2008

Human Resources for Health: Overview

LATH
LIVERPOOL ASSOCIATES IN TROPICAL HEALTH

HRH Strategy Group
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We have to admit it's getting better…

BACKGROUND

In any span of 20 years the world will change, and in looking back at health workforce development issues we note how much the changing global context has been a key determinant of the changing attitudes to human resources for health. In the past two decades, the ratio of health workers to population has changed little, if at all, in most African countries[1], while the burden of disease – led by HIV – has risen. The global picture has changed too, with a huge increase in the financial resources available for health. The major constraints to scaling up services are a health workforce that is not able to meet any more demands and health systems that are at the point of collapse.

The Liverpool Human Resources for Health (HRH) Group comprises staff from the Liverpool School of Tropical Medicine, Liverpool Associates in Tropical Health and associates with whom we work closely on human resources issues. The group has been teaching, researching and consulting in HRH throughout the changing global and country contexts for almost two decades. This overview paper highlights the changes that we have observed over time, in both the attention paid to workforce issues and the types of activities that we have seen. We hope that in sharing some of the lessons we have learned, we pass along their messages for others to use in the coming decades.

HISTORY

In the early 1990s, the strong links between health, social and economic development came to the fore, with a growing concern for Africa in particular, where the effects of the HIV epidemic were beginning to be seen and life expectancy and general health were declining[2]. The Millennium Development Goals (MDGs) recognise health as a central component of poverty eradication and highlight these need for fresh approaches and funding to achieve these goals. The immediate global response was to make available unprecedented financial resources to help countries achieve the MDGs. What then became rapidly clear was the precarious nature of many health systems in low income countries and especially of the health workforce. Years of under-investment and lack of interest in workforce issues have resulted in demotivated, poorly paid staff in many countries, with lack of practical education and training, poor supervision and management and ill-equipped facilities[3]. Suddenly the global spotlight was on the workforce.

THE GLOBAL HRH AGENDA

To the fore came issues of workforce production and planning, of migration of the highly skilled to more resource rich places, of productivity and motivation and of leadership and management. HRH finally emerged as a lead player on the global health agenda. Several members of our group were involved in the WHO Global Health Workforce Strategy group established in February 2000. Not long after, the Joint Learning Initiative began, initiated by the Rockefeller Foundation, and in 2004 published the first major report dedicated to exploring the state of the health workforce worldwide. Members of the Liverpool HRH Group were involved in writing papers and compiling the final report. We have also participated in designing and testing the Health Action Framework, used by the Global Health Workforce Alliance (GHWA) and more widely. And we remain involved with the GHWA, being part of the task forces that the GHWA has used to take forward the workforce agenda.

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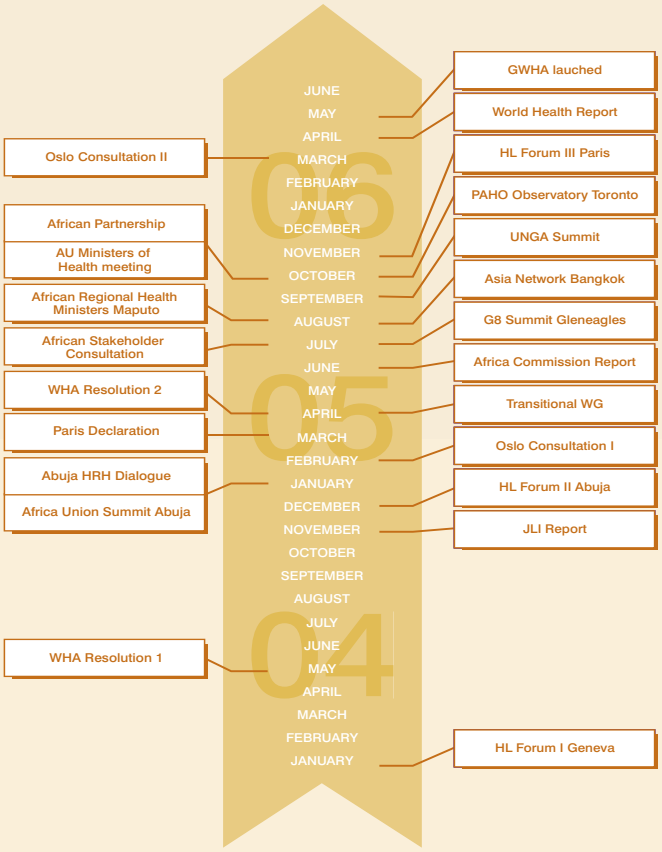
[1] *The Health Sector: Human Resource Crisis in Africa,* Support for Analysis and Research in Africa, USAID, 2003
[2] World Bank, *Better Health In Africa: Experience and lessons learned.* Washington DC, 1994
[3] Joint Learning Initiative, Human Resources for Health: overcoming the crisis. Global Equity Initiative, Harvard University Press, 2004

