# Building up skilled workforce and building up a nation

"*Today on #WorldHealthDay, let us not only pray for each other's good health and well-being but also reaffirm our gratitude towards all those doctors, nurses, medical staff and healthcare workers who are bravely leading the battle against the COVID-19 menace.*" -Narendra Modi, Prime Minister of India, Apr 7, 2020[1]

Dear Editor,

Kumar and Sarwal analyse ways for closing human resources gap in health and aim for moving beyond production to proactive recruitment in their review article published in the Journal in Aug 2022 issue.[2] In the write up the top think tank of the Government of India underscores trends in the increase in teaching/intake capacity of medical and nursing teaching institutions across the country and then trends in increase in human resources in health in its tables calculating data spread dashboards of different websites. Afterwards, they tabulate trends of vacancies in public healthcare facilities.

Having gone through the assorted data, what scenario emerges is that despite the huge increase in teaching/intake capacity of medical colleges nationwide, there is a divorce from enthusiasm of its workforce to join the public healthcare cadre. The authors cite various reasons in *Discussion* heading from which I differ on several counts and enumerate with reasoning.

Under a heading of *Results-Trends in increase in HR (Human Resource) teaching and intake capacity,* the members of the *Aayog* state in point number 3 that maximum intake capacity at MBBS level increased from 150 to 250. Here, I want to bring under their consideration a point that before this increase, several Medical Colleges in the country had more than the alleged intake strength (of 150). This webpage states in its College Achievements that it has an increase in MBBS seats from 190 to 250 at the first point.[3] Hence, I want to draw attention of the members of the top transforming body towards this factual error, which needs to be modified. One can make a good *Niti* (plan) when one has correct baseline information.

Afterwards in next point number 4, the authors underscore that the ratio of teachers to students has been rationalised. What do they mean is that now a teacher can teach more PG trainees and the process will *produce* more PG doctors.[4] But what infrastructure has been created/laid to do so, what arrangements have been made or planned or what feedback has been obtained from the trainees or the teachers; I could not find anywhere in the article. If such an increase does not have its beneficiaries in the loop, how will one assess its success or otherwise, I wonder. If the purpose is just to increase quantity *somehow*, the scheme is miraculously successful. But if there is some idea of maintaining quality too of such under- training manpower, it demands having some checks and balances and also creating a real time feedback loop, I suggest. Human resources will serve alive human beings where making mistakes can be fatal and it's more important to improve or at least maintain their virtues over sheer numbers. But surprisingly, the focus of the review is otherwise.

Under a heading *Trends of vacancies existing in public healthcare facilities*, the Members emphasize that two-thirds of the population (of the country) lives in the villages. And there they cite a World Bank reference. The reference shows a graph indicating a constant decrease in rural population as a percent of total population. And the writers also mention that there is an urban bias in the distribution of HRH. Looking at both the data simultaneously I draw a conclusion that doctors are following a pattern of what others are doing. So is there something unique with the healthcare workers which is different from the general trend, I wonder. If that is not the case, and the problem is larger and general in nature; whether selected and specific incentives will be useful or larger policy decisions will balance the skewed distribution, the Members should ponder about.

When the authors discuss "*Why are there (unfilled) vacancies in public health facilities despite increase of HR availability?*" In its second paragraph, the authors state various possible reasons behind existing shortfalls in HRH. I request them to add unnecessary political interference in the working of the hospitals as one of the reasons.[5] When administrators make intrusive, anti-social and overpowering interference in day to day working of a hospital/health centre without any accountability, its remedy does lies more in finding true solutions, paying due respect and legitimate rights to hard working medical and paramedical staff than in counting the unfilled vacancies or seats in Medical Colleges or giving some incentives. When you create comfortable working conditions around, people sense and feel it and join you and that may be long-lasting solution rather than inviting them for campus placements interview. In this era of social media-driven information age, one can find several such instances and the apex powerful body should dispassionately dissect the challenge and then suggest few solutions.[6]

Afterwards, they state that as close to 6900 Indian trained physicians are working in the USA, the UK, Canada and Australia, there is shortage back home. But why are their counterparts not arriving here, is not considered anywhere. If India is not a

lucrative destination of highly skilled people, its causes should be looked into and fixed. Or some plan should be made and suggestions should be invited from stakeholders. When someone migrates somewhere, analysing its circumstances may be more useful than analysing the person. Nobel Laureates for Economic Sciences in 2019, Abhijit Banerjee and Esther Duflo, have a good body of work on the issue.[7]

COVID-19 pandemic taught us in a tough way that all of us are not safe until everyone is safe. Health care equity has its own advantages beyond numbers when all of us are together in the boat. If we want to make a peaceful and prosperous society, we need to think about what ails us and then fix it. Conjuring up numbers from thin air alone will hardly serve the purpose, I suspect. If we too rapidly expand medical education without paying adequate attention to higher standards of training by cutting the corners and fulfilling the minimum requirements only; although a large workforce may be produced but may not be of the best of its kind. Our policymakers should make more investment and plan ahead thinking about not just for today and tomorrow but for decades ahead. And a weak workforce who got less than the best/perfect training may defeat the whole purpose of the exercise. Everyone wants to be treated by a doctor one can trust when one is at her the weakest point of life and trustworthiness requires staff to have more qualities than to be there in enough numbers.

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## Conflicts of interest

There are no conflicts of interest.

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