

# CHALLENGES to the MANAGEMENT of HUMAN RESOURCES for HEALTH

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2005-2015

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*This publication was prepared by Dr. Marta Novick and Dr. Carlos Rosales and is based on a series of consultation meetings held within the framework of technical cooperation in the area of human resources management in the public health sector, as well as a series of documents written by the Human Resources for Health Unit of the Area of Health Systems Strengthening of the Pan American Health Organization (PAHO). The contributions of the following individuals are greatly appreciated: Dr. Rosa María Borrell, Dr. Pedro Brito, Dr. Charles Godue, Dr. Silvina Malvarez, Dr. Mónica Padilla, Dr. Daniel Purcallas, and Dr. Félix Rigoli.*

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# PREFACE

The Pan American Health Organization (PAHO), in fulfillment of its mandate to promote the strengthening of national capacities related to human resources policy formation and management in the public health sector, presents this analysis of the principal management issues currently facing the health workforce in the Region of the Americas.

Without a doubt, the scenario is complex and characterized by a diversity of ongoing processes. There are critical areas that need to be addressed through joint action in order to contribute to the development of equitable health systems that are of universal access and high quality.

In addition to sharing with readers an analysis of the most salient issues now affecting public health labor management, this publication will also describe the changing relationships among the diverse actors in the field of human resources, as well as the technical cooperation needs that have emerged from the current scenario.

For the purposes of the discussion, human resources management will be understood to be a set of processes and activities that train, deploy, organize, and integrate health workers into teams in such a way as to enable public health institutions to achieve established health objectives. This implies that effective human resources management involves the active participation of all members of a given health organization; i.e., the management, staff, and workers' associations. The organization of health labor processes requires establishing personnel policies and harmonizing the institution's social functions with its health objectives. There is also a need to have in place adequate administrative and regulatory practices that will support the methods and tools used to capture, develop, and retain human resources. The underpinning of effective human resources management is the conviction that an institution's workforce is its most valuable asset.

From this perspective, and with the goal of facilitating the development of national processes for managing human resources in health, this paper presents an up-to-date analysis and defines areas of action for PAHO's technical cooperation efforts. The discussion is organized to highlight what are considered currently to be the principal dimensions of human resources management.

It is important to note that this publication is the result of the efforts of the entire staff of the Human Resources for Health Unit of the Area of Health Systems Strengthening of PAHO, as well as consultation groups called upon to enrich the analysis and presentation of findings. Among the contributions, those of Dr. Marta Novick, Undersecretary of Technical Programming and Labor Studies of the Ministry of Labor in Argentina, and Dr. Marisol Barría, Minister of Health of Chile, particularly stand out.

We hope that this publication will become a useful source of reference for all those, throughout the Region of the Americas, who have responsibilities for managing human resources in the public health sector, and, in the process, will contribute to improving the performance of this labor force within a context of dignity and decent work for all.

Finally, this publication is placed at the disposal of an Americas-wide community committed to the development of human resources at an opportune juncture when both the 2006 World Health Day and the Pan American Health Week have chosen to honor the vital role played by health workers in the health and well-being of all of us everywhere.

*Charles Godue, Chief  
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# INTRODUCTION

The purpose of this publication is to highlight the major issues and challenges associated with human resources management in the public health sector, and to affirm the importance of these as a priority focus for the technical cooperation efforts of PAHO's Human Resources for Health Unit and the World Health Organization (WHO) over the coming years. During 2006, WHO launched the Decade of Human Resources in Health, World Health Day has been dedicated to the honor of health workers everywhere, and the annual *World Health Report* this year calls attention to the need to build and sustain strong health workforces across the globe. Within this framework, an agenda for technical cooperation in human resources management in the Americas is presented, based on a series of experiences and studies carried out in various countries of the Region. This agenda encapsulates the dimensions, guidelines, and overall strategy of PAHO's technical cooperation thrust in areas related to human resources management.

The Region of the Americas is facing a double challenge. First, it is going through a time of change and adjustment to the aftereffects of reforms occurring during the 1990s. In spite of greater macroeconomic stability in the majority of the countries, the unfulfilled social promises and resulting crises have placed the credibility of democracy at risk.

The quest for excellence in health, both in terms of coverage and in quality of care, is a priority goal leading to the achievement of equity and an overall improvement in the quality of life. The health worker is a privileged intermediary between the knowledge required to reach these objectives and the benefits accruable to the population as a whole, in the framework of sector-wide institutions and the plans and programs associated with the delivery of health services.

At the same time, it is critical that we recognize and accept that we are immersed in the age of information, or a society of knowledge,<sup>1, 2, 3</sup> in which processes of learning and innovation constitute the pillars of relative competitiveness and integration in the new global economy. At least part of the importance of knowledge in today's society is based on the need to transform it into a common good, due to the multiplier effect it creates. Nevertheless, in many countries of the Region both access to and appropriation of knowledge are "restricted" and, therefore, not public goods.

These global transformations and challenges are also relevant to our analysis of the most salient issues in human resources management, calling upon us to take a new look at this discipline and perhaps develop new approaches. The trickle-down effects of global change on the public sector, and in particular, on the public health sector and its ability to sustain a healthy population, require renewed reflection and open discussion, both with the involved social actors and the Region's governments who, on a day-to-day basis, must respond to these new realities and provide adequate solutions that ensure the effective performance of their respective health systems. The management of human resources in health is a key component in the development of strong health systems and services, and approaching it is much more complex than might be supposed.

This publication opens with a brief synopsis of the economic growth, employment, and poverty situation in Latin America (Chapter 1), followed by an overview of the Region's public health situation as a whole (Chapter 2), an analysis of the current state of the field of human resources (Chapter 3), and a discussion of key points related to human resources management in the public health sector (Chapter 4). The publication continues with a description of the principal characteristics of various agendas for the management of human resources (Chapter 5), and concludes with a discussion of the main focuses for technical cooperation—institutional, labor, education, primary health care, and research—followed by a summary of the challenges facing each and opportunities for multinational collaboration. Since this publication is considered to be a work in progress, we look forward to readers' comments and contributions as input for future action.

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<sup>1</sup> Castells, M: «La era de la información: economía, sociedad y cultura», Vol. 1, La sociedad red, Alianza Editorial, Madrid, 1998.

<sup>2</sup> Lundvall, B: «Por qué la nueva economía es una economía del aprendizaje?» in Boscherini, F, Novick, M and Yogueel, G. (editors): «Nuevas tecnologías de información y comunicación. Los límites en la economía del conocimiento», Miño, Dávila and UNGS, Buenos Aires, 2003.

<sup>3</sup> Lugones, G, Bianco, C, Peirano, F and Salazar, M: «Indicadores de la sociedad del conocimiento e indicadores de innovación. Vinculaciones e implicancias conceptuales y metodológicas» in Boscherini, F, Novick, M and Yogueel, G (editors): «Nuevas tecnologías de información y comunicación. Los límites en la economía del conocimiento», Miño, Dávila and UNGS, Buenos Aires, 2003.

## Chapter 1

# EMPLOYMENT AND POVERTY: GENERAL SITUATION IN LATIN AMERICA IN THE CURRENT DECADE

The 1990's in Latin America ended with low economic growth levels, high financial vulnerability, high unemployment, and very weak advances in terms of equity.

Since the late 1980s, there has been a clear shift in Latin America toward policies of economic liberalization, privatization of public enterprises, liberalized trade, and a diminished role by governments. At the same time, between 1980 and 2000, the number of poor in Latin America grew by 75 million, currently standing at more than 200 million. Of the total of new poor in the Region, almost 95% are urban. The economic liberalization programs were inspired in large part by the so-called "Washington Consensus," a combination of political and economic mandates that, beginning in the late 1980s, defined a priority doctrine of trade liberalization and deregulation that was promoted by the developed countries and multilateral lending institutions to the so-called Third World countries. This paradigm generated not only poverty and indigence, but also dramatically accentuated socioeconomic inequities, spurred unemployment rates to soar above 15%, and precipitated, with an end to the State's traditional steering role of earlier decades, an increase in illiteracy and school dropout rates, diminished resources for public education, and an unprecedented deterioration in the public health systems upon which the majority of the Latin American population relied.<sup>4</sup>

At the beginning of the 1970s the rate of increase of the regional gross product was 6% annually. By the end of that decade it had decreased to 1.5%, and during the 1980s Latin America's economies experienced zero growth. In

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<sup>4</sup> Workshop on "Inequidades económico-sociales en América Latina", 29 May - 2 June 2003, Bariloche, Argentina.

the beginning of the 1990s the regional product grew by 3% a year, reaching 5.3% in 1997, but fell again in 1998 and 1999. The annual average growth rate during the same period was 3.2%. Even though there was a recovery in growth during the 2003–2004 period, the rates needed to increase and be sustainable in order to reverse the negative socioeconomic consequences of the previous decade.

The economic and social models implemented throughout the 1990s in most of Latin America (albeit with important differences between countries) significantly affected the existing productive, social, and economic organizational patterns. At an aggregated level, the different policies had a common central focus on the need to quickly improve productivity by opening local economies to international markets of goods, services, technology, and capital. It was held that the free circulation of goods and capital would introduce changes in the productive structure that help close the trade gap with developed countries. It was supposed that these actions would allow for the recovery of the productive dynamism which had fallen into crisis during the last stage of the model of import substitution industrialization. In particular, these policies stated that the deregulation of labor markets would improve both the quantity and quality of employment, given reallocation of resources and a new productive specialization. Interest changed from the objective of achieving full employment toward a subordination of the labor market to the emerging requirements of economic structural changes linked to the idea of free markets. As a result, unemployment levels rose to unprecedented heights while the most relevant activities weathered a severe restructuring and loss of articulation between the productive linkages (provider networks, etc.).

During those years, the world economy began moving from being an aggregate of national economies linked by trade, investment, and financing, toward progressively becoming a global network of production and markets transcending national borders. However, this ever-growing and strengthening trend was not accompanied by a concomitant expression of institutional development at the international level, and the structure today remains incomplete and asymmetrical.

Globalization did not produce homogeneity in the world economy, nor did it create a single and uniform dynamic for the requisite integration. On the contrary, it became an unequal and multidimensional process. According to International Labor Organization, the results of this uneven globalization were gaps in employment, in social protection, and in possibilities for social dialogue.<sup>5</sup>

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<sup>5</sup> World Commission on the Social Dimension of Globalization: “For a fair globalization: create opportunities for all”. Switzerland, 2004.

To advance toward the reduction of these gaps and accumulated deficiencies, the Millennium Development Goals established highly ambitious objectives for the U.N. member governments and civil society. These goals imply redefining the role of the State and enabling it to recover, through the use of new models and institutional roles, the capacity to implement public health policy and set achievable objectives, including in the area of human resources management, in view of the latter's pivotal importance in the health sector's ability to respond to the demands of the public it serves.

In the next chapter we will look at the health situation in the Region of the Americas as a whole and the challenges this reality has brought.

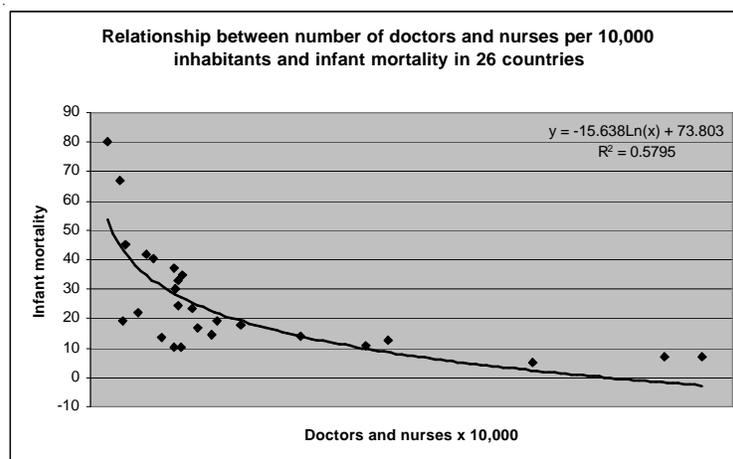


## Chapter 2

# HEALTH SITUATION IN THE REGION OF THE AMERICAS

By the end of 2000, life expectancy at birth in Latin America had reached an average of 70 years, a figure which corresponds to the target set within the framework of the Health for All strategy for the end of the twentieth century. According to data presented in PAHO's 1994 edition of *Health Conditions in the Americas*,<sup>6</sup> at the beginning of the 21<sup>st</sup> Century it was estimated that the values ranged from 54.1 to 79.2 years in the countries of the Region; that is, a difference of more than 25 years.

