Human Resource Policies and Practices for Public Healthcare System in Narmada District, Gujarat: A Case Study

By

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Abstract:A comprehensive health care services requires effective human resource (HR) management policy to ensure organizational success. Government is primarily concerned with the size of the workforce rather than the contemporary HR practices. This resulted into lack of attention to HR management in health sector.

The objective of the case study is to critically examine HR policies and practice for primary health care system in Narmada District, Gujarat. For critical analysis of HR policies and practices for primary health centers, related documents were analysed and the policies and practices were examined with reference to HR planning, recruitment, selection, hiring, staffing, probation, induction training, performance evaluation, salary and transfer policy in the organization.

At present, updated HR planning is not done regularly and due to lack of such updated information actual HR requirement is not calculated leading to shortage backlog. To fill up this shortage contractual model to recruit staff has been adopted by health department. There is no induction training and training need assessment done in the organization. There is wide disparity in pay and leave provisions for different category of regular and contractual staff working under the same roof of health facilities.

Disparity in salary, leave provision and other privileges in organization have brought discrimination and demotivation among employees. To deal with conflicting climate in organization comprehensive HR policy is suggested. Policy content should include HR planning, training and development, institute capacity building, HR information system, motivation, and retention strategies for HR.

Introduction

Human resource (HR) is indispensable for the health sector. Public health organization needs to ensure that all the employees feel their job as source of happiness. A comprehensive health care provision requires effective HR management policy to ensure organizational success. The World Health Report (2006) has given important boost to the global agenda for human resources for health (HRH). Government, which is directly or indirectly funding the majority of health care expenditure has been primarily concerned with macroeconomic issues, especially size of the workforce rather than the micro level focus of contemporary HR practices. This resulted into the lack of attention to HR management in health which has direct effect on motivation and performance of the workforce.[2]

Human resource policies and practices are concerned with employee's selection practices, training and development program and performance evaluation system.[3]HR policies defined by Armstrong as the continuing guidelines the organization intends to adopt in managing its people.[4]HR policies define the values of the organization to how people should be treated. From these, principles are derived for health managers to how to deal with HR matters. Therefore, HR policies serve a reference point for employment practices and decisions are being made about people. HR policies guides the actions required for achieving the objectives of the organization. Therefore, study was conducted with an aim to critically analyze HR policies and practice under primary health care system in Gujarat. The study would help in re-introspection of the terms and conditions of engaging/hiring/recruiting HRs and use of HR management principles to address the job outcome and enhance job satisfaction and motivation.

Materials and methods

This paper is based on the case-study methodology used in management studies. Case studies generally document real situations of organizations from multiple perspectives and include a description of the organization, key data in terms of inputs, process, outputs, and perspectives of key individuals obtained through interviews. As opposed to focused research, there may not be a

clear hypothesis; however, the problems faced by the organizations and some analyses are provided.

This case study analyzes how the current situation of the healthcare system affects the key indicators of HR policies and practices in public healthcare system. Past efforts in the public health area were analyzed to know their impact and challenges. New initiatives were studied to understand their potential.

Study was conducted in public healthcare systems of Narmada District, Gujarat where primary health care is provided byAnganwadis, Sub Centers (SCs), Primary Health Centers (PHCs), Community Health Centers (CHCs), Sub District Hospitals (SDH), District Hospitals (DH) under State Government. Public Healthcare services are headed at district level by Chief District Health Officers (CDHOs). Gujarat health services under in each district SCs, PHCs, CHCs, SDH are administratively controlled by CDHOs. These healthcare delivery institutions have HR like Medical Officers (MOs), Pharmacists, Auxiliary Nurse and Midwifes (ANMs), laboratory technicians (LT) and Laboratory Assistants both on regular and contractual basis to deliver the health care services. For critical analysis of HR policies and practices related documents were examined using observation check list. The documents were procured from the office of District Health Society, National Rural Health Mission (NRHM), and website of Gujarat Government Health Department. Various documents examined were: Practices for HR hiring, office orders, office memorandums, minutes of meetings, recruitment rules (RRs), offer cum appointment letters, terms and conditions of staff hiring, newspaper advertisements. The HR policies and practices were examined on parameters like: HR planning, recruitment, selection, hiring and staffing, probation, induction training, performance evaluation, compensation (like wages, salary, rewards, recognition, remuneration, pay benefits etc.), and pension scheme and transfer policy in the organization. Interview of middle and top level health managers, health care providers were also conducted to fill up the gap in information and to explore their opinion about HR policies and practices. After examining the documents analysis was made and presented in the form of tables and text in the results.

