

# Human Resources for Health in Major National Policies and Plans of Nepal

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## ABSTRACT

**Background:** Nepal first began planning for human resources for health forty years back. Since then a number of long-term and short-term plans, policies and acts have been introduced. This study is conducted to analyse the HRH gap in relation to objectives, guidelines, and priorities of the Ministry of Health and Population.

**Methods:** A combination of desk review of the HRH related policies, strategies, and plans of the government and stakeholder consultation was used for the study from October 2012 to March 2013. Ethical approval was obtained from the NHRC.

**Results:** Almost all the plans and policies highlighted human resources as central to successful health systems in Nepal. Still there are several gaps at the implementation level. The expanding health programs with increasing demand for health services has demanded more robust evidence-based planning of HRH. There are many vacant positions due to complicated health act including the issue of social inclusions of workforce due to poor implementation of program policies.

**Conclusions:** HRH needs to be recognized as dealing with more than just health personnel, but as assets necessary for the entire health system to function, plan, and manage it. There is the need to fill vacant positions in a timely manner, and increase the participation of excluded groups.

**Keywords:** Health policies; human resource for Health; policy implication.

## INTRODUCTION

The health sector is a major employer in all countries including Nepal, as it occupies one third of the total civil servants.<sup>1,2</sup> Health workers are critical to both quality and coverage of health services and consume a major share of resources allocated to the health system.<sup>2</sup>

Despite political instability in the last decade, Nepal has made remarkable progress in health sectors-child health, maternal health.<sup>3,4</sup> The interim constitution of Nepal has envisioned health as a fundamental human right and it is the state's responsibility to provide basic services to every citizen.<sup>5</sup> As free health care started, the number of service recipients has been increasing,<sup>6</sup> but with almost the same workforce of the 1990s.<sup>1</sup> We

need to increase human resources and infrastructure to deal with the rising number of health service seekers. And this requires policy interventions designed after the review of the gaps. The main objective of this study was to analyse the HRH gaps in relation to national policies, priorities and objectives.

## METHODS

Stakeholder (policy makers, district level stakeholders, and HRH Alliance members) consultation and a desk review of health and HRH related acts, policies, strategies, plans, and guidelines of the Government of Nepal were used to collect information. Stakeholder

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consultation caught the ideas and expectations regarding the priorities of various policy documents concerning HRH and their actions. It was undertaken over a seven-month period, between October 2012 and March 2013. Ethical approval was obtained from the NHRC along with informed consent and confidentiality of the information collected from each participant.

## RESULTS

The review of health policies and plan of Nepal revealed that the introduction of integrated community health programmes of 1974 is one of the initial efforts made to systematize the training process with the aim of developing all health personnel on integrated care and brought them into the integrated public health services from vertical projects. Since then series of different actions have been taken by the Government.

In the first long term health plan 1974, there is a chapter on health workforce. This plan identified the Institute of Medicine (IOM) as a major producer of health workers, especially certificate level workforce and medical doctors. This envisioned that there should be special health care regulation for effective management. However, this plan is mostly limited to the shortage of mid and lower level technical health professionals. Further in the development of the health sector, National health policy was developed in 1991 with the current organogram of the Ministry of Health and Population (MoHP) and its wings - female community health volunteers (FCHVs) - extended up to the community level to increase community participation. This policy has emphasized the cooperation for the development of the major academic institutions (IoM, CTEVT, NHTC, RHTC) to raise HRH production capacity. Moreover, the policy aims to encourage HRH to work in remote areas, plan out-transfers, and pursue promotion and career development procedures for HRH working at various levels.

