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IMPROVING THE PERFORMANCE OF THE HEALTH WORKFORCE: FROM ADVOCACY TO ACTION

*The single most important determinant of the performance
of health services delivery systems is the performance of health workers*

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Mr/Madam President of the Directing Council, Ministers of Health and Chiefs of Delegations, Dra Mirta Roses, many thanks for this cordial invitation to speak to such a distinguished audience. I welcome the choice of this topic for your regional meeting, as it raises issues which are critical to the success of your country's policies aiming at improving the performance of health services delivery systems.

Indeed, a well performing workforce –I will say what I mean by that in a minute-is the most critical determinant of the performance of services. Well functioning infrastructures and equipment do not serve if the people who deliver the services are not there (be it that there are none available, that they are absent from work, or that they are on strike). Well trained health workers, without the appropriate tools and supplies cannot do much either. And even when all ingredients are there, if workers are not motivated, services underperform.

Advocacy to convince policy and decision-makers, as well as international agencies and donors to do something to improve the performance of the health workforce (HW) has been fervent these last 3-4 years, and it has been quite successful. This has created an opportunity that cannot be missed, and now the challenge is to move from advocacy to action.

My starting point is that our response to this challenge will be stronger if we understand better the problems which need to be addressed. Put simply, the issue is how countries can move from awareness to effective action.

In order to be in a good position to shape strategies for performance improvement, we must define what we mean by “performance” of the HW, and we need to understand better the factors which influence it.

It is common to hear that a performing HW, is one which is sufficient in number, distributed in a balanced manner in terms of mix of occupations, levels of care, and geographical area, which is adequately trained, and which is motivated to produce effective and quality services in an efficient manner. So we know what we want to achieve. We also broadly know what type of HW problems we have to address (even though, in most countries, these are still poorly documented). These problems are typically:

- Imbalances in the number and the distribution of workers by occupational category: most low-income countries experience shortages of all categories of health staff (shortages are defined here from a public health perspective of not having enough workers to meet the needs of their population; this is not the perspective of economists, i.e. fewer workers available than the labor market is prepared to employ). Middle-income countries, and even

high-income countries, suffer more from imbalances between the various occupational groups, like having enough doctors (not always of the right kind), but not enough nurses, and too many non clinical staff;

- Geographical imbalances exist everywhere, not only between rural or remote and urban areas, but also within large cities, between areas of different socioeconomic levels;
- Gender imbalances are often overlooked, even though they can have major consequences: insufficient numbers of women doctors in traditional or more conservative areas may result in some female users refraining from utilizing services; the absence of women among managers, which is somewhat paradoxical in a highly feminized work environment, may lead to a lack of consideration of the needs of women by the health services, as well as of the needs of female health workers;
- A disconnect between the training offered to health workers, and the knowledge and skills which they will need when they enter the labor market. Examples are: lack of preparation to deal with the clinical, psychological and social aspects of HIV-AIDS (or TB), lack of public health or management training, communication skills, etc;
- Productivity (what economists call technical efficiency) problems. This can be weak productivity (i.e. underutilization of available capacity), or excessive productivity (one patient every two minutes), or inappropriate productivity as the one induced by fee-for-service remuneration;
- Dissatisfaction of workers with their working conditions, and for many, with their terms of employment. The use of short term contracts was meant to introduce flexibility in the utilization of personnel, but it has often been used instead as a savings mechanism, with negative effects on the quality of services, like the absence of continuity in care delivery.
- Migration to greener pastures (from the health sector to other sectors, from rural to urban areas, from poorer to richer country) is a major problem for sending countries (increased shortages and imbalances, loss of return on investment, reduced access to services: the delegations from the Caribbean brought up this issue to your attention at last year's meeting). Even though it is rarely highlighted, receiving countries also experience problems from relying on immigration to fill shortages (quality assurance, failure to develop recruitment strategies within their own countries, and cultural adjustment¹).

¹ Language problems, differing values, etc.

If we know what the problems are, and agree that something needs to be done (problem recognition is a major first step towards addressing complex issues), what will be the strategy? First, we need to see these problems as symptoms or consequences of more profound “diseases”. To understand them better, it is critical to know the factors which influence them, and how they do so. Only then will we be able to design sound and potentially effective strategies. The lack of detailed attention to those “determinants” probably explains why the policy advice which you receive is so short on specific solutions (though the last World Health Report 2006 made a serious effort in that direction).

We need greater clarity at the conceptual level, about the dimensions of HW performance, and about their determinants and the links between them.

