The Health Workforce and Workforce Performance

K. Rossel-Cambier

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CEB Working Paper Nº 03/011
2003
"The Health Workforce and Workforce Performance"

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Background document to my presentation on "Health Sector Performance" for the Achieving the MDGs: Poverty Reduction, Reproductive Health and Health Sector Reform, World Bank Institute, Turin, 26 August 2003

ABSTRACT

Over the last ten years, performance management for health sector systems has received increased attention. In many countries privatisation, decentralisation, user involvement and cost containment have changed the structure and the functioning of health delivery dramatically. The role and performance of the workforce in the health sector has often been considered only after reform has taken place, despite the high labour intensity of the sector. Performance management for organisations and individuals can work if we take into account the fragile balance between improving performance and providing decent working conditions. The international community has devised a range of measures to make human resources management and social dialogue a full part of health sector policy and practice.

1. The labour market in the health sector

Increasing demand

All countries at all income levels are experiencing a growing demand for health care. Low-income countries with fast-growing populations have large numbers of children needing care, and richer countries with ageing populations are experiencing rising demand for care for the elderly. The breakdown of traditional family structures has created a need for more external social services. Specific new health needs, including those relating to reproductive health care, HIV/AIDS, malaria and tuberculosis, make the need for specific services in certain countries especially urgent. The development of medical technology and new skills has also boosted the demand for new services, in particular in the industrialised countries. The rise in individual demand for health services has been accompanied by an important increase in health financing by many countries. For example, in the US health care used to account for only 4.4 per cent of GDP in 1960, but by 1989 it had reached 11.6 per cent and current expenditure is estimated at more than 13 per cent.

The provision of health care involves putting together a considerable number of material and human resources. The efficient allocation of available resources to new skills, facilities, equipment and maintenance of infrastructure requires delicate balancing and continuous monitoring. Certain financial resources serve indirect long-term functioning such as training and material investments and other financial resources need to be

1 The remuneration of nursing personnel, an international perspective, ILO, 1994.
allocated to direct recurrent functioning such as labour, maintenance and consumables. Besides the individual contribution of these elements, matching the different resources is a key factor in quality care delivery.

In many countries, health delivery has taken place largely in the public sector. Decentralisation of public health systems has resulted in greater autonomy of decision-making and increased responsibility of local governments for providing health care services. Privatisation has generally been introduced with the intention of achieving more efficient delivery of quality health services or simply solving the financial problems of local governments, which are often unable to provide the necessary funds to health service institutions. Non-profit private health care providers are also important. At the same time, globalisation has stimulated mergers and acquisitions by international health companies or health insurance companies.

The labour market

The health sector is very labour-intensive. Staffing costs and wages usually accounts for about three quarters of recurrent health expenditure. The ILO estimates that more than 35 million people world-wide are employed in the sector. Over the last three decades the health professions have grown rapidly in most countries, often more rapidly than the population itself. Employers include both private and public organisations. Other workers are self-employed or form networks for economies of scale and rationalisation. Despite their importance, statistics on trends in employment in health services are only available for a limited number of years and for a limited number of countries. The share of health and social service employment in total employment varies from one country to another. Generally, in developed countries it is high (an average of 10%) whereas in low income-countries it is much lower (an average of 4%)\(^3\). In all countries, the proportion of women in this workforce is very high and exceeds their share of total employment. Market changes can therefore be highly gender-sensitive.

As the general trend in health service employment is for it to rise, some countries are reporting staff shortages in the sector. One of the particularities of health services is that market mechanisms alone do not achieve an adequate balance between labour demand and labour supply. Market mechanisms fail mainly because of institutional and regulatory arrangements on the demand side and slow response on the supply side, which, in turn, is largely due to the long and strictly regulated education required for entry to the health professions. Demand is also limited by budgetary restrictions, especially in the public sector.

Of central importance to health workers is workload. Due to the nature of the services which are being provided during 24 hours, shift work, overtime, stand-by and appropriate rest have to regulated. Occupational safety and health protection are of particular importance in view of the special hazards great concentration of risks faced by health workers.

The health sector is thus highly complex, with several health-specific professional groups (e.g. doctors and nurses) having distinct roles and their own educational and regulatory structures.

\(^3\) ILO database on labour statistics (LABOURSTAT), 2002
2. Health sector reform and workforce performance

The impact of health sector reform on the workforce

The 1990s saw an unprecedented interest in health sector reform, but by the end of the decade it was clear that the high expectations of reformers had rarely been fulfilled. The objectives of all these reform efforts were important. They all aimed to improve the performance and efficiency of public service delivery. They sought to bring the public service closer to the people by ensuring more participation within a consumer-oriented approach. Moreover, they also shaped the employment outlook for health care workers, because the situation and working conditions of health care personnel are critical to the delivery of services in this sector.

