A Review Of Human Resource Issues in the Health Sector

Briefing Paper

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Introduction

Although it is widely recognised that improved management of human resources (HR) is key to providing more effective, efficient and quality health services, few developing countries have made significant progress in this area in recent years:

- there is still an over focus on quantities – producing (and often overproducing) health personnel without taking account of the sector's needs resulting in limited resources being spread too thinly

- productivity is low as health workers are underpaid (or not paid at all) and often turn to alternative (at times illegal) means of making ends meet

- human resource issues have become detached from the broader mainstream policy. Staff plans often represent little more than wishful thinking, bearing no relation to resource availability, and key issues and problems such as reconciling strategic management (e.g. maintaining equity) with responding to local needs remain unresolved.

This paper gives a brief introduction to some of the main issues, some of the key problems, some of the approaches taken and key challenges for the future. The paper argues for a balanced effort in four areas of HR planning and management in order to improve access to quality health services by the poor, particularly at the primary health care level. The four HR areas that will be reviewed include:

1. improving efficiency in the use of HR;

2. improving equity in the distribution of HR;

3. improving staff motivation and performance;

4. improving HR strategic planning capacity in Ministries of Health.

1. Improved Efficiency in the use of HR

Cutting staff numbers is often seen as one way of achieving this. Over recent decades increases in staff numbers combined with severe financial constraints have not only squeezed salaries but also essential non salary items of expenditure such as drugs and maintenance. Cutting staff numbers is never easy as such measures are unpopular and carry high political costs. In many cases staffing patterns are determined by national socio-economic policies or by civil service procedures which operate independently of health ministries. In others there is little incentive for service ministries to reduce staff costs as the benefits tend to go to the Ministry of Finance. In practice, the goal of "having less staff but paying them more" has rarely been achieved.

Changing the skill mix and reallocating tasks is another approach that offers potential but has been little tried outside highly industrialised countries. Greater use of

nurse practitioners, as has been shown in South Africa, can reduce staffing costs without reducing quality. Although this area offers major potential there is still little evidence as to its cost effectiveness in a developing country context, particularly as the broader implications for training and continued professional development also need to be considered. Greater use of generic workers may serve to improve the patient- focus of services, although breaking down the tradition of strict job demarcation is likely to encounter significant resistance.

Flexibility in employment arrangements is another area which offers potential. In general, these attempt to relate work more closely to performance. This could involve time based approaches (changing shift patterns, working hours, etc) or contract based approaches (temporary staff, fixed term contracts or even contracting out services – usually ancillary services, sometimes clinical services and on occasion whole parts of the service may be contracted out to NGO, mission or even private providers).

2. Improving Equity in staff distribution

It is well recognised that providing access to cost effective primary health care services is the best way of improving health status of the population. There is little incentive however for health workers to do this. In terms of rewards and quality of life qualified medical staff would often prefer to work overseas or, failing that, work as a private practitioner in an urban setting. South African doctors emigrate to the UK, doctors from Botswana work in South Africa and Zambian doctors work in Botswana.

Central level planning has attempted to address this problem but largely failed. Incentives such as remote area allowances or subsidised housing are in themselves ineffective unless salary levels are also increased.

Even where there are excess staff (Sri Lanka, Morocco) or where the centre has been able to exert significant pressure using stringent regulations and apparently rigorous planning norms (India, Pakistan, Nepal, S Korea) there has been some success but many health facilities in rural areas remain severely understaffed.

Wherever service coverage remains very low governments need to adopt more stringent approaches to rapidly increase staff availability. Thus in Guatemala service provision to large areas of the country previously under-served by the government health services has been subcontracted to private providers. Since many of these providers had little previous experience in health care delivery, the government set up a tight regulatory framework specifying service coverage targets against which performance of providers (and whether they deserve payment) can be assessed.