*The 1991 policy is a far-sighted document that has driven the national health system for more than two decades. Now it has to be updated and revised according to the changing scenario of population and disease patterns.*

### KII Participants

The eighth five year plan (1992-1997) basically identified two areas for HRH development, namely: (a) expansion of the capacity of training/academic institutions in a planned way, and (b) mobilization of public and private sectors to produce skilled HRH in the country. In addition, it also established a plan to train basic and medium level human resources in Nepal, while super specialized personnel could be trained abroad. The second long

term health plan (SLTHP) 1997-2017 aims to provide technically competent and socially responsible health personnel in appropriate numbers for quality healthcare throughout the country, particularly in under-served areas. It has given emphasis on HRH management. Nepal health sector plan (2004-2010) aims to develop clear, effective and functional human resource development policies, planning systems, and programmes. It provides direction on the minimum number of staff at health facilities. It also emphasized a range of implementation interventions in order to address HRH challenges. These included two-year compulsory service scheme for medical doctors who studied under the government's scholarship scheme; up gradation of maternal child health workers (MCHW) to ANM; vacant posts filled by contract staffs; incentive packages to retain HRH; SBAs policy and a long-term plan formulated and in-service training of SBAs started; and training of all health personnel including FCHVs in Integrated Management of Childhood Illness (IMCI).

Further, the Nepal Health Sector Plan II-2011-2015 includes HRH issues. It states "a competent, motivated health workforce forms the core of a high-quality, effective and efficient health system." It recognizes that there are HRH challenges, including shortage of health workers, low motivation and poor retention, incomplete human resource information, poor skill mix, and low participation of highly excluded groups. To tackle these challenges, various actions have been outlined in NHSP II. The scientific and robust projection of human resources, coordination with medical schools/academia and training centres for the production and supply of critical human resources, upgrade and update provider skills to enhance quality of care, performance-based and retention-based payment systems, strengthen HuRIS, multiyear contract provisions, and reduce skill mix imbalance are some of the strategies.

The analysis of Gender Equality and Social Inclusion (GESI), 2009 reveals that there is very low participation of Dalits and other highly excluded groups in the health workforce at both policy and service delivery levels and MoHP plans to hire staff locally from these groups. One of the senior staff said "we could not hire new staff due to the decision of stay order from the court. Another important part is that there is no value of qualification of individuals at least in health sector to promote them in higher position. This will be a new challenge of national health system. The court will give their decisions to promote health workers, we need to promote them and depute them in appropriate places without looking at their qualification. If such situation exists, this will be the biggest challenges for managing HRH in national Health system including GESI."

The first national HRH master plan (1993-1995) was prepared by MoHP with the aim of technically competent and socially responsible HRH and their distribution across the country. This plan also talked about recruitment, deployment, and supervision mechanisms. The master plan adopted the strategies like training of FCHVs and TBAs at community level and deputation of health work force of different cadre based on the level of health facilities. This further emphasized on the updated HRH inventory.

*HuRIS database is not giving accurate HRH information, as it is not regularly updated. Moreover, the data in HuRIS are incomplete for use as a reliable planning and management instrument while the Ministry of general administration (MoGA) is maintaining personnel information system (PIS) all the civil servant with the aim to support human resource operations in the country. The two systems are not compatible.*

#### KII Participant

A strategic plan for Human Resources for Health (2003-2017) focuses on three strategic objectives, including: specifying the direction of development of HR, defining HR objectives for the medium term, and identifying short-term policy actions for MoHP so that the system gets ready for more challenging reforms.

The HRH strategy (2011-2015) is aligned to support the implementation of the HRH strategies contained in the NHSP-II. The major aim of the plan is 'to ensure the equitable distribution of appropriately skilled HRH to support the achievement of health outcomes in Nepal and in particular the implementation of NHSP-II.' The plan is more detailed with a focus on the development of HRH and elaboration on the needs of various kinds of specialists with an indicative attrition rate. This plan was intended to: (a) specify the direction and growth of human resource (b) outline human resource objectives for the medium-term, and (c) identify short-term policy actions. It includes future human resource requirements and supply, and examines their implications for training and training institutions. The plan, which was formally adopted, projects a 71% increase in public sector workforce by 2017.