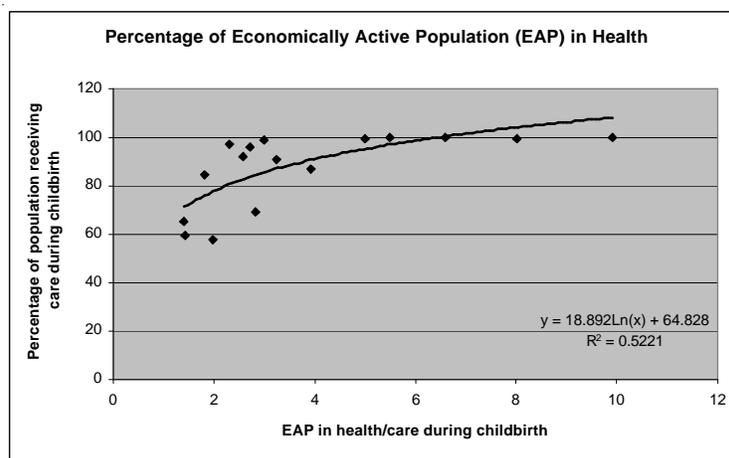
The period 1990–2003 registered the most rapid decline in the last decades in infant mortality, with an average of 25.6 per 1,000 live births, even though these regional averages of infant mortality hide the large disparities existing between countries. There is a group of five countries that have infant mortality levels below those observed in Europe in 2003, while a group of 12 countries register infant mortality levels above the regional average. Among these, Haiti stands out with a rate above 60 per 1,000, which reveals the generalized lag of this country, the poorest in the Western Hemisphere. The close relationship between availability of health workers and outcomes in terms of infant mortality can be observed in the following graph:



Source: *Health Situation in the Americas, Basic Indicators 2004*. PAHO/WHO.

<sup>6</sup> PAHO/WHO: "The health conditions in the Americas", 1994, Vols. I and II.

Regarding the mothers' health, available estimates indicate that in the past decade deaths continued to be 190 per 100,000 births in Latin America and the Caribbean. Because total births have not changed significantly since then, the number of women in the Region who die due to pregnancy or childbirth related causes has also remained stable at 22,000 per year. Nevertheless, poor maternal health has many other consequences aside from mortality. The World Health Organization has highlighted the high incidence of morbidity and disabilities resulting from the inadequate control and lack of attention during pregnancy and child delivery, including infertility and sexually transmitted diseases. The data shows there is only a small group of countries (Uruguay, Chile, Cuba, Saint Lucia, Argentina, Brazil, and Costa Rica) which have levels under 50 deaths per 100,000 births. The rest of the countries have rates that go from 60 to 520 maternal deaths per 100,000 live births in Haiti. One of the factors most closely associated to the reduction of morbidity and maternal mortality is qualified attention during childbirth. In Latin America 82% of child deliveries have qualified attention, a higher rate than other less developed regions (Africa 46%, and Asia 62%) but lower than the more developed countries in Europe and North America (99%). The following graph shows the relationship between the percentage of economically active population working in health (EAP in health) and the percentage of institutional attention during childbirth in 16 countries in Latin America and the Caribbean.



Source: Observatory of Human Resources. International Labor Organization and "Sistema de Información para América Latina" (SIAL), 2004.

In the majority of the Region's countries, the rates of birth control use range between 45% and 70%, although in three countries (Bolivia, Guatemala, and Haiti) the usage rates are far lower. Only Brazil, Colombia, Costa Rica, Cuba, and Puerto Rico report rates higher than 75%.

With respect to HIV/AIDS, according to data provided by the Joint United Nations Program on HIV/AIDS (UNAIDS), the Caribbean is second-highest in the world following sub-Saharan Africa in terms of prevalence among adults, with an average rate of 2.3, making HIV/AIDS the most important cause of death in the population's 15-to-49 age group. Throughout the Region there have been significant increases between 2002 and 2004 in the total number of people infected with HIV. It is estimated that in 2004 there were a total of 2.4 million infected in Latin America and the Caribbean, of which 21% were in the Caribbean.<sup>7</sup> Likewise, estimates show that during this period there was an increase of 200,000 people in Latin America living with HIV/AIDS, while in the Caribbean there are 20,000 people. A regional overview indicates that of the 27 countries in Latin America and the Caribbean reporting on HIV/AIDS status, 11 indicate a prevalence above 1%, and five of them above 2%. Eight of the 11 countries considered to have a high prevalence belong to the Caribbean subregion (if Guyana and Belize are included), and Haiti stands out as the only country in the Region with a prevalence higher than 5%.

It should be noted that the epidemic's age profile is also changing; half of the new cases of HIV infection have occurred in people between 15 and 24 years of age, which differs from the trend observed during the first half of the 1990s when the newly infected were principally in the 30-to-39-year-old age group. This phenomenon has been defined as a rejuvenation of the epidemic. Until December 2001, when, from a total of 1.82 million people infected with HIV in the Region, 240,000 were young females and 320,000 were young males. In the Caribbean most of the new HIV cases occur in women between the ages of 15 and 24. In Jamaica, the rate of incidence for pregnant girls is equivalent to nearly double the rate for older women.

As regards the incidence of malaria, of the 35 countries and territories that comprise PAHO, 21 report cases of active transmission of this disease. Of the 472 million inhabitants that make up the population of these 21 countries, 208 million (44.1%) live in areas exposed to some risk of transmission, and 131 million (59.8%) of those are exposed to a low or extremely low risk. In 2003 there were close to 850,000 reported cases of malaria in Latin America and the Caribbean. The countries that reported the largest absolute number of cases of malaria were Brazil, and those of the Andean subregion, with almost 82% of the total. The highest risk of transmission was observed in the subregion

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<sup>7</sup> UNAIDS/WHO: United Nations Joint Program on HIV/AIDS/World Health Organization. «Situation of the AIDS Epidemic», Geneva, December, 2004.

made up of French Guiana, Guyana and Suriname, where the annual parasitic incidence surpassed 200 cases per 1,000 inhabitants.

The deficiencies characterizing the public health systems of Latin America and the Caribbean represent barriers that hinder the possibilities of adopting cost-efficient measures to prevent or treat the main causes of maternal and infant deaths, as well as those due to communicable diseases such as HIV/AIDS, malaria, and tuberculosis.

The most important limitations are segmentation and fragmentation. Segmentation hinders or prevents the adoption of efficient measures for the different social groups because it imposes conditions for access to health systems services which only the most privileged groups can satisfy in terms of their social, employment, and economic standing,<sup>8,9</sup> a situation which serves to consolidate and even deepen existing inequities. One of the most severe effects of this situation is that it produces a segmentation of the right to health, which, in spite of being considered in inter-American and United Nations legal entities as a universal right, in practice is gravely restricted by such determinants as employment status and ability to pay. The results of studies conducted in several different countries in the Region show that between 20% and 77% of the population does not have access to public health care services when they are needed, and an average of 78% of the population does not have health insurance of any kind.<sup>10</sup> This situation has worsened due to changes in the labor market, particularly the growth of the informal labor market economy.

In Latin America and the Caribbean, close to 218 million people lack protection against the effects of illness, while more than 100 million do not have access to health services due to geographical factors. The information available on this issue indicates that in Latin America and the Caribbean no coherent strategies have been applied to reduce the exclusion from health services. As a consequence of the financial and budgetary restrictions resulting from economic crises, the health policies forged by most countries over the past 15 to 20 years have been generally aimed at cost containment and reduced spending.

The number of physicians per 10,000 inhabitants, as an indicator of the availability of human resources in health services in the Region, increased

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<sup>8</sup> OPS/OMS/OSDI: "Exclusión en salud en países de América Latina y el Caribe", serie Extensión de la protección social en salud, No. 1, Washington, DC, 2003.

<sup>9</sup> Behrman, J, Gaviria, A and Székely, M: "Social exclusion in Latin America: Perceptions, reality and implications" in "WHO'S IN AND WHO'S OUT: SOCIAL EXCLUSION IN LATIN AMERICA", John Hopkins University Press, Washington DC, 2003.

<sup>10</sup> OPS/OMS/OSDI: "Estudios de caracterización de la exclusión en salud" [on Internet] <http://www.lachsr.org/extension/esp/index.html>, 2001-2004.

from 13.1 in 1980 to 19.8 in 1999. Nevertheless, the indicator shows great variation among and within countries, thus reflecting serious inequities in terms of available health resources.

Another element currently under analysis, but for which there is less information available, is international migration. According to estimates quoted in *Health in the Americas* more than 1 million people entered the Americas in 2002, but the distribution of immigration is not uniform among the subregions. Two subregions in particular attract people: North America, with more than 1.35 million immigrants, and the Southern Cone with 12,000 immigrants a year. In contrast, the subregion with the largest net outflow is Mexico, with almost 300,000 people in 2002, followed by the Latin Caribbean, with more than 43,000 people annually. A further breakdown by subregion indicates that in North America, the United States receives 1.2 million people a year, and Canada, 150,000. In the Southern Cone, only Argentina has a net inflow of immigrants of 24,000 people a year, while Chile has a net outflow of 10,000 people. In the Andean area, all the countries show a net outflow or balance. In the Caribbean, there are small countries which have a net inflow, such as Guyana, with 1,320 people; on the other hand, Jamaica has an annual net outflow of 14,000 people. In the Latin Caribbean, the only country with immigration is Puerto Rico with 6,000 people yearly; the net outflows from Haiti and Cuba stand at 21,000 and 15,000 people per year, respectively. Health workers seeking improved working conditions in other countries are not absent from this profile, a phenomenon of growing importance in the Region.



## Chapter 3

# THE STATE OF HUMAN RESOURCES FOR HEALTH IN THE REGION

The human resources arena is not isolated from the dynamics of the processes just described and has experienced important changes in its configuration and the nature of the problems it faces. Most countries have witnessed the weakening of government institutions responsible for policy-making and the management of human resources, as well as a lack of mechanisms to establish planning, regulatory, and management strategies, both from an educational and employment standpoint. The reduced role of the State and its substitution in some countries by systems guided by self-regulation<sup>11</sup> have produced visible heterogeneities and segmentation.

The diversity of national human resource structures are determined by the economic and social development models applied in the national and regional frameworks. On balance, these new scenarios exhibit a lack of anti-cyclical policies, slow and unstable economic growth, high dependency on external financing, a reduction in domestic savings and investment, increased unemployment, lack of job security, growth in the informal sector, and deterioration in the distribution of income.

The reforms of the 1990s exposed the persistence and growing intensity of problems relating to equity, coverage, and quality of health care in the countries of the Region. These pose important challenges and difficult solutions that involve reforms of the State and public administration, particularly as regards health systems and the need for new policies and an increased investment in human resources.

The field of human resources in health is an endeavor that focuses on the issues of academic training and employment in public health and the related interventions of regulation, planning, management, negotiation, and assessment

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<sup>11</sup> Arroyo, J. "Transiciones y contra-transiciones en el desarrollo de capacidades institucionales en el campo de recursos humanos en salud," octubre de 2002.

of technical and social practices. The field has become increasingly complex due to the characteristics of the social and economic scenarios just described, the fragmentation of public institutions, the absence of a reformed vision, and the lack of an integral approach to the existing problems and new challenges.

The health sector is characterized by multiple public and private institutions both within the sector itself and in other related sectors. Among these are institutions that provide formal training, accredit, recruit, and employ human resources and regulate the gamut of health-related practices. The nature of this type of structure lends itself to institutional and sectoral fragmentation, in which each entity operates according to its own vision and mission, under different legal frameworks, and with distinct employment specifications, making governance over issues related to health care and services even more difficult.

As a forum for knowledge-sharing and action, the field of human resources in the health sector has responded over the years to a host of opportunities and setbacks that have enriched and redefined it, and at times changed the direction of its development. For example, for many years, actions were focused on educational issues, although more recently this focus has shifted to the labor market, due to changes in social organization, economic dynamics, and State reforms. Currently, efforts focus on striking a balance between the needs of both spheres (education and employment), a situation that requires consensus-building to resolve political problems and evidence-based strategies to solve technical challenges.

In this sense, basic actions in the field of human resources are inextricably connected to the vicissitudes of the labor market, including the sharp rise in recent years of labor strikes and disputes. At the same time they are affected by the linkages between academic preparation, social environment, and health services; the dynamics of the different professions; the new roles of professional associations and unions; the quality of educational training and workplace performance of health workers, and the growing emphasis on the need for continuing education, to name only a few of the most important factors.

Responding to these challenges, beginning with the publication of *Gestión de recursos humanos en las reformas sectoriales en salud: cambios y oportunidades* (Management of Human Resources in Health Sector Reforms: Changes and Opportunities),<sup>12</sup> the PAHO team of human resources specialists has worked consistently in the analysis and identification of cooperation processes to strengthen the formal regulatory and labor management systems

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<sup>12</sup> Brito, P, Campos, F y Novick, M: «Gestión de recursos humanos en las reformas sectoriales en salud: cambios y oportunidades» in PAHO/WHO, Washington DC, 1996.

that constitute an area of high strategic relevance in human resources cooperation. A concern with the need for suitable approaches and generalized improvement in all human resources management processes has guided PAHO's work over the past decade and has been addressed at several national and international fora with the support of the Human Resources for Health Unit.<sup>13</sup> The remainder of this publication will set forth a number of technical cooperation proposals to deal with these new challenges.

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<sup>13</sup> Particularly noteworthy are the following meetings: "Diálogo: Gestión del trabajo en los sistemas nacionales de salud: La perspectiva de los usuarios, los trabajadores de la salud y los gobiernos" (Dialogue: Labor Management in the National Health Systems: the Perspectives of Health Users, Workers, and Governments) in Brazil in July 2004; the "Seminario Anual de los Observatorios de Recursos Humanos en Salud en los procesos de reforma sectorial en la Región de las Américas" (Annual Seminar on Observatories for Human Resources in Health in the Process of Sectoral Reform in the Region of the Americas) in Brazil in November 2004; the meeting of a consultation group on the field of human resources management in Argentina in April 2005]; and two subregional meetings on human resources, one held in Costa Rica in July 2005, and the other in Peru in August 2005.