Organizational Structure and Management of the Public Healthcare System in Narmada District & Gujarat

State level

The Department of Health and Family Welfare (DHFW) is headed by a minister, under whom are two Additional Chief/Principal Secretaries. Below them is the Commissioner of Health, who heads the technical wing of the DHFW, assisted by Additional Directors. The major administrative divisions of the DHFW involved in the management of maternal health services are the Directorates of Rural Health, Medical Services, Medical Education and Research, Vital Statistics, and Family Welfare, and State Institute of Health and Family Welfare. All Additional Directors are doctors who do not necessarily have public-health or management qualifications.

Regional level

The Gujarat state is administratively divided into different health regions—each with 5-6 districts in a region—headed by a Regional Deputy Director (RDD). The regional directorates were set up in 1986 to decentralize authority and responsibility of managing day-to-day problems at health facilities, and policy-level decisions are taken at the state level. All government hospitals, including the FRUs and CHCs, now come under the RDD. The RDDs should monitor the functioning of the FRUs and district hospitals for EmOC.

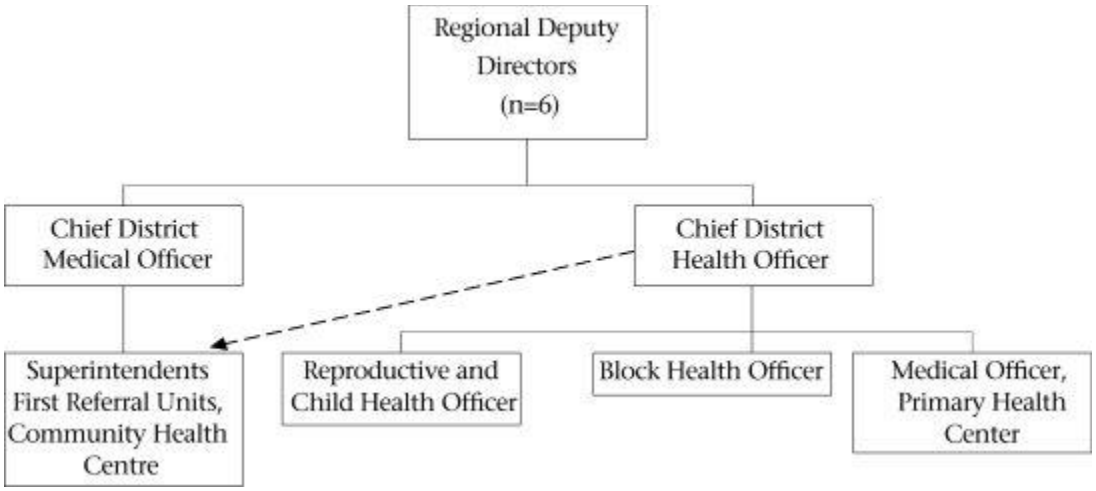
District level

A district has two hierarchical systems—one controlling PHCs providing mainly preventive services and the other controlling CHCs and district hospitals providing curative services. Public health services at the PHC level are supervised by the different Programme officers, working under the Chief District Health Officer (CDHO). Administrative and financial powers lie with the District Development Officer (from the non-technical Indian Administrative Services–IAS) leading to delays in decision-making and implementation of programmes at the field level.

Public Health Nurses (PHNs) supervise the LHVs and ANMs at the district level. There are two posts of PHNs; however, Narmada district have only one post filled. At the district level, the District Programme Management Unit (DPMU)—has been set up under the RCH programme, staffed by a health management graduate and support staff.

Curative services are monitored by the Chief District Medical Officer (CDMO), a doctor with postgraduate degree in medical or surgical specialty, in charge of all medical services in the district, including the CHCs and district hospital. One in five CHCs is designated as a FRU catering to 500,000 people and is supposed to provide comprehensive EmOC services. The activities of CDMO are monitored by the Additional Director, Medical Services, at the state level, not by the Additional Director, Family Welfare, which weakens the linkages of medical services with maternal health services. Refer (Fig.(Fig1.)1.)

