Medical Students Association of India

POLICY DOCUMENT

Health Workforce in India

Policy Proposer: Simran Garg, Sanjana Taneja (SCOME)

Policy Coordinator: Sri Hari Govind, Poorvaprabha Patil

Policy Statement

Introduction
The truism that 'there is no healthcare without the workforce' is universally acknowledged but poorly acted upon. The Government of India spares just 1.35 % of the GDP for public healthcare[4], as opposed to the global average of 6 %. On average, a government doctor serves a population of **10,926**, more than 10 times than what the WHO recommends.[5] India is training new doctors and nurses at a rate of 76 thousand and 125 thousand nurses per year[8], respectively. However, with India's rapidly increasing population these numbers fall short. Beyond the numbers, maldistribution and migration (international and private) of workers due to a variety of reasons, including poor working conditions and poor pay, place us further away from achieving UHC. Without adequate and relevant interventions to set up and scale up healthcare educational institutes to train at least 2 million doctors by the year 2030, India will continue to linger on the brink of a crisis.

MSAI Stance
MSAI affirms that the health workforce forms the backbone of healthcare systems and plays a crucial role in achieving Universal Health Coverage (UHC). In order to strengthen the healthcare system of the country, we acknowledge the need for a multi-sectoral approach, with social responsibility on the part of each stakeholder. The need of the hour is to increase the number of professionals while enhancing and maintaining the quality of care, and ensuring improved distributions of healthcare professionals, as well as equitable distribution of healthcare resources. Saying this, we also recognise the responsibility of the various stakeholders to cater to the needs of healthcare professionals.

Call to action:
Therefore MSAI calls on:

Central Government to:

- Increase the total expenditure for healthcare from the annual budget to meet global average of 6% or higher while ensuring better funding to the healthcare education and healthcare delivery systems
- Improve working conditions for health workers, including better access to personal safety, security and better timings
- Effectively train community workers and primary healthcare providers to raise their level of competency and credibility to rebalance healthcare tasks and develop models of care that enable all healthcare workers to maximise their competencies and output.
- Encouraging mobilisation of the present health workforce to the public sector and rural areas by adequate incentivization.
- Fostering sustainable Public-Private Partnerships.
- Adopt gender-transformative policies that challenge the underlying causes of gender inequities in the healthcare setups while working towards building a working environment which is equitable and encouraging of women in leadership positions.

State/ Local Government to

- Implementation, monitoring, and evaluation of central policies placed regarding human resources for healthcare.
- Devise and implement healthcare policies based on the needs of the local population.
- Initiate a greater deal of community involvement by giving the community responsibility and power regarding healthcare in their own community

NMC and other councils responsible for Healthcare Education to

- Increase the number of seats while ensuring quality training for all fields related to healthcare, including doctors, nurses and community health workers
- Make sure that the education institutions are aligned with country accreditation systems, standards, and needs.
- Build a strong medical curriculum that includes topics on health inequities and social determinants of health and sufficient knowledge about communities and health challenges, while inculcating principles of social accountability, focus on interprofessional and an integrated form of medical education.
- Providing healthcare workers with incentives in the form of money and kind, improve infrastructure and working conditions in the rural setup, to promote the development of the rural healthcare system.
- Recruit community health workers (CHWs) and the mid-level healthcare providers(nurse practitioners and physician assistants) in the healthcare system to meet the growing but unmet healthcare needs in terms of both number and quality.

Medical Universities/ Healthcare Educational Institutions to

- Introduce social accountability to their system ie providing community based medical education to raise socially conscious and accountable healthcare workers
- Provide a more problem based approach rather than textbook learning and more vertical integration.
- Promotion of mental health and providing counselling for the same as a priority in order to ensure better productivity from pre-service trainees to all practitioners.

Non-Governmental Organisations to

- Establish institutions to fulfill health and social needs of vulnerable communities.
- Recognise the gaps in the current healthcare system and advocate to bridge those in order to avert the global health workforce crisis.
- Funding and volunteering in programs that empowers citizens to help ease the load on the healthcare system
- Ensuring increased community involvement by providing an avenue for interaction of the community with healthcare providers in non formal settings.

Doctors to

- Participate in and develop awareness, education campaigns and activities on the Health Workforce related topics.
- Advocate amongst their own community for health camps or other organized activities for the betterment of community. Active involvement in activities beyond the curriculum, which enhance their skill set as future healthcare providers.
- Working effectively and collectively to ensure a need based approach towards delivery of healthcare, gauging the imminent needs of the population and intervening in areas lacking adequacy in terms of services provided as well as quality of those services.
- Participating in programs like the Vande Mataram scheme that empowers private healthcare workers and institutions to help ease the load on the public healthcare system

Medical Students to

- Participate in and develop awareness, education campaigns and activities on the Health Workforce related topics.
- Acquire evidence-based knowledge pertaining to the Global Health Workforce Crisis and be an active advocate in this field.
- Identify stakeholders and work actively on advocating for the quality assurance and accreditation in Medical Education.

