adequate capacity for HR planning and does not have internal HR professionals. A capable and full-fledged HR cell/unit is required to develop a comprehensive and long-term strategy to address health workforce in the State.

5.2 Kerala Health Department (including NRHM sub-department)

Kerala is a relatively smaller state than MP and is divided into 14 districts. Kerala has achieved good health indicators compared to other Indian states. It has become important to sustain the achieved levels of success at a time when the State is facing the emergence and re-emergence of some of the communicable diseases along with problems resulting from the epidemiological and demographic transition.

The state health infrastructure includes:

Facility	No.	Beds
Teaching Hospitals	13	10,674
General Hospitals	12	4,866
District Hospitals	15	4,854
Speciality Hospitals	19	5,740
Taluk Hospitals	80	9,502
Community Health Centres	230	6,527
PHCs (24x7 and regular)	835	5,525
Other Institutions	19	198

Kerala became the first state in the country to initiate administrative decentralisation in an extensive way including that in the health sector. All health care institutions except general hospitals, women and children hospitals, and speciality hospitals have been transferred to the three tier Panchayati Raj Institutions and up to 40% of the planned fund of various sectors including that of health sector.

5.2 a. Planning Process

NRHM requires that states decentralise the process of planning to the district and block level, such that local needs are identified and approved by the state. 'Establishment Units' have therefore been constituted in Kerala at each level—state, district, and facility. However, a distinct HR cell/ unit or dedicated staff members for HR Planning does not exist. The Deputy Director of Planning within the Department of Health is responsible for HR planning, although this position has additional functions.

Person	Responsibilities
Director of Health Services (DHS)	Appointing medical officers
Additional Director	Managing HR functions
Establishment Division	Supporting the Additional Director, looking after appointments and transfers. The division is staffed with a clerk, a junior superintendent, and/or senior superintendent
Nursing Section	Posting of nursing staff

The District Medical Officer (DMO) does not have control over the HR deployment in urban areas, as urban health delivery is not within the ambit of the Director of Health Services (DHS). This is cited as one of the reasons for re-emergence of dengue epidemics in the urban areas.

The NRHM PIP is prepared and approved annually and the HR requirements are included in the PIP. There is a proposal to plan HR requirements for a period of 2-3 years, as annual planning is considered to be a short-term measure. Planning for HR is done bottom-up, starting from the facility level. The demand for a creating a new post is sent by the facility head to the District Medical Officer (DMO), who analyses it and sends to the Director of Health Service, who in turn presents the evidence for the requirement to the Principal Secretary for approval.

To summarise, the HR planning in the Health Department occurs at three levels – state, district, and facility. Leadership at the facility, district, and state levels are involved in the planning process. The cycle of planning is annual. However, there is recommendation for shifting to a longer term planning process.

5.2 b. Basis of Planning

Planning is facility based, not population based, particularly for doctors. Planning is done based on the vacancies in the facilities, using IPHS norms as the benchmark. This system is not responsive to the local situation, especially in tribal and coastal areas, where it results in a mismatch between actual requirement and norms. These areas need customisation to access the unreached populations.

The State relies on manual records and databases to develop HR plans. The State does not have an electronic database of HR in the government sector yet. The other tools employed in HR planning are described in the ensuing section.

5.2 c. Micro Planning (Recruitments and Budget)

Estimating HR Needs (Number and Skill Set)

The State has defined a staff structure which is filled through the recruitment process. Each cadre further has a defined number of staff members. The cadres include:

- Administrative cadre
- Specialty cadre
- General cadre
- Administrative staff
- Paramedical staff
- Field staff
- NRHM staff

The State uses a bed-capacity-based system to create new positions. An increase in bed capacity leads to the creation of a post. This system is perceived as rigid, as it does not respond to actual (population-based) needs. However, population-based planning is carried out for lower level cadres such as, the Junior Public Health Nurse. Staff nurses and doctors are recruited on the basis of either sanctioned bed strength or in case of introduction of new services. The paramedical staff members are recruited based on the workload and facility capacity.

Recruitment and Deployment of Health HR

The Government of Kerala does not have a distinct HR Management Unit. Each department recruits through the Public Service Commission (PSC). However, there are Establishment Units that handle the administrative functions of Human Resources, particularly transfer and posting. The state DHS and DMO, who are the appointing authority in the State, send a list of requirements to the Public Services Commission (PSC) when a vacancy arises. The role of the PSC is limited to selecting the candidates and the appointment orders are issued by the appointing authorities. While the department is able to fill most positions through the PSC, it is not able to fill the position of doctors. The department therefore resorts to temporary appointments. The State further

appoints contractual staff under the provisions of the NRHM. The process of selection for doctors involves:

- Approval of positions and budgets under the PIP
- Release of a government order which contains the approved qualification
- Advertisement and receipt of online applications
- Verification of qualification
- Written test and short-listing followed by an interview
- Final selection by the Institute of Management in Government (IMG); IMG and NRHM staff are members of the interview board

The district-based PSC supports the recruitment of all other paramedical workforce, such as the staff nurse, pharmacist, and radiographer in each district. NRHM has also provided the opportunity to outsource HR intensive services security, hospital cleaning, biomedical waste management and disposal, and ambulatory care. This process has been decentralised to Chief Medical and Health Officer, who is the designate contracting authority for outsourcing.

There are no efforts or initiatives currently to revise the HR recruitment and planning processes or create linkages between medical education and HR planning.

Special Cadres

Kerala faces a challenge in posting doctors to serve in hilly and remote areas. To overcome this challenge the State has instituted additional remuneration with support from NRHM. When the State is unable to fill the position despite offering additional remuneration, a doctor already serving in the vicinity is identified and paid additional remuneration to service the area in question.. Graduate doctors often take up contractual postings in the rural health centres, attracted by better salaries and the extra time they gain to prepare for post graduate exams. This scheme has been met with a good response in the State. Although the retention of contractual staff is a challenge, it circumvents procedural delays and makes HR available in a short period of time.