## Chapter 4

# HUMAN RESOURCES MANAGEMENT

It is useful to reflect about the concept of management to understand that the challenges of changing health services and systems have multiple causes and therefore require integral and different alternatives for a solution. There is no one instrument that automatically and magically improves management. Organizational theory has evolved from an administrative perspective that views decision-making as a key factor in leading the actors that make up a given organization. Achieving the desired objectives for the health system may be called conversion (or transforming resources into goals, according to Tobar).<sup>14</sup>

The concept of management is wide-ranging, since it allows a comprehensive approach to organizations, where human resources are not just another factor of production but a component with unique characteristics. Various thinkers have offered interesting perspectives on the subject that are worth sharing here.

Ortún Rubio<sup>15</sup> defines the concept by saying that “management coordinates and motivates the people that make up an organization (in this case a health organization) to achieve its goal.” The concept of management is based on the idea that the actors of an organization are motivated by factors other than mere remuneration; for example, pride in the organization’s history and past achievements, personal professional satisfaction, social recognition, and a safe and adequate work environment.

According to Marcondi,<sup>16</sup> who focused on public sector entities, the strategic management of human resources may be understood as the definition

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<sup>14</sup> Tobar, S: “Alternativas para la formulación de políticas de macrogestión de recursos humanos”. Article written for PAHO/WHO, 2003.

<sup>15</sup> Ortún Rubio, V: “Innovación organizativa en sanidad», Asociación de Economía de la Salud” (AES), España. Política y gestión sanitaria: la agenda explícita, edit. R. Meneu and V. Ortún, Barcelona, 1996.

<sup>16</sup> Marcondi, N: “Políticas integradas de recursos humanos para el sector público”, Biblioteca Virtual TOP sobre Gestión Pública, [www.top.org.ar/publicac.htm](http://www.top.org.ar/publicac.htm).

of policies and guidelines to enhance staff skills and thus the organization's ability to achieve its objectives.

The Ministry of Health of Peru defines management as "the ability to keep the organization productive, efficient, and effective, through the appropriate utilization of human resources. The objects of human resources management are people and their relationship to the organization, as well as creating and maintaining a favorable working environment and strengthening the skills and capacities of workers in ways that contribute to personal and organizational development."<sup>17</sup>

Human resources management is the process by which management teams in a given institution organize work and distribute their "human capabilities" or "human capital" to achieve that institution's established goals.

Brito<sup>18</sup> proposes that when we speak about human resources management (or work management as it is called in Brazil), we are talking about a function that is more noble, essential, and complex than it might appear at first glance. We should not understand it as being merely "what people do in the personnel office," but as a theory and practice guiding processes (e.g., economic, political, technical, cultural) that affect the worker and his or her contribution to the health care of the population as he or she performs within a specialized institution, which is also a place of employment. This function is assigned to the leadership of the respective health services system, health care network, or health institution, which is oriented to the satisfaction of the population's health needs within the framework of current sectoral policies and organizational types. Only under these conditions, when such critical factors as rationalization and planning are incorporated, may one talk about a strategic perspective of human resources management.

The decentralization of the health systems, a process affected by many external realities during the preceding decade, precipitated significant changes in the management of human resources in the public sector. Decentralization occurred in almost all the countries of Latin America and the Caribbean and also in many European countries. In the case of the Americas, sector resources and responsibilities were either delegated to the meso level (i.e., from the national to the provincial or state governments) or, to a lesser degree, to the next lower level after these (municipal or its equivalent). The decentralization was not always accompanied by the transfer of resources or specialized skills,

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<sup>17</sup> "Ministerio de Salud del Perú: Programa de Fortalecimiento de Servicios de Salud, Área de Capacitación y Apoyo a la Gestión," 1999.

<sup>18</sup> Brito, P: "Impacto de las reformas del sector de la salud sobre los recursos humanos y la gestión laboral" en Revista Panamericana de Salud Pública, 8 (1-2), 43/54, 2000.

thus making it necessary for local health systems to develop mechanisms on their own to acquire and/or strengthen the necessary competencies.

A PAHO survey conducted in 18 countries of the Region indicated that the delegation of authority to manage human resources was decentralized in 16 of them, with varying degrees of decentralization and/or autonomy. These processes were generally not accompanied by a strengthening of the State's regulatory capacity (Brazil is the exception, with a national planning entity, while the other countries have only limited regulatory capacities). There is also a significant shortage of information systems to monitor the dynamics of human resources from a comprehensive perspective and thus provide vital input for the decision-making process.<sup>19</sup>

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<sup>19</sup> Arroyo, J. op cit.



## Chapter 5

# PROBLEMS RELATED TO HUMAN RESOURCES MANAGEMENT

In managing human resources, the Region's health systems must deal with the coexistence of three very different agendas, or labor models. This juxtaposition is due to multiple factors, including various unresolved problems of the past, the appearance of new issues related to the reform processes and their failures, and the emergence of additional challenges related to globalization:

- ♦ The first one is the old agenda,<sup>20,21</sup> called in the 1990s **the bureaucratic model**, which corresponded to a structure of stable and protected labor relations based on employment contracts of indefinite duration and, in some cases, to health career models tempered by the value given to seniority. The old agenda harbored difficulties in personnel administration that were never completely resolved and thus persist today. Principal among these is a rigidity in regulations that presents an obstacle to changes in human resources management. Cherchiglia<sup>22</sup> characterizes this stage as a traditional, or Weberian,<sup>23</sup> management system based on a stable model with protection of labor.

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<sup>20</sup>Dal Poz, M: "Trabajo presentado en la Reunión Regional sobre Recursos Humanos: factor crítico de las reformas sectoriales de salud," Programa de Desarrollo de Recursos Humanos, Serie Desarrollo de Recursos Humanos 8, OPS/OMS, San José de Costa Rica, 1998.

<sup>21</sup> Brito, P, Galín, P and Novick, M: "Labour relations, employment conditions and participation in the health sector" en Dal Poz, M and Ferrinho, P: "Towards a global health service strategy", ITG Press, Antwerp, Belgica, 2003.

<sup>22</sup> Cherchiglia, M: "La gestión del trabajo en América Latina y el Caribe: tensiones y conciliación entre el programa viejo y el programa nuevo", OPS/OMS, 2004.

<sup>23</sup> Nogueira R and Santana J: "Human resource management and public sector reforms: trends and origins of a new approach" en Dal Poz M and Ferrinho P: "Towards a global health service strategy", ITG Press, Antwerp, Bélgica, 2003.

***Main problems of the “bureaucratic agenda”***

- Absence of labor force planning based on a health care model
- High percentage of State expenditures on health personnel combined with low salaries
- Lack of balance in labor force composition
- Inequities in the geographical distribution of resources
- Imbalances and poorly defined composition of health teams
- Lack of continuity between educational preparation and workplace requirements
- Gender inequities
- ◆ The second—the **flexible agenda**—emerged from health sector reforms that most countries initiated in the 1990s and responds to a new model by a regulatory system based on flexibility in labor contractual relationships. The reforms of the health sector—irrespective of their starting point—introduced competitive elements in systems that were previously integrated, oftentimes utilizing free market and private sector approaches as central elements in the restructuring. This second agenda was thus focused principally on situations or problems related to decentralization, deregulation, changes in financing systems, and the separation between financing institutions and executing agencies. For Cherchiglia this is a «new» or flexible model, since it introduces such marketplace elements as flexibility in terms of hiring and maintaining personnel.

***Main problems of the “flexible agenda”***

- Decentralization of institutional competencies
- Labor flexibility/lack of job security
- Changes in regulatory mechanisms
- Generation of incentives for productivity and greater social pressure for improved quality
- Uncontrolled increase in availability of health education due to privatization
- Growing feminization of the health workforce
- Requirement of new skills to face new functions
- ◆ Finally, there is a third agenda, the current agenda, the unfinished agenda of skills rebuilding, that has come about as a result of the many problems related to the reform process, some of its failures, and the need to reestablish the State’s steering role in the realm of social policies, particularly health. As seen in the first two chapters of this publication, the levels of unemployment and poverty of a large proportion of the Latin American and the Caribbean population and

the emergence of new diseases are two factors pointing to the critical need to increase the efficacy of health systems, which, in turn, will require reevaluating and retuning the management of human resources, an issue that was largely overlooked during the health reform process.

***Main problems of the “unfinished agenda”***

*The need to “rebuild skills”*

- New global decision-making structure, weakness of the health authority
- Increasing brain drain of professionals from poorer to richer countries, indiscriminate international recruitment, and lack of regulations for international professional activity
- Weak human resources management at the different services levels and need for a greater systemic integration
- Deregulation of the labor market
- Lack of human resources protection (e.g., occupational health and safety risks, difficulties in access to health care and pension plans)
- Weakness of public health systems in managing global public policies
- Increased levels of labor conflict
- Inadequate training by recent university graduates for the effective management of human resources and health services
- Appearance of global initiatives with substantial resources for specific issues

The current situation requires recovering the social gains and recapturing the earlier focus on equity sacrificed by many countries during the 1990's in order to bolster the fiscal situation and bring their economies into closer alignment with international trade requirements.<sup>24</sup> The health sector reforms have failed to yield the expected results in the areas of poverty reduction and health care coverage, as seen in Chapters 1 and 2. Likewise, flexibility in labor relations has not generated the expected benefits, and many countries in the Region are starting to apply policies to address job insecurity issues. At the same time, with the intensifying of globalization tendencies, new challenges to the health sector arise due to such phenomena as international recruitment markets and migration and international professional certification agreements.

The three agendas, models, or stages just described are closely connected to functions assigned to the State in general and the health sector in particular.

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<sup>24</sup> Ocampo, JA: “Fortalezas, debilidades y desafíos del pacto fiscal”, Centro Latinoamericano de Administración para el Desarrollo (CLAD), Revista Reforma y Democracia, febrero de 1999.

In the Weberian model, the State acted both as a regulatory body and as an employer and service provider for large segments of the population. A centralized and bureaucratic mindset prevailed, with minimal emphasis placed upon costs or quality of service. The sectoral reforms altered the role of the State (in effect, weakening it) by imposing or promoting criteria derived from the application of private sector administration principles to the public sector. The redefined role of the State led to the treatment of what were once viewed as social issues now being a part of economics,<sup>25</sup> in the sense that the State was forced to compete with the private sector, increase levels of competence, and bring health closer to the concept of being a commodity rather than a common good or an individual right.

The situation today, in which problems from each of the stages coalesce, requires a transformation of the State and its steering role in health matters. The challenge lies in giving new significance to this role without reverting to the mentality of a bureaucratic State without cost controls, nor to the predominance of managerial or market flexibility criteria. Or, said another way, the solution will be to find a health management model that can recognize and adequately respond to new and evolving circumstances in the public arena, including epidemics, epidemiological shifts, and growing populations, utilizing the human resources currently at its disposal. At the same time, this model would instill a sense of collective commitment and individual excellence, provide decent working conditions, and offer contractual relationships that guarantee security, belonging, and motivation, while avoiding standardized arrangements inevitably leading to “lifelong stability.” It is within this context that a transformation of the State’s role serves as a catalyst for the necessary rationalization and redefinition of human resources management in the public health sector.

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<sup>25</sup> Cherchiglia, op cit 2004.

## Chapter 6

# TECHNICAL COOPERATION IN THE AREA OF MANAGEMENT OF HUMAN RESOURCES FOR HEALTH

The social and economic changes described in previous chapters point out the need to develop new strategies and open new areas for cooperation in the field of human resources management in the public health sector.

Despite the diversity of perspectives that have been offered regarding society's globalization, all would readily recognize the emerging possibilities for knowledge-sharing<sup>26</sup> and the profound consequences this offers for technical cooperation in health. In essence, it is an opportunity which places management and knowledge-building at the core of the process and transforms PAHO and the health community into producers and communicators of this new knowledge. In the case of technical cooperation in health, the growing importance of knowledge reinforces the positive effects of interventions on national health problems.

The centrality of human resources in today's information or knowledge society is more evident than ever before. Within this framework, health workers may be considered "intelligent mediators" and "interpreters," since it is they who convert specialized knowledge into solutions to health problems. It should be noted, however, that the totality of this knowledge is distributed along a continuum of actors and professional specializations in the sector and that no single domain is the sole purveyor of the accumulated body of information or knowledge. This means that governments and health organizations progressively define their probabilities of growth and development according to the investment and stock held in the new "capital," human resources, whose "codified" and "tacit" knowledge needs to be correctly and adequately utilized in order to improve the population's health. Therefore, health systems define the quality and overall effectiveness of their work according to the knowledge

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<sup>26</sup> Recursos humanos en salud: desarrollo de capacidades de gente que atiende a la gente. Relato de la reunión técnica de HSR (Health Sector Reforms), Lima, 7 al 9 de julio del 2002.

and implementation capacity of their personnel, conditioned by organizational arrangements and individual behavior.

Technical cooperation in knowledge management is conceived as a democratizing factor, by allowing the shared generation and use of this wealth. From this perspective, technical cooperation must be provided as an intervention in the management of human resources, as well as in the strategies for intervention, and in the recognition and recovery of local knowledge.

The fundamental pillars for technical cooperation based on this knowledge management are, on one hand, the transformation of information into knowledge, and, on the other hand, the dissemination and reproduction of this knowledge, and, finally, its incorporation by the various actors in and at their respective areas and levels.

