

Human Resources for Health: Tackling the Human Resource Management Piece of the Puzzle

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Introduction

The shortage in numbers of physicians, nurses, midwives and allied health professionals and their inequitable distribution has been well documented. There is an urban bias in the distribution of the health workforce for all the usual reasons—this too is well described and not new. However, less attention has been paid to the very important area of human resources for health (HRH) management systems. In fact, governments have been managing HRH badly for years, until almost all facets of human resource management (HRM) systems are inadequate at best, and can drive health workers from the system at worst. Problems exist at every level, from sector-wide planning and policy-making to managing a facility-level work environment. These problems in turn create obstacles at each stage of HR management, and serve to impede effective health worker production, recruitment, hiring, deployment, productivity and retention. Moreover, it is these rickety HRM systems—weak, understaffed by people with little or no background in HRM, often unsupported within their own ministries—that will be expected to be the key to absorbing and making effective use of rapidly expanding donor funding.

The international community is planning to more than double its funding for health beginning in 2009, much of it aimed for use in Africa. This historic level of assistance has the potential to make a very big difference in treating and preventing HIV and AIDS and other devastating diseases, but only if the countries will be able to absorb and appropriately utilize these financial resources. The inadequacy of HRH with required skills to make the system work has been a serious constraint to absorbing the large amount of financial resources made available by the international community in recent years. One can only imagine the difficulties ahead in absorbing at least twice the amount of resources without taking bold action to address the HRH problems.

In addition to having a serious negative impact on health care access and quality, the current shortages of HRH most likely contribute to slowing 1) disbursement of World Bank funds, 2) progress on providing antiretroviral drugs or voluntary counseling and testing under the President's Emergency Plan for AIDS Relief (PEPFAR), and 3) implementation of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. There is also evidence that intense competition for scarce human resources in turn contributes to inadequate services in other critical areas such as maternal and child health, family planning and reproductive health.

So, as we look to the future, we see a picture that includes both opportunity and challenge. On one hand, there is an unprecedented opportunity for significant progress given the expanded amount of donor money being planned for the health sector; and on the other, there are serious health worker shortages combined with very weak HRM systems that might serve as a brake on that progress. While this looks like a precarious situation, it is important to note that there is increasing attention being paid to HRH issues, and there are many pilot programs and schemes underway to attempt to address these issues, including tapping into promising private sector practices and innovations and expanding their role and contribution to address some of these challenges.

As one example of increased attention to the issue of HRH, in March 2008 the Global Health Workforce Alliance organized the first Global Forum for HRH, which was attended by approximately 1,400 participants, including ministers of health, education and finance, donors, experts in the field and regional and district-level health professionals and staff from countries spanning all regions. At the conclusion of the Forum, attendees endorsed the Kampala Declaration and Agenda for Global Action, a formal document recognizing the importance of the health workforce and issuing a call for action and cooperation among governments, institutions, civil society, the private sector and professional associations and unions in a global effort to bolster and improve the health workforce and ultimately health care delivery.

This technical brief describes in some detail the HRM problems that contribute to the health worker crisis, as these have often been underplayed—or not addressed at all. The brief also identifies specific



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strategic actions that ought to be taken to address these HRM challenges, and concludes with some examples of broad futuristic thinking and innovations to stimulate donor and programmatic funding opportunities for strengthening HRH.

HRM Systems Capacity: A Growing Cause of HRH Shortages and Maldistribution

Adequate HRM capacity is one of the critical missing factors in current efforts to meet the goals of national and global health system strengthening initiatives. In many cases, government HRM policies, practices and procedures are tediously bureaucratic, spread across different government entities and in need of radical reform in order to permit available external funds or technical assistance to be spent or utilized to create meaningful changes or results.

Failure to Value Health Workers: As an example of inadequate HRH management capacity, a woman had worked as a pharmacy assistant for a subdistrict hospital in the Coast Province of Kenya for seven years without a single promotion or salary increase. The housing benefit for herself and her two children was a small semipermanent house without electricity or running water. Since there was no HR manager at the facility, she had no one to turn to as an advocate to resolve these inequities¹.