Fig.1 Organizational chart at district level for preventive healthcare services, Narmada District, Gujarat



Subdistrict level

A medical officer, a staff nurse, and an LHV at the PHC are jointly responsible for providing antenatal care, conducting deliveries, providing basic EmOC and referral, postnatal care, and family-planning services in an area of 30,000 people. The ANMs are posted at the health subcentre covering a population of 5,000. They are responsible for house-visits to women, registering pregnant women, motivating them to obtain antenatal services, and institutional delivery. An ANM is supposed to attend deliveries at home, provide postnatal care, and refer women with complications. Beginning in 1966, with the target-oriented family-planning programme, programme priorities shifted from delivery care to family planning and

immunization programme (1980s onwards). Both family planning and immunizations are primary preventive activities carried out by the ANMS and can be done on a periodic basis. Both these lead to neglect of delivery care by the ANMs and MOs.[1]

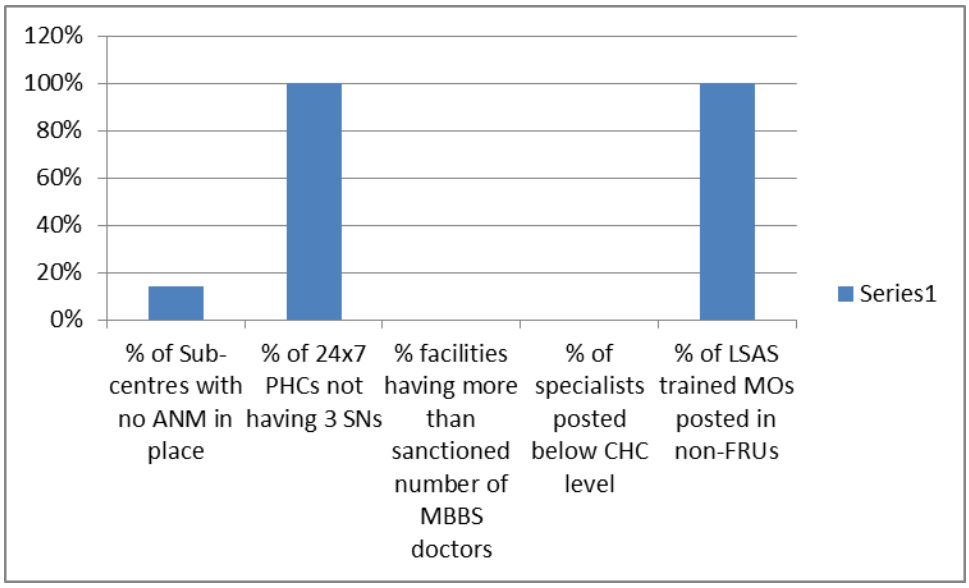
Human Resources for Public Healthcare System in Narmada District

The most crucial challenge faced by Narmada District is ensuring skilled birth attendance and availability of trained personnel at the FRUs for comprehensive EmOC.

All past programmes, starting with the CSSM in 1992, had a component of training the general doctors for 6-12 months on EmOC or on anaesthesia. Due to lack of focus, poor training facilities, objections from professional bodies, legal problems, and posting policies, not much progress has been achieved. Recently, training of MBBS doctors has started and is going well but problems of posting policies, absence of supervision, accountability, and lack of infrastructure and supply support are still not addressed. Ref. (Table.(Table.1).

Table. 1 Key Indicators of a HR in Public Healthcare delivery system

S. No.	Indicator	Status
1	% of Sub-centres with no ANM in place	14%
2	% of 24x7 PHCs not having 3 SNs	100%
3	% facilities having more than sanctioned number of MBBS doctors	0%
4	% of specialists posted below CHC level	0%
5	% of LSAS trained MOs posted in non-FRUs	100%
6	% of EmOC trained MOs posted in non-FRUs	0%