A first step is to understand the linkages between the HW and the performance of HSDS. We can define the “performance” of a services delivery system in terms of equity of access, effectiveness, efficiency, responsiveness to users’ expectations, and protection against financial risk induced by health problems². It is influenced by the performance of the HW, and by numerous other factors: policies, inputs, such as infrastructures, financial resources information and knowledge, and processes such as governance, regulation, management.

Second, we need to define how the performance of the HW links with that of HSDS. I suggest that four dimensions of HW performance are critically important:

- 1- coverage³, i.e. the extent to which the workforce provides services to the various sub-groups of the population and supply the whole range of services needed;
- 2- productivity, which refers to the outputs extracted from given inputs ;
- 3- technical quality, i.e. the degree to which the providers produce services according to professional standards, as they can be expected to be applied to the environment in which the providers work;
- 4- service quality, i.e. to the degree to which providers produce services which are acceptable to users, which meet their expectations, and which are organized in a way that makes them socially and culturally accessible.

² Adapted from the WHR 2000,

³ The WHR 2006 uses availability, which in my view does not imply that there is actual coverage.

These four dimensions are linked to the various dimensions of HSDS performance, and all are linked one to another, creating a complex network of interactions. For example:

- Coverage is clearly a determinant of equity of access. Imbalances in coverage also impact on financial protection, when people in need of services have to travel long distances or to spend out-of-pocket to get services from the private sector (often from the same person who should have served them in public services).
- Coverage impacts on efficiency: lack of availability of complementary categories of personnel reduces productivity, as is the case when doctors are not supported by adequate numbers of nurses or technicians, and work below optimal capacity level.
- Coverage also impacts on effectiveness and on responsiveness. This is the case when a clinical service is available, but there is no one to offer the complementary follow up (like post-operative follow up or psychological assistance). A shortage of staff, which translates in heavier workloads, diminishes the capacity to offer services which are personalized, which are attentive to users' psychological and social needs, etc.

The four dimensions of HW performance are influenced by numerous factors within the health sector and outside. They can be categorized as follows: individual, organizational, health sector, broader environment factors. Table 1 lists the main factors:

TABLE 1: DETERMINANTS OF HW PERFORMANCE

Category	Determinants
Individual	Age, sex, marital status, geographical origin, religion; Education, training received Competence level Personal values, representations, preferences, interests
Organizational	Structure/culture Management capacities, style, practices Decision-making process Working conditions Occupational safety Workloads Availability of other inputs State of infrastructures, equipment
Health sector	Health policies Organization of services HRH policies (terms of employment, career, placements, transfers, promotions) Regulation, labor relations mechanisms Dominant values, objectives Degree of centralization, of bureaucratization Role of interest groups (unions, councils, users groups, pharmaceutical, equipment companies)
Broader environment	Policies- priorities (finance, civil service, planning, education)-values, representations (see AIDS) Economic growth Security Quality of governance

For example, policies (contents and commitment to implement them) define how the work will be regulated (will there be space for self-regulation, how quality assurance will be done, who decides the scope and standards of practice, the contents and norms of training, etc.), and managed (centrally, top-down, bureaucratically, or strategically, by professional managers, in a

participatory manner). Policies also determine how much will be spent on the workforce, and how much on other inputs; often decision-makers are more attracted by spending on equipment and infrastructures –for reasons which you know- than on securing the continuous flow of medicines, or on supporting incentives schemes for staff. Policies originating from outside the health sector (finance, planning, education, civil service), have a major impact on the work environment and on working conditions, such as is the case when Civil service career structures apply to the health sector without taking into account the specific needs and expectations of health professionals.

WHAT MESSAGES CAN WE TAKE HOME FROM THIS?⁴

A better conceptual mapping of the links between HW problems and their determinants factors can be a powerful support for action.

- 1- A self-evident message is that we need to augment our knowledge and information levels. This may seem academic, but uninformed interventions are more likely to be arbitrary, and based on criteria such as political advantage, personal interest, and pressure of professional groups (these will always be there, but good information can limit their potentially negative impact). Let's take geographical imbalances: health professionals, like all producers, are sensitive to economic incentives, when they choose a career, a specialty, where to practice, how much effort they will invest in their work, etc.. We know that economic incentives are not enough to influence major decisions, like the choice of a practice location, and that what works with a specific group (doctors), does not necessarily work with another (pharmacists, nurses), that what works in one country may not work in another, that what works at one point in time, may not work at another. We do not know well which incentive or combination of incentives will work at a specific time and place. How is this useful to the policy-makers? It tells them a few "to do and not to do": (1) incentives are needed to convince health personnel to go to understaffed regions; (2) economic incentives are important, but they have to be complemented with others (professional, such as access to continuing education, to learning tools, to contacts with colleagues, to career growth opportunities; and personal, such as housing support, schooling for children, and spousal assistance); (3) studies are needed to understand the needs and expectations of the various categories of health personnel, with a view to design adapted packages; (4) incentives are likely to have a

⁴ Here I draw particularly on the messages found in the JLI Report (2004) and the WHR 2006.

time-limited impact, and packages have to be assessed and reviewed from time to time; (5) involving the major stakeholders is a prerequisite to augment the acceptability of policies.