Unfortunately, there are many stories of weak HRM policies and practices that indicate they are the norm rather than the exception in numerous countries that are already burdened by a health worker shortage and the maldistribution of the existing workforce. Although governments, donors and nongovernmental organizations (NGOs) have allocated scarce resources on health worker support—like in-service training—there is a general feeling that such investments could produce better benefits than they currently do if the systems used to manage and support health workers are also improved and strengthened. But given the fact that such investments are insufficient or lacking, low morale, poor work climate and unsatisfactory health worker motivation, retention, performance and productivity continue to be pervasive problems. Also, these are factors that are known to blend together to generate poor health worker practices, fuel migration and contribute to poor quality of services and low use of health facilities, especially by vulnerable populations.

Additionally, the focus of most recent reforms and initiatives to strengthen the health sector of developing countries has been on *what* to introduce, rather than the managerial issues related to *how* the planned changes can be achieved. Reforms have often been planned separately from HRM policies and improperly aligned with broader civil service reform and education policies, notwithstanding the importance of these areas. Moreover, different leaders and practitioners in the health sector often misunderstand or have differing understandings of HRM, and this in turn causes confusion or implementation problems. Given these management difficulties, it is not uncommon for health reform efforts to result in limited success or even outright failure².

The actual methods used to manage HRH may either hinder or facilitate the accomplishment of some of the core objectives and benefits of health sector reform as well as the goals of larger global health initiatives such as PEPFAR and the Global Fund. Improving how health providers are managed is key to improving the health services they deliver, and is therefore central to health sector reform³.

However, a singular focus on HRH numbers and shortages that has dominated and perhaps clouded the debate on the HRH crisis thus far does not tell the whole story. The way health workers are recruited, managed and supported is central to the quality of services that they are able to deliver. A modern and responsive HRM system that is managed by qualified HR professionals can work to ensure that staff are recruited and hired in an efficient and transparent manner, treated fairly (in terms of salaries, benefits, promotion and training opportunities), receive orientation and know what they are supposed to do (job descriptions and clear job expectations), get timely feedback (supervision and performance review), feel valued and respected (recognition and reward) and have opportunities to learn and grow on the job (career path and professional development).

But in reality, HRM is treated in a fragmented manner in most public health sector organizations in developing countries. For example, most ministries of health in sub-Saharan Africa have limited or no authority in key personnel areas such as setting salary levels, determining and implementing disciplinary procedures, recruitment and promotions and establishing an attractive and equitable career path that can help with retention. Moreover, the fracture of these key HRM functions is inherent in the government structures themselves. In Kenya, for instance, the Public Service Commission works closely with the Directorate of Personnel Management in the Office of the President (a different entity) to define jobs for all established positions within the civil service and determine qualifications and salary levels; the Ministry of Finance controls and determines the overall budget. An example from Uganda below also demonstrates the pervasive nature of inefficiencies in basic HR practices.

Broken HR Functions: An assessment conducted in 2004 in Uganda revealed that a hospital administrator waited one year to have a candidate sent to fill an opening for a doctor in his hospital. When the candidate appeared, he decided not to accept the

position because of the geographic location (job advertisements typically do not indicate job locations). The administrator had to start the staff-request process all over again. He reported that 43% of candidates posted to his facility do not accept the position offered. In addition, in cases of poor performance, his hands are tied. His only recourse is to refer a complaint to the local district health service commission, which can take up to a year to schedule a hearing. While the employee continues to collect a salary, the hospital administrator cannot fill the job.

The broad issue of human resources and how workers are managed is not just a technical concern that requires tools, innovations and guidelines to fix. It is also profoundly political and touches on aspects of governance and integrity of public sector management. For example, authority over human resources in terms of who gets selected to join training institutions, who trains, who recruits, who deploys, who promotes, who disciplines and who manages staff within a government ministry is usually a source of tremendous power and influence, and—in the worst cases—a source of corruption and abuse⁴.

Recognizing and understanding these dynamics and developing and applying the skill-sets and diagnostics to deal with them is important for donors, project planners and HR consultants engaged in HRM reform and health systems strengthening. In other words, technical assistance or tools and guidelines alone—important and relevant as they may be—are unlikely to yield sustainable results without some accompanying interconnected changes in perspectives and official positions on the part of senior-level public sector leadership and governance structures with responsibility for human resources.

Strengthening the HRM Function

Health workers are the heart of any viable national health system or service delivery organization. And good HR management with certain core functions is the glue that holds all the internal parts of an organization together, contributes to a positive work climate and supports high-quality services.

