INTRODUCTION

Human resources are the largest component of health care delivery in India, often accounting for seventy percent of state government health expenditure. National policies and programs, like the National Rural Health Mission (NRHM), have recognized that meeting the challenges of assuring sufficient numbers of well-trained and motivated health workers is essential for improving health outcomes for India’s poor.

But what exactly are those challenges – numbers, location, knowledge and skills, motivation – all of these things? The Joint Learning Initiative framework, referred to in recent NRHM reports, lists nine key areas for action: numeric adequacy, skill mix, social outreach, satisfactory remuneration, workplace environment, system support, appropriate skills, training and learning, and leadership and entrepreneurship. These are linked to three “workforce objectives” – coverage, motivation, and competence. Clearly all are relevant, even important. But change takes time. Skills and capacities to create and manage reform are limited. Where should policy and planning focus attention? The notes that constitute this first volume of India Health Beat attempts to address this question.

APPROACHING PRIORITY SETTING FOR HRH ACTION

Planners of Human Resources in Health (HRH) have used different approaches for determining workforce requirements. The simplest of these are based on explicit norms – for example setting requirements for numbers of workers of different types required for a given population size or setting staffing norms for specific types of health facilities so that the total numbers and types of staff needed are calculated based on the mix of facilities in an area. Staff requirements could also be determined based on average productivity in providing services and associated norms for service delivery targets. These approaches focus attention on the supply of workers and the human inputs needed to produce a supply of services.

More complex approaches try to incorporate population health needs to estimate service requirements and to consider the behavior and preferences of patients and service users that generate demand for services. But health systems are complex. They produce a wide variety of services to meet needs spread across the whole burden of disease. Users’ behavior responds to service-specific as well as system-wide factors. These more complex analytical approaches require much more information about which there can be great uncertainty. In addition, while workforce requirements can be estimated and projected based on such calculations, linking the numbers of workers to their distribution, effectiveness and ultimately health impact also requires consideration of factors that affect the quality of what workers do and their capabilities and motivation to work actively and properly.

Another approach would be to prioritize action strategies on HRH, by focusing on health system performance improvement. As described in Roberts et al (2004), to develop performance improvement strategies, reformers should follow a diagnostic journey which begins with health system outcomes which need improvement and analyzes a chain of causation determining poor outcomes. This chain of causation posits which health system elements, such as HRH, explain shortfalls in performance framed in terms of outcomes such as access to care, quality, and efficiency.

In developing a diagnosis, hypotheses and assumptions about the contribution made by determinants such as HRH numbers, location, motivation, knowledge and skills to the causes of unsatisfactory outcomes, should be made explicit. So should assumptions about the efficacy and cost of strategies to improve these determinants. Working through this kind of diagnostic journey can help set priorities for action in terms of emphasis on different types of health workers and which determinants may be most likely to generate improvements in health system results.

Priority setting grounded in an analysis of performance

1 The World Bank, Washington DC; 2 The World Bank, New Delhi, India; 3 The Public Health Foundation of India, New Delhi
improvement strategies is especially important in situations where the resources and capacities to reform HRH systems are limited – i.e. almost everywhere! In contrast, the norm-based approaches tend either to emphasize only numbers and distribution of personnel or to treat all HRH-related determinants as equally feasible, urgent, and important. The HRH field is very complex with different types of workers, a range of many types of services provided by comprehensive public sector health care systems, and a number of determinants of performance. When capacities for improvement are scarce, lack of critical thinking about which determinants are more important will diffuse efforts and effectiveness.

THINKING ABOUT PRIORITIES BASED ON OUR INITIAL STUDIES OF HRH IN INDIA

The work described in the following notes (nos 2-6) isn’t sufficient to develop a comprehensive diagnosis for setting priorities for HRH action to improve health system performance in India. It is unlikely that a single diagnostic analysis would be sufficient to address the complexity of health problems and HRH-related causes of poor performance. In addition, this work really should be done in collaboration with those who understand best the feasibility of different interventions and their potential impact. In India, this is likely to be administrators and HRH stakeholders at state and district level.

We can still summarize some preliminary observations from our studies which may guide in setting priorities as well as topics for further investigation and analysis. These are:

- For most MDG-related health outcomes, the higher clinical skills of physicians as front-line service providers are not required. Evidence suggests that recruiting and retaining physicians to serve in lower level health facilities in rural areas will be very difficult given both the physical conditions in those areas and the expectations and attitudes of medical graduates. Efforts to address numerical adequacy and retention of HRH in rural areas should not focus primarily on physicians.

1 While non-physicians like GMs are more receptive to government and rural postings, their training and skills and professional status are not today well-suited to their functioning as independent clinical providers and service managers. Strategies to increase HRH using...
non-physicians as providers and managers need to do more than just focus on recruitment and retention. New types of workers may be needed which would require developing new training programs, cadre rules, and professional institutions. Addressing this requires a broader approach than just expanding contract worker opportunities, increasing sanctioned posts, or building nursing schools.

- Inadequacy in support functions like facility management, supplies and logistics management, accounting, and public health planning at state, district, and block level are a major constraint to more effective service provision. HRH strategies should not focus on increasing HRH service providers only or even primarily. States need to couple efforts to increase service providers with committed efforts to develop HRH strategies for support functions.

- HRH issues need to be addressed primarily at state and district level, since states have the primary responsibility for HRH in the sector. The institutional environment for planning and decision making for HRH is dysfunctional in many states, especially in the lagging states. Investment in strategies to improve HRH in states needs to include analysis of institutional aspects and to couple increasing resources for production, recruitment, and retention to address HRH needs with incentives and conditions for bringing about institutional change. State-specific analyses and strategies should be developed. These could be based on the performance improvement approaches sketched out above.

- Earlier research has emphasized the importance of governance-related factors in determining human resource performance. Studies have reported high levels of absenteeism in government health facilities and weak enforcement of the labor contracts of government health care providers. There are widespread reports of sizable informal payments for preferred postings and transfers in many states. Many officials complain about how these undermine efforts to establish a merit-based reward system. Our studies have called attention to the need for formal institutional reform. But these problems go beyond those of formal institutions. Addressing them will require strong leadership and enhancing a culture of transparency and accountability in public service in health. These are important priorities as well, and amenable to research and dialogue.
Emergency obstetric services may be an important exception to this. Public-private partnerships, like the Chiranjeevi scheme in Gujarat or Janani in Bihar, may provide an alternative approach (see references for links).

REFERENCES
Chiranjeevi Yojana: gujhealth.gov.in/Chiranjeevi%20Yojana/M_index.htm
Janani, Bihar: www.janani.org/home.htm

For further information on “Tackling health human resource challenges in India: Initial observations on setting priorities for action” visit http://www.phfi.org or contact Krishna D. Rao, Public Health Foundation of India, New Delhi at kd.rao@phfi.org

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