5.2 d. Challenges

NRHM provides the funds and the system to attract health HR at higher remuneration packages, with shortened procedural systems. However, the State continues to face challenges such as:

- Rural area recruiting: Recruiting health personnel for rural areas such as Idukki and Wyanad
- Political influence: Plays a significant role in postings and poses yet another challenge in distribution of the workforce
- Lack of reforms: It is vital for the State to consider cadre reforms to respond better to emerging needs
- Absence of right skills: People involved in administrative work lack the right set of skills and need to be trained and inducted into the cadre early, they need to be nurtured as able administrators

5.3 Indian Railways

The Health Directorate of the Railway Board controls and supervises the Medical Department of the Indian Railways. The Indian Railways is divided into 16 zones. Each zone is under the administrative control of the Chief Medical Director (CMD) who is supported by the Chief Health Directors in some zones, about two to three Deputy CMDs and a few Group B officers.

The zones are further divided into divisions and headed by the Chief Medical Superintendents. In some places however, Senior Medical Superintendents are in-charge.

Indian Railways has a huge independent healthcare infrastructure which caters to its employees.

There are 125 Railway Hospitals and 133 private recognised hospitals under the Railways. These hospitals have a total bed capacity of 13,969 beds. The workforce consists of 2,506 Medical Officers, 194 Group B officers and 54,337 non-gazette cadre staff members.

5.3 a. Planning Process

The Indian Railways is a commercial entity and a self-financing government department. It allocates a separate budget annually and therefore carries out HR planning more on the lines of a business plan, as opposed to the HR recruitment plan elsewhere within the government. Details of levels and processes of HR planning could not be discerned, as the respondents of the study were not forthcoming.

5.3 b. Basis of Planning

The discussions revealed that HR plan is developed on the basis of standard government norms. The annual budgeting exercise caters to the gaps occurring due to retirements and resignations. Recruitment is also done as per government norms but procedural delays are reduced to the minimum. Initiatives for curtailing the expenditure on HR are in the pipeline and include paying private specialist doctors on case-to case or on-call basis.

The Railways Health Directorate regularly monitors gaps in service delivery and plans HR components to sustain the effectiveness of services. Some examples are shared here. The sanitation of all major stations was entrusted to the Medical Department and the Chennai Division managed this by creating additional posts of Health Inspectors to address the additional work. Doctors in hospitals which lack specialists have been connected through telemedicine mechanisms to specialists in larger hospitals to bridge the gap.

To summarise, the levels of planning or the approaches employed could not be identified. The number and kind of health HR however, follows government norms.

5.3 c. Micro Planning

The Indian Railways recruits full time medical doctors and paramedical staff for the hospitals. In addition, specialists are empanelled and provided remuneration for services rendered. The honorary visiting specialists are paid Rs. 20,000 for providing services for 6 days and Rs. 7,000 for providing

services for 6 days, per month. The organisation has invited specialist doctors from the private sector for consultations and surgical interventions on case-to-case basis.

The remuneration packages for anaesthetists, ayurvedic, and homeopathy doctors have been revised to fill emerging vacancies. The services of specialists, super specialists, and dental surgeons are made available through contractual

appointments, and by providing higher remuneration and additional transport allowance.

5.4 d. Challenges

The organisation faces the challenge of recruiting and retaining specialist doctors. Several systems, as discussed in the previous section, have been put in place to overcome this challenge.

6. Findings from the Private Sector

This study researched and explored HR planning systems in two private hospitals:

- Chirayu Medical College and Hospital, Bhopal
- Jawaharlal Nehru Cancer Hospital and Research Centre, Bhopal

Both private hospitals were not forthcoming with information on their HR planning process and budgets. This can be considered a natural response given their interest in retaining a competitive edge among other market players. We have shared the limited information that was collected from private sector hospitals in this section. The HR planning process is well-established in the private hospitals. There is a dedicated HR cell which is responsible for identifying HR gaps and needs, and initiating action to fulfil them.

6.1 Chirayu Medical College and Hospital, Madhya Pradesh

The hospital was established 15 years ago and has been operational since. It has a capacity of 100 beds. In light of the government's interest in expanding medical education facilities in the

State and the resultant invitations to the private sector to establish medical colleges, the Chirayu Group has started a medical college as well.

6.1 a. Planning Process

The hospital is led by the Chairman, who is supported by the Medical Director in performing administrative and financial functions. The hospital has a dedicated HR cell. However, each department within the hospital acts as a unit of planning. The HR cell is composed of a HR manager with post graduate qualification in HR, three HR executives with relevant qualifications or work experience, and two computer operators for clerical and data entry activities.

Each department initiates the recruitment process and submits a justified requirement to the HR cell. The HR cell collates information pertaining to personnel requirement, training needs, and performance reviews from various departments. Subsequently, the cell processes all the requirements and presents the collated needs to the senior leadership during monthly meetings for approval. In essence, staff members of each department and management personnel are involved in the HR planning processes.

6.1 b. Basis of Planning

Business is the driving force behind HR planning. Recruitment is guided not by norms but by the need. The process of estimating requirements takes factors such as workload, prescribed minimum Indian Medical Council norms, increase in bed capacity, and attrition into consideration.

6.1 c. Micro Planning

Recruitment is a self-feeding model as the medical college ensures human resource availability. The medical and the nursing college faculty provide Chirayu an in-house capacity for training. There has not been a need for any specific or special cadres so far. However, the organisation is cognisant of such requirements emerging in the future.

6.1 d. Challenges

The hospital has not faced any challenges in recruiting and retaining doctors as it is located in the capital city of the state.

6.2 Jawaharlal Nehru Cancer Hospital, Madhya Pradesh

Jawaharlal Nehru Cancer Hospital in Bhopal specialises in cancer treatment and has a capacity of 100 beds. The hospital headed by a senior journalist is managed by a trust. The organisation is driven by the motto to serve people.

6.2 a. Planning Process

The Chairman of the hospital participates and monitors the day-to-day activities of the hospital which facilitates performance and commitment among the staff members. Recognising the need to manage HR issues promptly and efficiently, the hospital has established a small HR cell, which is housed in the administrative wing of the hospital. The cell, comprises five dedicated HR staff, and is responsible for planning and implementing staffing needs and procedures.

