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An Exploration Into the Human Resource Management in Public Health Services Of Kerala

Medical Science

KEYWORDS :

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ABSTRACT

The paradox of High morbidity- low mortality in Kerala is a widely discussed observation. One reason for that could be the efficiency of care which cure the disease before progressing to death, which in turn depends on the efficiency of the treating team. This study attempted to examine some of the key aspects related to Human Resource management in the Public Health services.

Published official reports were searched and data gathered related to availability of institutions and manpower in public health care in Kerala. The data was analysed against the actual requirements.

Though actual availability of institutions Kerala state is more than the national standards, there is non-availability of trained staff. There is no paucity of doctors, but it is the paucity of specialists. There do exist scarcity for nurses while the seats in nursing colleges remain vacant.

Growth of health care in the private sector surpassed that in the public sector recently. Small or medium hospitals in the state are getting closed down. Charity hospitals also show same trend. Practices existing in private hospitals were reported to be not conducive for delivering quality healthcare to the stake holders. Decentralised planning failed to improve human resource management. The Cooperative sector have potential in addressing many issues in the field of heath care. But it is yet to prove its effect. Kerala also face increasing feminisation of Medical Profession and resulting issues.

Planned correction of mismatches with in the available institutions, categories of manpower and training facilities are suggested. The need to base it on a robust health policy is highlighted. Strengthening of Co-operative sector, supports for small and medium hospitals and rethinking in workforce planning to ensure gender justice are suggested.

Introduction

Kerala is known for better indices for the status of health. The Kerala paradox of High morbidity- low mortality1 is a widely discussed observation. A simple common sense conclusion which can be drawn from this observation is that people of Kerala become ill in large numbers, but the diseases are arrested before it kills the patient. Just as multiple factors cumulatively cause an illness, multiple factors cumulatively contribute for the recovery. Treatment efficiency is one such factor. However it is not mentioned in research literature.

For decades, the Public Health service was the main provider of health care in Kerala. The functioning of Health Services hence should come into picture when the Health of Kerala is discussed. This paper is not intended to examine the role of Public Health Services taken in the past in improving and maintaining the good health of Kerala's people. This attempt is limited to examining some of the broad aspects related to Human Resource management in the Public Health services. The draft health policy of Kerala appreciates 'Human Resource as the core building block of any Health system.'[2].

This study was aimed to find out the available manpower in the Public health institutions of Kerala at various levels and to analyze it against the requirements.

Methodology.

The official records were searched to gather information related to available institutions for Public health care in Kerala. Only the official reports available in the public domain were used for data gathering. The same method was adopted to collect information regarding available manpower in Public Health Services at various levels.

The Institutions and manpower in the Medical Education Department were not considered as they serve at tertiary level and their goals are different. ESI services also were not considered as they serve to predefined selected clientele. More over State Government policies and programs rarely influence their functioning.

The gathered data were subjected to detailed study by the investigators. The observations are presented and implications discussed.

Observations.

From the table 1, it is obvious that the actual availability of health care institutions in the State of Kerala is more than required according to the approved requirements.

Table 1: Health Infrastructure of Kerala.

Particulars	Required	In position	Difference
Sub-centre	3525	4575	+1050
Primary Health Centre	586	809	+223
Community Health Centre	146	217	+71
Health worker (Female)/ANM at Sub Centres &PHCs	5384	4173	-1211
Health Worker (Male) at Sub Centres	4575	1285	-3290
Health Assistant (Female)/LHV at PHCs	809	795	-14
Health Assistant (Male) at PHCs	809	633	-176
Doctor at PHCs	809	1152	+343
Obstetricians &Gynecologists at CHCs	217	NA	NA
Pediatricians at CHCs	217	NA	NA
Total specialists at CHCs	868	774	-94
Radiographers at CHCs	217	20	-197
Pharmacist at PHCs &CHCs	1026	1027	+1
Laboratory Technicians at PHCs &CHCs	1026	268	+758
Nursing Staff at PHCs &CHCs	2328	2014	+314

(Source: RHS Bulletin, March 2012, M/O Health & F.W., GOI).

