DFID HEALTH SYSTEMS RESOURCE CENTRE

Issues paper

Human resources in the health sector: an international perspective

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The DFID Health Systems Resource Centre (HSRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HSRC is based at IHSD's London offices and managed by an international Consortium of seven organisations: Aga Khan Health Services Community Health Department, Kenya; CREDES-International, France; Curatio International Foundation, Georgia; IDS (Institute of Development Studies, University of Sussex, UK); IHSD (Institute for Health Sector Development, UK); IHSG (International Health Systems Program, Harvard School of Public Health, USA); and the Institute of Policy Studies, Sri Lanka.

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1. The global context

The last decade has seen significant changes in the international development environment. The work of DFID and of many bilateral and multilateral development agencies has changed, and the focus is now on poverty reduction in highly indebted poor countries (HIPC), and on achieving a set of International Development Targets (IDT). The relevance of this to the health sector has been significant. The Poverty Reduction Strategies (PRSPs) in HIPC are being developed, and their health sector component is being refined. The strong links between poverty, low economic growth and ill-health have been given recent prominence by the Commission for Macroeconomics and Health (CMH). This has highlighted the need for continued efforts to develop more equitable and cost effective funding mechanisms at national and international levels, and for more investment in strengthening health systems with the capacity to deliver health care for poor people.

At the same time, there has been a growing frustration with efforts to reform public sector delivery mechanisms because these appear to be achieving little in the short term. Sector Wide Approaches (SWAPs) are attempts to combine new delivery incentives with sector wide funding support. But progress is slow and in parallel other global initiatives are being taken in communicable diseases control (the Global Alliance for Vaccines and Immunization, GAVI, and the Global Fund for HIV/AIDS, Tuberculosis & Malaria - GFATM) focused on reducing high priority diseases. What new funding initiatives have in common is the need for recipient countries to demonstrate sound policies (economic, social, pro-poor, programmatic and technical) before they become eligible for funding.

Unfortunately, the potential recipients of new sources of and approaches to aid delivery figure among the countries with lower institutional capacity, particularly in terms of policy implementation. These are countries where, generally speaking, health care, civil service and public sector reforms have encountered the greatest obstacles and failed to deliver on sector objectives. More important perhaps in the context of this paper is that low institutional capacity in these countries is, to a large extent, the result of deep rooted problems and inconsistencies in the way human resources, in health but in other sectors as well, have been planned and managed over the years.

2. The human resource scenario

Old and new challenges threaten the human resources (HR) responsible for health care planning and delivery in public sector funded national health systems. Among the old challenges, low pay and staff motivation, unequal and inequitable distribution of the health workforce, and poor staff performance and accountability remain key obstacles to health sector development. Among the new challenges, qualified staff move more freely among countries, and even countries that can train and produce large numbers of health workers are unable to retain them. The impact of the HIV/AIDS epidemic on the health workforce is not yet fully understood, but is likely to be significant particularly in Africa, where it has already resulted in absenteeism, attrition and a significant increase in workload.

The way development agencies and aid-recipient countries have traditionally approached HR problems has been ambivalent. The discourse of human resources being the most important asset of any health system has often been in sharp contrast with the amount of attention or the volume of resources that would be required to develop institutional capacity and to address deep-rooted problems in the human resource domain. This is not really surprising given the political and social sensitivities involved in tackling HR issues. But the complex nature of HR issues does not make these less important at the time of targeting aid, since the arguments for helping countries to deal with their HR situation are similar to the ones often used to emphasise, for instance, the need for sound macroeconomic policies as a pre-condition for aid effectiveness. And yet, it is characteristic of many aid programmes to refer to HR issues in the 'risks and assumptions´ column of their logframes when, given their gravity and importance, they should probably figure as free-standing purpose and output level objectives.

This paper, aimed primarily at DFID advisers and health sector analysts will attempt to map out selected issues relating to the planning and management of human resources by combining an international perspective with issues and trends emerging from individual countries. HR issues and challenges have been grouped into four broad objectives that poor countries, donors and advisers will need to address simultaneously over the next decade and beyond. The objectives are:

- Increasing coverage and staff retention to ensure adequate and equitable delivery of priority health services.
- Ensuring availability of key competencies and skills in the health workforce.
- Increasing staff performance against objectives.
- Strengthening capacity for planning and managing HR in the health sector.

3. Increasing coverage and staff retention

Effective coverage is determined by the ability of the health sector to attract staff both into training in the first place and subsequently into the health service. The challenge is then to ensure an equitable distribution of health professionals – both geographically and in the different areas of health care, and that they are adequately retained. Attracting staff into training and into the health service is strongly related to the levels of pay, to the social status accorded to the newly trained professionals and to the availability of jobs. Equitable distribution of health professionals and their retention is in turn related to the prospects of career progression and the incentive packages associated with the posts.