Besides these plan and policies, certain program also has developed policies regarding training like skill birth attendants (SBA policy 2006). The civil service act (1993) provides for recruitment of different positions of HRH by reserving the quota for different ethnic groups including female candidates. This act gives priority to post the non-gazetted and classless employees in a place convenient from their houses for health sector while the health service act (1997) provides for the management of

HRH especially in recruitment, deployment, promotion, transfer, deputation, and disciplinary actions.

#### DISCUSSION

Although some kind of HRH policies are in place, status of policy implementation has remained partial if assessed through the above described national and HRH policies and plans, including the Strategic plans drafted in 1993 and 1995 and the HRH strategic plan of 2003. The changing role of the GoN, expanding health programs and budget with increasing demand for health services has led to partial reorganization of MoHP structure and addition of some staffing positions. For example, policy decisions made towards mandatory employment with MoHP of fresh medical graduates under scholarship was a kind of relief oriented policy decision. Likewise, implementation of free health care was not rationalized with need of more HRH at health facilities as anticipated with increase patient load.<sup>7</sup>

Almost all kinds of health policies, plans, acts, and related strategies mention the Human Resource Information System (HuRIS) as a component of supplying HRH-related information in Nepal. It contains personal details on every permanent employees working within the MoHP. However, it does not incorporate the records of HRH working in the police, armed forces, or army hospitals and private sectors in Nepal.<sup>1</sup>

There is also an imbalance between HRH demand and supply. The National Health Policy, designed in 1991, has not been updated in terms of population data or burden of disease. This contributes to a gap in identifying HRH requirements including the retaining mechanism into that policy.<sup>1</sup> The another important gaps in National HRH is that there is delay in roll-out and ownership of the HRH Strategy (2011-2015) to support in achieving the health outcomes in Nepal due to political instability.

Most health facilities in Nepal are sub health post (75%) of public health facilities and headed by AHWs. The MoHP began upgrading all 3,129 SHPs to HPs, headed by HAs, and all 676 HPs to Primary Health Care Centres (PHCC), headed by medical doctors.<sup>8,9</sup> Similarly, the MoHP is planning to upgrade some PHCCs to community hospitals. Apart from this, the GoN is also planning to increase basic essential obstetric care (BEOC) and comprehensive essential obstetric care (CEOC) sites in PHCCs and hospitals.<sup>10</sup> This is indicative that there is a huge demand of human resources (doctors, nurses, and other staff) for each level of health facility. The demand for certain categories of health workers as mentioned in the HRH Strategic Plan is not adequately projected.

Absenteeism is yet to be adequately addressed by any plan or policy. The Service Tracking Survey found

that only 50% and 69% of medical doctor were present in PHCCs and district hospitals respectively. The availability of nurses at these places were 74% and 83% respectively. According to the findings of the survey, specialist doctors showed the highest absenteeism rates of all cadres in Zonal and Regional hospitals.<sup>11</sup> A study of 23 districts hospitals also revealed that only 85% health workers were presented for 12 months, with the 56% for medical doctors.<sup>12</sup> The main cause of staffing shortages in the government facilities is the inability of the government to attract and retain HRH. Issues of HRH migration are not addressed by any exiting planning documents of HRH though many doctors, nurses, and technicians emigrate from Nepal for higher education and better work opportunities and few returns.<sup>13</sup> Health worker migration, especially for those whose training is funded by the public, is a substantial loss of scarce public resources impacted in skill mix and distribution of health workers.<sup>14</sup> Similarly, each year significant number of health Diaspora frequently comes to Nepal. None of the existing policies highlights the issue of Diaspora engagement in Nepal.