There was an excess of 1050 sub-centers than the requirement. There were an excess of 223 Primary Health Centres and 71 Community Health Centers. But there was non-availability of trained staff. Deficiency of 1211 Female and 3290 Male health workers did exist in sub centers. At PHCs, there were deficiency of 14 female and 176 male health workers. While nursing staff (+ 314) and Lab technicians (+758) were in excess, Pharmacists were just adequate and radiographers (-197) were less than required. This showed there was mismatch between the available institutions and available staff and within different levels of staff.

It also showed that there is no paucity of doctors, but it was the paucity of specialists. There were 343 doctors in excess of the required number in Primary Health Centres, while it was a deficiency of 94 when it came to the availability of specialist doctors there. The data on the gap at state and National levels are available (Table 2).

Table 2: Man power required, sanctioned and available for health care in Kerala state and India

Category		Required	Sanctioned	In position	Vacant(S-P)	Gap (R-P)
Female HW	Kerala	5348	4232	4173	59	1211
	India	172415	185961	207578	14084	6630
Doctors PHC	Kerala	809	984	1152	nil	excess
	India	24049	31867	28984	6493	2489
Specialist at PHC	Kerala	868	640	774	excess	94
	India	19332	9914	5858	4328	13477
Radiographer	Kerala	217	15	20	nil	197
	India	4833	3126	2314	1180	2557
Pharmacist	Kerala	1026	930	1027	nil	excess
	India	28882	29639	26219	4895	5295
Lab Tech PHC CHC	Kerala	1026	238	268		758
	India	28882	18920	17525	3791	12494
Nursing	Kerala	2328	2099	2014	85	314
	India	57880	67242	66424	11764	13521

Source : Rural Health Statistics in India 2012 (Updated Up to March, 2012) Statistics Division Ministry of Health and Family Welfare Government of INDIA.

In this table the gaps were considered against the required and sanctioned posts with those actually available in position. This also showed the same picture of mismatch with in the available human resources

Discussion

Kerala still holds the indicators of good health. Recent figures on Demographic socio-economic and health profile of Kerala State as compared to India confirm that. (Table 3).

Table 3: Demographic, Socio-economic and Health profile of Kerala State as compared to India figures.

Indicator	Kerala	India
Total population (In crore) (Census 2011)	3.33	121.01
Decadal Growth (%) (Census 2001)	4.86	17.64
Infant Mortality rate (SRS 2013)	12	40
Maternal Mortality Rate (SRS 2010-12)	66	178
Total Fertility Rate (SRS 2012)	1.8	2.4
Crude Birth Rate (SRS 2013)	14.7	21.4
Crude Death Rate (SRS 2013)	6.9	7
Natural Growth Rate (SRS 2013)	7.8	14.4
Sex Ratio (Census 2011)	1084	940
Child Sex Ratio (Census 2011)	959	914
Total Literacy Rate (%) (Census 2011)	93.91	74.04
Male Literacy Rate (%) (Census 2011)	96.02	82.14
Female Literacy Rate (%) (Census 2011)	91.98	65.46

(Source: RHS Bulletin, March 2012, M/O Health & F.W., Government of India).

The observed mismatch between establishments and manpower is a matter of concern. Public agitations for want of staff in the hospitals are very common; especially during the periods of fever epidemics in the monsoon season. Both public observation and the official data point to the same anomaly. When the institutions are more than required, a corresponding higher number of manpower is needed. People in need of health care will approach nearest care delivery point. In the absence of staff, the expected service will be denied to them. This leads to complaints, protests and unrest. This observation also indicates that the training programs are not matching with actual needs in the society. The training institutions are established without taking into consideration of the current requirements and availability of centres and staff. Lack of comprehensive plan arising from a robust policy appears to be the origin of all the problems.

The mismatch within the available human resources also needs corrections. Mismatch between available posts and beds in Primary Health Centres could be a reason for underutilisation of some of PHCs. That could cause patient overload in Taluk hospitals, District hospitals and Medical colleges in the line of referral. Over burdening of specialist services in Medical Colleges pushes up the patient load to super-specialties. In the current scenario a cardiologist in Kerala Medical College gets hardly five to 10 minutes to examine a patient, though most of those patients need only monitoring of Blood pressure which can be done by a General Practitioner at the periphery close to patient's home.