WORKING AT NATIONAL LEVEL

At the start of this century, there has been an unprecedented interest in health workforce issues and an increasing frustration in the apparent complexity of workforce development and failure to find a fast solution, expressed in the rapid expansion of meetings and initiatives (see diagram).

Policy-makers became more willing to consider prioritising HR interventions at country level and donors to fund not only disease specific programmes but also recurrent costs such as salaries. We have supported countries to conduct HRH assessments and construct HRH plans, mainly in sub-Saharan Africa, to be used for strengthening planning and management for the health workforce, and as part of applications to the Global Fund.

This was a time of innovative approaches at country level. The continued glare of the international attention coupled with the search for some fast answers, prompted a new zeal to searching for solutions. We saw more strategic planning for HRH, increased interest in setting up HRH units and data systems, a greater promotion of public private partnerships and involvement of non government health providers and employers. There was more readily available funding for research in HR development and a flurry of research on migration of health workers, its impact and causes.



Source: Global Health Workforce Alliance Strategic Plan, 2006. Available at: www.who.int/workforcealliance/en/

KEY ISSUES

In this section, based on our collective experience, we set out three 'big' areas of great concern to national policy makers and to those interested in workforce issues in the international community. We set out the current issues and how we would go about addressing them.

1. MAKING APPROPRIATE STRATEGIC CHOICES FOR WORKFORCE DEVELOPMENT

In many countries we have found that decisions about the health workforce have been made with little workforce data and a poor understanding of the labour market. Often this is a result of the departments dealing with HRH being poorly staffed, sometimes by civil servants who have had limited training in planning and management of HRH. If HRH departments do exist, then they may not be at a high enough level to be involved in key, strategic HRH decisions.

We have found too that conducting an HRH assessment can be seen as an end in itself, rather than an impetus for strategic HRH planning and management reform. A process of managed change that involves all stakeholders and negotiates all-round acceptable positions, has frequently been missing.

Undoubtedly things are improving: there is greater awareness of, and action on, the need for good workforce intelligence and the recent establishment of the observatory models in Africa and Asia attest to this[4].

The importance of the dynamics of the labour market in health and beyond is being studied and it is becoming obvious that it is not only migration out of countries that affects the workforce, but internal migration too, and that it is not uncommon for unemployment and migration to co-exist. This increased competition is highlighting the need for addressing issues of motivation and retention, with both financial and non-financial incentives.

Increasingly there is a recognition of the complexity of HRH strengthening[5]. Because the health workforce is one system embedded within others, solutions that work for one problem can have unintended consequences in other areas. One simple example would be rapidly increasing training of health care staff to increase the workforce. If this is done without attention to creating funded posts to employ the new staff, all that will happen is that there will be increased unemployment and then migration. Progress has to be made on several fronts at once to be truly effective. A better understanding of complexity and the workforce will help all of us to be more strategic decision makers.

The importance of having a strong team to lead on HRH planning and management is more universally understood than ever before. Countries are creating career development opportunities for dedicated HR staff and donors are funding HRH adviser posts within Ministries of Health. Better advice is available even to non-HRH trained decision-makers.

[4] Information about the observatories can be found on the WHO website www.who.int by searching in the health workforce subject area.
[5] Hargadon J., Plsek P., Complexity and Workforce Issues. JLI Working Paper 6-2, May 2004.