In Peru, the government has used a Focal Health Spending Programme (funded directly by the treasury) to attract health professionals to remote areas. These professionals earn higher salaries and are entitled to higher allowances (housing, school, etc) than their colleagues practising in more affluent, better serviced areas. Unlike in Guatemala, the Peruvian scheme has put less emphasis on defining expected service or performance targets. Both schemes have achieved rapid increases in service coverage and staff availability although concerns have been raised about the quality of the services as well as regarding the financial sustainability of the schemes.

Decentralised HR planning has also been beset with problems and in some cases has led to even worse inequity. In Tanzania health officials did not have direct control of

staffing at PHC facilities. In Bolivia poorer districts suffered because they were less able to raise resources to pay staff. In Papua New Guinea provincial allocations were based more on political factors rather than need. But some success stories are also beginning to emerge when central level planning becomes more strategic and allows decentralised HR units to decide on specific staff strengths in each health facility. This is becoming the case in Ghana, Uganda and Thailand, where the establishment of decentralised HR units has gone in hand with better staff information systems.

Many countries have experienced a rapidly expanding and unregulated private sector yet governments have continued to target efforts at areas where the private sector (India) or social security health services (Latin America) are well established. Such duplication can be extremely inefficient and there is major scope for public/private partnerships to address this situation taking steps to ensure there is adequate protection for the poor.

Basic training of health personnel. As important as deploying sufficient numbers of health staff is to ensure they are able to do the right things. It is at the primary level of care that the main problems are experienced since training of many health professionals, particularly doctors and nurses remains hospital based and generally ill suited to the needs of primary care facilities. There are two main approaches to improve basic training (referring specifically to doctors and nurses). The first involves reviewing and adapting training curricula following better appraisal of service needs. This approach, though necessary, is slow and does not solve the often underrated image of primary care professionals vis a vis their hospital-based colleagues.

A second approach has been to create primary care specific professionals and two examples, one for nurses and one for doctors are worth mentioning. In the nursing profession the creation of public health nurses (PHN) in many African countries was a clear example. Unfortunately, few PHNs have been allowed to take a leading role in diagnosis and prescription of drugs thus reducing their potential to meet the needs of the population. In the few exceptions where PHNs have been allowed to practise (like South Africa, Namibia and industrialised countries like the UK and Scandinavia) they have clearly made a difference.

With reference to physicians, many countries (particularly in Latin America) are following in the steps of the UK, Canada, Spain and other countries by creating primary care specialist physicians, often called Family or Community Physicians. This approach has the advantage of raising the status of doctors working in primary care centres while enabling better targeting of services to specific population needs. Where doctors are likely to remain the main care providers this approach appears to be the way forward.

3. Improving Staff Performance

Individual staff performance is a key element in overall system performance. This, in turn, is governed mainly by the network of incentives, of which an adequate reward package, including a competitive salary is an essential pre-requisite not found in many developing countries. A second pre-requisite is for staff to have the means to do their work, especially drugs, transportation and communications, three elements often missing in many health facilities based in rural areas. There is increasing evidence from recent research that attempts to improve the performance of staff when these pre-requisites are not in place will not work and can be counter-productive.

This is because staff will perceive requests for improved performance as unfair unless similar efforts are made to improve their basic pay and work conditions.

An **adequate reward package** is essential but rarely achieved as health worker salaries are generally bound by fairly rigid public service guidelines; in some cases, however, health has been made a special case (the Philippines) enabling health workers have certain privileges.

Because governments are rarely in a position to improve civil service terms and conditions to any great degree de-linking health workers from the public sector has been tried (Ghana), but paying higher salaries still requires cost savings or income generation, both highly problematic. Experience in Zambia has also shown that health workers still place great value on retaining Government conditions of service.

Linking performance to rewards can take many forms and is in itself a complex issue. Suffice to say for this review that putting an adequate reward package is not equivalent to provision of financial incentives against performance achieved. The latter has proven problematic in both industrialised and developing countries.

In a nutshell, problems arise when incentives are either too small (why bother?) or too large (seriously affecting a worker's purchasing power), or when financial incentives are given to individuals for activities where a team effort is needed.