Technical cooperation efforts in knowledge production and management would all share the following characteristics and goals:

- a. **Go from an analysis of the problem(s) to synergistic, integrated action with countries and cooperation agencies.** The objective is to strengthen mechanisms for the production of national and regional information on the status of human resources management in health, highlighting shortcomings, practices, and successes in each case. To this end it is necessary to move beyond the diagnostic stage and stimulate the circulation of this information as a necessary premise for the identification and description of problems at the national, subregional, and regional levels. The technical cooperation effort should contain a component enabling it to support these processes and promote the generation of national, subregional, and regional opportunities for interaction among the producers of information and decision-makers. The information generated must be codified and disseminated to improve the capacity for policy formulation.

The final objective of this cooperation is **to improve the available information and broaden its use so that it may be transformed into knowledge by decision-makers and other relevant social agents.** New and expanded uses for the information should be developed, thereby obviating the need to substitute or create new systems. The horizontal dissemination of these results between countries will generate a synergetic development.

- b. **Improve the skills of human resources managers in the health sector.** PAHO's technical cooperation with the countries of the Region in the area of human resources has enabled it to develop a growing body of knowledge, methodologies, and tools. Each of these are further enhanced and fine-tuned over time as the nature of management problems changes. The systematization and dissemination of this

knowledge is one of the métiers of the Organization and sustain its operation. The experience of PADRHUS,<sup>27</sup> developed by PAHO together with diverse entities in South and Central America, has yielded a series of best practices for information dissemination that informs the educational expertise and enriches the knowledge base of a cohort of professionals committed to human resources issues.

Within the framework of organizational changes aimed at the decentralization of technical cooperation—consideration is given to expanding knowledge and number of personnel with competencies in management of human resources.

This working strategy aims at promoting the development of human resources management and the methodologies and technologies needed for their prompt and wide dissemination in the national and regional spheres. At the same time, in an effort to increase and improve coordination, the strategy must seek to combine the available knowledge resources with those of academic and service entities so as to promote collective theoretical reflection by the participants. Such an approach should improve both the quality of training for and practical application of human resources management.

The strategy to be implemented must generate teaching tools to:

- facilitate reflection and learning about the practices of human resources managers at the macro, meso, and micro levels;
- identify, invite, and incorporate members of academic programs into the learning process so they may interact with decision-makers; and
- systematize conceptual and practical advances achieved in the management of human resources, and organize and consolidate a network of interested actors for the purpose of knowledge-sharing.

- c. **Develop and exchange experiences (national and international) in the management of human resources in health.** As many countries in the Region have discovered (or are discovering), to achieve this third objective it is necessary to create alliances and opportunities for key actors to come together to analyze situations, develop joint strategies, and apply consensus-building skills to such issues as the operation of labor markets, professional regulation, and relationships with unions and other types of associations which may serve as examples of best practices and of integral and participative

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<sup>27</sup> PADRHUS is the Program for Distance Learning in Human Resources in Health in Brazil. Since 1992, PAHO and FIOCRUZ have carried out an advanced training at a regional level, and between 1990 and 1996, a similar initiative, under the coordination of the Health Training Program for Central America and Panama (PASCAP), was executed.

approaches.<sup>28</sup> Nevertheless, in this context, there are challenges for PAHO—taking into consideration its strengths and limitations—in terms of its specific role and the most appropriate strategy for adoption.

Therefore, technical cooperation efforts should aim for the inclusion of all actors in the field of human resources so that they may collaborate in the definition and analysis of the various work areas. It is necessary to construct and facilitate the operation of the greatest possible number of formal and informal mechanisms for exchange, generating community networks by specific thematic areas that together will contribute to the flow of information and the identification of problems in past practice and potential challenges for future endeavors.

The problems of the Region require that this stage of network creation and dissemination transcend national borders and extend to the subregional and/or regional levels. Now and even increasingly in the future, effective management of human resources in health will require facing emerging problems in a borderless environment: international migrations, disease outbreaks, professional exchanges, and skills certification. These demand the creation of collective frames of reference and codes that incorporate a common approach.

An analysis of PAHO's technical cooperation experience in the field of human resources management and the results of a consultation meeting on this issue held in Argentina in April 2005 provide the basis for identifying the principal challenges, proposing a set of possible work areas, and establishing goals in each one of these areas. At the same time, the establishment of specific goals will allow for the generation of assessment mechanisms.

The proposed areas, or dimensions, for technical cooperation actions are:

- Institutional and regulatory framework
- Employment in the health sector
- Education in management
- Human resources management to support the strengthening of primary health care
- Research in issues related to human resources management

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<sup>28</sup> Twenty two countries in the Region currently participate in the Observatory of Human initiative. The Observatory serves as a forum to join together relevant players in this field and stimulate participative political action. It has spurred the creation of national teams in such areas as education, employment, regulation and policies, labor market, and professional specialization, who in turn seek to develop proposals within an integrated framework of policies and implementation.

The development of each of these items includes a summary of the problem, followed by an identification of the priority issues that the cooperation activities should seek to address, and an indication of how technical cooperation might best focus its work on these priorities.

## 6.1 THE INSTITUTIONAL DIMENSION IN HUMAN RESOURCES MANAGEMENT

### 6.1.1 INSTITUTIONAL AND REGULATORY FRAMEWORK

BUILDING THE INSTITUTIONAL CAPACITY FOR SECTORAL REGULATION  
IN THE MANAGEMENT OF HUMAN RESOURCES

#### SUMMARY OF THE PROBLEM

The majority of countries in the Americas currently are facing a significant weakening of the leadership role traditionally held by the State due to political and technical factors resulting from the decentralization processes. These, in turn, have led to inadequate budgetary planning and resources allocation, compounded by a superposition of regulatory and/or contractual norms.

The Region's reform processes, mainly oriented to reducing expenditures, decentralizing administration, and separating financing from services delivery, initiated a set of actions and dynamics that, in fact, were superimposed on the current «bureaucratic» state models. Given that most of the reform processes were not integral, the new regulatory frameworks in many cases were superimposed on the previous systems which were not always homogenous or clear. Together with the reform processes, important programs to expand health coverage to ever-larger segments of the population were implemented using special regulations and ad hoc human resources policies. As noted earlier, currently in most cases the steering role in health issues is shared between the national ministries and the local jurisdictions which, by adding a greater heterogeneity, necessitates the negotiation of agreements and consensus in order to strengthen governance.

From an institutional point of view, most countries have:

- Heterogeneous regulatory frameworks, including forms of “self-regulation”
- Scarce planning, because each “model” generated different institutional modalities and processes that were not necessarily changed in the next stage, thus leading to the coexistence of different regulatory patterns and frameworks

- A lack of truly operational career-based plans or internal systems for the evaluation of actual performance, as opposed to compliance with bureaucratic exigencies

It is necessary, therefore, to tie in the health care models with the priorities established for the short, medium, and/or long term, to be able to plan—albeit with a certain degree of flexibility—human resources needs, required qualifications, and the composition of required health teams, taking into consideration the existing limitations.

Nevertheless, a well-known difficulty in Latin American and the Caribbean countries is the tension between social or labor policies and economic limitations. Generally, social aspects (health, education, and labor) are subject to the dictates of the economy and international financial commitments (in most cases, external debt). The experience of the past decade has demonstrated that economic growth alone does not generate employment or improve the population's health status. This growth must be reinforced with a variety of supportive public policies, if it is to achieve satisfactory results in the mid and long term (for example, an adequate fiscal policy to achieve equity).

It is also imperative to clearly establish government priorities, such as the need to improve public management and, particularly, the capabilities of the ministries of health. In general, these ministries are unable to develop projects and programs that may be considered investments rather than current expenditure. Therefore, it is necessary to generate the capacity to adequately justify budgetary demands and to collaborate in the building/rebuilding of the State at all levels, so that it can:

- Define the strategic issues
- Establish priorities
- Guarantee information for the production of indicators
- Identify the issues that must be regulated and specifically organized
- Regulate to guarantee the fulfillment of objectives

Undoubtedly, one of the first functions needing to be recovered is human resources planning, which in fact has had many different models throughout history. This planning must first characterize the care model and health services strategy that are most appropriate to achieve public health objectives.

The type of planning currently required, differing from the one-dimensional planning models from past eras, is flexible, interconnected, and in need of continuous revision, active input from the relevant actors, and joint evaluation. It also requires combining principles of supply and demand, establishing criteria to determine the supply that needs to be regulated. Planning assumes different degrees of flexibility and basic operational rules. It incorporates—as in

management—different levels: a) macro: national planning (or planning for a specific local jurisdiction) in which territorial distribution and equity must be taken into account, affecting the requirement needs for professionals and specialists in accordance with the specific health care model and goals established by the system; b) meso: requirements from the institutions that supply health services (hospitals, outpatient facilities, and their linkages) in accordance with the territorial and demographic area that is targeted; and c) micro: needs in each of the institutions and networks for an efficient organization and management of human resources in the specific health care processes called for.

Planning by itself does not guarantee the achievement of goals. Planning, regulation, and management cannot be separated. It is necessary to have a combination of social interventions coordinated by political definitions.

#### 6.1.2 MAIN AREAS FOR COOPERATION TO STRENGTHEN THE INSTITUTIONAL FRAMEWORK

- a. **Address the current coexistence of laws and regulations that immobilize the management of human resources and lead to labor conflicts.** These should be singled out and a detailed analysis conducted of the advantages and disadvantages of each, both as they relate to planning in general and to human resources planning in particular. Regulatory changes should arise from negotiations and from the legal possibilities and acquired rights in each case. The cooperation proposal would be based on the need to adequately respond to a variety of situations currently faced by health personnel and the type of incentive mechanisms to be implemented.

The different legal structures and jurisdictional agencies to which health workers are subject require systematization and a search for equitable regulatory mechanisms.<sup>29</sup> The weakening of the State's authority in this respect has facilitated an increase in self-regulated professional practices, to the benefit of medical staff due to their greater organizational power.

Thus, it is necessary to establish planning activities based on the proposed health care models and determine, albeit with some degree of flexibility, the needs and composition of the workforce for the different care levels, with greater integration among them. In building health teams, a more rational logic needs to be applied that is not based exclusively on the available supply.

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<sup>29</sup> While the multiplicity of contractual modalities existing in most countries of the Region is clearly a regulatory issue, this topic will be further developed in the next subsection within the context of decent work for health workers.

The objective is to create highly coherent systems that respond to the needs of both users and workers.

The cooperation should be aimed at:

- Developing planning processes for the short, medium, and long term, with a regional, national, and local vision
- Collecting and reviewing the various components of existing legal frameworks in the area of human resources
- Strengthening the budgetary negotiating capacity and the generation of arguments based on reliable, high-quality information
- Developing instruments and methodologies for analyzing staffing requirements for the different health care models and population to be covered
- Analyzing and rationalizing the systems that create difficulties in the decision-making processes in the services network
- Developing tools and studies to analyze the different forms of organization and administration of human resources

b. **Correct inconsistencies resulting from the ability of some professional groups to negotiate separate and favorable conditions outside the sphere of established norms and statutes, thereby segmenting the health worker community.** In addition to the heterogeneity of regulations just mentioned, the autonomy of some professional groups to achieve negotiations and/or special arrangements that further fragment human resources increases the overall complexity of this issue. In some cases, the special arrangements arise from the scarce supply of a particular professional group (e.g., nurses, anesthesiologists), which allows it to negotiate certain benefits such as salaries. In other cases, due to their enhanced capacity to mobilize and call attention to labor conflicts, these groups are able to achieve objectives that are separate from those of the larger collective group. The decentralization processes have brought to light the fact that enormous variations exist from jurisdiction to jurisdiction in terms of resources available to finance the health sector—particularly human resources—leading to asymmetrical situations that provoke labor conflict and migrations, among other trends.

The health sector is made up of a large number of individual and social actors of different types. There are professional associations and national, local, and/or municipal unions whose membership is considerably large in some cases. Labor representation in the health sector is a complex mosaic, occurring at a moment in time when even the ability of labor union leaders to adequately articulate worker grievances is sometimes questioned, and there are strong tensions between the collective structures and individual negotiations.

To help dissolve this tension, the cooperation should be aimed at:

- Establishing criteria for the normalization and development of guidelines for collective negotiations that better integrate professional groupings
- Training in conflict management and mediation

c. **Strengthen the currently weak budgetary negotiating capacity.** This is a pivotal issue in the management of human resources in the health sector, due to the importance of health sector expenditures in gross domestic product (11.3% if all of the Americas are considered, and 7.3% if Canada and the United States are excluded), and the weight that human resources have in the budget, which in general surpasses 60%. One factor contributing to the sector's weak capacity is the fact that the budgeted amounts are decided outside the sector, while at the same time, the sector experiences difficulties in generating and processing reliable information that ties expenditures to the achievement of health results.

In this sense, it is important to create the capacity to determine the cost-benefit ratio of the human resources component in the provision of health services. There are international studies<sup>30, 31</sup> that have demonstrated a positive relationship between the number of care personnel and health outcomes for the population as a whole (e.g., infant and maternal health), or that demonstrate the influence of the number of nursing staff on the health outcomes of different types of medical services. Yet few studies of this type exist within the Region of the Americas itself, despite the fact that findings of this nature would provide human resources managers with an important leverage tool and enable them to improve their negotiating capacity during the budgetary decision-making process.

Information available in the Observatory of Human Resources should be processed and analyzed systematically by the countries to generate evidence linking results in health care coverage and quality, with the quantity and quality of human resources and their geographical distribution.