- 2- A second message is the importance of intervening at the determinants level. For instance, to augment productivity, it is important, before intervening, to understand why productivity is low. Factors are likely to be multiple: individual (insufficient training, lack of motivation, age, personal preferences), organizational (lack of equipment or of medicines or consumables, working conditions, occupational risks, remuneration levels, poor management, authoritarian decision-making), health sector (centralization of decisions and processes, HRH policies, transfer practices, regulation of professional practice, labor relations), and broader environment factors (civil service policies, remuneration policies, education models —individualistic vs team based)⁵. Interventions to improve productivity will therefore likely be a mix of actions at different levels. This is not easy to design and requires a strategy more than a series of reactive piecemeal actions, such as additional training, or the introduction of some financial incentive. As they design such strategies, policy-makers and managers will consider what is feasible, not what can be done in a perfect world.
- 3- Third, isolated actions are unlikely to have a major and lasting impact. Given the interconnections between the various factors at play, the effectiveness of acting on one category, while ignoring the others, is very limited, hence the need for comprehensive approaches. To improve quality, policies may need to address the education and training of personnel, the available inputs, the incentives system, the management practices, etc. Working on only one dimension, say training, may be wasted without addressing the other HW performance quality variables.
- 4- A fourth message is that interventions will be a mix of short, mid and long-term ones. Some problems are more complex than others, and less easy to influence, and will require longer term interventions: For example, interventions on the education of health workers are known to have positive impacts on accessibility (focus on the needs of underserved areas), on productivity (learning to work in teams, learning to use new equipment or procedures), and on quality (familiarity with evaluation, psycho-social dimensions of health problems, management training), may include short-term actions (short courses), and longer term actions (introduction of continuing education, of recertification/relicensing, review of curricula and pedagogical methods). A mix of these

⁵ One issue for research is the relative weight of each factor and determinant, which Figure 2 presents as if they all had the same importance.

actions is more complex to design, but much more likely to be effective. A major issue here is how to ensure continuity beyond changes of administrative and political leadership. How can sound interventions, which require many years to unfold and to produce their effects, be sustained in spite of such changes? I suggest that the greater the support the intervention has from the main stakeholders, the higher the probability of continuity. This leads me to my fifth message:

- 5- A final message is that alliances are needed for HW interventions to be effective. If we look at the various dimensions of performance and its determinants, we see that many fall outside the control of the health sector: education of the most qualified providers is usually under the control of universities or autonomous schools. Conditions of remuneration and employment, career structures, systems of incentives, are often under the control of ministries of finance or civil service. Funds for scaling-up the production of personnel may come from external agencies. Within the health sector itself, the Ministry of Health has limited powers: it has to deal with professional unions, associations, councils, which may have different views on what the problems are, and what interventions are acceptable. Health workers are not a passive “input”, as the expression human resources for health implies; they are actors who can oppose change or facilitate it. To ignore this, or to treat them as the opposition, as is observed in many countries, is a guarantee of failure of most interventions.

CONCLUSION

HW problems are now on the political agenda. What can be expected from ministries of health and from technical agencies like PAHO⁶?

To ministries of health, I would leave the following suggestions:

- First, given the complexity of problems, their multiple causes, the interconnections between various processes, the diversity of actors involved, usually with competing interests, HW issues cannot be addressed in a mechanical manner, through formal processes, by unprepared managers. These problems require a clear understanding of their technical, economic and political dimensions, advocacy and communication skills, vision, and perseverance. Ministries should be prepared to invest (recruit and retain) a pool of highly qualified and visionary professionals (some would say leaders). To be

⁶ Since I have left the World Bank a few weeks ago to go back to the academic world, I can allow myself to be more prescriptive.

effective, they will need to be supported by an organizational and institutional environment which makes change possible. Political commitment at the highest level, in the health sector, but also beyond the sector is a prerequisite to effective action.

- Ministries need to bring the professionals at the policy table and recognize that they have a role in policy design and implementation. In too many instances, health workers are seen as the opposition, which may be true to some extent. But if they are not engaged in the process of improving the performance of health services, you can be assured that they will always be the opposition, and at the end of the day this does not serve the populations who need the services.
- Ministries should seek alliances within other critical actors within (education, finance, civil service, planning, international cooperation) and outside government (civil society, private sector, international agencies). In health, we have a tendency to believe that since we work for the well being of people, and we are experts, we do not need to justify what we do, what we spend, what we request. We forget that all ministries believe the same. Ministries need to document and explain what they do, to show that they are using their resources efficiently. They need to build the linkages with other actors, who are unlikely to come to them spontaneously.

