Original Articles

Imbalances in Human Resources for Health:
Can Policy Formulation and Planning Make a Difference?

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Abstract

Countries continue to have significant imbalances in their human resources for health (HRH). Frequently the failure to implement human resources development (HRD) policies is blamed on the lack of a favourable economic environment and real political commitment in countries. This paper proposes that a major explanation is the policy formulation process itself.

Policy-makers and planners must learn more about policy formulation processes in HRD. An assessment of different approaches in a variety of contexts (economic, social, stage of reform, etc.) can provide valuable lessons.

WHO has developed an analytical framework with which to categorize contextual factors and the resulting health policy and human resource policies. This framework has been applied to 18 countries.

Key findings of these country case studies include the following:

- The relationship (sometimes not direct) between the context and both national health policy and HRD policy and planning can be traced in most countries.
- Different countries have initiated different HRH policy responses to meet similar health sector objectives.
- HRD issues are often addressed primarily by education and training.
- Stakeholders are often not sufficiently involved in policy formulation, or are involved late in the process.
- Policies are sometimes not well defined and are therefore difficult to monitor and evaluate.
- Regular review mechanisms and structures are rarely thought about before policies get implemented.
- National capacities to develop and implement policies are still weak in many countries.

In the face of health sector reform initiatives, often resulting from political and macroeconomic changes, many countries are reviewing their policies for health development with a view to formulating new ones. The paper concludes that effective implementation requires a broad approach that takes into account all major contextual factors and key players and, even more important, their interlinkages.

Key words: Human resources development -- policy, planning, imbalances, staff development, health policy, health manpower, policy making

Introduction

Human resources development (HRD) policy makers and planners need to give more attention to the processes for policy formulation and planning. This is the message that emerged from a WHO Intercountry Consultation on Policy Formulation Processes and Implementation Methods with a special focus on HRD, Sri Lanka, 28 September-2 October 1998, in which 18 countries participated. By policy formulation we mean the course of action which needs to be taken to:

- set the general objectives and priorities in relation to production and utilization of human resources for health (HRH);

- define the general strategies and make the political choices needed to achieve the objectives.

With this understanding we find that a considerable number of guidelines and methodological approaches towards HRH policy development and planning have been and still are being developed[1-6]. Despite all of these efforts and many countries having developed HRD policies and plans, substantial gaps exist between policy statements and their actual implementation. Countries are indeed still faced with significant and lingering imbalances in their human resources for health[7-8]. The imbalances have been characterized as[9]:

- numerical: the difference between the number of health care providers of various categories and the numbers a country or community needs and can afford.
- quantitative: the mismatch between the type and level of training and the job that needs to be done.
- distributional: the mismatch between the geographical, occupational, public/ private, institutional, and specialty mix.

Frequently the failure to correct these imbalances is blamed on the lack of a favourable economic environment and real political commitment in countries. Another major explanation may lie with the HRH policy formulation and strategy development **process** itself, particularly in relation to the following issues:

- validity of assessing HRD problems;
- basis for setting priorities and objectives with regard to HRH production and utilization;
- criteria for choosing one or more strategies from several options to achieve the objectives (economic feasibility, acceptability, local capacity, potential change, etc.);
- involvement through consultation and negotiation with all actors concerned.

Since the political and economical environments are key to implementation, it would seem logical that these two important factors, as well as others, be seriously taken into account when formulating new HRD policies and plans. However, is this case?

Approaches to HRD: 50 years of World Health Organization (see summary table in annex I)

During WHO's earlier years, many developing countries first sought to increase the number of health workers, and then to improve their quality. Quality in the earlier years was primarily equated with training of higher level personnel, i.e. doctors and some nurses. This often involved trying to adopt or adapt the patterns of more developed countries. With the realization that these developments still left much of the population underserved, attention was shifted towards improving the efficiency of training and utilization, and then towards better planning.

During the 1960s and 1970s, much human resources policy and planning tended to be focused on numerical targets to the detriment of quality. Little attention was paid to the political dimensions of HRD.