There is a policy for those medical graduates who completed their study through government scholarships to be working in remote areas.<sup>10</sup> While in practice, the length of stay is often shorter than two years. Most of these cadres immediately look for an opportunity to work in urban and easy access areas. Similar circumstances are observed among other categories of health workers such as laboratory technicians, radiographers, nurses, etc. But, the conditional scholarship<sup>15</sup> for higher education followed by service in remote areas is also practiced by non government sector (NSI) in Nepal remains effective for retaining medical doctors. This indicates that existing rules and regulation regarding deputation of health cadres in rural areas are not implemented properly by public sector. While the introduction of performance based incentives as Aama program is effective to attract health workers and improved management of institutions.<sup>16</sup>

The non-compliance with acts and policies negates what is written in the Health Service Act, particularly towards human resource transfer. The rampant increase in unplanned transfer of senior level management health workers at the central level badly affects the execution of planned health programs. Some human resources remain at one place for long periods, while others with political connections are easily transferred out of remote locations to urban ones without serving the mandated time. There is no good governance and the existing acts, rules, and regulations are not implemented properly.

The allocation of quota for making health workforce representative of all population is one important part

of health policies.<sup>15</sup> NHSP II and HRH strategy 2011-15 also talk about the GESI in HRH. The NHSP-II envisioned that an additional ANM from a Dalit or other excluded group will be trained to join HPs in underserved areas such as Rahat (welfare workers). This remains partial at its actual implementation level. Health service act also ensured the inclusiveness in the health workforce, but, due to stay order of court, public service commission (PSC) could take exam of most of the cadre.<sup>9</sup> This results in shortage of staff and overburden to the limited number of staff.<sup>16</sup> For short term management of staff shortage, the PSC has mandated the MoHP to employ gazetted staff for one-year contracts in all the vacant position, which is enhance the performance of health workers.<sup>15</sup>

Health Training is spelled out by all the policies. A competent, motivated health workforce forms the core of a high quality, effective and efficient health system. In order to materialize this fact, the national health training strategy 2004 was revised in-between. The strategy has focused on development and management of human resources at all levels for delivering quality health care services through shared responsibility with non government sectors in training programs.

Increase number of student is one of the crucial parts of HRH.<sup>15</sup> Most of the policies on health speak about the production of HRH by public private partnership and monitoring from MoHP. The condition of the teaching infrastructure in most of the institutions is generally poor with inadequately equipped libraries and demonstration rooms, little practical experience, and few opportunities for in-service training. It appears that there is a question of quality education and production and increase role of professional councils in the country. The revision of curriculum based on the current disease pattern and health problems is also an important part for HRH production.<sup>14</sup>

Reward and punishment of health workers is important part of human resource management. All 75 districts are ranked by DoHS based on their health performance indicators, with a new system to reward the best performing district at the regional and national level. Recently the practice of recognizing health personnel based on extraordinary works has begun. Regarding punishments, not much is happening based on evidence. Written clarification or deporting staff are observed at the district level. In the public sector, a rewards and punishment system has very low significance and is not based on standards.

Formation of unions is the right of health workers, but over the last few years, different unions of health workers have prompted a culture of politicizing all

administrative and governance-related activities rather than working to safeguard the rights and interests of health workers. Health workers who have good links with top political leaders are able to use their influence to enjoy substantial benefits and are placed in urban and desirable locations.

## CONCLUSION

Although a good number of HRH plans, strategies, policies, and acts are in place, the status of implementation and follow-up remained partial. The changing role of the GoN, expanding health programs and budgets with increasing demand for health services has led to pressure to MoHP structure and hiring additional staffing. Besides, the interventions on HRH are indeed crucial in order to address gaps in the under-served and disadvantaged areas, without this, national health goals are less likely to be achieved. There exists low participation of Dalits and other excluded groups in the health workforce as identified by NHSP II and actions to increase their participation remains essential.

A database, HuRIS, that provides comprehensive, reliable, and up-to-date information about all the health workers is urgently needed. The overall recommendation is to ensure the equitable distribution of appropriately skilled HRH to support the achievement of health outcomes in Nepal.

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