To ensure both effectiveness and value for money, types of staff that are most appropriate for the service delivery strategy of each country should be used, and the service delivery strategy should be related to the levels of public sector expenditure. For example, the financial and technical feasibility of attempts to attract doctors to small, remote health facilities in India should be balanced against, say, recruiting more, better trained Auxiliary Nurse Midwives (ANMs) and offer them a more attractive reward package (such as remote area allowances). These approaches make a lot of technical and economic sense, particularly in countries with low public health expenditure where the opportunity costs of hiring doctors can prove exorbitant. And yet few countries (with notable exceptions) have attempted to address this obvious inconsistency.

Major issues in ensuring good coverage are: the level of pay needed to attract health professionals; the distribution and retention of those that are available; and the significant losses currently being experienced through international migration and HIV/AIDS.

> **Issue: Low pay and/or declining purchasing power of salaries.** Twenty to thirty years ago health worker salaries in many African countries were considered to be attractive. The real and comparative value of these salaries has gradually declined and a general medical officer in Zambia is now paid about US$200[1] per month (1999 figures); and nurse in Ghana US$75 per month (2000 figures)[2]. As opportunities in the labour market expand, it is becoming increasingly difficult to attract workers – particularly at a professional level - in the health sector with such rates of pay. There has been a reliance on a sufficient supply of new entrants into training for the sector. With more employment opportunities opening up where the pay is better, some countries are experiencing difficulties in attracting new recruits. Low pay is a major, but by no means the only, trigger for movements of staff once they have joined – either to other parts of the sector (from rural to urban areas; from the public to the private sector), or out of the sector or even the country completely. Those staff who remain may be 'moonlighting' to supplement their salaries and therefore unable to make an full contribution to their jobs. The cost of the kind of pay increases needed to make a real difference is substantial due to the number of the employees involved, and because of the nature of the employment of civil servants this is not an area over which managers of publicly funded health services can have much influence.

[1] KW6,161,772 p.a. as reported in the Zambian 10-year Human Resources for Health plan, 2000.

[2] Ministry of Health and Health Partners (2000). Chapter VIII: Human resource strategies. in Consolidating The Gains: Managing The Challenges. 1999 Health Sector Review, Government of the Republic of Ghana.

Responses:

- While low salaries and inconsistent salary scales may take time to deliver the expected results they are issues that donors and countries cannot afford to relegate indefinitely, for inhibition only makes matters worse. Experience with civil service and pay reform in Tanzania shows that sustained efforts over a decade have substantially improved the HR situation within the civil service, at least in terms of rationalising pay-scales. Just as an example, before such efforts were initiated there were at least 36 different allowances, 23 separate salary scales and 196 different grades in the Tanzanian civil service[3]
- It is recognised that governments in poor countries cannot afford salary increases of the magnitude required. On the other hand donors have traditionally been reluctant to contribute to the salary or incentives packages. The exception has been national disease control programmes, where cash incentives have been common practice and been seen as a key to success of these interventions.
- Given the lack of government funds to substantially increase salary levels, an obvious funding source to turn to is the donors and lenders. However, there is little experience so far in donors contributing to the salary bill of staff in the public sector and more experimentation is needed here. In Cambodia, DFID has considered the introduction of performance-based salary incentives within the national response to HIV/AIDS. Preliminary results recommend: (a) a contracting approach where specified outputs are specified in return for a given budget, so that provider units are able to decide on the best ways to deliver the agreed outputs; (b) the targeting of incentives to units and individuals who are both critical to the delivery of services and are based in the geographical areas where the bulk of implementation takes place; (c) the development of clear and explicit institutional arrangements (who funds, who pays and who measures performance) and operational guidelines (to tailor incentives to outputs and to the individual's civil service grade/level)[4].
- Working conditions matter as much as salary levels. NGOs and mission hospitals are often more successful than governments at attracting and retaining health professionals. They sometimes pay more, though if all of the benefits of civil service employment are calculated the overall package may actually be less. However, the working conditions and working environment are often better, which makes these employers more attractive to work for.
- In a free labour market, areas of scarcity will attract higher salaries in an attempt to eliminate the shortage. There is much less flexibility for using scarcity premiums within the public sector, especially within the civil service, due to the inflexibility of the system and the fact that changes within one particular cadre may trigger grievances of equivalent cadres in other sectors. Where exceptions are made, there may be opposition by other health workers who do not benefit, as experienced recently in Ghana when overtime allowances for nurses were paid on different terms as those for doctors. In the early 1990s health sector personnel in the Philippines got special allowances over and above general civil service rates, but this caused problems when funding for these allowances was not passed over to local government employers in the process of devolution.

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[3] K Kiragu. A historical perspective of public service pay reform in Tanzania. A Note by K. Kiragu, Nairobi, Kenya, at the DFID Governance Advisers Retreat in Kendal, UK, October 1-5, 2001.

[4] Grace, Wilkinson & Curtis, DFID-supported review and recommendations on salary supplements and incentive payments to government workers, Cambodia. DFID HSRC, Dec 2001.

- The option of circumventing civil service constraints by transferring the health workforce to another employer with the power to pay higher salaries has been taken by some countries. However, the move to autonomous health boards in Zambia proved to be a highly complex and lengthy process, and Ghana's move to a national health service has been very slow and the issue of new pay scales remains unresolved.

