

## Why missing doctors and nurses worry India Inc.

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India has proved that its best shot can take the country to Olympian heights. But as the country turned 61 and the best in it march toward the top of international rankings, there is the disquieting irony of the nation in the global "worst list" in many spheres. One area where the glaring inequities show scant signs of dimming is healthcare. Skilled surgeons underpin a booming medical-tourism industry in a country reeling under an acute crisis of health workers. India is among the 57 countries worst hit by a shortage of trained health professionals, according to the World Health Organisation.

Some telling indicators: While India's maternal mortality rate (MMR) per 100,000 live births remains a high 450, it is 45 in China, 58 in Sri Lanka and 320 in Pakistan. Similarly, the infant mortality rate in India is 56 per 1,000 live births against 12 in Sri Lanka and 23 in China. Even Bangladesh fares better than India in infant mortality, with 54 children dying per 1,000 live births.

The figures are from the UNDP Human Development Report 2007-'08. The government has its own numbers. But they too do not make India proud. For example, the latest official MMR is still at an unacceptably high 301 per 100,000 live births. Many of these mothers and children could have been saved if they had timely access to a skilled health worker or doctor. The National Rural Health Mission (NRHM) has spent money in the past three years recruiting new staff for the health sector. But a lot remains to be done. The 24-hour comprehensive emergency obstetric service, a major component of the NRHM, for example, is still not functioning in most health centres in states like Bihar which have lagged behind in other development indices too.

The hot button issue in most discussions about the health worker crisis is migration of doctors and nurses from developing countries to the developed world. Of equal importance is underproduction of health workers – a global phenomenon. The United States is producing 30 per cent fewer doctors than required, and in Malaysia many new hospitals are not able to open wards, intensive care units and operation theatres because of a shortage of nurses.

In India, the problem is not a new one. What is new and interesting is the growing attention the issue is getting from officialdom and the corporate sector. The reason: like every crisis, this one too has thrown up enormous challenges and opportunities. The acute shortage of health workers is now threatening to hobble the grand plans of NRHM launched three years ago with great fanfare, and derail national efforts to reduce child mortality, improve maternal health and combat major diseases in the country.

The corporate interest in missing doctors and nurses is more recent. A 2008 joint study by the Federation of Indian Chambers of Commerce and Industry (Ficci) and global consultancy firm Ernst & Young has forecast that India will need investments to the tune of Rs 3,70,000 crores to provide just two hospital beds for every 1,000 people, from the present level of 0.86. But simply providing additional beds will not make healthcare accessible to people. Equally critical is tackling the country's healthcare worker shortage. Against the requirement of 700,000 doctors by 2025, there was a net addition of just 17,000 doctors a year, the study noted.

India Inc is taking interest in these issues because it realises the costs and benefits of the human resource crisis confronting our healthcare system. As Ficci secretary-general Amit Mitra put it recently: "Currently, economic losses due to poor healthcare are estimated at 1.3 per cent of the GDP. If such issues are not addressed holistically, the losses would mount to five per cent of the GDP." Bodies like Ficci argue that to bridge this huge supply-demand gap, there is an urgent need for rapid expansion of quality healthcare and the sector needs to be accorded "infrastructure" status. The study by Ernst & Young and Ficci identifies boosting human resources and public-private partnership as the key to achieving India's aim of quality healthcare for all.

So what is being done? The response to the crisis has been varied. The Assam government, for example, has assured a government job in the state for doctors who are below 65 years. The conditionality: They must serve in Assam's rural areas. The recruitment drive has been necessitated by the sorry state of the rural healthcare sector in Assam, with doctors not willing to serve in the interiors. And it is not just missing doctors. Shortage of nurses in Assam has severely impeded immunisation programmes in the past few years. The state government has also decided to wield the stick against medical students who graduate from government colleges but shy away from joining government hospitals.

The Union health ministry has taken some steps to tide over the crisis. Regulations under the Indian Medical Council Act 1956 are being modified to relax operating, staffing and land norms and ease establishing of medical colleges in India. The government plans to set up six AIIMS-type institutions and upgrade 13 existing medical institutes, besides 60 new medical colleges and 225 nursing colleges as per the 11th Five-Year Plan. A recent government decision also permits Indian doctors with postgraduate degrees in medicine from the United States, Britain, Canada, Australia and New Zealand to practice and teach in India.

But producing more medical graduates is only a part of the solution. There is no guarantee that more medical graduates will translate into more doctors in the countryside, where majority of Indians still live. Migration of health professionals is not only across national borders. Many doctors are moving to other professions; many health workers are shifting from villages to cities, and others from the public sector to more lucrative private sector jobs. The underlying reasons are complex, relating to not only salaries, but also the work environment.

The good news is that the debate about health workforce shortage has sparked much-needed discussions about emerging trends such as "task-shifting". Training a doctor or even a nurse is a long process. Some of the tasks traditionally assigned to doctors can be passed on to nurses and those given to nurses now can be shifted to other cadres. This has already started in rural areas under the NRHM but a lot more needs to be done to strengthen supervision, and the initiative needs to be extended to semi-urban and urban areas.

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