

Strengthening the health workforce: a draft technical framework

This note provides a brief overview of the scope and nature of health workforce challenges in low-income countries; provides a simple framework for organizing the analysis of problems and responses; and outlines possible priority actions at country and international level. It will be revised and circulated more widely after the meeting in Montreux, on 4-6 April.

Critical challenges

The health workforce can be defined as the broad spectrum of individuals engaged in promoting, protecting or improving health – in both the *public* and the often sizeable *private* sectors. This also includes the health workforce engaged in non-personal public health interventions, disease prevention, health promotion services, research, management and support services.

All countries face health workforce challenges. The types of problems vary across regions and countries, but include shortages, imbalances and low productivity. The basic problem for most countries (with perhaps the exception of Eastern Europe) is an overall HRH shortage, which leaves gaps within the existing infrastructure and services, both within and outside the public sector. Overall shortages are commonly aggravated by skewed distribution within countries and a movement of health workers from rural to urban areas, from public to private (for-profit and not-for-profit), or to jobs outside the health sector. Contributing factors include insufficient investment in pre-service training, migration, work overload, freeze in salaries and work environment issues (infrastructure, technical, safety and community support).

Public sector work settings are characterized by vacant posts, high turnover and loss to the private sector or overseas. Paradoxically, many countries that report staff shortages also have significant levels of health worker unemployment. While recruitment ceilings to limit public expenditure are one reason for this, weak recruitment and management capacity is another constraint.

Some categories of skilled workers (certified nurses, health bureaucrats and to some extent physicians) are in high demand globally because of shortages in richer countries or international organizations. Lacking the ability to provide adequate incentives, poor countries are less well-equipped to prevent workers from shifting from 'backward' rural to 'advanced' urban settings or from underfinanced public to more lucrative private sectors.

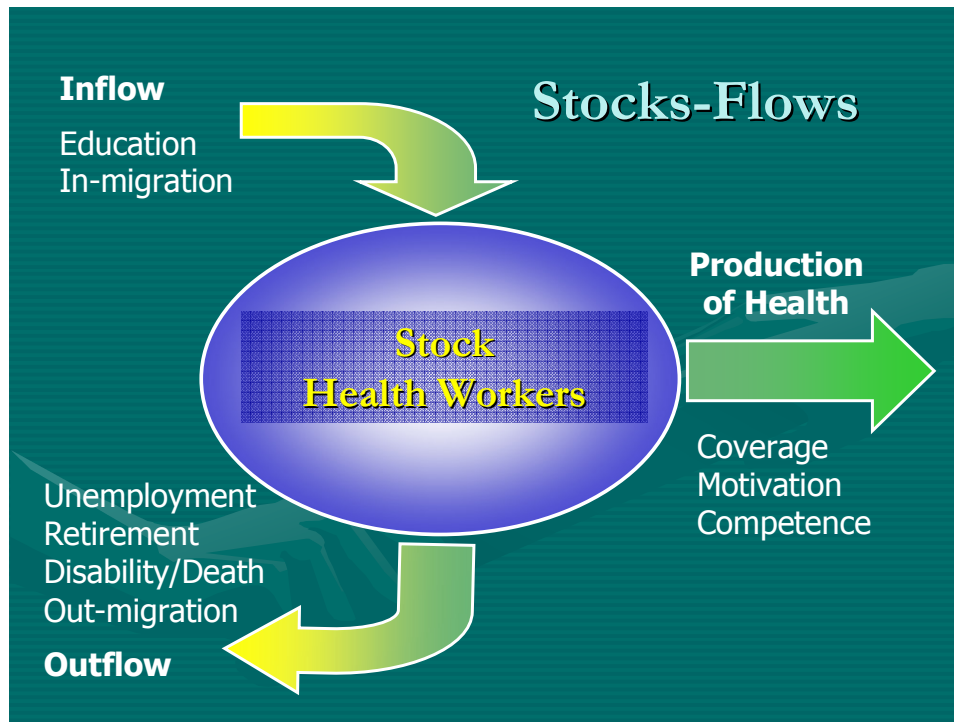
The problems are especially severe in countries in sub-Saharan Africa where access to proven and low-cost interventions is constrained by a massive shortage of health workers. The AIDS pandemic through increased workloads, the risks of infection to workers and the futility of not being able to treat dying patients when good treatment exists, accentuates the crisis of the health workforce. From these baseline conditions, the opportunity for scaling up access to antiretroviral therapy (ART) not to mention achieving the MDG targets for maternal or child health implies rapid expansion and improvement of the health workforce.