Issue: Distribution and retention of staff in post. Countries may report overall staffing 'shortages' due to the inability to attract and retain sufficient numbers, or due to financial constraints that may be externally imposed e.g. as part of structural adjustment. Yet there may be an over-concentration of staff in urban areas at the expense of poorer, more remote, under-served areas where posts are left vacant (Ghana, India, Bangladesh and many poor countries) and in Hospitals as opposed to primary care facilities. In the private sector it is largely the market that determines where people work. The same market will affect public sector employees, if they supplement their incomes with additional private practice. In countries where new graduates fill posts in rural areas as part of a bonding system (for example the community service in South Africa or compulsory rural posting for young Indian doctors) the shortages may be alleviated, but the inexperience of these staff means they are less effective and the high turnover caused by the desire to spend the minimum amount of time in these areas severely disrupts service provision.

Another dimension of overconcentration is the mismatch between staffing strengths and services actually delivered across health facilities raising the question of whether sanctioned staffing strengths are justified in the first place. For example, many Community Health Centres (CHCs) comprising 3-4 doctors in rural parts of Orissa and Madhya Pradesh remain grossly underutilised. In some of these areas the main cause of low utilisation is the presence of alternative private (allopathic or traditional) service providers who compete with public providers and are often preferred by the population (IIHMR, 2001). Some Township Health Centre doctors in Fujian province, China, are seeing as few at four patients a day[5]. Variations might be linked to the type of provider. In Zambia, two hospitals were found to deliver roughly the same amount of midwifery services despite one having four times as many midwives as the other (Devillé et.al, 2001).

Responses:

- **On pay incentives**. The private sector tends to pay higher wages in areas of scarcity than in areas of plenty as a means of dealing with geographical shortages (or in the case of health, does not bother locating in areas of low income/low population density, so there is also an access/coverage issue here). In contrast the public sector tends to use national pay levels, but may offer inducements such as remote areas allowances, priority access to further training or additional promotion points, to attract people to work in less desirable areas. The problem is that to effectively compensate for loss of additional income (moonlighting) available to someone working in urban areas and social comforts, the inducement package may be extremely expensive. Whilst possibly affordable to middle-income countries, like Thailand, poorer countries like Ghana, India or Cambodia are having to approach donors to fund such inducements.

[5] Preliminary data from field research on decentralisation and human resource management in China.

- **For incentives to be effective** better information is needed at the operational level on the location of greatest needs (geographical or types of service), so that inducements are properly targeted, and on the real staffing levels. This may be difficult in practice in health systems with a strong central planning culture (where local needs do not play a role in service planning) and an inflexible bureaucracy (where approved posts may be "filled" and yet there may not be staff in post). Inducements should be tied to the post, so that only those people working in these posts benefit from them.
- **Incentives in rural hospitals**. Whilst in the past much emphasis has been put on improving primary care, the contribution of secondary level hospital facilities to achieving some of the IDTs (such as reductions in MMR) is now recognised. Better obstetric and emergency services coupled with improved access to transport and communications are key to reductions in MMR and may have more impact than training large numbers of village midwives or TBAs. Where such circumstances apply it is important to strengthen and increase the autonomy of secondary hospitals[6], and thus the opportunity arises to make them more attractive places of work. This may prove costly and difficult in practice, but probably important in the medium to long term judging mainly from experience in more industrialised countries of the European Union (such as Spain) where the problem of attracting qualified staff to County hospitals used to exist.
- **Revisiting private practice for public sector doctors.** Some countries (including a few Indian States) are beginning to allow public sector doctors to engage in a limited amount of private practice as a means to improve retention by allowing practitioners to complement (low) government salaries. Some countries and donors have raised a number of concerns involving this practice, but doctors in many industrialised countries (including specialist consultants in the UK and Spain) have been doing it for a long time. If this response is to be followed private practice should be transparent, covered by contract and with risk sharing if applicable. It should also take into consideration that private practice is unlikely to attract new practitioners (especially consultants) to remote areas.
- **Delivering services through less costly staff.** Sometimes it is a losing battle to retain highly qualified staff in remote areas if a) controls are weak and b) financial incentives of additional income available in the cities are high. In the absence of the highly qualified staff the work can be done by non-professional health workers, who are often locally recruited, require shorter training and have lower salary expectations. In some countries this problem has been accepted and professional substitution used (for example Zambia's Medical Licentiate, in Karim et al. 2000). These initiatives are coming at a time when some countries are finding that the trend toward professional upgrading (e.g. abolishing the Enrolled nurse cadre and upgrading existing ones to Registered Nurse) is counter-productive and are re-introducing lower cadres (for example, Uganda's Nursing Assistant)[7].
- **Public-private competition and low service utilisation.** Where public services compete with the private sector the issue remains whether there is a justification for the public sector to be present at all. If the objective is to ensure service provision for those who cannot afford the cost of private providers it would be more appropriate for the government to target public

[6] The introduction of hospital autonomy would be for financial and more general management reasons. Improved staff distribution is likely to be a secondary issue - or from the HR manager's perspective, an opportunity to be exploited.