In the 1980s, WHO began to promote the linking of health systems and human resources development, so that the requirements of the former would act as a guide for policies and plans relating to the latter[10]. The central objective is to ensure that human

resources are relevant to the health needs and demands of the population. Although this principle of integration may seem obvious, the development of the educational and health services along two separate paths has created problems worldwide[11].

More recently a number of other concerns have become central to HRD approaches, such as:

- The search for more cost-effective ways of delivering health services;
- The need for appropriate legislation and regulation in relation to private/public sector growth and expanding scopes of practice for some practitioners;
- The reinforcement of quality improvement through capacity building, better integration between the delivery of services and the roles and mix of providers.

With health sector reform, civil service reform and other changes that have a direct impact on health care providers[12], WHO is seeking the best ways to assist governments (Ministries of Health) in responding to and managing these changes. This includes the development of appropriate strategies with clearly identified sources of financing, as well as reimbursement vehicles with incentives that contribute to meeting the goals of the national health policy. WHO is also developing approaches that will assist in strengthening the consultation processes between the many actors in HRD to ensure more effective implementation of policies.

A framework for analysis

Despite a better understanding of the forces affecting the workforce, as well as better planning methods and tools (including computerized personnel files and budgets, simulation and scenario construction models for decision-making), the results of HRH planning are often discouraging[13].

However, where HRD is only or principally led by market forces, i.e. the interaction between supply and demand, the results on the workforce are often negative, not to talk about the waste of money in long and costly training programmes[14].

In countries where there is little or no limitation of access to the health professions and the capacity of the market to absorb the trained personnel is at a maximum, the result is unemployment, underemployment or migration of qualified personnel. Since migration is easier for the more qualified providers, it may result in a decline of the overall quality of services.

Market forces on their own do not provide for a process of optimizing the production and utilization of the workforce. Even if central planning has been a failure in many respects and strategic planning in market economies has been discredited when it became used as a recipe or as a formal exercise[15-16], the need to define the problems, to formulate clear and valid objectives and priorities, and to design consistent and feasible strategies has not disappeared.

So far, major attention has been given to the quantitative aspects of HRH plans, leaving relatively little space for the more difficult aspects, which are of a more qualitative nature and deal with the way plans are actually prepared. The questions are therefore:

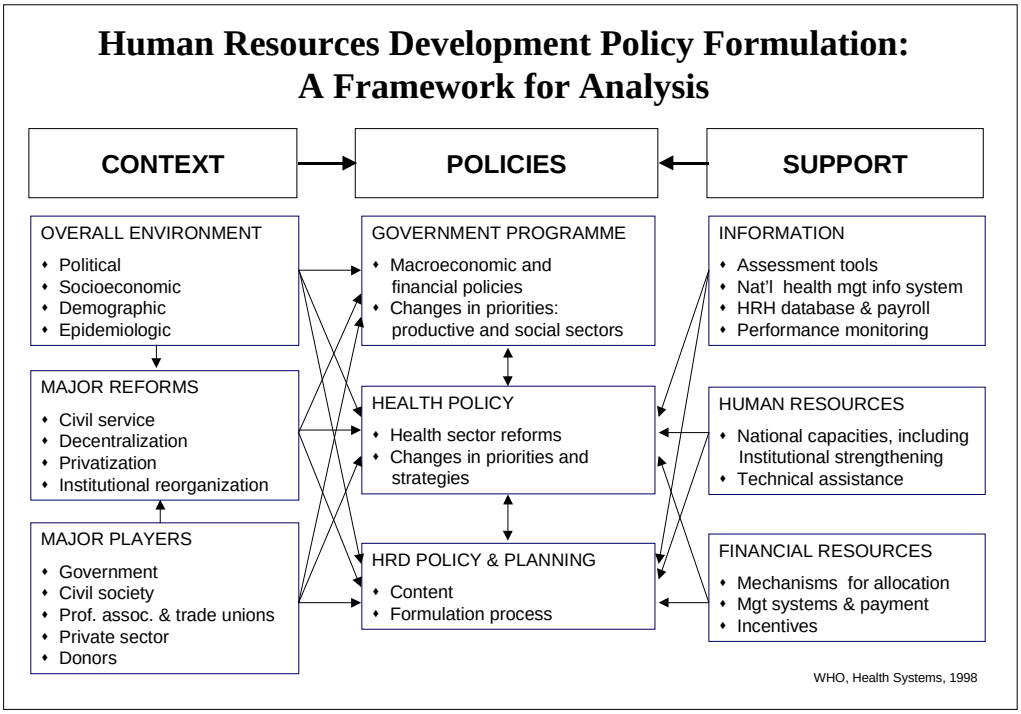
- how can HRH policies and plans be improved to increase their chances of being implemented and reduce workforce imbalances?
- how can WHO assist governments in developing processes which promote policy and plan acceptance, and ensure that they are geared towards implementation?