Each department within the hospital carries out HR planning, which is collated to develop an operational plan at the hospital level every month. The HR cell develops a training plan based on articulated needs of the department and conducts regular Continuing Medical Education (CME) sessions to keep the staff updated with technological advancements.

6.2 b. Basis of Planning

Managers of each department decide the HR requirement based on workload and emerging gaps and submit a requisition to the HR cell. The cell assesses each department's requirements independently.

6.2 c. Micro Planning

The staffing structure of the hospital is as follows:

Management — Specialist Doctors - Medical Officers - Staff Nurses - Ward Boys - Sub Staff

Adequacy of staff is maintained to achieve and sustain patient and employee satisfaction. New personnel are recruited when a new function, equipment, or department is added to the hospital. The additional workforce for the new functions is planned and recruited before the new functions are introduced. Task shifting is employed to meet staffing needs in the short-term. It is however, a temporary approach as the hospital recruits additional staff as a long-term measure.

6.2 d. Challenges

A general shortage of cancer specialists poses a HR planning challenge for the hospital. The respondents did not share any measures to counter the challenge.

7. Findings from the NGO Sector

This study reviewed the HR practices of three NGO-managed hospitals as well. The respondents were more forthcoming in sharing their HR practises and offered several positive experiences that can serve as a model for the public sector.

7.1 Aravind Eye Care System, Tamil Nadu

Aravind Eye Care System is an assemblage, which includes eye care hospitals, a research institute, a manufacturing lab, and an eye bank among other structures. Established three decades ago with the mission to eliminate preventable blindness, the system offers free and low cost care. The organisation has a network of 10 hospitals and the main hospital is based in Madurai, Tamil Nadu.

7.1 a. Planning Process

The leadership and hospital-wise structure of HR is as follows:

The Chairman leads the system and is supported by Directors in overall administration of the group of institutions

The directors include:

• Chief Medical Officers (CMOs) of Hospitals

• Directors: Medical Education, Finance, Projects, and HR

• Director, Mid-Level Ophthalmic Personnel (MLOP), who reports to the HR Director and the Chairman

Each hospital is staffed with:

• Doctors – 10–20% of the staff

• Para Medicals, also called MLOPs, – 60–65% of the staff

• Administration and support staff

HR planning is decentralised and each hospital has its own HR/personnel department. The HR planning, which is carried out in an annual cycle, is initiated at the hospital level. This is followed by a central consultative workshop to finalise the requirements. Each department and hospital carries out a strategic planning once in two years. The operational planning occurs quarterly.

7.1 b. Basis of planning

The departments and hospitals utilise various parameters pertaining to patients and personnel to develop the HR plan. The parameters include:

• Disease burden

• Medical and surgical intervention required

• Patient inflow

• Waiting time

• Availability of staff

This is a good example of Evidence Based Planning. The Mid-Level Ophthalmic Personnel (MLOP) approach is another example of good HR practice – task shifting – which results in the efficient use of the specialist doctor's time. The MLOPs perform majority of the routine tasks and reduce the burden on doctors, therefore, making the system cost-effective.

7.1 c. Micro Planning

Estimation of HR requirements

Each hospital and department estimates its human resource requirement independently. The broad structure of the HR within each hospital is as follows:

Doctors and fellows	Paramedical Staff	Admin and support
Chief Medical Officer	MLOPs	Management
Head of Department	Nurses	Coordinators
Fellows/Trainees	Nursing Superintendent	Directors

The hospitals estimate a requirement of 700 MLOPs annually and this requirement is met by administering a training course free of cost to young unmarried girls from their catchment area. The trainee is inducted into the hospital following the completion of the training course. The trainees work in the hospitals through the duration of the training, receiving practical inputs, and also serve the purpose of additional workforce. This self-feeding mechanism is therefore a pro-active planning model.

Recruitment Processes

The recruitment cycle starts in November/December. The plan is developed and marketing efforts are initiated by February. The marketing efforts include visits to schools in rural areas and orientation to potential students about the training course. Applications for the course are received between March and May. Upon the declaration of secondary schools grades, the selection is finalised through a structured interview process. The course starts in July.

Criteria for selecting of MLOPs:

- Age: 17–19 years old

- Should have completed secondary plus examinations

- Ranking based on marks

- Science students are accepted for clinical courses, whereas students from the humanities and commerce streams are accepted for non-clinical activities

The Aravind Group of Institutions have a value-based interview process. The girl's parents participate in the interview. The interview assesses the person's observation capacity and thought process. The selection process makes a special preference for girls who lack access to higher education. This process is credited with low turnover rates (15%) that the hospitals experience.

Criteria and process for selecting doctors:

The hospital scouts for doctors from premier medical institutions

Doctors are invited to visit the hospital for a period of two days to observe and understand the potential workplace. While the potential employee gets an insight into the advantages and disadvantages of working with Aravind hospitals, the organisation also learns about the potential employee through a feedback process from the staff. The feedback includes the potential employee's attitude and behaviour. This is followed by an interview process which includes as assessment of the value fit

Doctors at entry level are recruited through:

- Post graduate fellowships (two-year training for specialised training)

- Younger individuals are preferred, as that allows Aravind to groom them in its core values. (Post graduate – MBBS)

- In summary, while selecting a candidate, the emphasis is on both qualifications and the value base of the candidate. The system has resulted in less than 5% turnover. More than half of the doctors who undergo post graduate training in the Aravind hospitals choose to continue their careers with Aravind

The senior positions are generally filled internally

Special Cadres

The MLOP programme is a unique approach to developing and recruiting human resources. Task shifting is the key element of this programme. The MLOPs are paramedical staff members who

manage most of the non-specialised functions, leaving the doctors free to provide specialised services. The tasks include explaining procedures to patients and carrying out vision tests. The fellows/trainees also perform these tasks through the duration of the course, albeit under the supervision of a senior medical officer.