[7] Personal communication from Sally Lake.

subsidies to private providers for specific services. This approach has been successfully introduced in some parts of the world, including Bolivia's Mother and Child Health Guarantee scheme. Where public sector services do not have any competition from the private sector but utilisation remains low in relation to staffing levels there is a strong argument, particularly in poor countries with low health investment for staffing strengths to be revisited and redistributed to other areas or downsized. Staffing strengths can be determined using service activity analysis or audit to provide evidence of variations in workload between different units or individuals.

Issue: professional migration. This is not a recent phenomenon, but it has recently been brought up as a political issue in both bilateral and international fora. Whilst claims in this emotive area have often been based on poor data, significant losses from small, poorer countries inevitably has an impact on the country's ability to provide effective health services. Long-term migration also undermines the return on the country's investment in education and training. The reasons why health professionals migrate are not dissimilar to those for moving from the public to the private sector: better pay, better prospects and better working conditions. Where there is sufficient demand in the private sector (for example, for pharmacists) professionals will often prefer to stay in their home country. The desire of professions to ensure that they meet international standards simply assists migration. Whilst developed countries have been criticised for 'poaching' health workers, some developing countries (India, for example) have been arguing through the WTO GATS and other fora for greater access to international labour markets for their skilled professionals, as remittances may have a significant impact on national economies. Some countries act as both importers and exporters (i.e. Spain receives staff from poor or economically hit Latin American Countries while exporting staff to the UK; in the past South Africa has employed many health professionals from other sub-Saharan African countries whilst its own professionals migrate to the UK, Canada, etc).

Responses:

- The poverty of the current data on migration has been recognised as a major limitation. There appears to be a renewed interest in this area with research now being carried out by the ILO, WHO, the Commonwealth Secretariat and other researchers. There is a need to ensure that results of this research are synthesised and integrated into the policy making process.
- International migration is only one form of movement of labour. Strategies to reduce migration levels (where desirable) need to be integrated into other wider retention strategies. This will inevitably include but not be limited to the need to increase salary levels. However, it must be recognised that disparities will probably always exist and, for example, the Zambian public sector may never be able to compete with the US private sector. It may therefore make sense for a country to invest more in types of staff whose qualification is not recognised internationally, such as Zambia's Medical Licenciate.
- In a free market, international migration is inevitable; it also brings benefits such as the exchange of ideas and skills. Currently the full advantages of migration are not being realised: individuals are being exploited by recruitment agencies; because of the barriers to practice, skilled health professionals may end up doing menial work; and on their return home people may not be able to get back into the health service due to inflexible bureaucracy with the result that newly acquired skills and practice cannot be used. Forms of 'managed migration' such as bilateral agreements (e.g. fixed

term contracts and assurances of return) and agreements within trading groups (e.g. movement of nurses within CARICOM countries) may increase the benefits of migration to all stakeholders. Codes of practice on international recruitment are important in the management of migration. These have been introduced in England for public sector and some private sector employers. International codes are currently being developed by the Commonwealth Secretariat, the International Council of Nurses. Support will be needed for the implementation of these codes.

Issue: Staff losses due to AIDS. There is increasing evidence of deaths or long-term illness whilst staff are in-service most of which is attributed to HIV/AIDS in sub-Saharan Africa. The Malawi Human Resource Plan (1999-2004) worked on an assumption of annual losses of 2.8 per cent based on personnel data, though this is widely considered an underestimate. It is estimated that in South Africa there will be a dramatic rise in deaths amongst those aged between 25 and 44, and in particular amongst females who make up the majority of the health workforce (Dorrington et al., 2001) showing a much more serious problems.

The HIV/AIDS epidemic is also having a dramatic impact on work in some countries both in terms of a substantial overall increase in workload, and the fact that new types of care are needed (for example voluntary counselling and testing - VCT) for which few types of health workers have been trained. In addition, the epidemic is increasing social demands on the time of healthy workers such as for caring for sick relatives, attending funerals, etc. much of which eats into working hours. Overall the epidemic is having a serious impact on availability of staff and workload, not to mention the psychological impact, which is likely to affect performance.

Responses:
Major efforts are already underway to tackle the epidemic itself. However, many of the benefits will only be realised in the longer term. In the short to medium term the responses relevant to the staffing of health services are presented:

- Attrition in the form of long-term illness or death has been negligible in the past and therefore has not been of much concern to human resource planners. However, some recent HR plans (Zimbabwe, Zambia and Malawi) have attempted to determine rates and include this in planning scenarios. Better ways of recording this sensitive information still need to be developed.
- Little is known about the hazards to health workers of occupational exposure to HIV/AIDS, though one study on the use of prophylaxis is currently being carried out (Taegtmeyer, 2002). Improved protection is likely to need an assured supply of rubber gloves, disposable syringes, etc, and in-service training.
- Training in home-based and palliative care and VCT is taking place. However, the challenge is to meet the huge demand, and to maintain the quality in developing skills such as counselling which often require significant behaviour change for health workers.