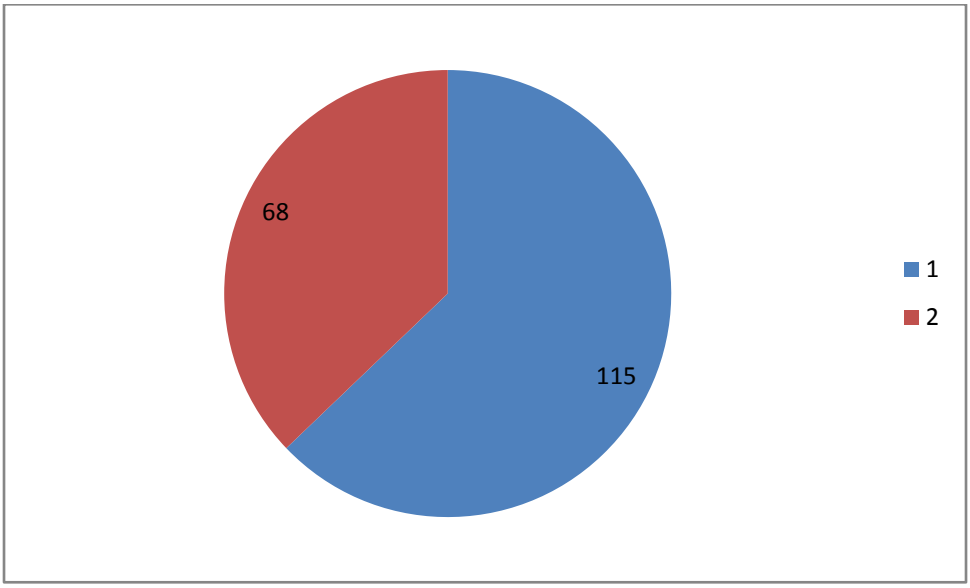
Graph. 1Key Indicators of HR in Public Healthcare delivery system in Narmada District

The ANM is the first-level contact for the community in the primary healthcare system at the village level. She is the main provider of antenatal, delivery and postnatal care services in rural areas. Yet, posts of ANM are vacant in Narmada District, Gujarat. These vacancies are caused by very weak human-resource planning and management in the state Department of Health. For example, forecasting required of health staff, including ANMs, has not been done regularly. Also, there is a little coordination between the training schools which train ANMs and the recruitment process at the district and state levels which can be long and politically influenced. In remote and difficult districts, adequate numbers of qualified candidates may not be available for ANMs.

Table.2Human resources available in Public-Health infrastructure of Narmada District,2015

Public-health worker	Sanctioned	Posted	Shortfall	%of Shortfall
Doctor at PHCs	50	29	21	42
Nurse/midwife	65	39	26	40
Total	115	68	47	40.86

Source of data: Mandatory Disclousure, September 2015



Sanctioned[1] Doctors/Nurses/Midwifes at PHCs

Filled/Posted[2] Doctors/Nurses/midwifes at PHCs

Fig 3. Human resources available in Public-Health infrastructure of Narmada District,2015

Even if recruited, most ANMs do not live in the villages they are posted to but prefer living in a larger town or in a city that may be several kilometres away. The time available for service-delivery in the community is, thus, limited, and substantial time is spent in commuting. Other reasons for not staying at the place of posting are complex and multiple, such as lack of adequate

housing facility, lack of safety and security, poor skills, and confidence to conduct deliveries, and a sociopolitical milieu which encourages lack of accountability. The ANMs not staying at their post cannot provide delivery care due to the unpredictably of childbirth. The TBAs, therefore, continue with conducting deliveries. Although this is a very important issue, the Government does not monitor the parameter of ANM's place of stay.

Antenatal care, delivery care, and postnatal care provided by ANMs are not monitored as strictly as immunization and family-planning activities because of the high priority for the latter programmes. The ANMs were supposed to be primarily community-based midwives but changes in programme focus from maternal care to family planning and immunization led to the shortening of training of ANMs in midwifery. The role of ANMs has essentially changed from provider of comprehensive maternal health services, including childbirth, to selected preventive services (immunization and family planning) provider.

The staff nurses and LHVs at the PHCs and CHCs are not adequately skilled to provide delivery care. In many places, staff nurses and LHVs did not also stay at the PHCs for reasons similar to those described for ANMs above, and hence, they are not available for 24 hours for delivery care. Medical officers posted at the PHCs are not skilled for delivery care and basic EmOC.