Some common questions inherent in improving workforce performance include:

- Are there ways to rapidly increase the number of skilled workers available for selected health interventions/services without disrupting other services?

A simple framework for mapping challenges and responses

In a very simplified view of the workforce, the complex dynamics of labour markets may be characterized by the diagram below depicting inflows, stocks and outflows.



According to this frame, there are three primary entry points for managing the workforce - 1) the inflow; 2) the outflow; and 3) the performance of the health worker stock.

1. Managing Inflows.

Traditionally seen as the primary point of entry for workforce policy, the inflow function of the workforce represents the opportunity for increasing or decreasing the numbers of trained health workers. There are a number of critical policy issues related to "pre-service training" that includes types of professionals or allied professionals to be trained, selection criteria for admission to programs, the numbers trained i.e. class size, the range of skills taught, and the way students are taught e.g. problem- or field-based. These issues are most directly linked to institutional settings, most often higher education or vocational schools. The state of training institutions in terms of their own financing, ability to recruit and retain faculty, and fees charged to students become critical determinants of whether and how much change is possible. The links of these institutions to government either through the Ministry of Education or Health is an important determinant of whether they are responsive to health systems needs (most often not!). Government policy on health worker training must broker agreement across multiple ministries (education, health, finance, public works) as well as with the International Monetary Fund (regarding public sector recruitment ceilings) and

provides (or doesn't) the latitude for training institutions to be responsive to health workforce needs.

Beyond pre-service training, significant inflows occur through other channels that represent opportunities to be managed. Health workers that have migrated and are living abroad might be given incentives to return to work (repatriation or brain gain) and/or be encouraged to develop remittances schemes that support the health workforce more directly. Expatriates are also represent a very sizeable and perhaps growing inflow in many countries ranging from Cuban doctors to those working with NGOs and specific partnerships or international programs. Policies for managing these inflows may be particularly important for responding to shortages in the short-term but require medium- to longer-term attention as well to insure that benefits outweigh costs. The size and diversity of the employers of expatriate workers makes them as a group extremely challenging to manage.

To effectively tap the various sources of workers that constitute potentially significant inflows, the mechanics of recruitment should not be overlooked. Recruitment capacity is deficient (slow, unfriendly, costly) and must be strengthened as a matter of urgency if resource poor countries are to compete more effectively in global labour markets where rich countries hire "Cadillac" recruitment agencies to find their workers.

2. Managing Outflows.

There are a set of factors which lead to workers exiting the workforce which in the context of overall shortages could be managed more effectively. In many countries, once health workers get on the public payroll they never, or rarely, come off even if they are not working. The various reasons for not working include primary employment elsewhere, migration and disability or death. The management of "ghost workers" through electronic personnel forms and periodic facility audits is low cost and yields significant resources that can be deployed for employing real health workers.

Environments where health workers safety is not secured i.e. women working on their own, or where there are significant risks to health due to the absence of infection prevention or control in hospital facilities, represent "unsafe" working conditions that hasten exit from the health workforce. Insuring the security of female health workers, providing better equipment to prevent infections and treating health workers for HIV/TB and other conditions represent high yield investments to minimize premature exit from the workforce.