2. COPING WITH SHORTAGES

The World Heath Report 2006 reported a global health workforce shortage of about 4 million workers, worse in poorer countries where health needs are the greatest. Paradoxically, there may be a co-existing surplus in large cities as a result of a combination of more attractive living conditions, better opportunities for earning additional income in the private sector, coupled with weak planning and deployment systems. While there may be continuing debate about the exact magnitude of the shortage of health workers, there can be no doubt that in most countries with a high disease burden there are not enough workers to do the job.

The overall shortage problem can be exacerbated by increasing demands to scale-up priority disease programmes, which are often wealthier than the general public health sector and can take staff from regular duties.

There have been instances of unemployed trained staff willing to work, but governments have been unable or unwilling to finance the vacant posts. Unwieldy and lengthy recruitment processes deter recruits from applying for public sector posts - for example it can take a year to recruit a health worker.

Yet, in some places, there are daring and creative approaches to deal with shortages. In Kenya an emergency hiring plan was put in place and hundreds of health workers, from within the country, were recruited and trained quickly[6]. In Ethiopia the Minister led the strategy of 'flooding' the labour market with health workers including a new cadre of field workers, with two years of training, who could provide more than basic health care. Donors have broken the previous barriers and for the first time funded salaries and provided significant pooled funding for a national emergency HRH plan[7]. In Ghana, there have been significant steps to increase salaries and benefits for health workers. We have seen too positive examples of local and national schemes to improve attraction and retention to rural facilities in Thailand and Zambia[8] through the use of financial incentives but also through improving living conditions.

Task shifting is now centre stage as a strategy for increasing productivity, with a set of global guidelines recently published by WHO and endorsed by Ministers from 62 countries[9].

3. MANAGING PERFORMANCE

The focus of HRH strategies in most countries is to increase staff numbers and retain them, but numbers do not tell the whole story about the health workforce. Most studies about productivity show that weak management and supervision alongside poor motivation result in around 30% of staff time being unproductive[10]. There are many reasons for this, and most of them have to do with the quality of management that staff have on a day to day basis.

The issues are often not complicated: staff need clearly defined job descriptions and supportive supervision to teach them how to do their jobs well. Professional values have to be fostered by supportive professional associations. Staff have to have the skills, equipment and environment to enable them to do a good job and feel pride in their work.

High performing health facilities share similar characteristics. They have a strong sense of mission and commitment – examples have been seen not only in rich hospitals but also in faith based facilities. Mission statements focus on results and having a culture that recognises and rewards results can improve performance dramatically. This is a reason for performance evaluation against agreed results – not seen too frequently in weak health systems.

Organizational culture can be as critical as direct monetary incentives. Giving feedback in a supportive way, allowing creativity and a degree of autonomy to staff, encouraging learning on-the-job – all of these measures can improve motivation and productivity[11]. That's not to say that pay is unimportant when personal resources are few: paying staff on time and enough for them and their families to live on is a key first step to increasing productivity.

MOVING ON

We have explored briefly three of the major recurring issues in health workforce development and we can see that we are living in exciting times. We (the global community with an interest in developing our health workforce) are making progress. How can we maintain and even increase the speed of this progress? We have five practical suggestions for the future:

1. THINK THE UNTHINKABLE! ENCOURAGE RADICAL THINKING AND ACTION.

When real movement has been effective in making a difference to workforce development, it is often through radical measures, such as emergency hiring, creating new cadres or radical task shifting. Making appropriate strategic choices is vital - that should not mean a lengthy and stifling bureaucratic process, but rather a dynamic and creative venture with the kind of leadership that allows such processes.

Thinking differently about workforce planning and management can be inspired by some of the new ideas currently being talked about and tested. For example, task shifting – the rational redistribution of tasks between health workers – can mean increased productivity and motivation as roles change. Including more volunteers, especially in a labour market with high unemployment, can free up nurses and doctors to do more clinical or specialised work. To do this strategically means involving professional groups and patients or clients from the start to avoid tensions as roles change. Policy makers also have to be involved so that a national framework emerges to support new workforce structures and practices.