In order to learn from experience, WHO has started to look into **current processes of policy formulation and planning for HRD**, focusing on the following issues:

- to what extent are policies and plans developed in response to an identified need versus satisfying the regular government planning/budgeting cycle or external demands?
- What are the approaches used and steps taken for policy formulation and planning?
- On what basis are priorities and objectives being set?
- Is resource allocation consistent with priorities?
- What are the mechanisms for decision-making?
- Are foreseeable obstacles to implementation considered?
- How much consultation and negotiation with all actors concerned is taking place?
- What kind of tools are being developed for policy implementation, including monitoring progress?
- Are national capacities sufficient to implement the new policy/plan?

Recognizing that most workforce problems are multidimensional and interconnected[12, 17-19], WHO has developed an analytical framework which tries to address these questions.

The framework (see below) aims at assessing different approaches under differing contexts (economic, social, stage of reform, major players, etc.), as well as some of the key support systems for policy formulation and planning (information, human capacities, and finance). It also strives to analyse the relationship between different levels of policy-making (government, health sector and human resources for health).



The framework has been translated into a questionnaire (see Annex II) which seeks to identify:

- the content of HRH policies and plans in relationship to other policy levels and the overall context in which they are to be implemented, and
- The processes that have been used, as well as the enabling factors and barriers to policy formulation and implementation.

It has been applied to 18 countries from the six WHO regions, of which 15 belong to the Developing Countries (5 Least Developed Countries [LDCs] and 10 others [ODC]) and 3 to Countries in Economic Transition (CET), based on the classification used by the United Nations in the *World Economic and Social Survey 1997* (see table below).

Table 1 Countries involved in the study

	AFRO	**EMRO**	**EURO**	**PAHO**	**SEARO**	**WPRO**
COUNTRIES	Angola (LDC)	Jordan (ODC)	Kazakhstan (CET)	Chile (ODC)	Myanmar (LDC)	Cambodia (LDC)
	Botswana (ODC)	Oman (ODC)	Kyrgyzstan (CET)	Costa Rica (ODC)	Indonesia (ODC)	Fiji (ODC)
	Guinea (LDC)		Lithuania (CET)	Jamaica (ODC)	Sri Lanka (ODC)	Philippines (ODC)
	Guinea-Bissau (LDC)					

AFRO = African Region EMRO = Eastern Mediterranean Region EURO = European Region
PAHO = Region of the Americas SEARO = South-East Asia Region WPRO = Western Pacific Region

Preliminary results

In October 1998 representatives of most of the participating countries met in Sri Lanka to discuss their experiences and the results of the studies. Although the country case studies will need some further analysis, the meeting allowed for the identification of a number of key findings and the drawing of some conclusions, which are presented below:

1. HRD policies and plans: how are they initiated?

Most countries have a formal cycle of policy formulation and planning with a logical sequence of steps. The sectoral priorities are identified within the government programmes indicated, which lead to sectoral and sub-sectoral policies, which are then translated into sectoral and sub-sectoral allocative plans or programmes of work, and finally become operational or activity plans.