There is also a severe dearth of specialists in the public-health system. In Narmada District, there are no sanctioned posts for specialists for providing comprehensive EmOC functions, such as obstetricians, anaesthetists, or paediatricians, in the CHCs. Even where there is a sanctioned post of specialist, vacancy is extremely high. These high rates of vacancies of specialists' posts are due to many reasons, prominent among them being that government doctors are not allowed to do private practice and working conditions in rural areas are difficult. The Government faces difficulties in disciplining employees due to strong employee unions and political interference. This leads to higher rates of absenteeism and avoidance of being transferred to remote areas. Most FRUs are non-functional due to lack of availability of specialists.

The management information system for human resources is also very weak. Data on filled-up/vacant posts are not updated regularly, and there is no monitoring of whether a posted healthcare provider stays at the place of posting.[1]

Results

The policies and practices for regular and contractual HR were examined on the various parameters, which are detailed as follows:

Human Resource Planning

Human resource planning for regular staff is done by planning department of Government of Gujarat. The RRs such as qualification, experience (essential and desirable) are framed if existing ones do not cover the post.

For contractual staff, demand comes from CDHO office, which is compiled at State Program Management Unit of Gujarat in State Program Implementation Plan (PIP) of Gujarat to Ministry of Health and Family Welfare (MoHFW), Government of India. After approval of PIP for state, required HR posts are filled for that particular financial year. However, at present updated HR planning is not happening in health department. For HR planning, every 2 years assessment of work load and number of posts needs to be done regularly. However, due to lack of such updated information, actual HR requirement is not calculated; and shortage backlog is increasing continuously; and to fill up this shortage contractual model to recruit staff has been adopted by Department of Health and Family Welfare. Under contractual model recruitment is done for 11 months to 1 year. But in practice, the contractual staff is continued for years and regular posts are not filled for longer duration.

Recruitment

For gazetted post like CDHOs, requisition for requirement is sent to Gujarat Public Service Commission's (GPSC). Under National Rural Health Mission (NRHM) the recruitment is done by State Health Society and District Health Society for 11 months and contract is renewed after satisfactory performance of employees for further 11 months. Under primary health care system three types of staff are working:

1. Regular staff,

2. District Health Society recruited contractual staff

3. Contract staff under NRHM and all having different terms and conditions for recruitment.

Probation

Probation is governed by CCS Rules[6] [7]for regular category of staff. There is no formal induction training during probation period, it is perhaps presumed that people recruited are professionals and they know their job. Probationer employee is supposed to perform his or her duties directly on job from very 1st day. With progression of time employee try to understand what the organization is supposed to do in health care delivery system. No formal training is imparted to employees at the time of joining so health care providers do their work as they understand without any objective in mind.

Trainings

Training is provided to MOs and paramedical staff whenever a new program is launched. No formal training need assessment is done every year. Under NRHM training calendar is prepared for specific programs. For paramedical staff like ANMs, Pharmacists and Lab assistants (LAs) or LTs, there is no provision of study leave as no guidelines are framed by the department. However, for contractual staff no provision for study leaves or long duration trainings is provisioned under terms and conditions of hiring.

Compensation/reward and recognition

For Regular employees like MOs, ANMs, Pharmacists and Lab Assistants and Lab Technicians, the salary and increments' are paid as per CCS rules. There is wide disparity in pay provision for different category of staff and working under the same roof of health facility. For contractual staff salary is fixed and there is no provision of enhancement every year. The benefits like leave travel concession (LTC), medical reimbursement, pensioner benefits, group insurance, study leave and child care leave etc., are for regular employees only.

Pension and other conditions of service

Officers and officials appointed prior to 1.1.2004 are governed by CCS (Pension) Rules 1972. Officers or officials appointed after 1.1.2004 are governed by New Pension Scheme. However, there is no contribution from the Government in respect of individuals who are not Government employees like contractual employees.

Annual appraisal reports

Appraisal reports are more of subjective rather than objective and need modification and change for contractual and regular staff.

Transfer policy

As per terms and conditions of recruitment of regular employees they are required to work in any department under health in Gujarat. The contractual staff is required to work under respective health society who has given the initial offer and appointment letter. At present there is no formal transfer policy in health department for contractual staff.