Budgeting Process

Aravind does not have a system for budgetary planning as they experience a healthy market growth (5–10% annually) and are financially stable. About 90% of their budgets are spent on inputs such as electricity, salary, and equipment. They finance the entire process internally.

7.1 d. Challenges

The Aravind Eye Care System has been implementing comprehensive HR initiatives through innovative and self-feeding plans. In addition, the emphasis on core values ensure that the organisation experiences very little turnover. The strategic team at Aravind articulated the following concerns for the future:

• Competitive salary structures at other institutions

• Waning interest in applying for the position of MLOP due to increased opportunities from other sectors and bank loans for higher education

• Need for retention and renewed training strategies

7.2 Karuna Trust, Karnataka, and Other States in India

Karuna Trust is a Public-Private-Partnership (PPP) model, that helps leverage the government's significant investment in public health care infrastructure by complementing it with a socially committed, not-for-profit and professionally competent management team.

The Trust manages 72 Primary Health Care Centres (PHCs) in eight states — Karnataka, Andhra Pradesh, Orissa, Arunachal Pradesh, Manipur, Maharashtra, Meghalaya, and Rajasthan.

Through PHCs it manages more than 1,000 health care professionals — doctors, nurses, and staff who reach out to over 1 million beneficiaries.

In addition, the Trust runs a ANM Training School which partners with and trains NGOs to scale up and sustain activities across the country.

7.2 a. Planning Process

HR Planning is decentralised to the level of PHC. Recruitment is done locally for each PHC and the Trust follows the government norms for staffing and financial compensation.

7.2 b. Micro Planning

Each PHC, as per the government norms, has the following staff members:

Personnel	Strength
Medical Officer	2
Pharmacist/compounder	1
Driver	1
Staff Nurse	3
Lab. Technician	1
Accountant	1
ANM	5
Class IV	1
Total	14

The Central Government periodically reviews the staffing norms and modifies it based on the requirements. In addition, funds from NRHM are utilised to recruit and retain contractual staff to address deficient areas of health delivery.

The medical officers and nursing staff are recruited by the Office of the Health Commissioner, State Government. The contractual medical personnel are recruited locally by the Medical Superintendent of the Community Health Centre/Chief District Health Officer (CDHO) of the district/Regional Deputy Director (RDD), Health. All other staff members are recruited by the CDHO of the district and RDD, Health.

mechanism. The divisional level appointments are conducted by the 'Rogi Kalyan Samiti' and the employee administration is as per Indian Public Health Standards.

The system of management by the Trust ensures that:

- One medical officer and one nurse are available at all times at the PHC

- One medical officer and three nurses are available on call on a 24X7 basis

- Staff members are available to attend any emergency at all times beyond the normal Out Patient Department (OPD) or working hours

- PHC is guarded by security personnel, 24X7

Additional Trust employees are posted to supervise the PHC staff. However, this varies depending on the region of implementation. The PHC may receive supervision from one technical supervisor and one administrative supervisor. The Karuna Trust has initiated multi-tasking as there is no provision for hiring specialists. For instance, managers are trained to carry out financial and HR activities.

7.2 c. Challenges

The overall dearth of doctors, especially of allopathic doctors in the north eastern states, poses a challenge to recruitment and retention.

7.3 Lourdes Hospital, Kerala

Lourdes Hospital is a faith-based hospital and presented us an opportunity to review HR practices driven by a different set of ideals of management and planning. Established in 1960, the hospital has a capacity of 650 beds and has a traditional 'missionary hospital' approach to management. Keeping with the changing times, however, the hospital introduced systemic reforms in the last decade, which resulted in the establishment of a personnel department.

HR planning is carried out by each department on the basis of the patient load, both in-patient and out-patient. The HR needs are estimated and new recruitments are planned by the personnel department. The number of nursing staff members is determined using the nursing council standards as the benchmark. Attrition, resulting from overseas opportunities, is a major challenge faced by the hospital. However, the hospital has not articulated a structured plan to address this situation.

8. Summary of Lessons Learned

Human resource management suffers from inadequate planning in most health systems, as identified by this study. While the private and NGO sectors have mechanisms ranging from rudimentary to comprehensive instituted for planning, many efforts at planning are influenced by a perceived crisis. Especially in the government system, one witnesses a lack of sustained support for planning. This is compounded by a lack of adequate HR capacities among people designated to lead planning within the health systems and a base of evidence which can be leveraged for planning. Some of the key lessons learnt from this study are presented here.

Health HR planning has to be led by a team of qualified HR professionals:

It is evident that the planning process has benefitted from the presence of HR cells in the private and NGO sectors studied under this effort. A team of qualified HR professionals designated with HR functions helps overcome the ad-hoc nature of HR planning and implementation. The HR teams/cells can not only plan based on evidence, but also generate evidence and inform policy makers facilitating resource inputs for HRM.

Evidence-based health HR planning facilitates programme outcomes:

As reported by this study, the private and NGO sector organisations are clear about their HR requirements in terms of quantity and quality. The government health systems follow norms which are derived from the past. The first requisite of planning for HR is to understand the need. The diagnostic studies that are carried out must inform the policy makers about current situations and future requirements as well. For example, while it is important to understand the availability and distribution of maternal health workforce (a current priority), it is equally important to understand the availability of specialist nurses who can cater to the emerging burden of non-communicable diseases. Another example is keeping track of growing patient inflow immaterial of the bed capacity to enable provision of proportionate HR.

Link need for HR adequacy with education system:

The example of the Aravind System demonstrates how the need for MLOPs is met through the mechanism of training young girls in the profession. Government health systems can benefit by linking reforms in medical and paramedical education to ensure adequacy of health HR within the sector.

Adequacy can also be ensured by multi-skilling and task shifting:

There is global evidence to this fact. The first point of contact for a patient in most western health systems is the nurse practitioner, thus reducing the need for the high-cost, less available doctor. The Aravind system demonstrates how the time of the specialist is efficiently utilised by training MLOPs in regular and less skilled tasks.