The time-frames for these cycles vary from one country to the other, covering a period which ranges from 3-20 years for the government programmes and national policies. However, in some countries such as Angola, HRD policy formulation and planning has preceded the formulation of an overall national health policy. The latter is to give clear directions on the rebuilding and reorganization of the health system, which in turn should determine to a large extent the quantitative and qualitative needs for health personnel. The

HRH policy formulation process in Angola therefore tried to ensure enough flexibility for adjusting its strategies to the forthcoming health policy.

Many policies and plans still seem to be developed more for the sake of having a policy and a plan, rather than for their implementation. A policy formulation exercise is meaningful only if its purpose is clearly spelled out and seen as a real opportunity for change. In other cases, policies are driven by donor agencies who often hire consultants to write up the policies and plans for the government. This is especially true for a number of LDCs which are highly dependent on external aid. This process has not been successful in leading to implementation and change.

2. HRD policies and plans: who is responsible and who is involved?

There is a similarity of composition of the major stake-holders across the countries studied, but there are differences in roles and level of responsibility or influence (see table below).

Ministries of Health are still often working in isolation on HRH policies and plans, and sometimes through a very small group of people based in the central planning unit or the department of HRH. In some countries, formal mechanisms were established for coordinating health policy and planning activities, including HRH. The linkages between overall health and HRH policies were therefore ensured, and in both cases HRD was recognized as being crucial and central to health systems development.

In the case of Cambodia, the planning structures included the four political factions and all major UN agencies. This structure provided a forum for consensus-building and negotiation between the major players before the general elections and national reconciliation.

Table 2 Major institutional actors in the countries studied

Institutional Actors (*)	**Examples from the country studies**
The state	• Ministry of Health • Civil Service • Health professions (private and public) and their representing bodies • Ministry of Finance • Ministry of Education • Ministry of Labour • Ministry of Planning • Judiciary • Parliament/politicians
Employers	• Central government • Semi-public agencies • Third party payers/private companies • NGOs/churches
Producers	• Medical and nursing schools • Public health schools • Technical colleges • Vocational training schemes • Third party payers/private organizations
Regulators	• Statutory bodies (medical, nursing councils, student groups) • Accountability institutions (licencing and accreditation)
Service providers	• Health managers at different levels • Health and support services personnel
Representative bodies	• Professional associations • Unions • Media
Consumers	• Individual service users • Consumer groups
External funders	• Development banks • Multilateral/bilateral aid agencies • NGOs

(*) Classification taken from Martinez, M.; Martineau, M.; Cassels, A., 1996.

In some countries, such as Botswana, Fiji, Guinea-Bissau and Indonesia, Ministry of Health links were established very early in the process with the Ministries of Finance and Planning, Education, and Public Service. These linkages have resulted in strategies for HRD which have been negotiated within the countries' macro-economic framework, including civil service constraints and institutional responsibilities.

The Philippines have established a process based on a philosophy of inclusion as described by Dr D. Batangan, Coordinator, Health Human Resource Policy and Program Development Project, in his country case study where "the preparation of the Draft Plan was accomplished through a series of workshops of the members of the Advisory Council Steering Committee of the Project. The proposed plan was finalized through public hearings,

technical review by HRD experts and national multisectoral consultations." Furthermore, a strategy of promotion, advocacy and networking was proposed. The strategy was intended to create a dynamic working relationship between policy makers, programme planners, the producers and regulators of health personnel, health care providers and consumers or communities. In Angola and Chile, the professional associations and trade unions are involved at all stages of policy formulation and implementation. Decision-making is based on a consensual approach and negotiation.

Many developing countries are highly dependant on external resources to an extent that the contribution of donor participation to the national health budget can exceed 80% for both investment and recurrent costs (e.g. Angola, Cambodia and Guinea-Bissau). Major efforts are being made in these countries to involve donor agencies through formal coordination mechanisms and individual negotiations. Although the international community has fully adhered to the new policies and plans, there are still a number of difficulties in practice, such as agencies not complying with the standardized national training courses and thereby creating additional problems of accreditation, and by-passing the Ministry of Health for negotiating and implementing new projects.