Given the severity of the HRM challenges that have been described in this brief, a wide range of actions need to be taken to make serious progress in the area of workforce management and support. These actions include:

Strengthening HR professional leadership for the effective planning and management of human resources in the health sector. HR staff must be specialists and not generalists. They should not be confined to playing a restricted, bureaucratic and reactive role. For this to happen, a new cadre of HR managers will need to be trained and enabled to have real input into operational and strategic decisions about HRM. This may involve a bundle of integrated and complementary strategies and actions, such as:

- **Establishing a partnership at the country level** wherein HRH function managers and staff—both at the central and district levels—have access to articulated training, coaching, mentoring and problem-solving follow-up over a two-year period. This can be done through a consortium of international and country-level partners (this is already under discussion among the Global Health Workforce Alliance, WHO/AFRO and the Capacity Project). This approach should be combined with donor and government agreement to recruit and fund a sufficient number of HRM managers and leaders so that capacity can be built and sustained. It is important that a large proportion of these potential leaders are not clinicians, as draining doctors and nurses away from actual practice represents a significant current loss. This “sufficient number” would have to be large enough to allow for some leakage, as—when skills and competencies are enhanced—some managers will likely take jobs available within the private and NGO health communities.
- **Providing sound readily-available HRM consulting support** to HR staff working at different levels of the system. This is especially important in settings where the HR role and functions have been decentralized to regions and districts.
- **Working with local and regional management training institutions** to support a serious and substantive HRM short degree program at one or more institutions in sub-Saharan Africa that agree to produce HRM leaders and practitioners (not just academics). This program should be closely aligned with ministries of health and other related nongovernmental agencies, and should include some sort of work-based, integrated practicum to assure relevance and operational reality.
- **Developing performance-based indicators** that measure HRM progress so that the HRM function and leaders can more easily be held accountable. It is also important to link the training, education, coaching and mentoring to these indicators.

Establishing, staffing and strengthening HR Units or Directorates in ministries of health to raise their profile and visibility and ensure that they have a reasonable budget and are more strategically placed within the organizational hierarchy to contribute ideas and decisions to meet the goals of the national health system. Progress in this area is somewhat limited, but episodic events are ongoing in many places. For example, in 2007 the HR Directorate of Kenya’s Ministry of Health conducted an intensive three-day course for 44 HR staff. Bringing these coworkers together in one room for the first

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time, the course focused on developing their skills and competencies in key HRM functions related to standards, results and productivity.

Developing and deploying HR managers to high-volume facilities and larger clinics and, in decentralized systems, establishing provincial and district HR focal point persons. In some cases, this may require the hiring of new HR qualified staff, but in most cases it may just involve recalibrating the role of existing staff, especially health administration officers where they exist, and giving them additional HRM training and support to begin assuming a fuller HR-specific role.

It is anticipated that the implementation of most or all of these strategies and actions will strengthen and significantly improve the capabilities of HR units that should be able to carry out certain fundamental HR functions and practices, including:

- **Developing and implementing long-term HR strategic plans.** These plans form the basis for country-level action. An HRH plan with an accompanying budget and strong champions who are able to articulate its value and merits can help lead to more funding from national governments and more predictable development assistance. Much progress has been made in this area (see example below), as there are HRH strategic plans either in place or in the final stages of approval in such countries as Kenya, Uganda, Tanzania, Malawi, Zambia, Botswana and Lesotho. Implementation challenges remain, but at least the foundational strategic plan is there to be used as a guiding force.

HRH Strategic Plan Launched and Ready for Implementation in Tanzania: In 2007, the Tanzania Ministry of Health and Social Welfare helped to organize and facilitate a three-day workshop that culminated in the finalization and adoption of an HRH strategic plan. The plan spans 2007–2012 and will assist the health sector in planning, development, management and utilization of human resources. With funding and technical support from the Capacity Project, 35 high-level stakeholders collaborated to strengthen content areas of the plan, realign and streamline strategic directions and objectives and realign the implementation plan in view of revised objectives. They also reached agreement on priority activities to be accomplished over the next two years. Going forward, the Project will continue to support the Ministry through the processes of costing, distributing, launching and implementing the plan.