The cooperation should be aimed at:

- Developing methodologies and securing information that will yield evidence on the availability, quantity, cost, and quality of health care and human resources, and the relationships existing between them.

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<sup>30</sup> Anand, S, Bärnighausen, T: "Human resources and health outcomes: cross-country econometric study", *Lancet* **364**, 2004.

<sup>31</sup> Needleman, J, Burhaus, I and Peter, MA: «Nurse staffing and patient outcomes in hospitals» Harvard, 2001.

## 6.2 THE LABOR DIMENSION IN HUMAN RESOURCES MANAGEMENT

### 6.2.1 LABOR DIMENSION

#### DECENT EMPLOYMENT FOR HEALTH WORKERS

##### SUMMARY OF THE PROBLEM

The profundity and complexity of this topic leads us to three important considerations:

- a. **The coexistence of numerous and diverse formal, informal, and ad hoc labor contracting mechanisms present difficulties for the decision-making processes, particularly as regards hiring, thereby creating problems within health teams and between the different services network components.** The analyses found in a variety of studies and sources of information, both in Latin America and the Caribbean<sup>32, 33, 34</sup> and outside of Region of the Americas<sup>35, 36</sup> unanimously point to the deterioration of the employment situation of health workers in recent years.

In addition to the expansion of salaried work, labor markets in general, and in Latin America in particular, have given rise to precarious forms of labor contracting, be it through lack of social protection, the disguising of salaried employment under supposedly autonomous firms, or through the temporary nature of the relationships established. This labor market flexibility in the health care sector occurs both in the public and private domains, in developed countries and in the poor, emerging, or developing countries and regions.<sup>37</sup> In the Americas highly heterogeneous hiring practices and contractual relationships for health sector workers have been identified, characterized by little or no social protection in comparison with earlier labor models.

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<sup>32</sup> Brito et al op cit.

<sup>33</sup> Galín op cit.

<sup>34</sup> Novick and Galín op cit.

<sup>35</sup> Bach, S: "Selected cases in Western Europe", in Gabriel Ülrich (edit) Labor and social dimensions of privatization and restructuring health care services, ILO, Geneva, 1998.

<sup>36</sup> Bach, S: "Human resources and new approaches to public sector management: improving human resources management capacity" (pp105/142) in Dal Poz, M and Ferrinho, P: "Towards a global health service strategy", ITG Press, Antwerp, Belgium, 2003.

<sup>37</sup> Brito et al op cit.

This phenomenon, which expanded considerably in almost all the countries of the Region, but particularly in Argentina, Brazil, and Peru, implies a coexistence of different hiring modalities for similar tasks as well as disparate levels of protection. A number of studies confirm this situation<sup>38, 39, 40</sup> but there is little research to provide evidence about the possible interrelation between the lack of job security and its consequences for quality of services care.

The confirmed lack of job security and interplay of numerous and dissimilar employment mechanisms introduces serious challenges for effective health resources management, because the current regulatory environment discourages the application of incentive systems, creates tensions within health teams, presents obstacles to change processes and even for the maintenance of routine tasks.

Many countries in the Region do not have management systems for human resources in the health sector that are separate from those of the general systems for public sector personnel as a whole<sup>41, 42</sup> thus creating another source for friction, since these systems lack the specificity necessary to take into account actual working conditions. At the same time, the considerable diversity of professional specialties and occupational segments in the health field require frames of reference that are more adaptable and specific to the sector's unique realities.

The growth of employment insecurity and worker vulnerability to unfavorable contractual arrangements, the deterioration of working conditions due to more open-ended work shifts, and an increase in work intensity due to the disintegration of health teams, manifest themselves, in their collective expression, as an overall deterioration in health practices and quality of services, thereby impeding the ability of health management to fulfill its responsibilities to the population it serves.

Outsourcing and subcontracting activities (e.g., cleaning, food, and security services) belong within this contextual framework and analysis. In their earliest appearance, these activities were focused in the area of general services, but currently they offer other professional services through the hiring of medical cooperatives and of nursing organizations for home care or rehabilitation, among others. In the

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<sup>38</sup> Ministério da Saúde, Conselho Nacional de Saúde: "Princípios e diretrizes para a gestão do trabalho no SUS (NOB/RH-SUS)", Brasília DF, 2005.

<sup>39</sup> Brito et al op cit.

<sup>40</sup> Galín op cit.

<sup>41</sup> Bach op cit.

<sup>42</sup> NOB/RH-SUS op cit.

case of Brazil, where the most information is available, in 1997, 49% of the workforce in large hospitals (151 to 300 beds) was subcontracted, 38% in hospitals of more than 500 beds, 10% in mid-sized hospitals (51 to 150 beds), and only 3% in small hospitals.<sup>43</sup>

Another greatly generalized situation in Latin America is the tendency toward **multiple employment**, especially in Argentina, Brazil, Uruguay, and Peru, and, to a lesser extent, in Chile. In the case of Peru, a study showed that 71% of the medical personnel interviewed hold two or more jobs. In Uruguay, since the beginning of the 1990s, in spite of the increase in the total number of health professionals, there is an average of 2.6 jobs per person, and among dentists, the average is 2.26. The practice of multiple employment was also found to exist in El Salvador and Panama. This phenomenon is most likely caused by several factors. One is the growth of part-time jobs. At the same time, low salaries promote the search for additional sources of income. Finally, the development of a “dual” labor market also facilitates the practice’s viability by combining better salaries and working conditions in the private sector, with low salaries and social protection and other benefits in the public sector. Among nurses, however, multiple employment is considerably lower, a finding that may be explained by the greater number of working hours required in each job. In the case of Uruguay, where this issue was systematically studied, the average was 1.34 jobs per person; that is, half of those registered for physicians.<sup>44</sup>

The health status of health sector workers themselves acquires special importance within the context of decent employment. On one hand, it is of great economic and social relevance because the health sector constitutes a significant source of employment, with close to 10 million workers in the Region of which a majority are women who also face gender inequities. The sector has a “glass ceiling,” since in spite of the high proportions of women, the highest-level jobs—public and private—are held by men. The lack of job security discussed earlier, and the introduction of technical advances without the appropriate procedures in place to guarantee occupational safety have deteriorated the working conditions and, therefore, the occupational health of this group.<sup>45</sup>

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<sup>43</sup> Cherchiglia, M: “Terceirização nos serviços de saúde: Alguns aspectos conceituais, legais e pragmáticos” en Lima JC, Santana JP (orgs): “Especialização em desenvolvimento de recursos humanos em saúde”, CADRHU, Natal OPS/OMS, (pp 367/385), nov 1999.

<sup>44</sup> Brito et al op cit.

<sup>45</sup> This situation has generated two mandates from PAHO’s Governing Bodies. A Resolution from the 1992 Directing Council calls on Member States to implement programs specifically focused on the health of workers in the health sector and to conduct scientific research to determine the health status of this group. Another Resolution adopted by the Council in 2001 refers to health workers health and security as part of the general management of the health services.

The lack of specific information on this issue is noteworthy. In a 2003 workshop held in Argentina where the subject was analyzed,<sup>46</sup> there was agreement that the inadequate attention paid to the health needs of health workers is due in part to the fact that the concept of occupational health in general and primary health care in particular, has been gradually weakened during the process of decentralization and efforts to expand coverage.

Cooperation, therefore, should be directed toward a consensual evaluation, involving key and representative actors in each country, of the ways to elevate the dignity of work within the health sector. This will not only bring benefits for the workers and their own health, but will also facilitate the achievement of overall health goals for the population.

### *PROFESSIONAL OR HEALTH CAREERS*

National efforts to address the issue of a career path in health services require an integrating framework which, using as its departure point a political vision of work in the health sector as an area of State responsibility in the current context, guides the decisions and the generation of regulatory frameworks and mechanisms, with the distinct aim of bringing coherence among these, and between them and the new trends and realities emerging in the regional and international health employment situation described in this publication.

Even though many names are used to refer to health career paths, human resources regulations or laws, health personnel statutes, law regulating the medical profession, or “job and salary scales,” these different names mostly refer to a body of norms that regulate the management of public health sector personnel. Besides, nomenclature, terminology, subject content, and comprehensiveness (highly detailed vs. generic) also vary, as well as whether the norms are legally binding or simply an internal statute issued by the particular health ministry.

As is the case with all types of written regulatory matter, this fact establishes a fixed power relation between the different actors, sometimes for long periods of time. Regulations are a management instrument and also a “pact”—a product of negotiations—between management and staff.

A large number of countries in the Region have initiated an analysis of the status of their labor legislation and are developing proposals for “health careers or professional careers,” in an effort to protect the rights of workers in an increasingly unstable environment. The most

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<sup>46</sup> Consultation Group SALUD DE LOS TRABAJADORES DE LA SALUD, Buenos Aires, November 2003.

frequent route is the “regulatory” one, but some countries also incorporate specific economic incentives as regulatory mechanisms and, less frequently, introduce changes in the roles and relations between the social actors involved in issues related to human resources in health.

The subject areas that are being included in the countries’ discussions as they attempt to establish a new order and coherence reveal the incorporation of topics that never held great relevance in terms of traditional public careers and that have to do with the individual’s mobility through the different levels of a national health system and the introduction of performance parameters that will guarantee social control over the health worker’s performance. These topics should include ethical and behavioral criteria in relation to users and mechanisms for users to increase control over the health services, integrating all the professions by unifying the old career paths, with proposals for salary uniformity and, as required, a process to develop specific staff competencies.<sup>47</sup>

- b. **How should human resources, salaries, and incentives (monetary and nonmonetary) be managed?** The increased complexity of institutions, technology, and health systems, together with the emerging trends in the management of human resources, make it necessary to update the techniques and tools to carry out this function.

The Weberian bureaucratic model described in the previous chapter was characterized by a management system in which employment for an indefinite period of time was accompanied by incentives based on seniority and tenure, a strict definition of hierarchy, and a clear division of labor. These criteria are clearly inconsistent with current needs which, more than the acquisition of specific techniques, require the ability to build effective health teams, to evaluate performance, and to seek to constantly update competencies, including those related to management. The new demands also embrace such behavioral aspects as motivation and leadership skills.

There is thus a need for new guidelines for the management of human resources in the public sector, which, admittedly, will be more difficult to apply given the environmental changes produced by the health reforms. The new models for services evaluation require an analysis of productivity as well as quality, both of which are closely related in turn to worker performance.

In recent years both the salary and incentive systems have acquired new relevance due to the challenges produced by productivity and

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<sup>47</sup> Rigoli, F. *La Economía Política de los Recursos Humanos*. Montevideo, 1999.

quality in the sector. There is an additional complexity in the public sector, because the salary ladders are generally fixed and established by higher hierarchical levels, many times by the ministries of finance. Nevertheless, the need to regulate and distribute personnel in different regions of the country with very heterogeneous conditions, and the importance of generating mechanisms that contribute to increase productivity and improve the quality of services, require developing guidelines for the design and implementation of policies on this subject. The incentive strategy must be developed in a contextual framework of an administrative unit overseeing such integral human resources issues as selection, promotion, education and training, and performance evaluation.

*The World Health Report 2000—Health Systems: Improving Performance* defines incentives as “all the rewards and punishments that providers face as a consequence of the organizations in which they work, the institutions under which they operate and the specific interventions they provide.”<sup>48</sup> This definition suggests that the organization, the work performed, and the area in which it is exercised will determine the type of incentive used and the resulting impact. Buchan, Thompson, and O’May<sup>49</sup> add another dimension by defining an incentive in terms of its objective: “an incentive refers to a particular form of payment that expects to achieve a specific change in behavior.” Incentives can be monetary: direct (such as pensions or supplementary allowances—due to illness or accident) or indirect (subsidies for food, housing, transportation, child care, etc.); but they also may be nonmonetary, such as granting days off, increasing vacation leave, flexible working hours, opportunities for education and training, etc. Chaix-Couturier et al.<sup>50</sup> show a typology of monetary incentives inherent to two types of remunerations. The main difference between the two is their scope, be it a total payment and a set of benefits, or targeting the types of payments used to remunerate physicians for the provision of medical care. This is more in line with the current interpretations of physician remuneration systems by incorporating one or more of four strategies: *training, shared economic risk, payment for services, and salary.*

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<sup>48</sup> *World Health Report 2000—Health Systems: Improving Performance*, p. 61.

<sup>49</sup> Buchan, J, Thompson, M, and O’May, F: “Incentive and Remuneration Strategies in Health Care: A Research Review” In press, 2003.

<sup>50</sup> Chaix-Couturier, C, Durand-Zaleski, I, Jolly, D, Durieux, P: “Effects of Financial Incentives on Medical Practice: Results from a systematic review of the Literature and Methodological Issues”. *Int J Qual Health Care* 2000.

**c. What are appropriate managerial and administrative responses to labor conflicts in the public health sector, and how might these be regulated?** During 2003, 37 national level labor conflicts took place in 12 countries of the Region. These disputes affected public health services with shutdowns and strikes ranging from 24 hours to 9 months in Bolivia, Chile, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Peru, and Uruguay. The following year, 64 national level strikes occurred in 10 countries, representing an increase of 72.97% over 2003. Three countries accounted for 55.55% of the strikes. Of the 64 strikes during 2004, 81.25% represented demands for higher remuneration and for increases in the health sector budget.