3. HRD policies: what scope and what priorities?

Examples of principal policy areas addressed by 14 of the participating countries are presented in the table below. As can be seen, the scope of policy content areas varies according to countries. In many countries there is a heavy emphasis on education and

INDICATORS OF HRH POLICY DIRECTIONS
(Based on Preliminary Analysis of Case Studies)

Policy directions	Participating Countries													
	Philippines	Cambodia	Lithuania	Kyrgyzstan	Indonesia	Fiji	Guinea	Jordan	Angola	Egypt	Chile	Costa Rica	Jamaica	Guinea-Bissau
Rational Utilization														
Redistribution of health workers	❁			❁	❁		❁				❁			❁
Multi-purpose health workers		❁	❁	❁		❁								❁
Rational Production														
Reform of medical education	❁	❁	❁	❁	❁	❁				❁	❁	❁	❁	
Continuous and in-service training	❁	❁	❁	❁	❁		❁	❁			❁	❁	❁	
Capacity Building														
Evidence base, analytical research								❁	❁					❁
HRH Inventory Development	❁	❁	❁	❁				❁	❁				❁	❁
Accreditation and registration system	❁	❁	❁	❁	❁	❁			❁	❁				
Institutional strengthening							❁				❁	❁	❁	❁
Management Issues														
Performance monitoring			❁	❁		❁	❁	❁	❁		❁	❁	❁	
Rewards and incentives	❁	❁	❁	❁	❁			❁			❁			
Public/private partnering and deregulation	❁				❁		❁	❁	❁				❁	❁

training. More and more countries are developing incentive schemes, for example free accommodation or increased pay for the health personnel working in rural and remote areas. These schemes are linked to specific policy objectives such as improved access and equitable distribution of health services.

The many policy directions discussed in the case studies are outlined using the categorization below:

1. Rational utilization - policies that have as their objective improvement in the use of health care personnel. This will include distribution of health personnel, matching skills to the function, the building of effective teams, etc.;

2. Rational production - policies that are designed to ensure that the health personnel produced are consistent with the needs of the country. This will include educating and training the required numbers and types of health personnel, continuing education, etc.;

3. Capacity building - policies that are aimed at strengthening the ability of the country to deal with its own human resources concerns, including human and institutional capacity building, developing the institutions to collect data and to conduct research and analyses;

4. Management issues - policies that are designed to improve the way in which health care personnel practice, their productivity and motivation, the way in which they are paid and managed and the public/private mix.

4. HRD policies: is there a relationship with the context and overall health policy?

Most countries studied are under considerable economic pressure, including structural adjustments programmes, which result in the reduction of public spending. Some countries suffer also from an unstable policy environment, characterized by political instability or labour-related unrest leading to political agitation.

Major reforms include political and administrative decentralization, public service and civil service reforms (downsizing the public sector workforce, restructuring the financing and remuneration systems), policies designed to increase the role of the private sector in health, all of which have a significant impact on the direction and organization of the health sector. The extent of the changes in each of the above factors will have a direct impact on the expressed need for health care workers, and the capacity of the system to educate, train and effectively employ them.

The relationship (sometimes not direct) between the context and the national health policy, as well as the HRD policy, can be traced. HRD policies and actions are often consistent with the national health policy. The information also shows that different countries have initiated different HR policy responses to meet similar health sector objectives.

5. HRD policies and plans: what information systems and assessment tools?

In countries where, for different reasons, no reliable data was available on HRH, the first step has been to undertake an inventory of the workforce. The inventory of the Ministry of Health in Guinea-Bissau, for example, counted 2310 health workers and detected around 700 “ghosts” when compared with the payroll of the Ministry of Finance. Strong resistance to reporting was encountered in the central hospital and the referral centres in the capital city, which has still not been completely overcome.

Inventories usually require the development of a computerized database, adapted to local needs, and considerable efforts to build the necessary national capacities for using such a tool. Some of these databases are set up by consultancy firms, which are conversant in programming only but not in personnel information requirements, nor the linking up with other information systems (such as the payroll).

