Cah. Socio. Démo. Méd.,
XXXXIIème année, n°2-3, p. 167-178 (Avril-Septembre 2002)

Cah. Socio. Démo. Méd.,
42 (2-3) : 167-178 (April-September 2002)

FROM HUMAN RESOURCE PLANNING TO HUMAN RESOURCE IMPACT ASSESSMENT: CHANGING TRENDS IN HEALTH WORKFORCE STRATEGIES

Wim Van Lerberghe *
Paulo Ferrinho **

* Institute of Tropical Medicine, Antwerp, Belgium
** Associação para o Desenvolvimento e Cooperação
Garcia de Orta, Portugal

De la planification à l'estimation d'impact : changement de stratégies dans les ressources humaines de la santé

Il y a une décennie, la pensée dominante était en faveur de la planification des personnels. Aujourd'hui, on s'aperçoit que certains problèmes, qui n'étaient pas pris en compte, sont cruciaux. Il en est ainsi de l'existence du secteur privé, qui, par nature, ne peut pas être planifié par les pouvoirs publics. Or, dans beaucoup de pays, le secteur privé est prédominant dans le système de santé. On sait peu de chose sur les flux de personnel en ce secteur, les conditions de travail, les méthodes de gestion, etc... De même, la planification préconisée dans le passé ne tenait pas compte du double travail dans les deux secteurs public et privé, c'est-à-dire des deux sources de revenu d'un grand nombre de travailleurs de la santé. La décentralisation est un autre problème à aborder. Elle peut être la source d'une élévation de l'efficacité du système de santé, par le biais de la réduction de la bureaucratie centrale. Mais elle peut aussi susciter des craintes, en dépossédant les gens de la stabilité d'emploi et de la garantie contre l'arbitraire des administrations locales. Pour toutes ces raisons, et bien d'autres encore, il semble important de procéder à une estimation d'impact sur les personnels avant de mettre en œuvre de grands projets ou une politique nouvelle.

Introduction

The international community is reluctantly recognising that human resources constitute one of the major bottlenecks limiting the performance of health care systems. The problems in this field are extremely complex and intricate. In contrast to e.g. financing or stewardship no clear new paradigms have come to dominate the field in recent years.

One would like a health workforce strategy to be global, locally relevant and evidence-based. Unfortunately, preciously little such evidence is available. For example, a recent review of the impact of payment methods on the behaviour of primary care physicians found only six studies that met pre-defined inclusion criteria – and even the conclusions of these six could not be generalised (*1*).

Extrapolations from common sense and patchy documentation can be hazardous. Over the last decade, for example, continuous medical education has developed into a multibillion-dollar business. It is now the main justification of the self-regulatory privileges of many professional bodies and one of the few concrete human resource strategies development agencies readily resort to. Still, there is no real evidence that conventional methods of continuous medical education have any impact on the quality of care (*2,3*).

From planning ...

A decade ago a discussion of problems with human resources would invariably end in calls for more and better planning (*4*). Although still the case, the emphasis has definitely changed. Human resource planning is no longer seen as a mechanical exercise in determining the rational optimum of quantities, skill-mix and distribution of manpower. With hindsight the expectations that the implementation of such plans would be straightforward appears overly optimistic, if not naive.

Traditional human resource planning has been discredited for setting unrealistic or vague targets, based on inaccurate and outdated information and delinked from the health policy agenda (*5*).

In the meantime many countries have embarked on 'health sector reforms', most often in conjunction with less immediately visible civil service reforms (*6*). In as labour-intensive a domain as health care delivery, reform cannot take place without far reaching labour adjustments (*7*). The forces driving these adjustments are very strong. The level and mix of staff deployed is a central element in the cost of care, as staff accounts for over 70% of all health care provision costs (*8*). The workforce has naturally become a focus for cost containment (*6*).

Some countries have indeed focused on human resource management as a priority in health sector reform (*9,10*) In many cases, however, the reform agenda neatly skirts around the workforce issue (*5,2*). To some extent this is understandable: a context of structural adjustment and inadequate working environments is not exactly conducive for building support for reform amongst the workforce. But more than a case of selective blindness or reluctance to tackle delicate issues, the failure to address the human resource agenda is essentially a question of hesitations about where and how to start.

