ISSN 2348-1218 (print)
International Journal of Interdisciplinary Research and Innovations ISSN 2348-1226 (online)
Vol. 6, Issue 3, pp: (95-99), Month: July - September 2018, Available at: www.researchpublish.com

CAPACITY BUILDING AS AN INTERVENTION FOR HUMAN RESOURCE CHALLENGES IN HEALTH CARE SECTOR

[1]Dr.Shaji .K. Joseph, [2]Prasuna.Kuragayala

[1]Associate Professor, Dept. of Commerce, D.T.S.S college of Commerce

[2]Assistant Professor, Dept. of commerce, NCRD's Sterling College of Arts, commerce & Science

[1, 2]Email: skjoseph_2000@yahoo.com, nagaprasuna79@gmail.com

Abstract: **Providing optimum health service coverage to the population is possible only when the highest standards are attained by the country in the availability, accessibility, acceptability and quality of health systems implemented. Availability of health workers with equitable distribution for covering the entire population is equally important. The population of any country can avail qualitative health services only when the health workers possess required competency. It is essential that the health workers are continuously motivated, supported and empowered at all level levels to deliver qualitative care as per the socio-cultural expectations of the population. A strengthened health system can be built by any country with proper planning in health care education which is the root for future availability of human resources for health. However developing countries face the difficulty at varying levels for building an efficient health system right from education, deployment, retention, and performance of the health workforce. This paper focuses on human resource challenges in India in health care and the concept of capacity building as an intervention in health care education to overcome health workforce shortages.**

Keywords: **Health Care Sector, Capacity building, Health work force, Human resource Management.**

1. INTRODUCTION

India's economic growth has not translated into commensurate improvements in its health indicators and the country continues to face difficulties in ensuring the effective health services to its people. One of the main obstacles is India's low health worker density. According to the world health organization (WHO) there are less than seven physicians per 10,000 population. These shortages of health workers includes physicians, trained nursing and midwifery personnel, paramedics and other allied health personnel who are all important for effective delivery of health services as a team effort. The growing gap between the supply of health care professionals and the demand for their services is a critical issue to build an efficient health. Apart from shortage in the availability of health workforce in numbers the other factors which attribute to imbalance distribution of health workforce are poor human resource practices and unsatisfactory working conditions. The policy makers need to focus attention on implementing a proper human resource management in health care sector with attention to use incentives to motivate health workers and improve other aspects of human resource practices such as recruitment, selection, training and development and overall improvement in work settings. Thought India is having a comprehensive public health care system it is facing its own set of challenges in terms of absence or underutilized facilities and poor management of health work force. There fore addressing the challenge of health workforce availability through capacity building intervention is central to the development of an health system.

OBJECTIVES OF THE STUDY:

- To present the challenges of health workforce shortages in Indian Health care sector.
- To understand the importance of the concept of capacity building and its relevance in Health care sector
- To analyse the importance of capacity building as an intervention in medical education to address the health workforce shortages.
- To present major issues in capacity building of health workforce

LIMITATIONS OF THE STUDY: The Study is based only on the information gathered from Secondary data.

2. LITERATURE REVIEW

Capacity Building (CB) is defined as the process of developing and strengthening the skills, instincts, abilities, processes, and resources that organizations and communities need to survive, adapt, and thrive in the fast-changing world. This involves developing skills and systems within health services to order to enable them to increase communities ability to foster good health. It is the process by which individuals, organizations, institutions and societies develop abilities to perform functions, solve problems and set and achieve objectives. It needs to be addressed at three inter-related levels: Individual, institutional and societal. Capacity building in broad sense is concerned with:

a) Human resource development of equipping individuals with the understanding, skills, and access to information, knowledge and training that enables them to perform effectively.

b) Organizational development through processes and procedure to strengthen management of relationships not only within organizations but also between different organizations and sectors.

c) Institutional and legal framework development through changes at all levels (Legal & Regulatory) to enhance their capacities

Capacity as an ability of individuals, organisations or systems to perform appropriate functions effectively, efficiently and sustainable (UNDP: Milen A Leppo K - Paul S ,2001) .The use of capacity building is intended to encompass a variety of strategies that have to do with increasing the efficiency, effectiveness, and responsiveness of government performance. Efficiency relates to time and resources to produce a given outcome, effectiveness to the appropriateness of efforts undertaken to the production of given outcomes and responsiveness relates to the link between the communication of needs and the capacity to address them (Hilderbrand & Grindle) .Capacity is the ability to carry out stated objectives. Capacity building is a process or activity that improves the ability of a person or entity to carry out stated objectives (LaFond &Brown Goodman 2001). Capacity is the ability of individuals and organisations or organisational units to perform functions effectively, efficiently and sustainably.