Owing to continuous financial pressure, health systems are exploring approaches to private and commercial management with the intention of achieving high-quality services while containing costs. As the sector is very labour-intensive (labour can represent up to 70% of the total health budget), human resources management is crucial to this process. The performance of health care systems depends ultimately on the knowledge, skills and motivation of the people responsible for delivering services.

The sector often faces persistent problems such as imbalances in the availability, composition and distribution of the workforce, lack of management or performance evaluation, and ineffective use of incentives. Moreover, training initiatives often are repetitive and centralised, and make little impact. In many countries, the sector suffers from a lack of motivation, low participation, high absenteeism, and a lack of skilled personnel.

Public sector reform includes measures such as decentralisation, structural changes in ministries, new financing and management schemes and new models of care. These have a major impact on the management of human resources in the health sector. There is more focus on performance, functions change, and new skills and new standards on quality and productivity emerge. The reforms can lead to changes in the way work is organised, and may involve new types of contract. Certain reforms call for more flexibility and mobility from the workers by offering them short-term contracts or other unstable working conditions, which reduces social protection. Often, human resources management becomes more complex as different labour regimes coexist within similar occupational categories.

Some countries have to deal with an increasing flow of uncontrolled migration in health sector personnel, leading to poor working conditions and low esteem for certain categories in the health sector.

In many low-income countries, the departments responsible for human resources for health are ill-prepared to carry out the principal functions of integrated human resources management, including planning, training, management and evaluation.

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4 WHO, S.Bach, Human resources and new approaches to public sector management: improving HRM capacity, Workshop on Global Health Workforce Strategy, Annecy, 2000
Critical questions for policy makers

In 1999, an international round table of experts was held as part of a joint programme by the ILO, the WHO, the German Foundation for International Development (DSE) and the International Council of Nurses (ICN). This meeting led to the identification of significant and sometimes unforeseen consequences of reform on the working conditions and quality of life of health sector personnel.

As a result of the discussions, a list of critical questions for policy makers highlighting human resources issues was developed. This tool is meant to assist decision-makers in international organisations, governments and civil society in undertaking the complex process of review, reform and restructuring. It aims at helping to design, introduce and implement public service and health sector reforms in the most effective and sustainable way.

During a preparatory phase, it is essential to establish a common understanding amongst all stakeholders of the situation of the country before and during public sector reform and of the challenges to be addressed. In addition, the strengths and the weaknesses of the public and health sectors need to be known.

During the formulation phase, as well as during implementation, the key words are communication and co-ordination with stakeholders, including personnel. The core planning unit should be appropriately staffed, and the mechanisms for decision-making, negotiation, feedback, interim evaluation and dealing with deviations should be well established.
3. Improving workforce performance

More stress on performance management

Traditionally, discussions on human resources in health have ended in calls for more and better manpower planning and management-trade union relations and for ensuring organizational adherence to policies on recruitment, appraisal and training. Today's emphasis is no longer on the mechanics of optimising the quantities, skills and distribution of manpower. One of the new concerns claiming most attention is performance management.

Different international norms and targets for national health systems and labour market - such as the MDGs, ISO standards set by the International Organisation for Standardization, and performance indicators of the WHO - stress the importance of tangible improvements in the efficiency and effectiveness of health care delivery. All these factors affect the importance of performance at the national, organisational and individual levels.

On the other hand, as decentralization brings human resources management closer to actual operations, increased client pressure pushes local managers towards performance management.

Performance management at the organisational level

At the organisational level, performance management focuses on achieving targets and goals as expressed in business plans and measured by performance indicators. It is the result of a mixture of factors which provide input into the operations of health organisations, such as human and financial resources and work organization. Performance management is closely linked to quality management, which means that, in the health services, performance indicators have to refer to outcomes for public health and to publicly regulated quality standards.

There is increasing interest in developing countries in contracting with NGOs and the for-profit private sector to deliver health services, particularly primary health care. Much of the impetus for contracting has arisen from a perception that publicly provided health services may lack effectiveness and efficiency.

In Haiti, NGOs provide basic health services such as immunization and prenatal and maternal care. In an effort to improve the effectiveness of some of these organisations, USAID introduced performance-based contracting in 1999. The new system set performance targets and withheld a portion of their budget, allowing them to earn back the withheld amount plus a bonus if they met the targets. To ensure that the NGOs viewed the change as advantageous, the MSH used a collaborative approach in

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designing the new system. The results of the pilot study suggested that performance-based payment could be a powerful way to hold NGOs accountable for results. The key lesson was the need to define indicators that relate directly to health impact, client satisfaction and institutional sustainability and to measure and monitor performance in a way that is not prohibitively expensive.