In this changed environment, there are a number of 'new' issues that come up time and again. The interferences and overlaps between public and private health care delivery are no longer ignored (*11,12,13*) and there are persistent references to performance management, against an explicit backdrop of decentralisation and civil service reform (*8,9,10,14*). As such these issues are not new: private health care has been around for years, as has decentralisation. What is new is the central position they are taking in the human resources debate.

... and coping with change ...

Firstly, discussions on human resources no longer avoid the issue of private health care delivery and its implications. Most traditional health workforce planning implicitly or explicitly considered training and employment of personnel and provision of care as essentially a public sector concern. Yet in many countries the public sector is by no means the dominant provider. A substantial part – if not the bulk – of care is provided by a multiform and poorly regulated private sector (*15*), with a growing public-to-private brain-drain (*16*). Nowadays one can hardly imagine a discussion on human resources without reference to private health care (*6,78,9,10,17,18*). On the other hand, there is a striking lack of information on private sector workforce flows, conditions of service and employee experiences of private employers, although in many countries diversity of employment has become the norm rather than the exception (*17*). More progress has been made in the documentation of another taboo issue of the 1980s and 1990s: the fact that throughout the world public sector staff boost their income with private practice, often in an ambiguous context that compromises their public sector remit (*19,20,21,22*). In the past, the failure to take this into account has often led to a mismatch (*5*) between human resource planning and de facto health policies of both governments and development agencies (*23,24,25,26,27*). Documentation of these phenomena is now increasingly available, and there are signs of readiness to tackle the issue openly and with the necessary serenity.

Second, the human resource debate is now unmistakably linked to decentralisation and increased managerial autonomy. Decentralisation – a panacea for a wide range of policy and political goals – has been advocated as the structural solution to many human resources problems (*7*). Gains in sense of ownership, responsiveness and adaptation to local needs are supposed to offset the real inherent risks of fragmentation,

inefficiency and inequity. There are indeed examples of the positive effect of the managerial incentives made possible by decentralisation (*18*). But health workers themselves tend to be wary of the often-dramatic implications for their own working and living conditions (*14,28,29*). Decentralisation often reduces job security, as health workers no longer enjoy the lifetime employment guarantees of a civil servant. Upward career mobility prospects become slimmer (*17*). The prospect of being hired, disciplined and even fired by local authorities or local committees, often independent from the Ministry of Health can be threatening or destabilising. In many countries this has led to stiff resistance, if not prolonged social unrest among health workers (*10,29*). Increased management discretion offers new opportunities, but also provide greater scope for arbitrary appointments, favouritism in promotion and erosion of equal opportunity standards. In some cases this has led to major problems in recruiting and retaining staff (*30*). On the whole, there is no evidence for an *automatic* link between decentralisation and more effective management of human resources or greater efficiency. In many instances, human resource problems are simply transferred from the centre to the periphery, where they are replicated or even aggravated. Decentralisation thus requires specific attention to reform of the management of human resources, so as not to let deteriorated labour relations cancel out the benefits from the decentralisation (*9*).

If decentralisation shifts the onus for human resources management closer to the actual operations, increased client-pressure pushes managers towards quality assurance, benchmarking and performance management (*10*). This is part of a 'new public management' current that has come to dominate the human resource debate of the last years (*31*).

The principle is straightforward. One sets objectives and targets to steer individual performance. This makes it possible to link individual behaviour to broader service and organisational

objectives. Once performance towards the set targets is objectively measured it becomes possible, at least so goes the theory, to promote desired behaviour through (essentially financial) incentives and disincentives(*7,18*), Ultimately better performance – a human resource outcome – thus has to lead to better quality of care – a service outcome (the conventional separation between both does not make much sense (*9,10*).

Attempts at performance management have certainly improved the information basis for HR planning (*5*), if only because they require sophisticated computerised management information systems (*2,3,7,8,32*). They also have provided powerful support for institutionalising continuous medical education (*2*). But there is very little evidence that formal performance management systems actually affect quality or patient outcomes (*10*), and certainly not that gains in efficiency outweigh the costs of setting up the systems. On the other hand, there is no evidence either that it does not.