The 2003 strikes of national scope were called by 31 organizations of health professionals and other workers, and in 68% of the cases their principal demands were based on issues related to the allocation of financial resources in the health sector (e.g., increases in salary and health systems budget).<sup>51</sup>

The case of Argentina is worth considering. During 2003, 38 conflicts of different levels and varying lengths took place,<sup>52</sup> increasing to 51 in 2004 (representing an increase of almost 40% over the previous year), and in the first half of 2005 that number climbed to 81. Close to 50% of the conflicts between 2003 and 2004 were due to salary demands, rising to almost 90% in 2005. Many of the conflicts involved strikes and work stoppages with extensive worker participation.

Even though strikes are seen as the quintessential expression of labor conflict, disagreements as such are not limited to strikes. The strike is a temporary interruption of work by one or several groups of workers with the object of making claims, rejecting demands, expressing complaints, or supporting the claims or complaints of other workers.<sup>53</sup> The inability to reach agreement on labor issues may also take other forms, such as public demonstrations and protests (with or without work interruption), and “work to rule” (work is performed strictly by the basic contractual conditions, resulting in low production).

In an effort to reconcile the needs of the population with the interests of workers, in many countries there are limitations to the right to strike, citing the right of the community to uninterrupted access to these essential services.

<sup>51</sup> Scavino, J. “La Conflictividad de Alcance Nacional en el Sector Salud en la Región de las Américas en 2003” (in Internet) <http://www.lachsr.org/extension/esp/index.html>. 2003.

<sup>52</sup> Centro de Investigación Social Independiente (CISI). Data specially tabulated for this document.

<sup>53</sup> Novick, M: “Guía metodológica para el análisis de las relaciones colectivas de trabajo en el sector salud” en Dal Poz, M, Galín. P, Novick, M and Varella, T: “Relaciones laborales en el sector salud”, OPS/OMS, Quito, agosto 2000, <http://www.lachsr.org/observatorio/esp/publicaciones.html>.

### 6.2.2 MAIN AREAS OF COOPERATION TO DEVELOP THE LABOR DIMENSION

- a. **The need for bringing greater uniformity to hiring modalities for health sector personnel.** The studies for Latin America already mentioned<sup>54, 55, 56</sup> reveal important changes under way in the hiring modalities of the sector, a trend toward seeking multiple employments, longer working days, and the loss of social protection. The question that arises is: How do these new hiring situations affect the quality, efficiency, and quantity of health services? Even in the absence of specific studies to address this issue, it may be hypothesized that the linkages between the two dimensions would be discernible and of considerable weight.

Technical cooperation must be directed toward facilitating the analysis of these situations (i.e., lack of job security, multiple employment, etc.) so as to find mechanisms to establish integral regulatory frameworks that respect the rights of health workers as well as those of health care users and guarantee efficient and effective services.

Cooperation should be aimed at:

- Analyzing alternatives to create new regulatory and contractual frameworks for public health personnel, balancing safety conditions, career interests, and quality of service issues
  - Conducting studies of the different existing employment systems and evaluating their effectiveness in optimizing the use of available resources
  - Utilizing information available from the Observatory of Human Resources to analyze the most critical issues related to human resources management and disseminating study findings
- b. **Increase awareness of the need for greater protection for health workers and develop protective mechanisms.** The major concerns highlighted in the previous subsection, further aggravated by the health sector's budgetary challenges, have a negative impact on the working conditions and personal health of health care personnel. Given the scarcity or total lack of information on this subject, there is a critical need for further analysis to correct this situation.

At the same time, the emergence of new problems, such as HIV/AIDS, present new risks for health workers who are already exposed to a variety of other disease-causing pathogens, subject to excessive physical and mental workloads and long work shifts, and suffer a

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<sup>54</sup> Brito et al op cit.

<sup>55</sup> Galin op cit.

<sup>56</sup> Novick and Galin op cit.

scarcity of the supplies needed to adequately perform the assigned tasks. Some of the difficulties in obtaining reliable information on the extent of these factors may be attributed to the fact that statistics and other records of workplace-related accidents and/or illnesses do not disaggregate public health sector information from data collected from other sources.

Cooperation should be aimed at:

- Generating and/or compiling information in health care establishments about the risks associated with the health conditions treated and the degree of compliance with the current occupational health and safety legislation
- Supporting the establishment and use of monitoring and risk detection mechanisms in the work environment
- Developing methodologies to systematize and disseminate information relating to the occupational health situation of public health workers

**c. Management and regulation of personnel conflicts in the health sector.** In operational terms, “a work conflict or labor conflict is a disagreement referring to an issue or set of issues over which there are discrepancies between the workers and employers, or where workers or employers express claims or complaints, or support the claims or complaints of other workers or employers.”<sup>57</sup> In the case of the public health sector, the employer is the State (whether at the national, provincial and/or municipal level), and the mechanisms for resolution or arbitration of conflicts are not always established.

Given that the health sector renders what are considered to be essential services, it is important to know the specific norms affecting and regulating it. It is important to establish the minimum number and type of workers needed to operate the basic services and the existing limitations to the right to strike.

The increasing levels of discord in the sector undoubtedly require upgrading the available management abilities, either by improving the regulations affecting management, to include the acquisition of negotiation and coordination strategies, or by enhancing managerial abilities at each level of service to handle conflict. It should be remembered that public health sector authorities possess specific technical knowledge and a unique professional background that makes it unlikely that they will be experts innately skilled in conflict management, despite their periodic exposure to labor disturbances.

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<sup>57</sup>Novick, M. op cit.

This is therefore clearly an area where technical cooperation could make an important contribution.

Cooperation should be aimed at:

- Improving the ability to effectively manage and resolve conflicts through the exchange of experiences and methodologies
- Training in the acquisition of effective negotiating strategies
- Providing tools to optimize the ability to analyze both the manifest and hidden roots of conflicts

d. **Management of human resources, salaries, and incentives (monetary and non-monetary).** The goal of cooperation in this area is, on the one hand, to work systematically with new tools for the management of human resources, especially at the institutional level (hospital, health centers, etc.), to create an up-to-date human resources management system that responds to both the needs of the health workers and the services units. This requires advancing simultaneously in creating both consensual and variable strategies, in agreement with the needs of one and the other.

On the other hand, faced with the rapidly changing hiring regulations, a large number of countries in the Region have begun analyzing their labor legislation and are developing proposals framed in the so-called “health career paths or professional careers”, in an attempt to protect the rights of the workers in this scenario of increasingly unstable working conditions.

The technical cooperation efforts should concentrate on reinforcing the dimensions that are most closely linked with current practices in the sector and on sharing the full range of possibilities used in other countries during joint discussions and political negotiations so that these are not limited merely to administrative and salary issues. Public health authorities should also include the participation of key social actors and encourage their input in identifying the basic elements and needed courses of action for the implementation of viable structures supporting a career in public health.

The new conditions and technological changes characterizing the labor market call for the modernization of human resources management techniques, particularly as regards the selection, promotion, professional training, and integration of public health teams, and their performance, as well as the development of systems of remuneration and incentives that take into account the current realities.

Cooperation should be aimed at:

- Strengthening the management of human resources to facilitate the analysis and implementation, at a micro level, of strategies and techniques related to performance evaluation, team-building, motivation, leadership, incentives, productivity, and services quality
- Reviewing the remuneration systems, salary scales, internal distribution, and possible incentives for the different categories of health sector personnel
- Designing of public health career paths
- Developing methodologies for a participative construction of these career paths

## 6.3 THE EDUCATION DIMENSION IN HUMAN RESOURCES MANAGEMENT

GENERATING A “CRITICAL MASS” IN HUMAN RESOURCES  
MANAGEMENT ABILITIES

### 6.3.1 EDUCATION IN MANAGEMENT

#### *SUMMARY OF THE PROBLEM*

In the last decades, two major issues in health education—skills acquisition and staff performance—have acquired great importance within the context of changes in management processes as well as those related to medical diagnosis and treatment. The growing complexity now found in most organizations—due to their need to balance technical, financial, and social exigencies—has transformed the nature of the occupational skills required for effective management, particularly as regards the field of health. In the public sphere, managers traditionally supervised the execution of resources allocated by a central administration, in which procedures and statutes of a general nature were based on established «routines» and were required to be respected, even though this created difficulties due to the lack of autonomy in decision-making regarding budgetary and human resources issues.

The decentralization processes described earlier, the need to reduce costs in an increasingly complex and costly technological superstructure, and changes in staff composition, together with the higher level of labor conflicts, imposed the need for new skills and more complex competencies in area of human resources management in the health sector.

The curricular training available in most countries of the Region and the academic profiles of the graduating students are oftentimes incongruent with the new professional demands this group will be called to respond to, nor do the older and more experienced professionals usually have access to adequate continuing education programs that would equip them to be optimally prepared to respond to their constantly changing environment.

In an April 2005 consultation meeting on human resources management held in Argentina, as specifically regards issues of academic preparation and training, participants highlighted the responsibility of university educators to motivate students to increase their knowledge and awareness of human resources issues. On the other hand, the educational curricula of most countries revealed that no, or very little, course material was available to students in the areas of management and administration.

Participants also highlighted the fact that no evaluations existed of the experiences of management educational programs implemented during the 1990s as had been done in the mid-1980s. Management and its related fields have grown a great deal, yet the content of educational programs has not kept apace, thus distancing itself from current sectoral needs. At the same time, even though the discipline of public health education is admittedly interdisciplinary, it is also highly influenced by fashions; nevertheless, course materials dealing with human resources management have not been introduced from a labor perspective, so that the prevailing focus is oriented more generally toward formal administrative procedures. On the other hand, looking at this issue from the viewpoint of the essential public health functions, there is a movement under way toward making these functions truly operational, which could also serve as a catalyst for the implementation of the needed curricular changes. Indeed, a growing interest on the part of students to gain access to managerial positions has been demonstrated, even if the programs that could impart the necessary training and skills are not yet in place.

The relevance of educational programs in human resources management might be greatly strengthened if these programs were to be carried out in the actual workplace and guided not only by traditional practices but also by demand in terms of the specific problems faced by the different areas of management. There is a need to balance goals over the medium and long terms. In this sense, the educational system should foresee the skills and educational profiles that will be needed in the future, continuously adjust and fine-tune its curricula accordingly, and, at the same time, respond to specific demands of health centers and other facilities. This situation highlights

the urgent need for better linkages and consensus between educational systems and health care institutions.

A fundamental premise for the argument that the workplace is the best place to learn is that it is here where the needs emerge and changes occur. In the work environment, there are no rigid boundaries between management by learning and management by experience, between action and reflection, and, therefore, the border between human resources education and management, traditionally understood as “training” and “personnel management,” should be less clear. Learning is associated with the coupling of acquired competencies and experience and their application to problems, while management is also a process of organizational learning. In this sense, the experience component indicates that the rigidities of academic structures are more easily broken with the inclusion of actors that are external to the educational institution, and are associated with the workplace and the social needs.

From this diagnosis, the following needs emerge as principle areas of focus:

- Develop adequate management skills consensually between educators and health service providers
- Include the subject of human resources management with updated approaches in personnel training processes

### 6.3.2 MAIN AREAS OF COOPERATION TO STRENGTHEN EDUCATION IN MANAGEMENT

- a. **Develop the skills and competencies for human resource managers consensually between educators and health service providers.** An important contribution of the cooperation should be to work jointly with the countries to define and characterize the management profiles required in the short and medium term. This would imply being able to establish general cross-cutting competencies and specific skills that correspond to the different types of services (i.e., primary, secondary, or tertiary care) and units according to size, complexity, and/or specialty.

As it is, there are basic general skills required for any type of management in the area of human resources, associated with the everyday oversight of these resources, as well as promotion mechanisms and incentives aimed at motivating a personnel body that is usually characterized by considerable professional and social heterogeneity. At the same time, each level in the management of the health sector requires specific competencies that must also be adapted to the local cultural and geographical realities. Some fundamental elements which should not be overlooked include:

- At a national and/or provincial/state/municipal level: the management of human resources requires knowledge of the current rules and statutes in each area as well as the ability to formulate strategies for change as regards both regulatory and certification mechanisms. At the same time this group of professionals should be knowledgeable about, effectively manage, and disseminate aggregated information about the available human resources and their national and regional distribution.
- At an institutional level: the management of human resources requires knowledge of the organization's particular statutes and regulations, how to manage specific resources, and how to oversee and resolve conflicts while, at the same time, motivating the institution's personnel. It must also generate participative planning mechanisms to develop strategies for the management of human resources, particularly salaries and remunerations within the established framework.
- At the level of specific services: the management of human resources must be able to organize individual and team work, assign responsibilities, resolve conflicts, motivate staff, and continuously and systematically identify the training needs of teams and of each differentiated professional group.

To achieve the objectives at the services level, it is necessary to improve coordination between these services and the educational institutions, preferably local, (graduate and postgraduate), be it through already-existing mechanisms or by creating new entities to establish efficient channels of communication and consultation between both actors, in order to, in turn:

- Encourage academic institutions at the graduate and postgraduate levels to include in their human resources management curricula the necessary components leading to mastery of the competencies required to carry out the essential public health functions
- Increase the demand for specific managerial skills and profiles to be provided by the educational institutions
- Establish viable linkages between the educational and working environments

Cooperation should be aimed at:

- Developing methodologies for curricular analyses and consensus-building mechanisms for use between educators and health service providers
- Proposing studies and analyses of the inconsistencies between current educational processes and the needs of health services

- Advocating the inclusion of a human resources management approach in graduate and postgraduate public health education curricula that incorporates the perspective of the essential public health functions
  - Facilitating the needed analyses by educators and health services providers of the specific human resources management skills profiles required to face the challenges just described at each of the service levels
  - Improving the continuity between the educational and working environments by establishing ongoing and viable linkages
- b. Include the subject of human resources management with updated approaches in personnel training processes.** Even though the need for staff education and training in management and other related fields has grown significantly, most of the existing programs and curricula have not adapted to the new demands and, thereby, have distanced themselves from the needs of the workplace.