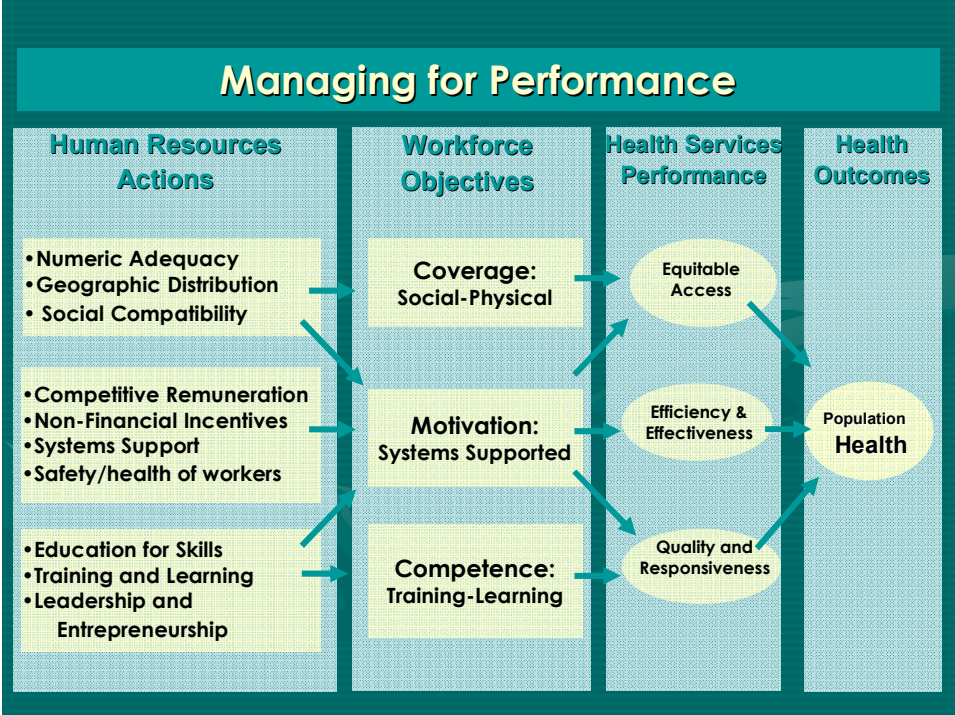
Another important factor to manage is the age of retirement of the workforce. In many countries it is arbitrarily chosen either inherited from the Bismarkian standard (65 years) or other cut-offs e.g. 50 years, that are not linked to capacity to work. A policy on retirement that is linked to workforce needs (as well as fiscal considerations) could have major implications on the size of the health workforce.

The global reality of international labour markets for health workers, makes out migration from resource poor countries a significant and growing "outflow". Management of migration is challenged by the need to recognize the rights of individuals to migrate along with the need for low-income countries to avoid subsidizing the training of health workers for OECD countries. While efforts at establishing "ethical recruitment guidelines" are proving mostly ineffective, OECD countries have expressed an aversion to compensatory mechanisms. A number of countries are proceeding with bilateral agreements whose effectiveness remains to be determined but whose scaling up is unlikely if one considers the number of agreements that would be required. Mandatory service to pay-off training prior to permitting migration is

another option. Developing an institutional training capacity to cater to the export market is a way of anticipating international demand while preserving domestic supply. Efforts on this front in the Philippines for example have not been systematically studied. Finally, many have argued that by improving working conditions in source countries, the incentive to migrate would diminish considerably.

3. Managing the stock of workers: motivation, coverage, competence

Ideally the workforce should be managed to contribute maximally to health outcomes and health systems performance. The table below identifies a set of workforce objectives based on performance outcomes including coverage, motivation and competence. Workforce coverage involves physical or geographical distribution as well as a workforce that understands and is responsive to population health needs. Motivation objectives relate to the set of financial and non-financial incentives and requisite systems supports for workers including insuring the health and safety of workers. Competence, relates to the requisite on-the-job problem-solving skills, including leadership.



Motivation, coverage and competence are part of a spectrum of inter-related challenges that employers of health workers must learn to manage more effectively to insure that services are responsive to health needs. There are a myriad set of opportunities that merit consideration depending on specific contexts including: a) pay increases; b) dedicated financial incentives; c) more attractive living conditions for workers (i.e. better housing, education for children); d) creating credible career structures; e) better personnel management capacity; f) delegating authority and providing incentives for problem-solving; g) supporting team work; h) improving in-service training or continuing education opportunities; i) strengthening supervision, mentoring and management; and j) ensuring essential infrastructure and equipment for workers to do their jobs.

How to tell if things are getting better or worse

Until very recently there really have been no assessments of the performance of the health workforce. The JLI report drew attention to the multiple reasons for concern especially in Africa but was limited by the absence of well accepted methods and credible country-level data. The absence of methods and limited data are indicative of the current state of affairs -- pretty dire! As a matter of priority it is imperative to develop some metrics that can be relied upon to gauge whether health workforce performance is moving in the right direction.

The range of indicators necessary to describe the profile and monitor the progress of the health workforce is extensive, integrating many aspects such as occupation, industry, training and others. A number of challenges must be faced to enhance cross-national comparability. The roles of health care workers vary from country to country, and the professions also have different national histories and cultures. It can be difficult to categorize data when professional boundaries are not well defined.

Selected categories of information for health workforce monitoring can be identified, such as:

- stock of HRH; skill mix; attrition through migration, HIV/AIDS other causes; institutional sector; earnings; production capacity for level of HRH;
- distribution of HRH by gender, location, etc.; distribution of education facilities; distribution of entrants by location, gender, etc.;
- provider productivity, production cost – for efficiency.