**Individual performance**

A results-oriented approach to performance management in the labour-intensive health sector depends on staff motivation and individual performance. Employees should be treated as assets rather than as cost-creators. Each asset has different competencies that need further development. Individual performance appraisal should take place within a framework of incentives to perform agreed tasks, based on high-quality standards, which contribute to organisational performance. Financial and material incentives, provided through salaries and other benefits, have often been considered important in making the performance appraisal attractive.

Where performance appraisal is being used as a tool of performance management, it may be linked to incentives, but there must also be adequate safeguards against abuse. The practicability and fairness of individual performance contracts are being called into question today, and modern performance management puts more emphasis on promoting teamwork, staff development and establishing planning review processes. Other types of incentive are gaining importance. These include employment security, improved working conditions, career advancement, participation in decision-making and in overall work processes, training and skills mix. In industrialised countries, the promotion of "family-friendly" working practices has also been a prominent recruitment and retention strategy. Performance appraisal systems also have an important role to play in ensuring that staff are aware of what is expected of them, and that promotion criteria are transparent.

The link between organisational objectives and workforce performance should be transparent and coherent. Accountability of management is essential for performance management in the health services, and must be consistent with the overall organisational objectives and performance indicators.

In Haiti, to motivate staff to focus on results, two of the three NGOs introduced bonus schemes for staff and community agents, cutting their salary in half and reserving the rest for bonuses tied to performance. But it found that transferring that much risk to relatively low-paid staff lessened their motivation.

Performance management at the individual level can work if employees value the rewards on offer, if they are able to raise performance, if the management measures in a way employees believe fair and if extra pay is attached to higher performance\(^\text{11}\). Effective performance management should hence be designed in collaboration with the different stakeholders.

Before introducing them, it is important to examine whether performance management systems may actually affect quality or patient outcomes. One possible solution is "human

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resources impact assessment" during the preparation phase, to examine likely effects of policy on the health workforce. These could then be monitored during implementation.

4. Ways forward

Recognising workforce performance as a key factor in achieving goals

A first step is recognising the workforce as a key factor in optimising quality and productivity. This implies designing or adapting performance management and appraisal systems. Performance can only be managed if it can be measured. There is therefore a need to produce standards of performance and mechanisms with which to measure it.

During the preparation of public health reform, impact assessment exercises can be undertaken to estimate the effect of the changes on the workforce and on its performance.

Valuing human resources management

It has become increasingly recognised that poor human resources management remains a dominant constraint on the reform of health services. It is important not to see human resources as an obligation, but as a tool, a strength.

Reforms are likely to require human resources management to move from simple planning to a much more strategic approach. Human resources management should not be isolated but should be integrated into other elements of health sector policy, planning and management.

Comprehensive human resources management will, for example, deal with liaising with other ministries and overseeing changes in organisational structures and staffing levels to ensure that all essential parts of the system continue to function. Where human resources management is being decentralised, the establishment of new management systems such as recruitment, performance appraisal and local pay bargaining, and the provision of skills for staff to operate them, should be developed. This involves new roles for central and local human resources personnel as the reforms are implemented\(^\text{12}\).

Social dialogue as a motor for change

If a human resources agenda precipitates defensive reactions from staff, employees have been insufficiently involved.

Decentralisation and privatisation are changing the roles of the trade unions. The challenge to the social partners is to develop structures which can deliver efficient high-quality health services to the public and, at the same time, offer decent employment and working conditions to personnel. This, in turn, has an impact on the quality of services\(^\text{13}\).

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\(^{13}\) Social dialogue in the health services: Institutions, capacity and effectiveness, ILO, 2002
Trade unions are often criticised for finding it difficult to move beyond defensive campaigns to limit the negative effects of privatisation on their membership. Alliances with service users are high on the agenda for discussion. In comparison with the analysis of privatization, the increasingly important issues of how privatized services are regulated by the state to meet the public interest, the degree to which globalisation has weakened national regulatory capacities and the extent to which worker representatives and service users are involved in the regulatory process have received little attention.

The public and private health sectors have evolved differently with regard to collective bargaining. In the public sector, negotiations used to be highly centralized. Now they have shifted to a more de-centralized process, "lowering" the negotiating level. In the private sector, labour relations have been individualized14.