The doctors are not scarce in government hospitals in rural areas, but the specialists are. The need for the day is not to have more Medical colleges to produce basic doctors, but to maximize the production of specialists by appropriately increasing the Post Graduate seats in all Medical Colleges. Making more Post graduate degree holders will ensure the availability of specialists. However the current policy is to open new medical colleges in every district, ignoring the scarce faculty and other resources; and 'avoid talking about the Postgraduate courses'.

There do exist true scarcity for nurses. At the same time BSc Nursing seats progressively fall vacant every year since 2012. In 2013-2014 alone, three Nursing colleges in the state were closed down on the ground of non-viability. When the product's demand is in the global market, it is difficult to accurately predict the need. But a balancing between the available seats for Degree and Diploma courses could be considered, to meet the local requirements. It is the Nursing Diploma holders who join services in Kerala's hospitals, compared to Graduate Nurses. Organizing campus selections for Nurses can reduce the time gap between their passing out and recruitment to jobs; which could be another strategy to counter their migration elsewhere.

'Kerala's development experience' has been distinguished by experts for its primacy in the social sectors. But growth in the number of beds and institutions in the public sector had slowed down by the mid-1980s. "From 1986–1996, growth in the private sector surpassed that in the public sector by a wide margin. Spending in the Public sector revealed that in recent years, expansion has been limited to revenue expenditure rather than capital, and salaries at the cost of supplies. Growing literacy, increasing household incomes and increasing number of chronic illnesses, probably fuelled the demand for health care; already created by the increased access to health facilities" 3. The current trend is the demand for sophisticated specialist care rather than general health care. Private sector either benefited from this

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or made use of this scenario for their advantage. The Public Health services failed to counter this change.

In 1890s Travancore dynasty allocated up to 2% of its expenditure for health care. The health sector enjoyed Governmental support for another century, even after the shift to democracy. This enabled the Public sector to maintain its primacy in health care. Whereas the number of beds in public sector institutions was 13000 in 1960-1961; it was 36000 in 1986. After that the pace of growth slowed down. "The public health care expenditure (as a proportion of the gross state domestic product) decreased by 35% between 1990 and 2002, making Kerala one of the states with the highest reductions in public sector contributions and the highest increase in private funding for health care." [4]. The growth of Kerala's private sector in healthcare was to meet the unmet demand when government started withdrawing from its responsibility on the ground of financial strain. "Currently the private sector accounts for more than 70% of all facilities and 60% of all beds" [2] in Kerala,

According to Indian Medical Association, about 2500 small or medium hospitals in the state were closed down in recent years, because they were not viable. These hospitals were run by doctors or private owners depending on single doctor or doctor couple having a long standing practice in the same locality. Their practices were built on their clinical skill and trusting relationship with patients. It functioned as an informal General Practice system with effective referrals between local practitioners and specialists in secondary level centres functioning in towns. Even missionary run charity hospitals are facing the same problem with vacant beds and deserted Out Patient Departments. It may be noted here that the Government's support to private sector is limited to large hospitals only, by way of inclusion in various schemes for reimbursements, insurance or benevolence.

There is difficulty in getting doctors to work in small or medium sized hospitals, functioning at a below capacity level. The same is applicable to some of the hospitals in Government sector also. The current trend is to join established centres with modern infrastructure and investigation facilities. Many among the new generation of doctors are not at ease with practice based on clinical skills and professional relationships. They are not prepared to build up practice with own style of patient care. The current training pattern may not be adequately equipping the doctor for it. It could also be the result of defensive practice resulting from excessive consumer consciousness; a part of which is irresponsible and ill intentioned.

The corporate run big specialist hospitals with high tech gadgets, wide advertisements (camouflaged as health education) and appealing promotion of five star ambiences are new entry into the field. They have Supermarket style of functioning. Wide varieties of services are made available under one roof. One can make selection based on fascination and not on requirement. The covert pressures make one to purchase the attractive ones also; not limiting to the essentials. Only a few services would be of good standard and all may not be priced at comparable rates. In Government system a uniform minimum standard is ensured for all services and it cannot recapture the expenses with higher pricing of one against another low priced one.