Asia Pacific Network (APN) for Global change research supports capacity development activities that enhance existing capacities of developing countries at three levels:

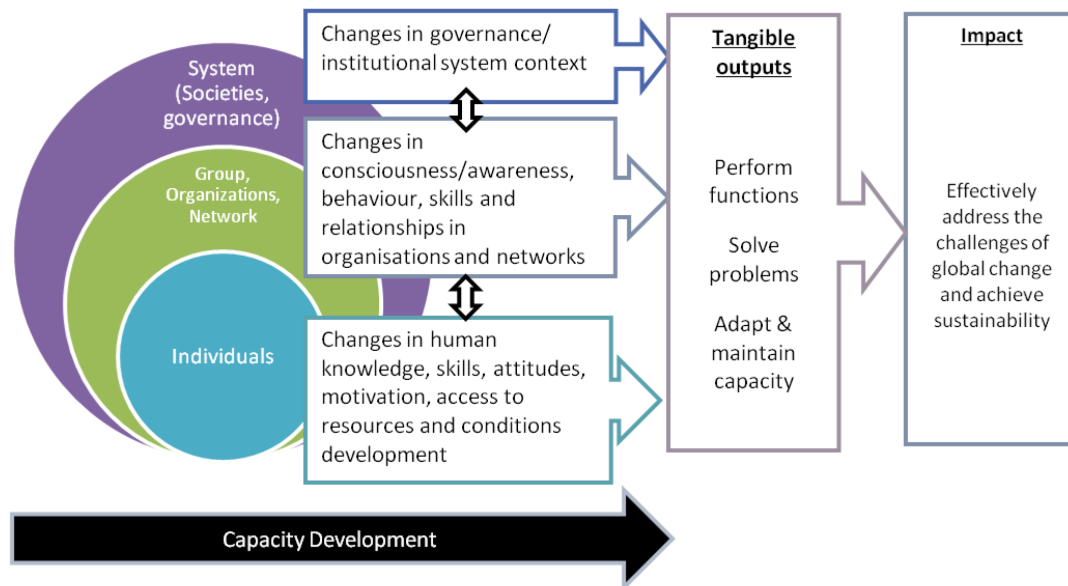
1. Individual-based capacity development
2. Group, organization, network-based capacity development
3. Societies, governance, system level capacity development

APN defines capacity development as a process whereby individuals, groups, communities, organizations, governing bodies and society in general, collectively enhance their awareness and abilities – including knowledge, skills, attitudes and behavior – in order to respond effectively to the challenges of global change and sustainability by mobilizing and using resources, and empowering existing capacity to effectively perform new/existing functions and solve problems.

For the purpose of this research the conceptual Framework for Capacity building framed by APN has been adopted.

ISSN 2348-1218 (print)
International Journal of Interdisciplinary Research and Innovations ISSN 2348-1226 (online)
Vol. 6, Issue 3, pp: (95-99), Month: July - September 2018, Available at: www.researchpublish.com

Figure 1: Conceptual Framework for Effective Capacity Development in the Asia-Pacific



(*Source: - APN - E-lib: http://www.apn-gcr.org/programmes-and-activities/capable*)

Based on the above conceptual framework the capacity building is to be initiated at three levels – Systems level which includes societies & governance, group level which includes the network of organizations involved in health care and individual i.e. health workforce.

This paper will present the initiatives of capacity building at systems level of Indian health care sector.

3. EVOLUTION OF HEALTH SYSTEMS IN INDIA

The roots of traditional health care practices in India have originated from the Veda's and is known and widely practiced as Ayurvedic medicine. In addition Yoga, Unani, Siddha and Homeopathy are also being practiced since the age old times. Under the colonial rule of British, allopathic system of health care got introduced into India. During the last century this allopathic system of health care got adapted and became a prominent health care practice of India.

Chronological developments in the health sector (1946 - 2002)

The Indian Government made its move since pre-independence days towards building its modern health care system by setting up various Expert committees and Policies which are as follows:

Table 2(A): List of Expert committees & Policy proposals

1)	*Bhore committee (1946)*	*8)*	*Alma Ata declaration (1978)*
2)	*Mudaliar committee (1959)*	*9)*	*National health policy (1983)*
3)	*Chadha committee (1963)*	*10)*	*Bajaj Committee (1987)*
4)	*Mukherjee committee (1965)*	*11)*	*National population policy (2000)*
5)	*Jain Committee (1966)*	*12)*	*Millennium development goal (2000)*
6)	*Kartar Singh Committee (1972)*	*13)*	*National health policy (2002)*
7)	*Shrivastava Committee (1974)*		

The recommendations made by the various committees, policies and commitments have bought in core policy changes in the Health services structure which can be summarized as follows :

- Establishment of Primary health centres for delivering integrated health care services and encouragement of public participation in health programmes. (*Bhore committee, 1946*)

- Performance evaluation of various disease control programs implemented. Induction of various field workers, assistants, medical social workers, surveillance workers as various categories of health work force apart from medical officers and nurses for effective implementation of each program. (*Bhore committee, 1946/ Kartar Singh committee, 1972*)

- At the grass root level AWWs and Multipurpose health workers for each program were designated. To create the first link with the community in the health service chain community health workers were selected from villages and trained. (*Kartar Singh committee, 1972*)

- Medical and health education commission was recommended for maintenance of standards in medical and health education and a separate education policy for the same was formulated. (*Shrivastava committee, 1974*)