Some initiatives

Various initiatives have been taken to improve the balance between performance improvement and sustainable human resources management.

Nursing personnel are covered by many international labour Conventions and Recommendations that lay down general standards concerning employment and conditions of work, such as instruments on discrimination, on freedom of association and the right to bargain collectively, on voluntary conciliation and arbitration, on hours of work, holidays with pay and paid educational leave, on social security and welfare facilities, and on maternity protection and the protection of workers' health. Moreover, a specific ILO Convention, No. 147, was created to stress the need for constructive working conditions and labour protection in the sector, conditions at least equivalent to those of other workers in the country in terms of hours of work, weekly rest, paid annual holidays, educational leave, maternity leave, sick leave and social security. As follow-up, the ILO is developing its knowledge of the impact of social dialogue on the health sector.

The Pan-American Health Organisation (PAHO) has set up an observatory of human resources in health sector reform in Latin America and the Caribbean. The aim is to produce information and knowledge necessary for improving human resources in health policy decisions, and to share the knowledge obtained to improve the management of human resources development in the health services sector.

These initiatives should link up with new developments in performance appraisal. The recent Health Systems Performance Initiative (EHSPI) by the WHO may act as a catalyst for this challenging task.

14 P.Brito, P.Galin and M.Novick, Labour relations, employment conditions and participation in the health sector, WHO Workshop on Global Health Workforce Strategy, 9-12 December 2000, Annecy, France
Annex 1. A set of critical questions: formulation of PSR with regard to human resources
(Source Public Service Reforms and their impact on health sector personnel, DSE, ILO and WHO, Berlin, 1999)

Managerial and organisational structure

- Who is responsible for drafting and costing of PSR?
- How will the participation of stakeholders in consultations and negotiations be ensured?
- What approaches would be effective in gaining acceptance of PSR among affected parties?
- By what process should the management team formulate an action plan for the implementation of the PSR?
- What are the consequences of PSR for health staff?

Provisions for management of change

- What measures could be taken to secure and retain political support for the proposed changes?
- What measures should be established to regulate and co-ordinate public and private sectors?
- What is the time frame?
- How will the co-ordination between different types of reform and across sectors be supported?
- How will the health sector deal with conflict between stakeholders?
- How will abuses in the system be addressed before they become a threat?
- What are the social and economic costs and benefits of PSR?
- How will reforms be monitored? (see set 4 of questions)

Provisions for human resource development

- How will the competitiveness of the public sector be strengthened?
- What policies will ensure adequate human resource development?
- What are the criteria and systems for staff appraisal and advancement?
- What mechanisms are needed to maintain and develop health personnel skills and capacity?
- What are the (re-)training needs for:
  - staff with new functions?
  - retrenched staff?
- How will the health sector deal with redundant workers?
- How will PSR affect the relative pay and working conditions of health personnel?
- How will PSR affect ethical practice within the health sector?

Provisions for the impact of reform on health services

- How will the quality of health services be enhanced by reforms?
- How will the reforms support equitable accessibility of services?
- How will the reforms improve care for vulnerable groups?
- How will the reforms promote respect of patients’/consumers’ rights?
- How will patient care be financed?
- What are the criteria for the evaluation of health services? (see set 4 of questions)
Annex 2. Example Pilot project Performance Contracts MSH Haiti
(Source Promoting preventive health care, Paying for performance in Haiti, P.Eichler, P.Auxila and J.Pollock)

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<tr>
<th>Indicator</th>
<th>Target</th>
<th>Share of bonus</th>
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<tbody>
<tr>
<td>☑ Women using oral rehydration therapy to treat diarrhea in children</td>
<td>15% increase</td>
<td>10%</td>
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<tr>
<td>☑ Children ages 12-23 months receiving full vaccination coverage</td>
<td>10% increase</td>
<td>20%</td>
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<tr>
<td>☑ Pregnant women receiving at least 3 prenatal visits</td>
<td>20% increase</td>
<td>10%</td>
</tr>
<tr>
<td>☑ Discontinuation rate for oral and injectable contraceptives</td>
<td>25% reduction</td>
<td>20%</td>
</tr>
<tr>
<td>☑ Clinics with at least 4 and outreach points with at least 3 modern methods of family planning;</td>
<td>100% of clinics 50% of outreach points</td>
<td>20%</td>
</tr>
<tr>
<td>☑ Average waiting time for attention to a child</td>
<td>50% reduction</td>
<td>10%</td>
</tr>
<tr>
<td>☑ Participation in local health organizing committee (UCS) and coordination with MOH</td>
<td>UCS defined</td>
<td>10%</td>
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