Availability can be enhanced by adequate linkages to incentives and supportive supervision:

While some form of incentive is available in most Indian health departments to encourage HR availability in rural remote areas, this is not fortified by provision of a supportive work environment or supervision. The Karuna Trust is a good example of how teams in remote areas are provided adequate support in addition to incentives (within the government framework) to enhance sustained availability of HR in difficult situations. This study explored capacity building and performance management in the Armed Force Medical Services (other reports in this series), and found similar instances of how medical officers are trained and supported to function in various difficult situations such as mountain terrains, battle grounds, and many more, exemplifying the need for a comprehensive strategy for making HR available across the geography.

Planning for competency requires comprehensive capacity building policy:

Planning for capacity building is an integral part of HRM planning. It is evident from the study of health systems in private and NGO sectors that capacity building is regarded as an investment and a critical input to achieving the articulated outcomes. Highly trained and capable managers and leadership contribute to quality delivery of health care services. Investing in the capacity building of human resources should therefore be considered a critical function of institutions and organisations.

9. Recommendations for Strengthening the Health HR Planning Processes

The study of HR planning process in public, private, and NGO sectors reveal that similar challenges are faced by the health sector in making capable and adequate HR is available to provide quality health services. While this study throws light on innovative approaches adopted by institutions to overcome challenges, there is a need for comprehensive HR planning effort within the health sector to reach the millennium development goals.

Not only is there a need to meet current requirements, a longer term strategy is required to forecast future HR requirements as well.

9.1 Meeting Current Requirements

The National Rural Health Mission has added more than 82,343 skilled health workers to the public health workforce (2011). The challenge to make physicians available in rural areas or multi-skilling nurses to act as nurse practitioners however, continues.

Responsive Policies

Health is a state subject and the major portion of providing primitive, preventive, and curative healthcare lies with state governments for public health. Many states have adopted various policies and approaches to streamline their HRH in the absence of a dedicated HRH planning and management cell. In the 11th Plan, some states such as Kerala, experimented with a division similar to HRH cell, but have met mixed results. Tamil Nadu on the other hand has a well-planned HRH policy which is supplemented with information from Tamil Nadu Health Systems Project. But no state has a dedicated HRH cell at present.

Studies show that all the HRH interventions, which were implemented individually or in combination,

have had a positive impact on maternal mortality and resulted in a significant decrease in crude fatality rate — an observation in many countries. While in the area of public sector of healthcare there have been substantial policy level changes in India, human resource management will have to be managed strategically and in an integrated manner. Devolution of power and functions to local health care institutions provide resources and flexibility to ensure service guarantee. Some recommendations include:

- State-specific human resource management policy and transparency in management of health cadres is required

- It is recognised that solutions for HRH issues go beyond the health sector and are linked to broader fiscal and financing policies and processes

- Recruiting local candidates and counselling for the location preference is necessary for addressing the distance issue

- Affirmative action for entry of doctors originating from the underserved areas needs to be deployed

- Addressing the proportional representation of staff with a distinct social, ethnic, and gender background in the workforce is also critical

- A coalition of interested stakeholders, including professional associations should be created to promote and influence policy changes. Such partnerships, should be built on mutual respect and include community participation, for example civil society groups, from the outset

- Instead of maintaining the over-staffing trend by continuing to temporarily contract staff members, states could re-organise the human capital they already have. The increased political priority, managerial capacity, and resource allocation will determine seriousness of efforts and future of maternal health in India[xiv]

- The need of the hour is to pool all human resources, such as formal and informal, allopathic and AYUSH, doctors, nurses, and paramedics, in appropriate ways

- By multi-skilling and different types of skill mixes essential health services can be provided even if certain categories of specialist staff are not available

- Innovative public-private-partnerships can avoid duplication of services and resources; telemedicine links can connect rural and remote areas better with human resources in big cities; and powerful incentives can be used to attract talented, young medical graduates to rural areas

- The approach must shift from traditional 'personnel administration' systems to more modern 'human resources development' policies and practices

Gender Considerations

Sociocultural affinities, geographical affinities, power equations, and gender are salient biases that underpin inequities in the workplace, operating via different areas such as promotions and incentives, workload, and postings among others. Gender issues in the form of gender discrimination, stereotyping, marital status, sexual harassment, and family responsibilities present significant barriers to achieving equity and equality within the health workforce.

A specific area of concern is the lack of gender considerations while planning HR requirements. A review of workloads of nurses in West Bengal and Andhra Pradesh by Academy for Nursing Studies & Women's Empowerment Research Studies (ANSWERS), reveals that the current availability falls short of requirement in large hospitals. The IPHS does not give norms for hospitals that have more than 500 beds and serve as teaching institutions, probably because they do not come under public health. However, these hospitals are used for training of nurses and in-service education. Hence, it is necessary to ensure that minimum requirements are met. The Indian Nursing Council (INC), recently (2008) relaxed the requirements for

bed strength of hospitals to have training institutions attached to it in the interest of producing required health personnel as early as possible. The INC adds 30% leave reserve while calculating requirements for nurses. This is important, especially for female-dominant occupations and in particular for nursing where round-the-clock services throughout the year are critical.

| Challenges	Strategic Approaches
Inadequate availability and capacity of human resources, which worsens in remote rural and tribal areas. District leadership lacks capacity in programme management and technical areas across sectors Absence of comprehensive health HR policies in most Indian states	Comprehensive approach to HR systems: - Diversifying human resource needs - Multi-skilling - Rationalisation - Task shifting - Proactive filling of vacancies - Incentive approaches - Recruitment policy - Linking HRMIS to programme management
Retention: lack of responsive mechanisms for - performance management - recognition and grievance redressal	Multi-stakeholder consultation
Absence of gender considerations	A comprehensive framework for capacity building, strengthened training infrastructure, and capacities to ensure capable and motivated staff
Sub-optimal monitoring and utilisation of HR MIS	Gender disaggregated HR MIS