Financial incentives – for individuals or teams – are the central feature of many performance management systems. Current consensus has it that this has been misguided, and underestimates the importance of non-monetary incentives and disincentives (*18*). Some go further, and point out that the critical determinant of the success of performance management is not the design of the system or the link with pay, but managerial skill, leadership and ownership (*8,10,17*).

Centralised bureaucracies do not support this kind of performance management; decentralised systems could do so, at least in theory. Few decentralised systems have however been successful in managing performance, precisely for want of managerial capacities (*9,10*).

Seductive as it may seem, performance based management is a largely unproven strategy to tackle the complex human resource issues. One cannot stress enough that basic preconditions have to

be met – ranging from a reasonable basic salary to functioning bureaucracy and a sufficient degree of transparency and accountability. The paradox is that the countries that would benefit most from new public management are the ones where it is *a priori* most difficult to implement on a large scale (*33,34*).

... to human resource impact assessment

What then can one do? The reluctance of governments and development agencies to tackle such complex matters is understandable. Strong evidence to underpin a global workforce strategy is lacking. For much we have to rely on expert opinion, committee reports, or, in the best of cases, qualitative and descriptive studies. In health sciences this is usually considered to be the least robust kind of evidence (*35*), but it does show that human resource problems are always largely context dependent system issues. This makes it unlikely that blanket policy prescriptions or managerial magic bullets would be of much use: piecemeal approaches embedded in local realities are likely to remain at the core of most of current attempts to deal with unsatisfactory performance and growing labour unrest. However, for human resource problems to be tackled, even in a piecemeal way, they have to be on the policy agenda. The challenge is not unlike that of getting the environment on the development agenda a decade ago or health on the agenda on the common agricultural policy of the European Union (*1*). One of the ways this was done was to force policy makers to make an explicit impact assessment of major development plans either on the environment or on the health status. Even if this often was a perfunctory and formal exercise; it did help foster awareness and transforming environmental concerns into something natural.

Human resource problems are similarly complex and context dependent. A formal and routine 'human resource impact assessment' in the appraisal phase of major new projects or policies would carry a triple benefit: (i) it would draw the attention of decision makers on the potential consequences of

their decisions for human resources; (ii) it could help steer organisational or financing decisions so as to minimise negative effects on the workforce and enhance positive dynamics; and (iii) it would help to gradually build up the documentation on the interaction between reforms and human resources that is presently so sorely lacking.

Bibliography

(1) Gosden, Forland, Kristiansen, Sutton, Leese, Giuffrida, Sergison, & Pedersen. Impact of payment method on behaviour of primary care physicians: a systematic review. J.Health Serv.Res.Policy 6(1), 44-55. 2001.

(2) Shahabudin SH. Life long learning and continuing education – assessing their contribution to individual and organisational performance. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.

(3) Azizi F. Continuing Professional Development in Health Sector. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.

(4) WHO. Health manpower requirements for the achievement of health for all by the year 2000 through primary health care. Technical Report Series 717.

(5) Bach S. HR and new approaches to public sector management: Improving HRM capacity. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.

(6) Pokharel PK, Jha N, Khanal SS, Koirala S. Integrating Workforce Planning, uman Resource, and Service Planning: Developing Country Perspectives, Nepal. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.

(7) Smith DA and Preker AS. Labour market adjustment in health systems. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.

(8) Buchan J, Dal Poz MR. Role definition, skill mix, multi-skilling and "new" workers. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.

(9) Bandaranayake D. Assessing performance management of human resources for health in South-East Asian countries: aspects of quality and outcome. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.