- **Making investments in human resources information systems (HRIS),** including hardware, software and skills to use data to make HR planning and management decisions. The assumption here is that even trained HRM staff will not play their roles effectively without greater emphasis on workforce planning and management based on quality data and analysis. Several countries—including Rwanda, Uganda, Kenya, Tanzania, Namibia and Swaziland—are in the process of investing in developing and refining their HRIS. As one such example, Lesotho's Ministry of Health and Social Welfare is monitoring and tracking the country's health workforce using an HRIS. Ministry staff received training in the management, maintenance and reporting of deployment data using the new system.
- **Strengthening recruitment and deployment practices.** On average it takes 12–18 months for most ministries of health in sub-Saharan Africa to recruit and deploy a health worker, even when funds and workers are available on the local labor market. It is therefore imperative to encourage and actively support activities and changes that will strengthen efficiencies in public sector hiring, deployment and payroll processing procedures and practices. The quickest path to these improvements may involve identifying and utilizing private sector practices that are already available in-country or promoting small but efficient franchises to which these functions can be outsourced at competitive rates. At least two prominent examples of streamlined recruitment and deployment exist and have been documented in Namibia and Kenya (see example below, which also includes a short description of how the overall approach helped to strengthen HRM systems).

Kenya Emergency Hiring Plan Results in Faster Recruitment and Deployment and Strengthens HRM Functions: In 2006, the Ministry of Health in Kenya used a private sector outsourcing mechanism to design and implement an innovative rapid-response staff recruitment and deployment model that reduced the time it takes to recruit and deploy health workers from 12 to four months. Designed to increase the number of qualified health professionals available to work in public health facilities, the model helped the Ministry to expand access to treatment and care through the rapid hiring, training and deployment of 830 health workers to serve in 219 facilities across the country. The recruitment process was fair and transparent. The new approach also focused on the same geographic areas where staff is needed, in the expectation that people would be less likely to transfer if they were given a choice on where they wanted to work or worked close to home. An evaluation of this initiative showed that these factors helped to strengthen some basic HR functions and also had significant positive impact on health worker retention, motivation and productivity.

- *Developing participatory HRM audit and assessment initiatives.* These can form the basis for identifying an organization's HRM status and making concrete plans for management improvements. While this is a relatively new area, see below for a very good example from Uganda of how this can be done, and what might result from it.

Using HRH Assessment Results to Strengthen District Plans in Northern Uganda:

In 2008, the Ministry of Health conducted a detailed analysis of HRH needs in the nine districts of Northern Uganda that are emerging out of nearly two decades of conflict. A team from the Ministry of Health and Ministry of Public Service held a workshop to disseminate the findings to 37 participants from the nine districts. The major findings relate to inadequate HRH information, significant staffing gaps, incomplete composition and poor facilitation of District Service Commissions, delays in accessing payroll, lack of induction of newly recruited staff, low productivity, shortage of personnel officers and lack of staff promotion. Next the team held further discussions with more than 100 staff in the nine districts to work out implementation plans. In July, management training was conducted for 39 personnel officers, administrators and financial managers from the nine districts. Discussions on ways to further support recruitment of health staff for the districts are ongoing.