Since most of the indicators require extensive data collection at the individual worker level in order to be calculated, the initial focus can be on those that can be calculated more easily, using routinely collected and centralized information already available in various settings.

Taking the agenda forward: summary of priorities and processes

Recent national and global developments

Tackling health workforce challenges, like all other aspects of health system strengthening, is not a purely technical exercise. People's livelihoods are at stake. Many stakeholders need to be engaged, and for many of the more "structural" changes, high-level commitment is needed, plus a long-term vision. A series of developments over the last two years have placed health workforce issues more squarely on national and international policy agendas. A more concerted effort involving multiple partners is beginning to emerge through the High Level Forum on Health MDGs, the Joint Learning Initiative and the Oslo Consultation on HRH.

Country Action Alliances

The recognition of the workforce as a primary constraint to health progress; its "back-water" status in health and development policy, its "technical" and "political" nature, and the diverse set of actors necessary for moving effective action, has led to the recommendation for the formation of "country action alliances" at country level. These alliances aim to strengthen government sector leadership to establish ambitious but viable HRH strategies with high level political backing from government and interested partners. The alliances would have a convening capability within countries of the critical stakeholders including

private sector and civil society and would articulate a full range of technical options for HRH from assessment, policies, and programs through to evaluation. Elements of such strategies that would address both short- and longer-term challenges might include:

- One HRH assessment – harmonized and local!
- Increase inflows – train more, more efficiently, differently and draw on untapped pools within and outside countries,
- Reduce outflows – eliminate ghost workers, set appropriate retirement age, treat ill health workers,
- Improve yield of current workforce – better pay and payment mechanisms; improve working conditions; performance incentives; accountability criteria and enforcement; housing, education, health and transport benefits, careers advancement
- Manage migration – bilateral and multi-lateral agreements; export-oriented strategies
- Integrate HRH policy/strategy more effectively into priority programs - e.g. HIV treatment, maternal health or immunization.
- Links to broader fiscal financing policies and processes

Intercountry and global action to better support country health workforce development

A global platform for HRH: It is widely recognized that there is a need for coherent response to HRH challenges at a global level and to ensure that agencies work together more effectively. The recent Oslo Consultation on HRH reached a consensus for developing an inclusive platform that will enable existing agencies and new actors to learn to catalyze priority tackle health workforce challenges

Supporting better intelligence for HRH: There is a wealth of experience from within various countries that can provide inspiration and evidence for activities in other countries. This should be harvested. The need for more formal evidence and research is also recognized. Building intercountry collaboration and regional coordination mechanisms and networks can foster the sharing of experience, research and information. HRH observatories can be a mechanism to improve intelligence for HRH and to support and promote evidence-based policy-making. The observatories are envisaged to comprise national observatories (in-country networks) in partnership with multilateral and bilateral agencies and to be coordinated by a regional secretariat. The theme of the *World health report 2006* will be human resources for health; the report is expected to make a major contribution to pulling together existing information.

Improved technical cooperation and expertise: In addition to shortages of health workers, most countries also face shortages of management and planning capacity at both national and lower levels. Technical cooperation would, therefore, be important to facilitate attempts to address these shortages. This will be one of the areas of global responsibility; international and bilateral agencies must be prepared to mobilize technical assistance rapidly.

At present the group of experts and institutions assisting countries to strengthen their health workforce is relatively small and fragmented. Because a potential increase in demand and a potentially incohesive response are recognized, a mechanism to pool and connect the expertise in HRH is needed in order to boost the global HRH expert field; to establish a mechanism for access to HRH expertise on country demand; and to upgrade HRH expertise within developing countries. To develop an HRH network that responds to requests for

support requires overview and analysis of country needs, conceptual thinking, and identification of the available HRH experts. This should strongly target investing in strengthening national capacities individually and institutionally.

Developing capacity for human resources for health policy making and management

Regional and intercountry efforts can contribute to yielding a critical mass of expertise that is able to understand and address the challenges of human resources for health, and to design and implement long-term policies, organizational and institutional changes, and plans for health workforce development. A number of interventions can be considered, such as regional workshops for high-level decision makers and policy leaders; customized short refresher courses for technicians and managers; master's and PhD programs in health workforce development; and support to networking and communities of practitioners.

Every effort must be made to involve local institutions in developing and delivering the capacity-building activities. In the long run these institutions should be able to respond to the needs of their country in a fairly autonomous manner.