Media to

- Acquire evidence-based knowledge pertaining to the Global Health Workforce Crisis and be an active advocate in this field.
- Broadcast the issue of the crisis to bring this grave issue under the attention of the government and other stakeholders

Position Paper

Background

The health workforce can be defined as “all people engaged in actions whose primary intent is to enhance health” (1) The ability of a country to meet its health goals depends largely on the knowledge, skills, motivation and deployment of the people responsible for organizing and delivering health services. Numerous studies show evidence of a direct and positive link between the numbers of health workers and population health outcomes (2, 3). Human resources are arguably the most essential asset of any system or organization, strengthening the health workforce and addressing the critical shortage must be made a priority in moving towards Universal Health Coverage (UHC).

Manpower for health services is “heart of the health system in any country”. It is one of the most important aspects and critical components of health policies.
It doesn’t just include frontline doctors and other healthcare providers, but innumerable stakeholders, including those responsible for planning and organising healthcare services.
In a country like India, with the second-largest population base in the world, where we see increasing disparities in multiple dimensions of healthcare, we would like to shed light on the multiple aspects through which this crisis can be addressed, possible interventions and a vision to sustain a socially responsive healthcare system while avenging the dire workforce shortage.

Financing Healthcare

India’s spending stands at a **little over one per cent of the GDP** (1.34%). this is poor even when compared to other developing countries, where public healthcare spending stands at around 2 to 2.5 per cent of their GDP and developed countries spend about 5- 6% (4). This kind of funding indicates very little to no improvement in the healthcare system in the years to come as well.

India is a country which has an increasing trend of privatisation of healthcare, leading to increased out of pocket expenditures. The growth of the health sector has been 5 times that of GDP, i.e. the **expenses within the sector are increasing, despite a disproportionate increase in healthcare funding**. There is an urgent need to increase government funding related to the sector in order to cater to a wider population base and minimise rural-urban disparities, leading to better outcomes from healthcare both with respect to patient satisfaction and growth of the system. With various social security schemes already in place, the government needs to invest adequately to optimise benefits from them. The goal of achieving universal healthcare has at its helm the healthcare workforce, however, the optimization of resources including human resources is the way forward. A revamped healthcare financing model can help us achieve our outcomes in a more holistic manner. (12)

Health Workforce Availability

At present, the doctor-patient ratio is 1:1445 against the WHO recommended 1:1000, and the nurse-patient ratio is 1:483 against the ideal 1:4, resulting in the aggregate density of doctors, nurses and midwives to be 2.08 per 1000 population, which was lower than WHO’s critical shortage threshold of 2.28. (5). In addition, due to the increased privatization of healthcare in the country, most of these healthcare workers remain inaccessible and unaffordable to most of the public. Thus the **ratio of government allopathic doctors, which is 10,926:1 patient conveys a more realistic and dismal reality.** (5) There have been efforts to expand the health workforce to meet demand. However, these efforts have been hampered by increases in factors such as the high birth rate, purchasing power for health services within communities, life expectancy. (7)

As per the WHO, the time and money spent by governments to strengthen public and private health sectors are only a part of the solution to the crisis. There is an increasing need for Health Management professionals, in order to be able to use the available resources effectively and achieve measurable results. Through multiple initiatives like the NHM and diplomas in various public health courses, the Government of India has moved towards the development of a strengthened public health cadre, involving more than just healthcare providers. However, the problem of numbers still remains with an existing number of 3463 health management professionals as opposed to a need of 11304.

Health Workforce maldistribution

Imbalanced distribution, especially in rural and remote areas, poses a barrier in access to quality health services. According to the 2011 Census, 68.84% of the population is concentrated in the rural areas and the remaining 31.16% occupy urban areas, whereas approximately 80% of doctors, 75% of dispensaries and 60% of hospitals are located in urban areas,(6) which suggest a need to increase production, deployment and retention of rural-practising health workers of all cadres.

The strongest motivator associated with rural recruitment and retention is rural origins. Working environment, respectability, financial incentives and opportunities for professional advancement represent the other personal, professional and social factors that should be offered to improve the disparity in the health workforce.

In addition, strengthening the existing network of ASHAs and MPWs by equipping them with greater training and responsibilities to bridge the gap between the rural population and the overburdened and understaffed health workforce.