Since I am at PAHO, an agency which I have known for 20 years, and for which I have much respect, allow me to use the occasion to make a few suggestions regarding what the agency could do to support the countries, with its very limited resources. Generally speaking, it should concentrate on enhancing country capacity to be autonomous in policy development and implementation, and in doing what goes beyond the capacity of countries, like:

- To help build the data base needed to inform strategy. PAHO can be active in supporting the training of the individuals who will collect, analyze, and disseminate the data (PAHO may and probably should not train these groups directly, but the organization would encourage and support these efforts)
- To collect, analyze and disseminate the information on good examples, from the region (Brazil family health program, the UNI program funded by the Kellogg Foundation to make the education of health professionals more relevant, Canada's recent efforts to address the recruitment and retention of nurses, and the geographical imbalances issues), and from elsewhere (Thailand on policy development and adjustment, Iran on coverage, the use of community workers in Bangladesh) of strategies used to address HW problems. There is no

such thing as “best practices”. Problems are time and context specific and blueprint or imported solutions do not serve. Strategies to improve HW performance have to be home-made, but having access to information about what was tried, what worked, what did not worked, can provide good guidance.

- To mobilize the commitment of political leaders and other stakeholders, including the health workers themselves. PAHO, by its nature and status of technical agency, can offer unbiased advice, and help ensure that HW interventions have continuity beyond changes at the level of political decision-making. The previous three tasks can be done, for a good part, through the network of human resources for health observatories which PAHO has launched and supported. Efforts in helping more countries to develop their own observatory are needed, which will require a major investment from PAHO, and its allies (see next point).
- To mobilize other critical actors, such as the development banks, the bilateral donors, the foundations active in the region, in support of HW interventions, with a view to create better conditions for the success of the other health programs it supports. This also implies that PAHO treats HW issues as cross-cutting issues, not as a specific topic which should be dealt with by a department working in isolation.

I do not want to list dozens of things to do, which is the perfect recipe for not doing anything well. Most of what should be done has already been stated in the so-called “Toronto call for action”. Just doing a few basic things, which will show that there is a genuine commitment to addressing HW problems in a rational manner, can do a lot. Also, much can be done at little cost; in various studies on the motivation of health workers, it is observed that one of the main sources of work dissatisfaction –itself a major source of poor performance- is the perception of the lack of due process in appointments, transfers, promotions, and other managerial decisions. Much can be done, at almost no economic cost, to change that situation. Similarly, social recognition, does not cost much, but sends strong positive messages to the health workers.

On the other hand, many actions will require substantial investments (I use the word deliberately), and the question of economic feasibility and sustainability has to be addressed. To augment the number of health workers induces not only recurrent costs related to their remuneration and benefits, but indirect ones which their activity will induce. To improve working conditions in the health sector will lead to requests from other sectors for the same improvement. The costs, as well as savings from efficiency gains, need to be estimated. This is the first information which your colleagues from finance will want to know. Then the issue is: is their fiscal capacity (or fiscal space) to support such interventions. Here, there is no given

answer: fiscal space can be created by efficiency gains, which means that rigorous management can track wastages and at the same time promote efficient practices. Examples are (1) making the utilization of hospitals more appropriate through greater use of ambulatory services and better coordination with primary services; (2) better utilization of support staff, starting with increasing the number of nurses and enlarging their scope of practice, (3) using the various options of payment mechanisms to create incentives to improve efficiency (move beyond salaries, and fee-for-service). Fiscal space in health can also be created by reallocating resources currently used for other purposes; this raises the issue of the value given by decision-makers to providing accessible and good quality services. This is why issues of how to organize health service, how to finance them should not be left to the technicians who negotiate between closed doors. Then, new money can be raised through taxes or loans, but this is possible only if the population is convinced that investing in health makes it worth. In a word, feasibility and sustainability are not predetermined, they can be built.

In sum, the challenges are significant, but we know what we want, we know what the problems are. What we need is a better understanding of the problems and their causes, the willingness and the capacity to design adequate and feasible strategies (priorities, objectives, plans of action) to address them, and the leadership which will make possible the mobilization of stakeholders and of necessary resources. This is your agenda; the costs (political and financial) of doing something about these problems can be high, but the benefits will be high. The cost of not addressing these problems is much higher, and brings no benefits. I hope that this will help you advance in your efforts to improve the performance of the workforce, on which your populations rely to meet their health needs.