General considerations for DFID and donors to support improved staff coverage and retention

- Countries need more effective HR strategies to improve attraction, retention and distribution. HR capacity is generally weak and undervalued. Donors should use influence and provide assistance for countries to deal with, or at least to map out, the HR scenario. TA support should also be offered.
- Donors can no longer overlook the need to address the salary issues if they are serious about meeting IDTs, developing sector capacity and engaging in longer-term development efforts.
- When dealing with salary or incentive issues donors need to keep in sight the wider public sector, and recognise that changes in one part of the public system have implications for the system as a whole. Pay and civil service reforms may take time to deliver results but are unavoidable.
- Donors can only address these complex issues if they speak with a single voice and work as partners of the government. SWAPs and budget support are a step forward, but experience with them is still limited and much more (in volume and scale of effort) needs to be done. SWAPs are sector specific, so they may not be the right approach in countries requiring extensive civil service reforms.
- The HR component of health sector appraisals needs substantial improvement in terms of separating shorter and longer-term HR policy issues. Failure to articulate HR strategies will limit the potential impact of initiatives such as the GFATM, in the same way as it has limited the impact of aid for health care, public sector and civil service reforms.

4. Ensure availability of key competencies and skills

Coverage and retention are important but, as some would argue, what is the point of keeping people in post that are unable to do their jobs? Indeed, problems relating to competencies and skills plague the health sectors of poorer countries. Typical examples include: doctors posted to primary care facilities and expected to supervise public health programmes lack the necessary public health skills; access to service management positions is only open to medical practitioners – they often lack basic training or are simply unfit for the job; health workers with very basic training are expected to perform fairly sophisticated public health tasks – sometimes because of the absence of more qualified health personnel. Even when workers have been initially fit for the job lack of on-the-job training has allowed their skills to deteriorate.

Training and development systems are needed that will a) provide new recruits with appropriate skills with which to do their jobs and b) ensure that people's competences and skills are maintained, and updated as their jobs change or as they change their jobs (through transfer or promotion) within the health sector. These systems need to be responsive to the change in types of skills and competencies needed and to the volume of people needing them which may increase dramatically at time of major systems change. The way in which skills and competencies are developed is also extremely important.

Donors have traditionally supported training through funding and technical assistance, whether as part of disease control interventions (where selective training has been key to programme success) or in the context of wider sector development efforts (through management development, where results have been often disappointing because simultaneous systems strengthening efforts have either not taken place or failed). The following categories of issues are reviewed in this section:

- Entry qualifications for a post and training output do not match the job description.
- Job descriptions are unclear or vague.
- The training needs of health personnel are not updated and acted upon.

Issue: entry qualifications for a post and training output do not match the job description. When the training output does not match the job requirements the link between the planning of staff numbers and types and the curricula of the training institutions is lost, and staff joining the service feel unprepared to do the tasks expected of them. This situation has been fairly common -and is more understandable- when training facilities are run by the Ministry of Education, but frequently the non-degree training is run by Ministry of Health and problems are still found. In poorer countries the limitations may be due to the shortages of tutors, partly because of the lack of attractiveness of the job (Malawi). Training institutions may be seriously under-utilised due to the change in demand, and thus be wasting resources that could otherwise be re-directed.

When entry qualifications do not fit the job description, or when entry qualifications are not specified or enforced staff joining the service may be unfit for job. Common examples are medical doctors taking up managerial positions or being assigned to non-hospital based care just because they are doctors and without undergoing any service specific, induction training. A good example of both problems is the Indian health system where medical officers are promoted to block or district level administrative positions, or are posted to primary care facilities and expected to supervise extension workers and primary care interventions for which they have not been trained.

In some cases it is becoming harder to attract people into training for health professions. Yet of those that do join the courses many either fail to complete them (Ghana, Malawi) or to subsequently go into the health sector following graduation.

Responses:

- To overcome resistance of the professions and to ensure incumbents are fit for the jobs countries have adopted several strategies:
    - They have established new entry qualifications and/or established new training requirements that all incumbents must meet.
    - In the case of medical doctors progressing to management positions, some countries have simply widened entry requirements (so that other professionals may compete for the post) while enforcing basic job-related training and induction.
    - To deal with the problem of inexperienced, hospital-trained medical graduates being posted to primary care facilities countries have either set induction training (UCT training model in South Africa) or –in what appears a more permanent solution- they have created a new medical specialty such as the family doctor (an ongoing trend in middle income countries of Latin America and the Former Soviet health model).
- Because lack of training capacity may prevent much-needed expansion of training output, special top-up funding may by used to attract people back as tutors (Malawi); refresher training for tutors may also be needed to support this.
- Rationalisation of training institutions to make a smaller number of institutions viable (Ghana) and thus make training more sustainable.
- Need more of a commissioner/client relationship between health service providers and training institutions (as per UK training consortia) to ensure most effective use of training resources.
- The development of the essential package of care is more clearly defining the work needed to be done, and therefore the competency requirements. This makes the design of curricula technically easier (Zambia), though these changes may run into problems with the professions.
- In some cases the re-orientation of the work of health professionals may be so radical (e.g. move from specialist medicine to general practice – Georgia and other FSU states) that national trainers have no experience conducting such training. The expertise can be developed by study tours to see approaches to training in other countries and by technical assistance from outside the country (Georgia).
- Monitoring of attrition from training helps identify at risk groups and/or stages of the course which can be targeted to improve retention e.g. high rates in midwifery (Malawi)
- System of accrediting training institutions – usually by relevant professional bodies. Perhaps more thorough and relevant systems need to be developed (Malawi refusing to use well-qualified expatriates; Georgia developing detailed accreditation system for medical schools along side introduction of new curricula).
- Provision of training budgets to districts and hospital boards (Zambia) can improve the relevance of training provided.