Issues and perspective of Human Resource Practices

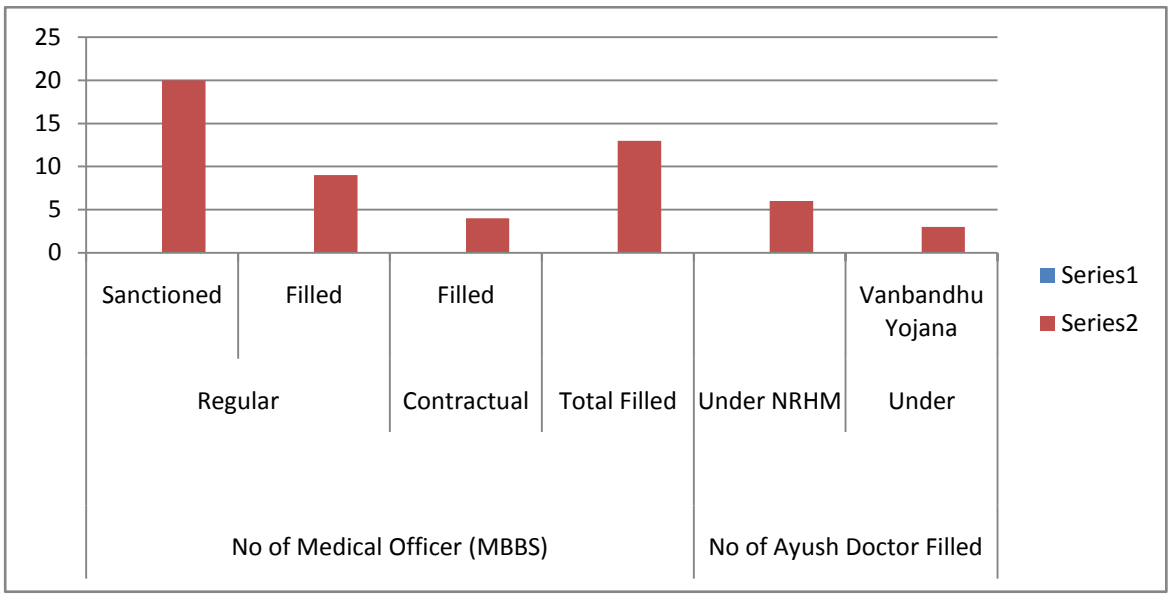
The ultimate goal of HR planning is to facilitate enabling environment in the organization for optimal performance/achievement. It is believed that the potential of HR, unless capitalized fully by the definite justified principles in the organization, one can't achieve the ultimate goal of an organization. The organizations are generally structured in hierarchical order but the production/achievement is accomplished by dedicated team work culture at the lowest unit in the hierarchy. The upper layer of the organization develops policies and programs and creates facilities for the employees of the organization. The unity and diversity at the lowest units of the organizational structure depends a lot on the principles followed at higher level in terms of the employees' selection and their development, definite package of privileges including salary, promotion, incentive, reward and other facilities such as medical reimbursement, study leave, housing, pension, LTC etc. An organization can ensure team work culture at the lowest level if it follows definite principles. However, any system, which is conglomeration of employees appointed on different criteria, pay and pay package can't ensure unity work culture. In organization, it is possible that some employees are motivated and others are de-motivated. In this case, the net motivating environment is the difference between motivating and demotivating forces. If the difference is higher toward positive side it indicates highly favorable environment in the organization and vice versa. In Gujarat state, the employees working under primary health care system have got differential identities because they are recruited by different agencies; and these agencies create their own rules and regulations, terms and conditions. Those who are

regular avail all the facilities and privileges as per government rules, whereas the staff recruited under contractual model do same work but on differential pay packages. Hence, these health care providers are different in their motivational profile for work. Such employees likely to spend more and more time for comparison and attribution rather than concentrating emotionally with the responsibilities they are given to perform in the organization. It is essential on the part of HR planners to advise to the concerned organizations about the major principles of HR development.[9]Ref. (Table.(Table.2)2)

Table 2. Contractual and regular staff details in Health Department of Narmada District, Gujarat

No of Medical Officer (MBBS)				No of Ayush Doctor Filled	
Regular		Contractual*	Total Filled	Under NRHM*	Under VanbandhuYojana*
Sanctioned	Filled	Filled			
20	9	4	13	6	3