(10) Martínez J. Assessing quality, outcome and performance management. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.
(11) Fernandes A. What are the positive and negative aspects of existing conditions of employment. Personnel drain from public to private sector. Pp 89-90 in Ferrinho P, Abreu A, Van Lerberghe W (eds). Health Manpower Policies in Southern Africa. The Contribution of Research. European Commission Workshop in Maputo 14-18 November 1994.
(12) Damasceno A, Van Lerberghe W, Ferrinho P 2000. Coping through private practice. A cardilogist in Maputo, Mozambique. Pp 157-162 in Ferrinho P, Van Lerberghe W 2000 (eds). Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(13) Ferrinho P, Van Lerberghe W, Julien MR et al., How and why public sector doctors engage in private practice in Portuguese-speaking African countries, Health Policy and Planning, 1998, 13(3):332-8.
(14) Dovlo D. Measuring and monitoring staff performance in Ghana. Pp 101-106 in Ferrinho P, Van Lerberghe W 2000 (editors). Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(15) Ferrinho P, Bugalho AM, Van Lerberghe W. Is there a case for privatising reproductive health? Patchy evidence and much wishful thinking. Paper presented at the EU Round Table on Maternal Mortality. Brussels, November 2000.
(16) Fresta E, Fresta MJ, Ferrinho P. The internal brain-drain in the Angolan health sector. Pp 45-53 in Ferrinho P, Van Lerberghe W 2000 (editors). Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(17) Standing H, Baume E. Equity, Equal Opportunities, Gender and Organisation Performance. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.
(18) Adams O, Hicks V. Pay and non-pay incentives, performance and motivation. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.
(19) Ferrinho & Van Lerberghe. Providing health care under adverse conditions. Health personnel performance and individual coping strategies. 1-275. 2000. Antwerp, ITG Press.
(20) Roenen, C., Ferrinho, P., Van Dormael, M., Conceição, M.C. and Van Lerberghe, W. How African doctors make ends meet: an exploration. Tropical Medicine and International Health 1997; 2 (2): 127-135.
(21) Backström B, Gomes ADC, Fresta E, Dias F, Gonçalves A, Lerberghe WV, Ferrinho P 1997. The coping strategies of rural doctors in

Portuguese speaking African countries. Abstract Te 22, Revista Médica de Moçambique; 7 (1,2) Supplement 1: S13.
(22) Macq J, Van Lerberghe W. Managing health services in developing countries: moonlighting to serve the public? Pp 177-186 in Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(23) Dussault G. World Bank policies in relation to human resources development in health. Pp 177-186 in Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(24) Adams O. Internal brain-drain and income topping-up: policies and practices of the World Health Organisation. Pp 177-186 in Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(25) Lea R. Internal brain-drain and income topping-up: policies and practices of NORAD. Pp 177-186 in Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(26) De Backer L. Internal brain-drain and income topping-up: policies and practices of the Belgian International Cooperation. Pp 177-186 in Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(27) Schmidt-Ehry B & Popp D. Internal brain-drain and income topping-up: policies and practices of GTZ. Pp 177-186 in Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(28) Cuéllar CJ. Health sector reform and human resources in Bolivia: the perspective of an NGO, pp 73-77 in Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) Health Personnel Performance & Providing Health Care under Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(29) Pangu K. Health workers motivation in decentralised settings: waiting for better times " pp 21-31 in Ferrinho, P. and Van Lerberghe, W. (eds.) (2000) Health Personnel Performance & Providing Health Care under

Adverse Conditions. Individual Coping Strategies. Studies in Health Services Organisation & Policy; 16. Antwerp: ITG Press.
(30) Maiga, Traoré Nafo, & El Abassi. La Réforme du Secteur Santé au Mali, 1989-1996. Studies in Health Services Organisation & Policy (12), 1-132. 1999. Antwerp, ITG Press.
(31) Boston J, Martin J, Pallot J and Walsh P. Public Management: the New Zealand Model. 1-406. 1996. Auckland. Oxford University Press.
(32) O Brien-Pallas L, Birch S, Baumann A, Murphy GT. Integrating workforce planning, human resources and service panning. Paper prepared for the WHO's Workshop on a Global Health Workforce Strategy, Annecy, France, 2000.
(33) Moore M. Public sector reform: downsizing, restructuring, improving performance. Geneva, WHO: WHO/ARA/96.2, 1996,7,1-21.
(34) Schick A. Why most developing countries should not try New Zealand reforms. The World Bank Research Observer 1998;13(1):123-131.
(35) Woolf, S.H., Battista, R.N., Anderson, G.M., Logan, A.G., and Wang, E. Assessing the clinical effectiveness of preventive manoeuvres: analytic principles and systematic methods in reviewing evidence and developing clinical practice recommendations. Journal of Clinical Epidemiology 43 (9) :891-905, 1993.
(36) Whitehead M. and Nordgren P. (eds), 1996. Health Impact Assessment of the EU Common Agricultural Policy. Swedish National Institute of Public Health, F-serien 8.