Issue: job descriptions are unclear or vague. It is not uncommon in large**,** centralised health systems for job descriptions to be out of date and bear little relationship with the tasks that staff actually perform or should perform. Although it may seem too obvious clear job descriptions linked to the post are essential.

However, it would be wrong to expect the mere re-drafting of job descriptions to make a difference unless other more systemic issues are looked at simultaneously, such as checking whether entry qualifications match the post or, in decentralised health systems, allowing service managers to have some say in recruitment procedures rather than just 'being assigned' new staff.

Issue: the training needs of health personnel are not updated and acted upon to ensure development and updating of skills. The need for ongoing skill development due to change of types and ways of working has been recognised. The challenge however remains how to provide this skill development effectively. The perverse effect of attendance incentives used by donor-funded programmes has been well documented (e.g. inappropriate people attending; large amount of time off site). There is an increasing recognition of the need for management skills even at quite low levels while, at the same time, the lack of high level strategic planning and management capacity is definitely holding back implementation of major development initiatives (e.g. SWAps, budget support, GFATM, GAVI and others).

Responses:

- Co-ordination of in-service training; while a lot of work has been done in this area (e.g. Ghana) it has often been ineffective against the pressure and financial power of national programmes and the attractiveness of income generating opportunities for individuals that are provided by courses
- On-job learning (including action learning) has been used successfully, but particular kind of facilitation and motivational skills required makes these initiatives very difficult to scale up.
- National management development approaches targeted at service providers and at health managers have been used in many countries (Ghana, Tanzania, Nepal, India) but results have been mixed: even when competencies have been acquired these may not be put into practice due to the rigidities of central planning structures.
- High level strategic planning and management capacity is difficult to develop through one-off training courses, yet most strategic initiatives within the health sector cannot succeed without competence at this level. The selection of individuals who will take up these posts is very important. As there may be no history of the initiative being introduced e.g. decentralisation exposure to countries where there is experience can be helpful (South Africans to Philippines for devolution; Malawians to Zambia for SWAp)

5. Increasing staff performance against objectives

It is important to ensure there are adequate numbers of appropriately skilled staff available, but they will not deliver quality health services without effective performance management. Whereas there has been a reliance on professional ethics to drive performance, this is now less effective partly due to the new requirements in many health systems for health professionals to behave differently.

Issue: Failure of existing performance management systems. Many government health systems still carry out staff appraisals despite these not being related to performance or being ineffective in terms of measuring, comparing or indeed enhancing the performance of staff. A recent research study looking at the practice of performance management in 15 health care organisations (11 in developing countries and four in the European region) found that only two of them (both in Europe) had developed and were implementing performance management (PM) in a rigorous way.

Despite a multitude of public sector reform programmes, effective performance management is rare in any sector in the developing country public services. This may be explained by the fact that effective PM relies on several prerequisites being in place, which are often missing in developing country health systems. Among these requirements the need for staff to receive a competitive salary (so that staff are not forced into ´moonlighting´), to have the tools to do their work (drugs, equipment, transport) and to be familiar with a local planning culture where targets are set and reviewed periodically. From a management perspective, for PM to be effective it requires levels of local decision making and personnel management that are in short supply in most developing country health systems (Martinez and Martineau, 2001).

Responses:

- Of all the prerequisites for PM perhaps the most critical one is the existence of a local planning culture that enables staff to set objectives and targets and review these periodically. For individual performance cannot be assessed unless broader service, unit or team targets have been previously agreed. In fact, most European health systems put greater emphasis on setting clear performance targets (aligned with funding mechanisms and with national health priorities) for the service unit as a whole than on setting individual performance targets. A useful way to introduce a local planning culture among health service providers is to set measurable service quality improvements that take the opinion of users into consideration. A culture of Quality Assurance in service delivery therefore facilitates PM.
- It is much more important to use simple systems that can be sustained than to attempt sophisticated systems that are too complex or labour intensive, particularly as it is much harder to re-start a performance management system following a previous failure. One district manager dramatically improved punctuality simply by standing at the hospital entrance at the beginning of the working day (Martineau et al., 2001).

Issue: effective use of incentives in managing performance. The use of both monetary and non-monetary incentives to drive performance is not new. However, it must be clear to individuals what they should be achieving through the setting of targets based on wider organisational plans. Such incentives only work if they are seen to be linked to improved performance on the part of the person or group being rewarded. Promotion may be officially linked to good

performance, but this is a risky approach as it may not be possible to promote all good performers or to promote them all the time. Besides, if known poor performers are seen to be promoted (perhaps due to patronage or other reasons), promotion ceases to act as an incentive. The same is also true when promotion is only seen as a way of increasing salary level (Malawi). Incentives can also be used to drive change of behaviour, for example to spend more time on preventive and promotive work instead of curative work, or to influence prescribing habits.