It is important that technical cooperation efforts focus on strengthening educational processes at the graduate and postgraduate levels developed in the workplace. It is equally necessary to establish effective negotiation mechanisms so these processes are guided by, and directed toward, current institutional demands.

This cooperation should favor the development of analytical and consensus-building processes to strengthen curricular change based on a critical analysis of emerging practices and possible future scenarios. This will require conducting research in areas where more input is needed and improved communication channels for the exchange of practices and related ideas.

It is important to develop continuing education programs with innovative teaching methods in which the work environment is the central focus of the learning process.

The cooperation should be directed at:

- Creating methodological instruments and curricular contents for the development of management education, and strengthening the flow of information between health services and research in this area
- Compiling, systematizing, and disseminating a compendium of best practices as regards the educational development of managers
- Including the knowledge of legal framework of human resources management in the training of managers.
- Promoting the development of distance education programs
- Establishing competencies-based managerial profiles

## 6.4 THE DIMENSION OF HUMAN RESOURCES MANAGEMENT TO STRENGTHEN PRIMARY HEALTH CARE

### BUILDING THE PRIMARY CARE TEAMS

#### 6.4.1 MANAGEMENT DIMENSION

##### SUMMARY OF THE PROBLEM

In 1978, the International Conference on Primary Health Care, which took place in Alma-Ata, Kazakhstan, adopted the concept of primary health care (PHC) as the main strategy to reach the goal of Health for All in the Year 2000, along with its corresponding action plan approved the previous year at the World Health Organization's World Health Assembly by the WHO Member States.<sup>58</sup> The PHC vision developed during the Conference was embodied in the Declaration of Alma-Ata and in a set of 22 recommendations. It marked the beginning of a political commitment by the world's governments to improve the collective health of all people and the establishment of a renewed platform of international health policy.

In the Americas, countries endorsed the four basic principles of PHC recognized by the Conference: i) universal access and coverage based on health needs; ii) commitment, participation, and individual and community self-sufficiency; iii) intersectoral action for health; and iv) cost-effectiveness and appropriate technology, as available resources permit.

Since then, the Member States have devised and implemented national primary health care strategies based on the development of the following priority components: expanded coverage of health services and improvements in the environment, community organization and participation to improve collective well-being, creation of intersectoral linkages, research and development of appropriate technologies, development and availability of critical products and equipment, training and utilization of human resources, sectoral financing, and international cooperation.

Nearly 30 years after the historical landmark at Alma-Ata, the population of the Americas has accumulated gains in health that may be attributed to the impact of priority PHC activities in the areas of education and health promotion, food and nutrition, water supply and sanitation, maternal and child care and family planning, immunization, prevention and control of endemic diseases, treatment of prevalent illnesses and injuries, and access to essential drugs.

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<sup>58</sup> WHO Resolution WHA30.43 approved by the World Health Assembly in 1977.

However, the implementation of the PHC strategy was characterized both by its heterogeneity and its discontinuities. At the conceptual level, it was subject to different interpretations that reflected divergent political and health perspectives. Under the original definition, PHC was implicitly a strategy to secure essential health among the populace as well as the establishment of a minimum level of health care services. In the Region of the Americas, many countries understood PHC as the primary level of care; that is, as the point of contact with the community and the population's gateway to the health system. Other countries considered PHC as a health care strategy based on social justice principles, and it was envisioned as the possibility of providing health care to poor marginalized populations who lacked access to such services. There was an attempt to reduce the PHC strategy to a set of simplified and low-cost interventions known as "selective" PHC. Nevertheless, it must be emphasized that in its initial design, PHC was not a policy of "limited intervention for poor people," but a basic strategy by health systems to secure greater coverage and equity,<sup>59</sup> based on the formation of multidisciplinary teams that could respond to the population's health problems using an integrated approach.

At different levels of scope and intensity, the countries of the Region adopted the PHC strategy as a starting point for the development of human resources in health. PHC became the frame of reference for adopting and implementing policies to reallocate human resources to community health services. It laid the groundwork for the formation of local multiprofessional teams whose joint efforts revived and enriched the discussions on interdisciplinary cooperation. In the most successful experiences, the interdisciplinary work and community participation led to the definition, development, and evaluation of comprehensive health care competencies at the local level, thus revitalizing the clinical and public health capabilities of the teams.<sup>60</sup>

Progress in expanding the coverage of basic health services in several countries—despite the persistent lack of equity in access—is credited to the regional experience in the development of PHC. This progress led to greater community outreach, a growth in resources mobilization, and enhanced participation by community partners in such areas as immunization programs, maternal and child health, essential drugs, health education, and basic water supply and sanitation.

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<sup>59</sup> 44th Directing Council. 55th Session of the Regional Committee, Washington, D.C. 22–26 September 2003. Primary Health Care in the Americas: Lessons Learned over 25 Years and Future Challenges.

<sup>60</sup> PAHO/WHO: Atención primaria de salud y desarrollo de recursos humanos, Unidad de Desarrollo de Recursos Humanos, Área de Desarrollo Estratégico de la Salud, Oficina de Gestión de Programas. Madrid, Spain, 2003.

In spite of these advances, the work ahead is enormous. Due to many of the factors described in Chapter 1 of this publication, there remains considerable exclusion from mechanisms for social protection in health. Despite the call for health promotion and disease prevention at Alma-Ata and the appeal for the reorientation of health services in the Ottawa Charter (1986), the prevailing models of health care in the Region remain primarily curative and based on specialized medical and hospital care. Preventive activities, such as health promotion and health counseling, enjoy a much lower profile and are much less widely practiced.

Likewise, initiatives for intersectoral coordination have failed to become part of daily practice at the local level, whether between private and public health services or between health promotion activities in the community and those carried out in hospital clinics. At the same time, concern over the poor quality of health care, both in terms of technical quality and as seen from the perspective of users, is a challenge being faced by every country of the Region. Issues of quality reveal themselves in low levels of efficacy, efficiency, acceptability, legitimacy, and health services' safety.

Viewed within this context, linking PHC with the management of human resources in the health sector constitutes a key factor for planning and managing the availability, distribution, and application of skills to meet the needs and realities of the target population.

However, significant weaknesses remain in the political and institutional frameworks that hinder the full incorporation of community-level personnel, the creation of an adequate level of social participation, and the use of information produced for decision-making. An additional weakness is the difficulty in bringing together, organizing, and training the types of health teams needed.

#### 6.4.2 MAIN AREAS OF COOPERATION IN RESOURCE MANAGEMENT FOR THE STRENGTHENING OF PRIMARY HEALTH CARE

- a. **Overcoming difficulties in defining and organizing PHC teams.** The differing proportions of physicians and nurses observed in the countries of the Region show the existence of various different health strategies. In general, the number of physicians is larger, and they constitute the dominant group.<sup>61</sup> There are also significant differences regarding

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<sup>61</sup> In fact, in an analysis of seven countries in the Americas regarding the proportional relationship between physicians and nurses, the following was observed: Canada (95.8 nurses vs. 22.1 physicians per 10,000 inhabitants), United States (87.8 nurses vs. 24.5 physicians per 10,000 inhabitants), and Belize (7.6 nurses per 4.7 physicians per 10,000 inhabitants). In the Latin American countries studied, an inverse relationship was observed: Chile (4.2 nurses vs. 10.8 physicians), Honduras (1.7 nurses vs. 2.2 physicians), Mexico (4.0 nurses vs. 10.7 physicians), and Venezuela (7.7 nurses vs. 19.4 physicians). Land, S. Community Nursing in Latin America and the Caribbean, Home Health Care Management and Practice. December 1998. P.2.

the way in which the teams are constituted. In this sense, the Cuban model, in which physicians and nurses constitute the basic team, can be contrasted with the models used in Bolivia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Peru, and Venezuela, in which physicians, nurses, obstetricians, and dentists are assigned to rural and marginal urban areas to provide health care.<sup>62</sup> Another model is the Family Physicians' Training Program in Brazil, made up of physicians, nurses, and other community health agents.<sup>63</sup>

Although the Region has stressed the incorporation of community personnel and social participation in health care, there is a recognized need to continue the strengthening of social participation in health, since the advances made to date are insufficient in many countries, and in many local contexts community participation is limited to sporadic consultation. Even though there is a unanimous acceptance of the need to root local health systems in the principles of primary health care, the lack of professionals with adequate training and experience in family medicine remains an obstacle to be overcome.

Cooperation should be aimed at:

- Providing technical support to the process of definition and organization of PHC teams
- Cooperating to identify the optimum organizational structures for PHC teams, including a definition of competencies and team roles
- Identifying techniques and procedures to improve the work dynamic within PHC teams and collaborating in the development of mechanisms to facilitate subsequent follow-up and evaluation of the community teams' work
- Assisting in the development of methodologies to generate evidence regarding the impact of PHC teamwork

**b. Addressing weaknesses in the organization and management of continuing education and training for PHC teams.** The incorporation of PHC content into the basic study programs for health professionals and technicians varies from one discipline to another, with a greater presence in nursing-related curricula than in physicians' training. In practical experience, there is an ongoing debate regarding the impact that academic exposure to PHC strategies has had on the quality of health services, since the evaluation has not generated definite conclusions. The evolutionary changes in occupational profiles and

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<sup>62</sup> OPS/HSR: «El servicio social de medicina en América Latina. Situación actual y perspectivas». Informe de taller regional. Washington, DC, Abril, 1997.

<sup>63</sup> Ministerio da Saude- Brasil: Programa de Saude da Familia: <http://portalweb01.saude.gov.br/pits/> y <http://www.saude.gov.br/psf/programa/index.asp>.

the demand for new skills for large groups of health workers has necessitated the development of massive training processes in the Region, the adoption of new educational paradigms, and the implementation of updated styles of management for educational programs and projects, creating a strong and vigorous market for training<sup>64</sup> to improve the overall performance of health services and systems.

An evaluation of 15 training projects in eight of the Region's countries revealed a large variance in the amounts of money utilized for these purposes. The global projects devoted between US\$ 700,000 and US\$ 350 million, where the educational component represented between 2.76% and 6.50% of the total funds for the projects. The evaluation indicated that even though the projects helped to improve the skills and abilities of the participants, producing favorable changes in the services, there was no improvement in the policies regarding human resources allocation, a critical aspect to guarantee the sustainability of the changes generated by the training processes.<sup>65</sup> Likewise, the training model fragmented by technical programs, widely used in the health sector during the 1990s in projects financed by international lending institutions, did not improve the institutional capacity or alleviate the phenomena of job insecurity and high worker mobility. This analysis reveals that the issue of adequately incorporating PHC contents in academic and continuing educational programs remains a challenge to be addressed.

Cooperation should be aimed at:

- Supporting the formulation, implementation, and evaluation of continuing education programs for PHC personnel in order to ensure that their skills are suited to meeting the current populational health needs
- Developing educational mechanisms and structures based on the individual competencies needed within multidisciplinary community health teams

**c. Addressing the weakness in technological policies in PHC services.**

A response to the dilemma about what should be the function of PHC and its relation to the population's health; that is, if PHC should

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<sup>64</sup> There are different educational management modalities such as competing bids for funding as in Chile, Costa Rica, and Peru; the creation of academic networks to act as project support agents as in Brazil and Peru; international and national contracting; and other innovative practices such as distance learning and educational encounters and discussion groups.

<sup>65</sup> PAHO/WHO: Situación de los Componentes Educativos en Proyectos Relacionados con los Procesos de Reforma del Sector Salud. Países Seleccionados. Región de las Américas. Washington, Working Paper, May 2001. Available at: [http://observatorio\\_rh.tripod.com/observatorio-rh/id10.html](http://observatorio_rh.tripod.com/observatorio-rh/id10.html).

be viewed as an assistance program for the poor, an inclusion strategy, or a strategy of better reaching the community, requires not only the proper diagnostic and treatment technologies but adequate management that is able to gauge correctly the needs of local communities and is integrated with the rest of the system.

The management of human resources in community PHC teams requires more complex tools because beyond the traditional challenges of managing health teams, the integration of community agents more closely related to the local culture has to be dealt with, while at the same time, there is a mandate to solve specific needs, to respond to isolated demands, and to propose a comprehensive strategic plan to serve that population.

The cooperation should be aimed at:

- Collaborating in the establishment of guidelines for technological incorporation and management in PHC
- Collaborating in the development of competencies and the improvement of capacities to incorporate new tools and technologies in human resources management in PHC.

## 6.5 THE RESEARCH DIMENSION IN HUMAN RESOURCES MANAGEMENT

GENERATING EVIDENCE FOR DECISION-MAKING IN  
THE MANAGEMENT OF HUMAN RESOURCES FOR HEALTH

### 6.5.1 RESEARCH DIMENSION

#### SUMMARY OF THE PROBLEM

The identification of problems and possible cooperation focuses presented in this publication clearly suggest numerous areas for future research. In 1999, when the Observatory of Human Resources was established as an interagency effort by PAHO, WHO, the International Labor Organization, and the Economic Commission for Latin America and the Caribbean, it was decided that a set of core data on human resources for health would be collected with the principal goal of monitoring human resources policy development within the framework of health sector reforms. The Observatory, organized by the countries themselves, 22 of which currently participate, has released systematic information on many of the central issues related to human resources management. It is a strategy for promoting the production, analysis, and dissemination of information on human resources, as well as the decision-

making process in matters of policy, regulation, and management by educational, services, and corporate actors.