In quite a few countries a comprehensive situation analysis was carried out to identify the major HRD issues and prioritize them for action. In many countries, however, policies have been developed in response to government priorities, which are often of a

political nature, without studying carefully their implications or potential to reach the health sector objectives. Indonesia, for example, has engaged in a massive training of midwives in response to a need to reduce maternal mortality. As most of these midwives are very young and inexperienced they are often not well accepted in the rural areas, where the traditional birth attendants are currently supervising most deliveries. The referral systems have also not been well thought out, leaving the midwives without the necessary support system. This has therefore not resulted in the level of reduction of maternal mortality that was expected.

6. HRD policies and plans: are monitoring and evaluation systems part of it?

Quite a few countries do have HRH policies, as part of an overall national health policy. These policies consist usually of a general statement of intentions which do not clearly point to a set of actions and targets. In these cases, there is no in-built monitoring and evaluation system with performance indicators. Such indicators can indeed be developed only if the process of policy implementation, and its outputs and outcomes, have been well defined.

In a number of other countries, the HRH policies have been translated into a work plan with clearly defined objectives, strategies and expected results, with a time-frame and resources attached to them.

In some countries, especially those which are subject to political instability or rapid changes, the work programme has been further broken down to a short-term and medium-term strategy which allows for closer monitoring and more rapid adjustment to the changing realities.

In terms of review mechanisms currently used in the various countries, these include the following: periodic reviews (annual, biannual, quarterly, monthly); action research; formal evaluation; public hearings/fora; round table discussions by key stakeholders. The structures for these review mechanisms include policy level task forces, internal coordinating meetings and inter-ministerial (intersectoral) coordination meetings. However, despite the existence of these mechanisms, there is often no process for readjustment of the policy or the implementation plan.

7. HRD policies and plans: how are they financed?

Allocative planning, which involves a system for making decisions about how the health sector will use its resources in relation to policy priorities, did take place in some of the countries studied. In the Philippines, for example, health systems decentralization with the transfer of responsibility to local government for recruitment and payment of health personnel was initiated without securing the necessary resources. Consequently, many health workers have not been paid for several months and are leaving the public sector to work in the private sector.

8. National capacities and institutional strengthening

In many LDCs there is a rapid turnover of cadres, due essentially to poor working and living conditions. As HRD issues are both complex and difficult to address it requires a very committed and strong leadership, which often does not exist or is changing rapidly. To build up the necessary capacities is a lengthy process which not only requires sustained and long-term technical assistance, but also the setting up of an enabling and rewarding work environment.

Another major issue in many LDCs is the often very low level of education, which requires long training periods to reach the necessary quality standards. Many donor agencies programme their support for much shorter periods.

Conclusions and recommendations

The Consultation with the countries participating in this study concluded that, to improve the likelihood of HRD policies being implemented, countries should give **greater attention to processes of policy formulation**. This calls for a better understanding of the broader contextual factors that have an impact on health policies and on the related HRD policies. Many health sector reform initiatives have failed to adequately consider their impact on the health workforce or the fundamental impacts that the health workforce can have on the course of the health sector initiatives. The conclusions of this study are presented in six areas, as follows.

1. HRD Policy Analysis Framework

The framework allows those involved in the formulation of HRD polices to consider the broader contexts in which the policies are being developed and must be implemented. It suggests that the relationships between health policies within and outside of the health sector require attention and analysis. As a tool, a systematic use of the framework may also encourage the bringing together of actors to think through the processes and to get a better appreciation of how the policies affect them.

2. The scope of HRD approaches

Each country's health care system and human resources situation is specific. In addition, most workforce problems are by nature multidimensional and interconnected. The country case studies clearly identify the need to examine the contextual factors if we are to understand why different options are taken. These factors, therefore, require an assessment which takes the complexity and interlinkages of issues into account while relating to the specific context of each country. Such an assessment, and subsequently the development of appropriate strategies, can only be achieved with a multidisciplinary team. Judgements about the outcomes of different approaches will require in-depth research which examines economic, social, cultural and political factors, current major reforms and the interests of the key players.