[6] Report of the Joint Design Mission to the Kenyan Health Sector, 2007.
[7] Help Wanted: confronting the health care crisis to expand access to HIV/AIDS treatment. MSF Experience in Southern Africa. MSF South Africa, May 2007 www.msf.org
[8] Koot, J and Martineau, T. Mid Tem Review: Zambia Health Workers Retention Scheme 2003-2004, March 2005. Available at: www.hrhresourcecenter.org/node/868
[9] Addis Ababa Declaration, January 2008, www.who.int
[10] See www.hrhresourcecenter.org in productivity for a selection of studies
[11] Fritzen S., Strategic management of the health workforce in developing countries: what have we learned? Human Resources for Health 2007, 5:4 www.human-resources-health.com/contents/5/14

2. CONTINUE TO BUILD EXPERTISE AND CAPACITY IN HR

The Joint Learning Initiative report said: 'We must spark a virtuous circle of acting, learning, adjusting and growing'. That is still exactly what is required for all of us as we continue to build and share our knowledge of what works best to promote a strong health workforce in every country. It is vital that we become national, regional and global learning communities to build a firm knowledge base for continued effective action. At the same time we have to create and value leaders at all levels – to implement high level change, but also to be supportive supervisors and change old cultures into learning organizations, being brave enough to value mistakes because they teach us something.

3. MAKE SURE THERE IS A HIGH LEVEL COMMITTEE TASKED WITH OVERSEEING WORKFORCE DEVELOPMENT

It is in the interests of all ministries and government to have a more healthy population and this simply will not happen without a strong health workforce. The health workforce is often the biggest labour force in a country and is usually the most expensive item in the health budget. Yet decisions are often delegated to staff with little access to key influential politicians and high level civil servants. Workforce development is a technical and a political process. There are many concerned stakeholders and moving them to consensus requires political commitment and leadership. Several countries have already established inter-sectoral collaboration committees, some in the Prime Minister's office, that bring together stakeholder groups.

4. ENSURE MULTI-STAKEHOLDER INVOLVEMENT IN STRATEGIC HR PLANNING.

There are now many opportunities for multi-stakeholder involvement, using SWAp-like mechanisms and with tools that are being developed[12] to bring people together to plan. We hear sometimes that the health labour market is viewed as a "them and us" situation where the private sector – for profit or not for profit – are seen as "poaching" staff. But this is how the labour market works and we need to be finding ways of influencing it.

5. GET BETTER LABOUR MARKET INTELLIGENCE!

Global health initiatives will continue to impact on the labour market but it is impossible to know what exactly will be the effects. Better data is needed not only within countries but between countries too. Surveillance of changes helps everyone to react quickly to control the impact on the home workforce. The observatory model that we have referred to already facilitates this constant labour market monitoring. It is a new way of working but as the health workforce becomes more mobile and the world shrinks, good national and international data will be an essential tool for strategic planning.

LEARNING VALUABLE LESSONS

The Liverpool HRH group has moved between the global advocacy level and the country, action-oriented level, balancing the different perspectives and trying to apply emerging lessons of good practice. It seems to us, at this important stage in the health workforce agenda, that there are some key lessons and questions:

- There are no 'quick fixes' in workforce development. It is a complex area, requiring a systems approach that takes into account that the health workforce is one system within other larger ones. There is therefore an imperative to keep workforce issues on the agenda. How can the level of advocacy we have seen in the last decade be maintained?
- For the same reasons we have to ensure sustained increase in targeted investment, mainly for salaries and allowances or incentives, and some for expanding and improving training. Will there be donor fatigue?
- Research into the effects of having a weak health workforce consistently show that health outcomes are adversely affected. Mechanisms are now needed to translate increased investment into improved HR outcomes that address current health problems. How can the big funds put into HRH development best be monitored and over what time frame?
- We have to find ways to continue to document successes and effectively disseminate them, while also giving the confidence required to implement them. This is knowledge management in international HRH – and it is an area of growing importance as it is in other fields of health. HRH came late to knowledge management, but must make strides to be a front runner.

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This document is available at: www.lath.com/our-expertise

For more information, please contact us directly to discuss your requirements with a member of our HRH team

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[12] See www.hrhresourcecenter.org for examples