The Observatory and various studies connected with it seek to find answers to the following questions: How many individuals work in the public health sector, and what are their specialties? How are they distributed geographically? What are the extent and characteristics of labor flexibility in the Region's health services? What is the degree of job insecurity? Is the greater participation of women in the health sector an expression of more equal opportunities for both sexes, or does the lack of gender equity persist?

Each country has advanced in its collection, systematization and analysis of data related to each of these questions, and the nature of the information's usefulness has varied according to the interests of the different actors. The availability of the information itself in each country differs according to the characteristics of the country's national statistical system, and its relative usefulness depends upon the capabilities of the individual health systems.

As regards the issue of human resources management specifically, it is necessary to make a qualitative leap in order to demonstrate the relationship between human resources management and outcomes in terms of quality of health care, (and, ultimately, how better care quantitatively translates into improved populational health status). Interest is thus focused on studying how the already-described scenarios for job insecurity, the rise in labor conflicts, salary instabilities, and decentralization affect the quantity and quality of public health care. The objective is to generate evidence at the macro, meso, and micro levels regarding the various issues currently under review.

What is the best strategy in relation to hiring systems? What are the experiences using flexible systems that, at the same time, offer employment security? What is the best strategy for the resolution of labor conflicts? How are the quantity and type of health personnel related to the health of the population? Studies along these lines have demonstrated a relationship between the number of health personnel and the health situation of the population<sup>66</sup> or the number of nurses and the health outcomes for different types of health conditions<sup>67</sup>.

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<sup>66</sup> Anand, S y Bärnighausen, T: *"Human resources and health outcomes: cross-country econometric study"*, Lancet 364, 2004.

<sup>67</sup> Needleman, J, et al.: *"Nurse staffing and patient outcomes in hospitals"*, Harvard University, 2001.

Within this context, future research should produce several different kinds of studies:

- ◆ Those that generate evidence regarding the management factors associated with better health care
- ◆ Those that identify and can serve as dissemination vehicles for “best practices,” and that encourage the exchange of information for adapting and implementing these, taking into account local and national situations and the unique characteristics of each
- ◆ Those that generate indicators for monitoring and evaluating human resources performance

#### **6.5.2 STUDIES AND/OR RESEARCH THAT GENERATE EVIDENCE ON THE MANAGEMENT FACTORS ASSOCIATED WITH BETTER SERVICES IN THE HEALTH SECTOR**

In the April 2005 consultation meeting on human resources management held in Argentina, the importance of generating information associated with this issue was underscored. Specific proposals forwarded at this event included the:

- ◆ Creation of mechanisms for cooperation among the Region’s countries to facilitate the circulation of evidence-based information
- ◆ Promotion of efficient mechanisms for the incorporation of all pertinent available information in the Observatory of Human Resources.
- ◆ Development of research about human resources policies as a tool for the analysis of current problems
- ◆ Strengthening joint research strategies to provide input for policy formation and decision-making
- ◆ Stimulation of the production of information that includes user perspectives in the evaluation systems; (i.e., qualitative research)
- ◆ Promotion of studies and the production of information regarding:
  - the impact of human resources training on improvements in health status,
  - characteristics of the current labor force,
  - working conditions,
  - existing mechanisms to reduce job insecurity,
  - the nature of labor negotiations and extent of conflicts,
  - international human rights regulations,
  - views on the relationship between the right to health and workers, and gender inequities in the public health labor market and their influence on the feminization of the workforce.

The objectives of technical cooperation in the area of research would be to:

- ♦ Design instruments that generate evidence about the impact of incentives in the human resources management process
- ♦ Stimulate the development of methodologies for the evaluation of institutional and individual capacities
- ♦ Develop studies and methodologies to assess the impact of policies
- ♦ Stimulate the development of methodologies for the assessment of institutional and individual abilities.
- ♦ Generate studies and develop methodologies to assess the impact of policies.

### 6.5.3 IDENTIFICATION AND DESSEMINATION OF «GOOD PRACTICES»

In the majority of the countries of the Region, “best practices” already exist, but little is known about their success outside the confines of the local environment. It is therefore important that these positive experiences be shared with other communities and countries facing similar challenges.

On this issue, the Argentina consultation group participants proposed:

- ♦ Identifying new models for structuring human resources in the health system and disseminating their key elements
- ♦ Developing mechanisms to strengthen institutional capacity, in order to, in turn, reinforce the capacity to create and systematize successful experiences
- ♦ Identifying and disseminating positive experiences in matters related to programs for quality management and certification or accreditation of process of quality programs.
- ♦ Disseminating mechanisms that facilitate an effective incorporation of results into practice
- ♦ Disseminating innovative human resources management practices through special events and publications on this topic
- ♦ Holding periodic meetings at the regional level to build and sustain consensus.
- ♦ Creating opportunities for discussing the analysis and implementation of programs

Cooperation should be aimed at:

- ♦ Identifying and disseminating indicators for monitoring and performance evaluation of the different dimensions of human resources management identified at the beginning of this chapter: sectoral

regulation, the public health care labor market, educational training for human resources managers, management to support strengthening PHC, and research on human resources management

- ♦ Developing studies to gather evidence related to human resources management and its impact on the overall quality of services
- ♦ Disseminating “best practices” through regional workshops, publications, and country-to-country exchanges
- ♦ Strengthening national capacities for collecting evidence and developing pertinent studies
- ♦ Promoting multicenter studies to improve the analysis of the different dimensions involved in human resources management

The following table summarizes the most salient points related to the five dimensions for technical cooperation opportunities discussed in this chapter.

6.6. SUMMARY TABLE OF TECHNICAL COOPERATION AREAS

Dimensions	Scenario	Problems	Cooperation Actions
Institutional	Build the institutional capacity for sectoral regulation in the management of human resources in public health care.	<ul style="list-style-type: none"> <li>· Coexistence of laws and regulations that immobilize the management of human resources and produce labor conflicts</li> <li>· Existence of professional negotiations occurring outside the sphere of established norms and statutes, causing segmentation of the health worker community</li> <li>· Weak budget negotiating capacity and difficulties in leveraging adequate funds for human resources needs</li> </ul>	<ul style="list-style-type: none"> <li>· Develop planning processes for the short, medium, and long term, with a regional, national, and local vision</li> <li>· Collect and review the various components of existing legal frameworks in the area of human resources</li> <li>· Strengthen budgetary negotiating capacity and the generation of arguments based on reliable, high-quality information</li> <li>· Develop instruments and methodologies for analyzing staffing requirements for the different health care models and population to be covered</li> <li>· Analyze and rationalize the systems that create difficulties for decision-making in the services network</li> <li>· Develop tools and studies to analyze the different forms of organization and administration of human resources</li> <li>· Establish criteria for normalization and development of guidelines for collective negotiations that better integrate professional groups</li> <li>· Develop training for conflict management and mediation</li> <li>· Develop methodologies and secure information to yield evidence on the availability, quantity, cost, and quality of health care and human resources, and the relationships existing between them</li> </ul>

continues...

Dimensions	Scenario	Problems	Cooperation Actions
Labor	Advocate for decent employment for health workers.	<ul style="list-style-type: none"> <li>· Coexistence of numerous and diverse formal and informal labor contracting mechanisms, leading to job insecurity, lack of social protection, multiple employment, etc</li> <li>· Lack of information on and inadequate attention paid to health and occupational safety of health workers</li> <li>· Obsolete health career models and lack of career opportunities within new labor environment</li> <li>· Weak salary and incentive systems and lack of information on effectiveness of monetary and nonmonetary incentives</li> <li>· Rising levels of public health sector labor conflict</li> <li>· Weak policies and strategies for the administration and management of health personnel at different levels</li> <li>· Need to increase quality of health care services and staff performance</li> </ul>	<ul style="list-style-type: none"> <li>· Analyze alternatives to create new regulatory and contractual frameworks for public health personnel, balancing safety conditions, careers interests, and quality of service issues</li> <li>· Conduct studies of the different existing employment systems and evaluate their effectiveness in optimizing the use of available resources</li> <li>· Utilize information available from the Observatory of Human Resources to analyze the most critical issues related to human resources management and disseminate study findings</li> <li>· Generate and/or compile information in health establishments about the risks associated with the health conditions treated and degree of compliance with current occupational health and safety legislation</li> <li>· Support the establishment and use of monitoring and risk detection mechanisms in the workplace</li> <li>· Develop methodologies to systematize and disseminate information relating to the occupational health situation of public health workers</li> <li>· Improve management and conflict resolution capacity through the exchange of experiences and methodologies</li> <li>· Train managers and staff in the acquisition of effective negotiation strategies</li> <li>· Provide tools to optimize the ability to analyze both the manifest and hidden causes of conflicts</li> <li>· Strengthen management of human resources to facilitate analysis and implementation, at a micro level, of strategies and techniques related to performance evaluation, team-building, motivation, leadership, incentives, productivity, and services quality</li> <li>· Review remuneration systems, salary scales, internal distribution, and possible incentives for the different categories of health sector personnel</li> <li>· Design public health career paths</li> <li>· Develop methodologies for a participative construction of these careers</li> </ul>

continues...

Dimensions	Scenario	Problems	Cooperation Actions
<p>Management Education</p>	<p>Generate a «critical mass» in human resources management abilities</p>	<ul style="list-style-type: none"> <li>· Significant incongruities between the current skills profiles of professionals and new competencies required by health services</li> <li>· Little or no course material available on human resources management in educational training curricula</li> <li>· Lack of continuity between course offerings at educational institutions and actual workplace professional demands</li> <li>· Inadequate definition of skills needed for the different occupational profiles and categories</li> </ul>	<ul style="list-style-type: none"> <li>· Develop methodologies for curricular analyses and consensus-building mechanisms for use between educators and health service providers</li> <li>· Propose studies and analyses of the inconsistencies between current educational processes and the needs of health services</li> <li>· Advocate for the inclusion of a human resources management approach in graduate and postgraduate public health education curricula that incorporates the essential public health functions perspective</li> <li>· Facilitate the needed analyses by educators and health services providers of the specific human resources management skills profiles required to face the different challenges of management at the national, institutional, and services levels</li> <li>· Improve continuity between the educational and working environments by establishing ongoing and viable linkages</li> <li>· Create methodological instruments and curricular contents for the development of management education. Strengthen the flow of information between health services and research in this area</li> <li>· Compile, systematize, and disseminate best practices regarding the educational development of managers</li> <li>· Integrate knowledge of legal framework of human resources management</li> <li>· Promote the development of distance education programs</li> <li>· Establish competencies-based managerial profiles</li> </ul>

*continues...*

Dimensions	Scenario	Problems	Cooperation Actions
<p>Management of Human Resources to Strengthen Primary Health Care (PHC)</p>	<p>Build primary health care teams</p>	<ul style="list-style-type: none"> <li>· Challenges in defining composition and in organizing PHC teams</li> <li>· Weaknesses in the organization and management of continuing education and training for PHC teams</li> <li>· Addressing the weakness in technological policies in PHC services</li> </ul>	<ul style="list-style-type: none"> <li>· Provide technical support for the definition and organization of PHC teams</li> <li>· Cooperate to identify optimum organizational structures for PHC teams, including a definition of competencies and team roles</li> <li>· Identify techniques and procedures to improve the work dynamic in PHC teams</li> <li>· Collaborate in the development of mechanisms to facilitate subsequent follow-up and evaluation of the community teams' work</li> <li>· Assist in the development of methodologies to generate evidence regarding the impact of PHC teamwork</li> <li>· Support the formulation, implementation, and evaluation of continuing education programs for PHC personnel in order to ensure that their skills are suited to meet the current populational health needs</li> <li>· Develop educational mechanisms and structures based on the individual competencies needed within multidisciplinary community health teams</li> <li>· Collaborate in the establishment of guidelines for adopting and managing technology in PHC.</li> <li>· Collaborate in the development of competencies and skills to adopt new tools and technologies in the management of human resources in PHC.</li> </ul>

continues...

Dimensions	Scenario	Problems	Cooperation Actions
<p>Research on Management Issues</p>	<p>Generate evidence for decision-making in the management of human resources for health</p>	<ul style="list-style-type: none"> <li>· Need for regional studies showing the interrelationship between availability and quantity of human resources and the quality and efficiency of health services</li> <li>· Insufficient use of existing information in the Observatory of Human Resources for the above activities</li> <li>· Need for increased exchange opportunities between countries to facilitate dissemination of successful experiences</li> </ul>	<ul style="list-style-type: none"> <li>· Identify and disseminate indicators for monitoring and performance evaluation of the five different dimensions of human resources management described in this Table</li> <li>· Dissemination of «best practices» in the five dimensions/areas through regional workshops, publications, and country-to-country exchanges</li> <li>· Carry out studies that generate evidence related to human resources management and its impact on the overall quality of health services</li> <li>· Promote multicenter studies to improve the analysis of the different dimensions involved in the management of human resources</li> <li>· Strengthen national capacities for collecting evidence and developing other pertinent studies</li> </ul>



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