HR and Management Leadership

Public sector enterprises need to progressively invest in strengthening leadership, supervision skills, and autonomy at workplaces in order to improve and sustain the motivation of its health officials. Improving motivation for the health staff also involves issues related to infrastructure, involvement, supervision and monitoring, continuous medical education and training, human resource planning, smooth reporting process, administration and audit requirements, and prioritisation and synchronisation of health programmes.[XV]

- State health directorate should have a full-fledged HR department with specialised staff and dedicated budget [XVI]

- The HR division or cell for HR management should have senior level officers with technical and administrative backgrounds

- The HR Cell should have the powers to change HR rules. It should review, plan, and monitor HR situations [XVII]

- There is also a need for separate cell/divisions for HRH at the central, state and district level [XVII]

- Creation of Nursing Directorate in states would remove bottlenecks of infrequent committee meetings and thus review the need for career promotional opportunities, thereby facilitating retention [XIX]

Recruitment

The single and most obvious sign of an ailing public health system is its burden of vacancies. In the case of the public health system in India, this lack of public health personnel in the public sector boils down to three essential factors – inadequate supply of professionals, recruitment bottlenecks, and poor retention. Organisational factors and reduced incentives contribute to the recruitment bottlenecks and to the difficulties in retention. An obvious solution, therefore, to ensure effective delivery of public health services lies in a proper framework of the public health workforce, their classifications and standards, and their career

pathways and progression. The process of bringing the entire public health workforce under a singular responsibility is a complex exercise. However examples exist globally. (See figure).
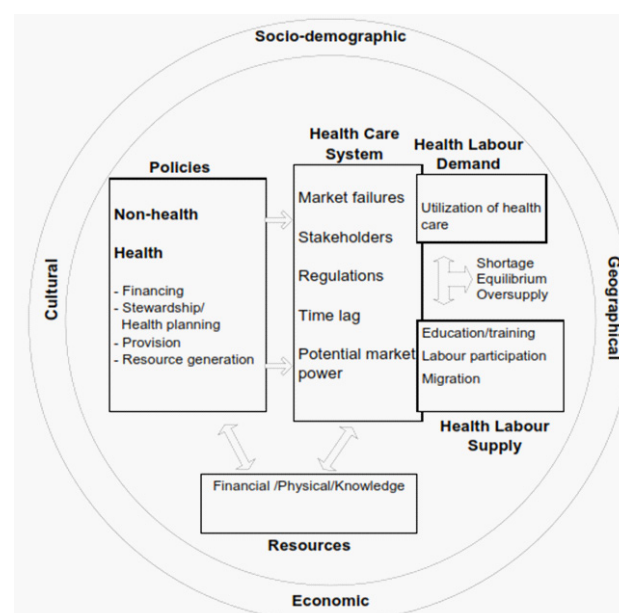
- Existing recruitment rules should be reviewed and modified in the light of changing job requirements

- State governments should avoid ad hoc appointments and regularise the existing ad hoc staff

- Recruitment process must be simplified. It should be done either by the recruiting agency or the department should carry out direct recruitment of technical staff

- The process should be informed by the requisite numbers, the level of attrition, and the current vacancies status [XXI]

- Substantive interventions aimed at building a positive image of government health services among the rural communities as well as a positive image of the government health services would attract new recruitments in rural areas [XXII]

- Decentralised health financing systems can contribute towards health workforce recruitment, performance, and retention [XXII]

- A robust state specific analyses, policies, and action strategies need to be carried out to solve the recruitment issues [XXIV]

Retention

- States should adopt a time bound transfer policy for a doctor who serves in the rural and remote areas for fixed duration, and the transfer should be as per the choice of the doctor [xxv]

- Facilitation of employment of the spouse in the same area and the admission of the children in high quality schools might be an alternative motivation, because increase in pay scale may not feasible by every government [xxvi]

- State government should consider a time bound promotion policy for all staff categories and link the future ones with training, and higher skills relevant to service delivery [xxvii]

- Reserving PG seats for the in-service doctors would also create opportunities for further learning and training for the doctors [xxviii]

- A mix of payment systems and incentives would create a significant change in individual work performance

- A graded salary based on the remoteness and difficulty of terrain /difficult areas with additional benefits would be beneficial in the context of implicit risk to personal security and social isolation by the doctors serving in these areas [xxix]

- Performance-related Incentives are expected to produce positive changes in the government culture and provide an impetus to collaborative goal setting

Data for Planning

Data on human resources in many Indian states are limited, inconsistent, out-dated, or unavailable. Consequently, policy-makers are unable to use reliable data to make informed decisions about the health workforce. Computerised HRMIS enable governments to collect, maintain, and analyse health workforce data. The HRMIS strengthening process consists of four critical steps which include:

- Building HRIS stakeholder leadership

- Strengthening the ICT infrastructure

- Building the capacity to manage the HRMIS

- Ensuring data quality and security

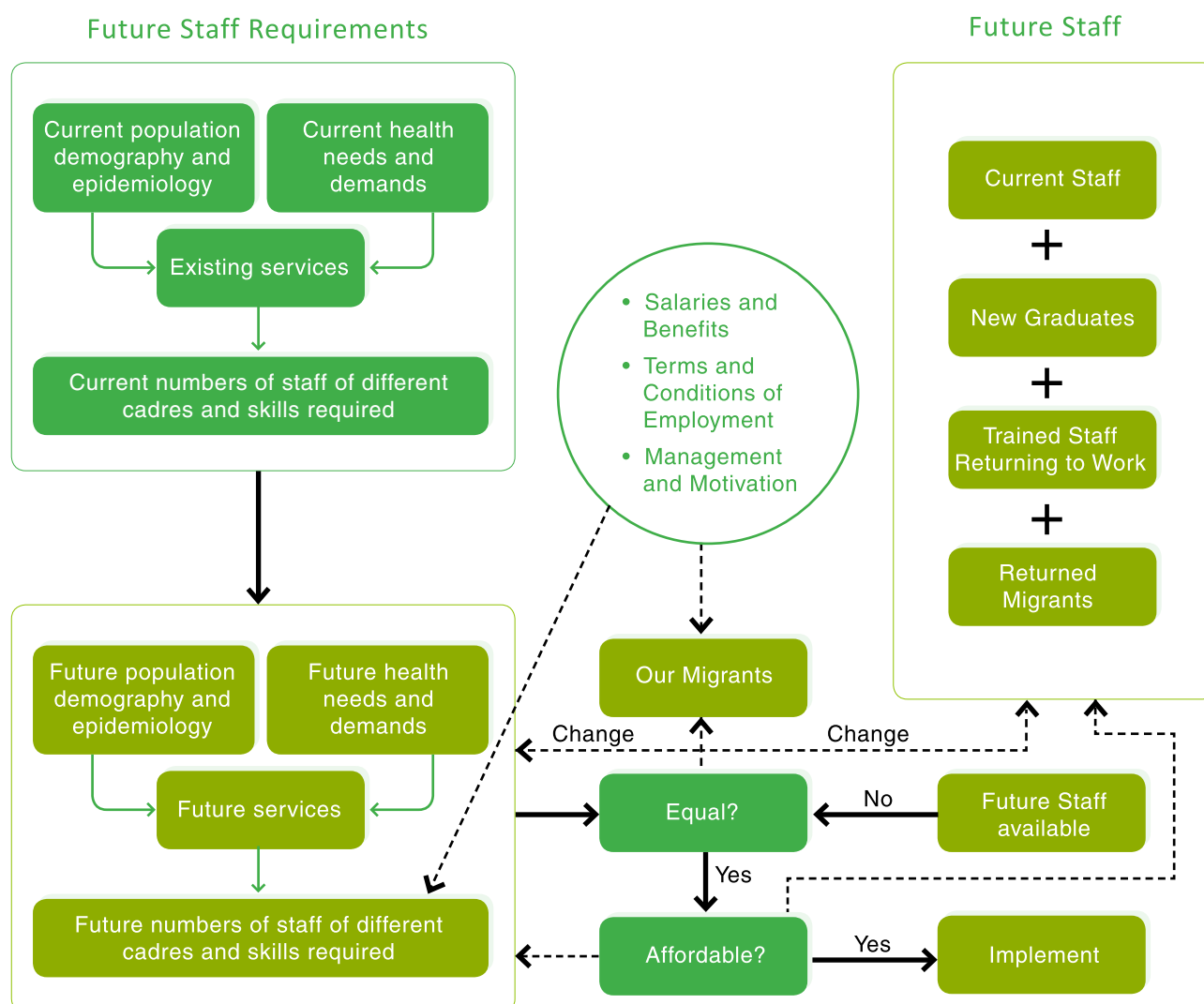## 9.2 Meeting Future Requirements

In the long term, public sector careers have to develop as attractive options for medical and health professionals. There is a need to create and articulate career structures at national, state, and district levels, especially in the public health sector. The options include institutionalisation of a public health service / Indian health service / All India Cadre for public health at central, state, and district level with clear career pathways.

In addition, a structured plan is required to generate and nurture new base of health professionals.

Medical Council of India (MCI) Regulations are being amended to rationalise existing norms to address the shortage of medical colleges. Some of the suggested measures recommended for HR planning (2011) include:

- Establishing Medical Grants Council

- Establishing medical colleges based on gap analysis

- Linking every medical college to the block and making it responsible for overseeing the implementation of national programmes and providing valuable public health experience for students

- Involving the private health care sector in post graduate and specialist training

- Establishing regional centres of excellence to support medical colleges

Planning Workforce Requirements and Supply Projections
(Source: Hornby 2007)

Future Staff Requirements

Future Staff

Current population demography and epidemiology

Current health needs and demands

Existing services

Current numbers of staff of different cadres and skills required

Future population demography and epidemiology

Future health needs and demands

Future services

Future numbers of staff of different cadres and skills required

- Salaries and Benefits
- Terms and Conditions of Employment
- Management and Motivation

Our Migrants

Current Staff

+

New Graduates

+

Trained Staff Returning to Work

+

Returned Migrants

Change

Change

Equal?

No

Future Staff available

Yes

Affordable?

Yes

Implement

Annexure 1: Methodology and Discussion Guide

The study was planned in four stages.

Stage 1 : Inventory of existing best practices in the country

A detailed listing of various initiatives that are relevant to the study was carried out. The list was created with the help of literature review, and consultations with stakeholders and HRH experts. Four regional workshops were conducted as part of the People for Health Project across India from June 2011–12, with stakeholders representing the government and the NGO sector. An inventory was developed consisting of all the policies and government orders, key organisations and programmes from government and non-government sectors, and successful employers (such as the Railways, Military, Wipro, and Accenture, among others).

Best practices were shortlisted from within the inventory based on a set of criteria to select areas for field visit and further learning. The criteria ensured that the sample would be representative of a range of players such as the type of sector, stage of reforms, geography of operation, and government or non-government led programme. The study employed the convenience sampling technique to select the institutions.

Stage 2 : Field level documentation of the selected best practices

The study team visited the selected organisations and programmes between August and October, 2012. The team met with organisation leaders, programme managers and interacted with various stakeholders within the institution to better understand the practices related to HR. A semi-structured interview protocol was used to collect data.

The study used key informant interviews, group discussions, and report reviews as key tools of qualitative methodology. Following the field visits,

a detailed analysis of various learning points was carried out and these were synthesised to arrive at the major learnings from each initiative. This led to the identification of challenges of each programme and distillation of best practices that could be recommended to other institutions.

Stage 3 : Presentation to Partners for Health Team and Project Advisory Committee

The key analysis of the visits will be presented to the Partners for Health (P4Health) Team and the Project Advisory Committee. It will focus on the evolving patterns across the best practices and the recommendations to improve HR practices. This is scheduled to be held in August 2013.

In joint consultations with the Partners 4 Health (P4Health) Team, preliminary strategies will be evolved on what practices work and which ones can be taken forward by other institutions. The team will also look at applicability of these recommendations in the context of different states.

Stage 4: Dissemination and the way forward

The report will be disseminated by the P4Health Team at the national level to Government of India and multilateral and bilateral donors. The emerging strategies for improving HR will be presented and discussions will be held in that meeting on devising short, medium and long term strategies for HR for Health.