The Human Resource management practices existing in private hospitals in Kerala were reported to be fairly satisfactory as observed in a study specifically done on it [5] . However the same study revealed that the "existing HR practices are not conducive for delivering quality healthcare to the stake holders". It concluded that "Policies which will address issues relating to employee discontentment and introduction of a more professional approach to HR management practices is the need of the hour."

Kerala is in the forefront of decentralisation of powers following the 73rd and 74th Constitutional Amendments. The hospitals and schools in Kerala were widely distributed and existed in every Panchayath. The government order of 1995 has transferred the health care institutions at various levels to the local self-government institutions (LSGI). The general usefulness of decentralisation of health care was acknowledged by both the elected members of the LSG and doctors working in the hospital"[6]. But there were complaints about lack of proper staff deployment hindering the functioning of medical facilities and it's under use.

In between Government sector which is heavily subsidized and the Private sector which is profit making on user fee, Co-operative sector can have a position with user fee on a 'no loss no profit basis'. This can stay as a control system like ration shops distributing commodities at a lower price (Table 4).

Table 4: Availability of Co-operative hospitals of Kerala in 2011.

S.No.	District	Functioning	Nonfunctional	Liquidated	Total
1	Thiruvanathapuram	3	2	4	9
2	Kollam	6	4	2	12
3	Pathanamthitta	2	0	0	2
4	Alappuzha	1	6	2	9
5	Kottayam	3	6	2	9
6	Idukki	2	5	2	9
7	Ernakulam	5	3	1	9
8	Thrissur	10	5	1	16
9	Palakkad	6	4	3	13
10	Malappuram	9	3	3	15
11	Kozhikode	19	1	4	24
12	Wayanadu	0	2	3	5
13	Kannur	24	4	5	33
14	Kasargode	9	7	2	18
15	Total in Kerala	99	52	32	183

Source: Statistical wing, State co-operative Union.

There is wide coverage of health care institutions in Kerala under co-operative sector [7] .These range from primary care level to tertiary care level.

An active referral mechanism between the levels is important for the sustenance of any multilayer system. For a referral system to sustain, it should be active in both the directions. In the current practice, a patient referred to higher centre is lost forever to the practicing doctor and centre at the primary care level. They have to be referred back after acute care and for follow up. A fee for bypassing this can be considered (except in emergencies) and the dispensing of the medicines on refill requests for prescriptions can be limited to local PHCs. This can be implemented in Co-operative sector also if a networking is made. Co-operatives of Nurses, Lab technicians and (perhaps) doctors rather than a co-operative society of others employing them are the actual need.

Feminisation of medical profession is a global observation which was debated upon considerably. A Kerala Study [8] also showed the similar trend. Sex ratio of applicants and selected students for MBBS course increased between 2002 and 2011. Women representation among Kerala Medical students is well above the sex ratio of general population in India and Kerala. Increasing feminisation of Medical Profession is to be expected in Kerala also and a rethinking in workforce planning is needed to address the related issues. Non-availability of doctors in remote areas and concentration of them to city based hospitals may be due to the changes happening in the sex ratio. This also need to be addressed

Summary and Conclusions.

Kerala is well known for the unique experience of health development in spite of economic backwardness. This article attempts to explore few issues related to human resource sector which has been described as the core of health system development. The major problems identified is the mismatches prevailing in the whole system. This do exist in terms of number of institutions and staff, the proportions between specialists and non-specialists, distribution of trained persons to various levels and availability of seats for trainings and courses .

The true scarcity of human resources in the context of apparent abundance is presented as a new phenomenon. The demand for health care need to be redefined in the context of disparity in access, availability and also house hold expenditure on health and all these factors can be influenced by the proposed changes in human resource development sector. Another important influence is that exerted by private sector which has become dominant recently. The influence of privatization has been in the line of corporatisation which has shaped the health care industry to function in a supermarket style with considerable shop casing of services and promotion strategies aimed at increasing profit. Looking in to the alternatives showed that decentralized governance and health care under co-operative sector have been introduced timely but yet to evolve as an efficient models. Improving referral process and achieving gender equity are also suggested as a few corrective steps for making human resource sector more effective.

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