- *Focusing on performance management.* Supporting and developing health workers has to become a central responsibility of HR managers and their staffs. This is best achieved through a systematic approach to the process of setting work goals, monitoring performance and conducting high-quality performance assessments. While there is much interest in this area, and some countries (Kenya and Tanzania, for example) are initiating reforms in this area, it remains a very difficult process to set up workable performance management systems that make a positive difference in performance.
- *Strengthening supervision and performance support.* All the available evidence suggests that the traditional model of a visiting supervisor has not worked well, has consistently been found to be costly and has not improved the performance of many types of health workers. In contrast, experiences from other health and business sectors demonstrate that a site-based approach to workforce performance support—whereby teams work collaboratively with their site supervisors to set priorities, remove obstacles, resolve challenges and enhance skills and competencies—can improve performance, job satisfaction and motivation.
- *Enhancing workforce productivity and retention.* Supported by a growing evidence base, HR leaders need to be willing to identify and test innovative productivity and retention schemes to address shortages, balance maldistribution and improve staff and service productivity. This area is a hotbed of activity with many lessons being learned in different countries and, as such, there needs to be continued South-to-South dialogue to make certain those lessons are being appropriately shared and considered as new or altered schemes are initiated. There has been much activity in retention schemes over the past eight years, with a variety of schemes having been tried (with varying degrees of success) in such countries as Kenya, Uganda, Ghana, Tanzania, Malawi, Zambia and Ethiopia. Much has been written about these schemes, including descriptions and initial results, and is available on a variety of websites (including the Capacity Project's HRH Global Resource Center). There is also ongoing work in the area of productivity in Tanzania and Ghana; the Tanzania pilot program is hoped to result in guidelines for improving productivity that can be used in all countries.
- *Promoting task shifting.* The key here is the realization that task shifting has the potential to be used radically, not only for redistributing tasks but also for planning and managing the health workforce. A new way of looking at the workforce would be not as a collection of professionals in historically determined and accepted roles, but rather as a group of providers with different competencies who could form teams with a range of knowledge and skills to offer appropriate health care in different situations to satisfy particular needs. Workforce planning could then be done by using a database to show not only numbers and locations of health workers, but which competencies they had been assessed as having, and at what level. Additionally, rearranging shift patterns and increasing time flexibility could offer another way to increase worker productivity. As such, task shifting as a strategy could potentially achieve a better match between staffing levels and workload at limited cost. In reality, there is much informal, almost *de facto*, task shifting that is already going on in many countries and it is helping to bring stability to the existing workforce and also expand access to basic health services.
- *Leveraging governance and democracy reform initiatives* in the wider public sector. This will help to develop local management capacity for sustainable public health management capacity-building programs to improve the effectiveness of the public health sector.

Overall, some bold moves and large-scale interventions will be required to address the HRM challenges facing national health systems in developing countries.

Visit the HRH Global Resource Center to find, share and contribute human resources for health knowledge and tools. For those working at the country or global level, the HRH Global Resource Center provides information to:

- Improve strategic planning and decision making
- Strengthen reports and presentations
- Support HRH advocacy
- Enhance professional development
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Conclusions

HRM and the HR function are at a crossroads. Many ministries of health do not have enough HR-qualified professionals who understand HR business issues—a necessity for recruiting, managing and retaining talent. At the same time, the ways in which the current HR units, systems and practices are set up fail to provide even the most basic HR services efficiently. In this brief, we outlined the depth and breadth of the HR management challenges as well as potential areas to invest in that would be likely to yield significant long-term results.

Policy-makers could make better use of their existing health workforce by creating an environment of improved HR leadership and managerial capacity to use all the key HRH levers and functions and by investing in HR management training and development on an ongoing basis. The current system of personnel officers who keep track of administrative decisions and simply maintain files is inadequate because they have limited authority to address problems. Trained, experienced and empowered HR managers with adequate staff and budgets can play a vital and effective role in developing strong HRM systems that integrate the planning, hiring, deployment, training and development of health staff. They can also lead an organizational response to common HRH challenges such as retention, low morale, unsafe working conditions and inequities in salaries, promotions and allowances.

Overall, some bold moves and large-scale interventions will be required to address the HRM challenges facing national health systems in developing countries. We would like to conclude by describing one such measure required to finance and support a comprehensive and long-term approach to HRM strengthening.

Support a Global Health Initiative to Rebuild the Health Workforce

African governments cannot tackle this HRH challenge on their own—they need help urgently. Additionally, the current financing mechanisms, models and approaches will not meet the region's needs quickly or effectively. What is required is the enactment of a large-scale global health initiative modeled on the Global Fund or PEPFAR instruments for resource mobilization and disbursement but devoted solely to addressing the workforce crisis over a period of 10–15 years. Such a fund will assist and complement the efforts that governments are already working on using their own tax revenues. Further, such an instrument will have several advantages, the most important of which is the ability to create front-loaded reliable funding over several years to rebuild the shrinking stock of health workers—and strengthen the capacity to support and manage them—for effective health delivery and sustainable health outcomes.

One relatively easy way to gain funding for HRH over the 2009–2014 period would be to get the various donors to mandate that a certain percentage of funding be allocated for HRH—and to use that to develop a Global Fund- or PEPFAR-like instrument for HRH. A subset of this amount should be allocated for strengthening fundamental HRM functions and capacity over the long term.

Gijs Elzinga, Tim Martineau, Dykki Settle, Anne Wilson and Fatu Yumkella contributed to this brief.

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