Response:

- Incentive systems will only lead to improved performance where there are transparent and robust systems for measuring performance and rewarding it appropriately. Some studies in Guatemala, UK and Spain have shown that incentive payments have actually been reduced over time in agreement with staff and management as they have been seen as too divisive (Martinez and Martineay, 2001). This may explain increasing international interest in looking at team incentives and sharing gains in health sectors to try and avoid the issue of divisiveness.
- Incentives may be built into funding mechanisms. In the UK and Spain payments to GPs are a combination of capitation and fee for service which combined with the quotas for referrals and the targets for specific services condition the behaviour of physicians. In practice though combining various types of payments systems requires fairly sophisticated health, management and payroll systems that many countries do not have, and work better where the provider/purchaser split has been introduced.
- Problems occur where there is a lack of clarity about the purpose of incentives and where these are provided inappropriately. Some, as discussed above, are used to attract and retain staff and should only be provided to people in posts where a shortage has been identified. In the case of performance management, incentives should be linked to the achievement of targets that are somehow above the average level of performance and should only be provided to individuals or teams that meet those targets. Experience has shown that when performance related incentives are not clearly regulated or based on measurable criteria they end up being perceived as a form of unconditional pay rise.
- Donors are beginning to support the provision of incentives within aid programmes (as in Cambodia) in what can be considered a positive trend, but it is too early to assess the effectiveness and sustainability of these incentives.
- The increasing pluralism of the health sector means that ministries of health have less direct influence on the performance of health professionals. Some influence can be directed through professional regulation and standard setting (in the Philippines continuing professional development has been introduced as a requirement for re-registration, in Martineau, 1993). Other forms of performance management of private sector providers and those in the public sector where commissioner and provider have been separated relies on a contract specifying outputs of the unit or institution. This in turn should drive the performance management of individuals. However, this is problematic in situations where the separation is only partial (as in Ghana and Zambia at the moment) where provider units have been made accountable for meeting service targets, yet the majority of the staff are still employed by the commissioning agent.

Issue: Opportunities created by organisational changes.
Performance is strongly influenced by organisational culture, and hence improvement in performance can be slow and difficult in organisations that have not been focussing on outputs. Structural changes or changes in the nature of employment offer opportunities for more rapid change in organisational culture, but these opportunities are often missed. An example are changes that result in people moving from permanent to fixed-term contracts, with renewal dependant on good performance. However, there are plenty of examples of performance criteria not being set and contract renewal being taken for granted thus invalidating the performance management tool. In Malawi the government introduced performance-based contracts as an option for senior managers which substantially raised salary levels without specifying any performance standards (Martineau, 2001)

Response:

- There may be few examples of opportunities created in the health sector being used to develop an improved performance culture. Lessons may be learned from other sectors. In Ghana when the new Forestry Service was being developed out of a ministerial structure, a comprehensive strategy (including building the work culture *before* the transition) was used to ensure that a new and effective work culture was established.
- Decentralisation should lead to increased accountability – for example to a local management board. If the board members are well prepared for their roles, this form of governance can provide the external pressure to drive internal performance management (plans for Zambia).
- The ability to spot the opportunities in organisational change for improving performance depends a lot on having effective HR personnel, the subject of the next section.

6. Capacity for planning and managing human resources in the health sector

We have laid out some of the key HR challenges that need to be taken up as a matter of urgency. However, a strategic coordinated approach to the planning and management of human resources in any sector of the developing world is uncommon, and even rarer in poor policy environments. Added to this the management of staff in the public sector is usually done by a 'one-size-fits-all' system driven by central government but involving many other stakeholders, and anything outside this - NGOs and private-for-profit organisations – remains largely unmanaged. The relevant policy issues are therefore the nature and location of the policy and decision–making processes, and the requisite institutional capacity to make and implement appropriate policies and decisions. This would be challenging enough in a static system, but most countries are undergoing reforms in some parts of government which either directly involve the health sector, or have an impact on it.

Issue: mapping out stakeholders. HR in the health sector has a large number of stakeholders including many departments of government (Treasury; civil service office; public service commission, the education sector and increasingly local government), professional organisations, trade unions, regulatory bodies, education sector providers and representatives of the private sector. The process of policy and decision-making is therefore very complex and in the public sector may also involve different levels (national, regional, district, institutional). This impairs the responsiveness of the system.