- Delinking family planning program from malaria eradication program was taken up so as to effectively implement each program separately. Extension of PHC services for specialist and maternity care was recommended. (*Mukherjee committee, 1965*)

- Establishment of health and manpower development and research cells in all states and UTs and strict adherence to regulation of MCI was made mandatory. (*National health policy, 1983*)

- Holistic approach to nursing profession for its development and education and training for various categories of allied health professions at district level through developed integrated training modules. (*Bajaj committee, 1987*)

- Commitment of "health for all by 2000 AD" and to achieve universal targets of public health issues on international platforms. (*Alma Ata declaration, 1978*)

- Population stabilization and separate health schemes for vulnerable sections were planned. (*National population policy, 2000*)

- Commitment to achieve universal targets, related to health systems, *viz*., reducing child mortality, improving maternal health, combat critical diseases, and ensuring environmental sustainability. (*Millennium development goals, 2000*).

The overall basic framework and foundation for the public health care system of India can be attributed to the implementation of the guidelines evolved based on these committees/ policies.

To effectively align the *Millennium development goals* and *National health policy*, Government of India has launched the *National Health Mission* in 2005, with an aim to provide accessible, affordable and quality health care to the rural and urban poor, especially the vulnerable groups.

4. MAPPING CAPACITY THROUGH MEDICAL EDUCATION IN INDIA

Efforts were made from time to time to address the shortages of human resources for health through policies in Medical education. India has the largest numbers of medical colleges in world with a figure of 356, and out of these, about 162 are government institutions and 194 colleges are run by private management. The opportunities for medical education have expanded rapidly in India, especially in the last two decades. At the time of independence there were 19 medical colleges in the country, with a total of 1200 doctors graduating each year. Current estimates from the Medical Council of India indicate that there are 270 medical colleges with over 28,000 students graduating each year (Rao et al 2011). The expansion of the private sector is particularly notable in the states of Maharashtra, Andhra Pradesh and Karnataka. In Andhra Pradesh, only 13 of the 36 medical colleges are in the public sector, in Karnataka the proportion is even lower with 10 of the 38 medical colleges being run by the Government (Medical Council of India, 2011). The increase in the share of private medical colleges has serious implications for the supply of doctors to work in rural areas as well as the public sector more generally. Medical graduates, who have often taken large loans to finance their education, have a natural and understandable desire to recover this money through working in the comparatively lucrative private sector. In addition to this there are great imbalances in the distribution of medical colleges around the country. The four southern states of AP, Tamil Nadu, Karnataka and Kerala, along with Maharashtra have 58% of all medical colleges in the country, but account for only 31% of the national population. In these states in particular, political interests have invested deeply in medical education, leading to the creation of an entrenched interest group that is difficult to regulate. On the other hand,

the poor states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh which have 36% of the Indian population have only 15% of medical colleges between them.

While medical education has been the subject of much discussion and debate in India, nursing education remains deeply neglected. The lack of autonomy of nurses, compounded by the lower social and educational position they occupy vis-a vis doctors, the influence of the medical profession in setting the agenda as well as poor financing of nursing education by the government are all cited as reasons for this (Rao et al 2011). Indian Nurses are in high demand abroad, and several corporate hospitals have begun training institutes to cater to the foreign market. Attractive salaries and working conditions abroad when contrasted with the poor salary and lack of autonomy that nurses often encounter in the Indian scenario, is leading to the departure of a large number of nurses from the country.

Major Issues of capacity building – For the existing health workforce lack of clear Human resource development policy, inadequate training facilities, lack of induction training are the major challenges of capacity building. Other problems like lack of willingness of doctors to service in rural areas, lack of proper records of registered doctors and attractive opportunities in private sector are additional challenges. Apart from this lack of performance monitoring and inadequate attention to the needs of health workforce for capacity building are additional issues.

5. CONCLUSION

However good a health worker may possess in theoretical knowledge, which may have been acquired from class-room lectures, one cannot render effective services to the public unless and until the practical aspect is considered. Therefore, training is highly essential. Health workforce will do much better if they are acquainted with the cultures of the people for whom services are meant stress has to be emphasized on programs capacity building. Some incentives and benefits need to be given for health workforce undergoing additional training programs.

REFERENCES

[1] Brown, L. (2003). A guide to monitoring and evaluation of capacity-building interventions in the health sector in developing countries. *Measures evaluation Manual Series*, (7).

[2] Capacity Development of Agrarian Research-Policy-Technology Personnel in Sri Lanka on 'Global Change and Sustainability'," *APN E-Lib*, accessed October 10, 2017, http://www.apn-gcr.org/resources/items/show/2041.

[3] Grindle, M. S., & Hilderbrand, M. E. (1995). Building sustainable capacity in the public sector: what can be done?. *Public Administration and Development*, *15*(5), 441-463.

[4] Leppo, K. (2001). Strengthening capacities for policy development and strategic management in national health systems. *World Health*, *16*, 18.

[5] Rao, M., Rao, K. D., Kumar, A. S., Chatterjee, M., & Sundararaman, T. (2011). Human resources for health in India. *The Lancet*, *377*(9765), 587-598.