While we take into consideration the growing urban-rural gap in terms of available healthcare facilities, we must also keep in our foresight the concept of access to healthcare, and the idea behind people's attitudes towards healthcare. While there are multiple barriers when it comes to access to healthcare, a very important bias to be considered is the acceptance of the healthcare solutions we offer. Ideal healthcare must be available, accessible, acceptable and affordable to the public. Keeping that in mind, one of the first steps towards narrowing this gap is to address the differences that arise due to issues of acceptability, which translate into issues of compliance. Secondly, we must address the multiple extrinsic factors that lead to decreased access to healthcare. This indirectly affects the healthcare workforce as it poses a threat to the outcomes of healthcare being provided, which in return leads to lesser and lesser people opting for serving the rural areas and furthering decreased funding.

Another aspect of the Health Workforce Maldistribution can be attributed to the increased privatization of Healthcare in India. While Private Healthcare is of arguably better quality, it is unaffordable for low income and to some extent middle income families. Privatisation leads to a steep hike in health expenditures, attributable to the increased costs of medical consultations, drugs and devices, medical tests and hospitalisation.

Health Workforce Production and Retention

The total number of undergraduate seats in India are presently 79,498 which is a 60% increase compared to just six years ago where 49,508 seats were available, nursing seats have also shown a similar trend. However most of the increase was noted to be in Maharashtra and the Southern states whereas in the Empowered Action Group states which account for almost half of the country's population, they still house only approximately one-fifth of the medical colleges and a quarter of the dental and nursing institutes. (8) Furthermore, a major part of these new seats belong to private colleges, which are unaffordable for the population. (8)

In addition, Historical data shows that despite the consistent increase in health-worker production, posts in public-health facilities remain unfilled. Between 2007 and 2009, the stock of health workers, i.e.

doctors, dentists, nurses and midwives increased by 264 225. Over the same period, however, the total number of vacant posts in government health staff positions improved little or increased. This indicates that not only is health worker production important. (16)

One-third of the freshly qualified physicians leave India every year for residency training and/or practice abroad.(10). With 59,523 physicians of Indian origin working in the English speaking Western world (the US, UK, Australia and Canada combined), India is by far the single largest source of emigrating physicians in the world. (9)

Reasons for this lack of retention, popularly termed as “Brain Drain” in the healthcare system can be primarily attributed to the large gap between the number of undergraduate doctors qualifying each year and the number of post-graduation seats available (less than 38 thousand for MD/MS and Diploma(8)) In addition, poor working conditions, including violence against healthcare workers are attributed to the Brain Drain in India.
“Brain drain is defined as the migration of health personnel in search of the better standard of living and quality of life, higher salaries, access to advanced technology and more stable political conditions in different places worldwide.”
One of the principal conduits of permanent migration is the quest for higher education, which along with better incentives leads to people seeking a better life abroad. Targeting these factors with additional investment in infrastructure, education, as well as scientific, technological development, may help us convert this loss into wisdom gain. In addition, the government and relevant authorities must take employee safety as a priority and strengthen laws to ensure healthy and safe working conditions for health workers, with a greater penalty for those violating these.The world is currently seeing changing demographic trends, which in turn are affecting composition and distribution of the health workforce, hence decision-makers need to have a long term vision in order to retain the health workforce while providing adequate incentives while ensuring the development of a socially responsive system. (15)

Quality Assurance in Health Education
While it is necessary to increase the quantity of the health workforce it should not be at the cost of the quality of the workforce.
Reforms in the health sector should not be confined to strengthening healthcare centres alone, it should extend to the roots of healthcare- healthcare education. To ensure that the product of the system is a competent doctor, important inputs, other than curricular reforms are needed to deliver on this paradigm shift from knowledge-based to competency-based education. These include providing required adequate quality facilities and learning opportunities for the learner to practice skills and receive feedback until they achieve the expected level of competencies. There is also a need to sensitize faculty, academic leaders, and policy/decision-makers that we need to move from quality-attainment to quality-improvement.(11)
Social Accountability in Medical Education, i.e. education focussed and relevant to the needs of the population they serve, is one of the most crucial aspects to achieve UHC.

Conclusion
It is a Universal Truth: There is **no healthcare without a workforce**.

What India really needs to achieve Universal Healthcare Coverage is a strong health information system with a strong human resource component that can help build the evidence base in order to plan for availability and accessibility of needed health workers in the right **place, at the right time and in desired quality. (16)**

A fit-for-purpose health workforce should have the competencies and quality standards required to meet the current and anticipated future population needs and achieve the intended policy outcomes. The availability, accessibility, acceptability and quality of the workforce are collectively able to deliver, both

now and in the foreseeable future, effective coverage of the services required: that is, to attain, sustain or accelerate progress on universal health coverage and the principles and obligations of the right to health. (17)

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