Recent research in Catalonia, Spain, suggests that if financial incentives are to be provided these will need to benefit all staff against individual, group and facility performance indicators. As for performance related pay, this requires fairly sophisticated management information and payment systems which few developing countries have, and its relevance to the health care industry – where performance and productivity are not always equivalent, is subject to debate in industrialised countries. In any case, for performance management to work it must go in hand with improvement in work conditions and with a decent level of pay.

Incentives for good performance are very weak. Although systems such as staff appraisal are often in place they are rarely enforced. Health service managers (typically clinicians) usually lack the necessary HR management skills to establish good systems. In addition, it is extremely difficult to measure performance unless specific, tailor-made outputs and indicators are defined for individual staff or units against which performance is measured. In practice though line managers may be reluctant to make judgements on others performance. Many may fear reprisals (Mozambique) but even when they do spot a problem they rarely have the power to take appropriate action. Finally, because staff seldom work along clear, individual objectives judgements on performance are often made on personal or political grounds rather than objective, technical criteria.

Health workers must also possess the **requisite skills**. A common finding emerging from best performing health systems is that the gaps identified during staff appraisal must be addressed speedily enough for the worker to have a chance of performing better. In many developing countries this is hardly ever the case for various reasons. First, training budgets are often centralised and training provided is often programme specific and unrelated to the specific needs of staff. A second problem is finding suitable training providers.

Many of the ongoing reforms require new skills which are often management (and not clinical) related and existing training providers are often ill equipped to meet this need. In these cases innovative approaches such as special mobile capacity building teams

(Zambia, Philippines, Colombia) will need to be put in place to meet this need, and existing training providers will have to adapt or new ones will have to be established.

As many qualified staff enter private practice, consideration should be given to the financing of training – is it appropriate to subsidise the private sector in this way?

A clear **career structure** can play a significant motivating role. This rarely exists, however, with the exception of doctors and nurses. With the shift from clinical to general management career ladders have become flatter reducing scope for advancement. Promotion tends to be based on seniority and patronage, not professional ability.

In summary, improving staff performance involves a set of inter-related interventions rather than just the application of one or other particular model. The focus of performance management should be to get the best out of staff and help them achieve their targets. Methods to deal with serious misconduct and grievances, although important and necessary should be just a small component of performance management systems. Wherever basic levels of pay and reward so permit improving staff performance involves the following steps:

- Definition of individual staff targets, in the context of overarching service targets and priorities.
- Performance review (usually six-monthly or annually), identification of gaps and action on identified gaps. Facilities to have and use their own training budgets.
- Performance management is facilitated when trained human resource managers (working for one of more facilities) are selected and work closely with both staff and facility managers.

4. Development of HR Policy and planning capacity – the challenge of health care reforms

Human resources are often mistakenly equated largely with training. Whilst training is certainly an important component of HR management, without strategic HR planning, HR policy development and HR management, good performance in the health system will not be achieved. As with other management functions in the health sector, reforms are likely to require HR management to move from the personnel administration function that usually does some simple human resource planning, to a function with a much more strategic approach. the monitoring of the staffing situation, but will also demand the development of strategic choices based on information from the monitoring process.

This will require:

- implementing the changes in organisational structures and staffing levels, and monitoring the effects to ensure objectives are being achieved. This will include raising the profile of the HR function.
- an adequately staffed HR unit with effective leadership.
- greater inter-sectoral collaboration – especially with Ministries of Finance and Local Government particularly where decentralised HR planning is involved.
- bringing professional bodies on board especially where the reforms involve changing conditions of service, job roles or initial training.

- establishment of new management systems (for recruitment, performance appraisal, local pay bargaining) and the provision of skills for staff to operate them.
- redefining the roles of the centre, regional and local level in HR management. At the local level HR skills may have to be integrated into the overall management function as there may be little case for dedicated HR staff.
- improvement of the information base. Effective planning requires up to date information on staff by location, type of facility, cadre, grade, sex etc. A computerised system is preferable but great care should be taken in the design and steps taken to ensure that all levels are involved and that data entered is accurate and is used as it should be – for planning and management purposes.

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