Data Management and Analysis

With consent from the participants, the study team recorded the interviews on tape and also took notes to understand emerging themes and patterns in the data. The recorded data was transcribed verbatim. The team conducted a thematic data analysis

manually, which aided in systematising and structuring the data under codes and themes.

Limitations of the Study

Following are the limitations encountered during the course of this study:

1. Time: It took a long time to finalise interview appointments with organisation leaders and managers. The team was left with little time to conduct the interviews. Even during the interactions, the interviewees could spare very limited time

2. Sensitivity of HR issues: Given the sensitive nature of HR issues, most corporate and private run hospitals were unwilling to share their information with the team. This was also true for the non-health corporate sectors

3. Verification of facts: Due to shortage of time and resources, all the facts that were shared during the interview could not be verified. Furthermore, documented information on human resources was very limited

4. Sampling: The team could not meet with organisations that would have benefited this study as the selection of organisations was done largely based on the social capital of the existing team. Contacting organisations where the team did not have direct contacts was difficult and hence, some such organisations could not be included in the study

5. Government information: The HR data received from government departments was disaggregated owing to the involvement of multiple sub-departments in the process of recruitment and management of medical staff. Also, loss of institutional memory resulted in dearth of information (following the changes in informed staff)

6. Meeting with Medical Council of India (MCI): MCI could not be met due to various reasons. Hence, the inputs from MCI on medical education could not be included in this study

References

[i] Models and Tools for Health Workforce Planning and Projections; (Human Resources for Health Observer, 3); WHO 2010

[ii] Health Workforce in India, WHO, India 2007

[iii] Indian Health Workforce: Size, Composition and Distribution by Krishna D Rao, Aarushi Bhatnagar, Peter Berman, Indrani Saran and Shomikho Raha 2008.

[iv] Eleventh Five Year Plan (2007-12) Volume II, Social Sector, Chapter 3- Health and Family Welfare and AYUSH

[v] Experts: NRHM answer to healthcare ills Bangalore, Dec 11, 2010, Deccan herald, national conference on ''Bringing Evidence into Public Health Policy: five years of National Rural Health Mission"

[vi] Human Resource for Health: Human Resource for Health: The Crisis, the NRHM Response and the Policy Options, T.Sundararaman and Garima Gupta

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

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

[ix] Personal communication with Dr M Prasanna Kumar, Ex Addl DGHS Kerala on 3rd Apr 2012.

[x] Human resources for maternal health: multi-purpose or specialists? Vincent Fauveau, Della R Sherratt and Luc de Bernis, http://www.human-resources-health.com/content/6/1/21, Published: 30 September 2008

[xi] Proceedings of Retreat of Health Ministry Officials with Experts, 2011

[xii] Tackling health human resource challenges in India: initial observation on setting priorities for action by: Peter Berman, Shomikho Raha, Krishna D. Rao.

[xiii] Health workforce attitudes towards Rural Service in India: Results from Qualitative Research. November 2010. Krishna D. Rao, Sudha Ramani, Seema Murthy, Indrajit Hazarika, Neha Khandpur, Maulik Chokshi, Saujanya Khanna, Marko Vujicic, Peter Berman, and Mandy Ryan.

[xiv] Maternal Health: Are We Serious?? Prof Dileep Mavalankar, The Nursing Journal of India, Vol C, No.6, June 2009

[xv] Strengthening Human Resource Practices in Healthcare in India: The Road Ahead, Aashima Agarwal, Shalini Garg, Udai Pareek, Journal, Indian Academy of Clinical Medicine Vol. 12, No. 1 January-March, 2011

[xvi] 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

[xvii] Human Resources for Health (PPT), Dr. D. Thamma Rao, Bangalore, Dec 10, 2010

[xviii] National Workshop on Human Resources for Health Options and Challenges 5-6th April 2007, IHC, New Delhi A Report

[xix] Some Priority Challenges of the Nursing Sector in Indiaby: ShomikhoRaha, Peter Berman, AarushiBhatnagar

[xx] 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

[xxi] Challenges in recruitment of doctors by government by: Peter Berman, Shomikho Raha, Krishna D. Rao

[xxii] Why some doctors serve in rural Areas: A Qualitative Assessment from Chhattisgarh State. BY: Dr Kabir Sheikh,BabitaRajkumari, Dr Aruna Bhattacharya, Dr Krishna Rao, Dr T Sundaraaraman,DrGarima Gupta, Dr Kamlesh Jain, Dr PratibhaPatanwar,MahindraGaware, Dr KR Antony.

[xxiii] Emerging opportunities for recruiting and retaining a rural health workforce through decentralised health financing systems Mahjabeen Haji Varatharajan Durairaj, Pascal Zurn, Laura Stormont & Maximillian Mapunda, Bull World Health Organ 2010;88:397–399 | doi:10.2471/BLT.09.072827Introduction

xxiv Challenges in recruitment of doctors by government by: Peter Berman, Shomikho Raha, Krishna D. Rao

xxv 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

xxvi Why some doctors serve in rural Areas: A Qualitative Assessment from Chhattisgarh State.

BY: Dr Kabir Sheikh, Babita Rajkumari, Dr Aruna Bhattacharya, Dr Krishna Rao, Dr T Sundaraaraman, Dr Garima Gupta, Dr Kamlesh Jain, Dr Pratibha Patanwar, Mahindra Gaware, Dr KR Antony.

xxvii 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

xxviii Health workforce attitudes towards Rural Service in India: Results from Qualitative Research. November 2010. Krishna D. Rao, Sudha Ramani, Seema Murthy, Indrajit Hazarika, Neha Khandpur, Maulik Chokshi, Saujanya Khanna, Marko Vujicic, Peter Berman, and Mandy Ryan.

xxix Working Together for Health. The World Health Report 2006, WHO

xxx National Consultation on Public Health Workforce in India A Report, 24-25 June 2009 New Delhi

xxxi Proceedings of Retreat of Health Ministry Officials with Experts, 2011