Response:

- In the health sector, managers with HR functions (for example, chair of an HR taskforce, chief executive of a professional association, HR director within the ministry of health) need to map out all the important stakeholders and identify their different agendas. A generic map has already been used and adapted in numerous situations (Martineau and Martinez, 1997). An important second step is to streamline communication between the various stakeholders once it is clear who they are. Varying degrees of success have been achieved in Malawi (in the HR planning process and subsequent to that) and the Republic of Karelia, Russia (through the development of an HR strategy to support the reforms, in Martineau and Buchan, 2000) but such initiatives are notoriously difficult to sustain partly because of the high turnover of key individuals.
- Some measures have been taken to improve the responsiveness of the system, by reducing the number of different stakeholders involved. For example, in Ghana where excessive delays in appointing staff exacerbated shortages, the Personnel Administration section of the ministry of health was merged with the HR department (which deals with HR planning, management and training), in order to speed up administrative procedures and reduce vacancy periods (Ministry of Health, Ghana, 2000).
- A more radical response to the inefficiencies caused by the involvement of multiple stakeholders or by the lack of clarity about their individual roles and responsibilities is the de-linkage of the health workforce from the civil service, as has taken place in Zambia and more recently in Ghana. However, this has proved in both cases to be vastly more difficult – technically, financially and politically – than anticipated.

Issue: weak HR capacity in the health sector. As there are moves to put more responsibility for developing HR strategies within the health sector – either

as a result of some form of delinkage from central government management, or as part of initiatives such as Sector Wide Approach or budget support – the weak capacity for HR planning and management within the health sector must be addressed. Problems are both structural - with HR units at low level and sometimes not much more than a clearinghouse for fellowships – and related to competencies. Few qualified and experienced HR professionals are to be found and key posts are often temporarily held by clinicians on their way up the administrative ladder. Furthermore, there is rarely any experience of managing HR in the context of organisational change, such as health reforms. HR information systems are often incomplete and inadequate as the basis for planning decisions. The HR function, if it exists, is often unconnected to mainstream service planning in organisations. It is therefore unsurprising that the HR units lack voice and credibility in decision-making fora.

Response:

- Structural problems relate to the disparate location of the units making decisions about HR and the apparent powerlessness of some of these units. Examples of merger to improved efficiency, and total re-design have been given above (for Ghana). Reforms may present the opportunity for having better placed HR units, though until recently this opportunity was not properly taken up by Zambia's Central Board of Health. HR information systems are required, based on an agreed minimum data set approach, involving stakeholders.
- Changing the structure must be supported by adequate staffing of HR staff (numbers and quality). To support the reforms process early on in Zambia, an HR professional was brought in. However, when the ministry was split to create a Central Board of Health overseeing the majority of the public sector's 30,000 health personnel there were only two staff, neither of whom were HR professionals. Without adequate investment in HR capacity there will be a lack of effective strategic management that will undermine or prevent changes and reforms.
- Since major organisational change is infrequent in many developing countries, it is unsurprising to find there is a shortage of in-country HR professionals. However, there are many lessons to learn from other countries undergoing reforms – especially countries like the UK where restructuring seems to have become a habit. Well organised study visits or exchanges can at the minimum provide plenty of food for thought on the type of challenges that will be faced.
- Adequate attention and resources will only be provided to develop capacity in HR planning and management when its importance is fully appreciated. Making HR a discreet part of health sector reviews (as in Bangladesh, and in 2000 for the first time in Ghana) sends an important message. WHO and more recently the World Bank have hosted international meetings on HR bringing in a wider selection of stakeholders than usual, which have also served to highlight the importance of this area.
- Whilst there are plenty of generic courses on HR management and planning, there are very few available for developing countries that are specific to the health sector. WHO has recently conducted a short two-part course in South Africa. The base for training is often research and development and this is very much in short supply in health sector HR issues, as is capacity at both country level and internationally to carry out such research. Through its Alliance for Health Policy and Systems Research programme, WHO is supporting both the development of young researchers in HR as well as more substantial research initiatives. This should stimulate further research and the spread of lessons learnt in HR in the health sector.

7. Conclusion

The problems that developing countries are experiencing in attempting to reform their health systems and their public sector are, to a large extent the result of long term neglect in the planning and management of human resources. Such is the neglect that some countries even need to become convinced of the need to have working human resource units. This is remarkable since no one would seriously question the need to have well resourced human resource departments in large commercial service organisations. One of the reasons why these commercial organisations are successful or at least able to survive market changes is their well articulated employment, deployment, retention and professional development policies. This is in sharp contrast with what we have witnessed in ministries of health from around the world, some of them responsible for tens of thousands of staff where the HR units were staffed with two or three people.

A traditional approach of donor agencies has been to focus on systems building processes but to avoid getting too involved in the complex and politically sensitive human resources agenda. What we have learned so far is that, left unmanaged, health sector human skills markets take years and decades to respond to market forces, and in imperfect markets such as health such adjustment may never take place unless purposeful action is taken. Donors must face the challenge that recipient countries are facing of dealing with complex HR scenarios through the provision of training and technical assistance, and through maintaining a longer term attention and consistency in their approaches.

Even the most complex HR problems require co-ordinated, step-by-step interventions, not all of which are so controversial or unpalatable as we are sometimes driven to believe. Tanzania, Uganda, Bolivia, Cambodia, South Africa or Ghana all had deep rooted HR problems 10 years ago that they have been able to address with the help of development partners. For some of the new funding initiatives aimed at reducing poverty and the disease burden to succeed international partners will need to become more open to addressing the HR scenario that they have been so far. If poverty cannot be eradicated without a sound macroeconomic context, neither can health care improve without stronger focus on human resources.

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