*Contractual Staff details



Graph 2. Graph showing details of contractual and regular staff in Health Department Of Narmada District

Discussion

Human resources are essential element of a health system and it is an important organizational asset. Without HR management, it is not possible to achieve the Millennium Development Goals (MDGs) and other goals and objectives of NRHM. For achieving the MDGs, more focus is required for strengthening of HR in health. At present updated HR planning is not happening in health department. Due to lack of updated information in planning; actual HR requirement is not calculated; and backlog is increasing continuously. Similar finding was found in a study conducted by Central Bureau of Health Intelligence (CBHI), MoHFW in Madhya Pradesh and Gujarat,[5] where no formal mechanism for health workforce planning is existing. Study by CBHI revealed that decisions regarding creation of new posts and filling up of vacant posts are done as per the need and mostly program driven. Factors such as population growth, demographic changes, disease burden, patient load and health seeking behavior are not taken into consideration while doing HR planning in Madhya Pradesh and Gujarat.[5]

Findings were reported by CBHI, MoHFW in Gujarat, where backlog of a number of vacancies of doctors is increasing due to slow process of recruitment by the Gujarat Public Services Commission and it has allowed ad-hoc recruitment of doctors for years.

Compensation and reward system in Gujarat show disparity in pay and allowances between regular and contractual staff. This has brought discrimination and demotivation in employees in PHCs. There is wide disparity in pay provision for different category of staff and they are working under the same roof of health facility. For contractual staff salary is fixed and there is no provision of enhancement every year. The benefits like LTC, medical reimbursement, transport allowance, pensioner benefits, group insurance, study leave and child care leave etc., are major cause of discrimination and lower satisfaction. Stagnation in career for para-medical workers is cause of dissatisfaction even in regular staff. Contractual staff feels that they are discriminated for leave provisions though they perform same kind of work in the organization. Similar constraints of difference in remunerations and other privileges between regular and contractual staff are reported for same kind of services from Punjab, Uttar Pradesh, Madhya Pradesh, and Manipur by Sixth CRM Report (2012).[8]

There is lack of transfer policy in the health department for HR. Review of documents revealed that transfers take place as per need and exigencies of department. There is no formal provision for the transfer of employees in the organization.

Conclusion

Health care system is HR intensive, and delivery of services is linked with HR policies and practices. It also depends upon motivation and satisfaction of health care providers. Over the years, the planning exercise has been primarily focused on creation of new infrastructure and institutions. After the launch of NRHM, Gujarat took steps to assess the vacancy and supply factors of HR. However, the organization has not assessed whether the existing terms and conditions of HR recruitment are attractive enough and what needs to be done to attract and retain the staff at various positions. The state health department despite having such a large workforce does not have a specialized HR department to guide on various HR functions. Staff working on ad hoc basis for longer duration is not given number of benefits, which are otherwise available to regular staff. This is a leading cause of dissatisfaction and demotivation among the contractual staff. In spite of well laid out rules and procedures of recruitment on regular basis, vacancies are filled by contractual method. The delay on the part of institutions such as GPSC has been cited as the reason for larger backlog of vacancies. This is true to a great extent as these organizations are burdened with recruitment of staff for all departments of the State. The policy of appointing staff on contractual basis is seen as a short term and ad hoc solution to the actual requirement. Higher officials viewed the contractual system as a parallel system, which is imposed by national health programs in the country but in practice such staffs are posted for routine activities in the health care system. Comprehensive HR policy should be developed for health care system in the country. HR policy content should include HR planning, training and development; institute capacity building, HR information system, motivation and retention strategies, in-service trainings, vision and mission for HR. HR Policy should clearly define the priorities of organization to be achieved from HR in health. Policy should take care of issues emerged out in present study like; HR planning, privileges attached with job, disparity, career development, trainings, transfer policy and HR management. Regularization of contractual staff is recommended if already working staff fulfills the eligibility criteria as laid down. Creation of posts by the finance department for already exiting contractual staff working for >3-5 years in

the organization is suggested. Considering all the recommendations listed above, primary health care system needs comprehensive HR policy keeping regular and contractual employees into account.

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