While human resources development issues are multiple, they are often still addressed solely or primarily by education and training. Issues such as working conditions, lack of drugs and equipment, lack of transport, threats to safety, etc. are often ignored. In addition, education and training is very complex in its own right. One single strategy is not likely to have a long-lasting effect. A long-term change process requires:

- a minimum set of strategies,
- which have been carefully chosen amongst other options,
- which are valid and effective, and
- which are likely to reinforce each other.

3. Actors/stakeholders

The importance of involving the key actors in the HRD policy formulation and implementation process was identified as a critical element in the success of a policy. Processes and structures for building consensus and ownership are critical to the success of the implementation of a policy.

The following guiding principles, based on the different country experiences, are proposed:

- A check list of actors in the HRD arena within the country as a useful guide in the identification of those who must be brought on board with respect to a particular policy.
- All the actors who should be involved may not be apparent to policy makers until the implementation stage. It is important, therefore, to continue to identify actors throughout all stages of the policy development process.
- Actors may not be as homogenous as they appear and, therefore, should be carefully screened (e.g. gender, age, religion, public, private etc.)
- Actors may have different interests at different stages of the policy formulation process, interests should, therefore, be repeatedly confirmed.

4. Stakeholder interaction

It is important to develop culturally appropriate methods to bring various actors into the HRD policy process, to exchange views, share ideas and aspirations and to work collectively to achieve the health policy goals and objectives.

Even if Ministries of Health recognise that many HRD issues are intersectoral, they tend not to have regular working links with other ministries and partners. With most countries being faced with economic constraints to health care financing and many having engaged in decentralization of their health system, the need for consultation and negotiation with other sectors, in particular the ministries of the economic area and of the civil service, and all levels of the system, has become increasingly evident.

For countries which are highly dependant on external resources, it is important to engage in a regular dialogue with the funding agencies to agree on HRD priorities and strategies. It is essential that the inputs of external donors be coordinated and consistent with national policies.

Consultation and negotiation require skills and time, which are not always available to Ministries of Health, either because the necessary capacities and resources are lacking or the political agenda of the government does not allow for it. In any case, the chances for successfully implementing an HRD policy will depend to a great extent on how much effort has been put into genuinely involving all the actors concerned, including donor agencies, and negotiating both priorities and strategies with them.

5. Implementation and monitoring

There is also a need for developing an HRD monitoring system which is not only aimed at measuring progress towards achieving policy objectives, but also at detecting changes in HRD determinants.

Due to the dynamic nature of the health sector there is a need to monitor the impact of the HRD policies on the objectives defined during the policy-making process. This process itself will have an impact on the behaviour of the various actors. Monitoring these and other changes will assist policy analysts to document and present likely scenarios to policy-makers and managers so that policy levers (regulations, legislation, taxes, subsidies, certification, licences, etc.) can be introduced or adjusted. This is particularly important in view of the fact that:

- it takes a long time for HRD policies to become effective, as the production and optimal use of human resources are often associated with a lengthy process of training and development;
- HRD is costly both in terms of production and recurrent costs;
- HRD bears a high opportunity cost: human cost as well as measurable economic costs;
- most countries are faced with increasingly rapid changes which are closely linked to changes in their region and worldwide.

These are all reasons which point to the necessity for a regular HRD policy and strategy review as part of an evolving and dynamic overall change process. The following guiding principles have emerged from the country case studies:

- in the monitoring of policies there is a need to keep the 'big picture' in mind while looking closely at the specific issues.
- translating policies into detailed plans with specific intermediate outputs and indicators in addition to sharing the details with relevant actors facilitates the monitoring process.
- policy assumptions need to be made explicit and it is important to monitor them with regard to their continued relevance.
- the plan for monitoring should be developed during the policy formulation stage.
- a clear distinction should be made between monitoring and evaluation.

6. National capacities and institutional strengthening

If the policy directions and strategies for implementation do not properly reflect the views of all those concerned, it will be very difficult to stick to priorities and fulfil objectives which are imposed rather than owned. The sustainability of policies and plans which do not result from a process of national capacity building is questionable. However, such a process takes much time and effort.

Summary

Improved policy formulation processes and planning for HRD can make a difference. The challenge is for countries to devote the required resources to understanding and strengthening these processes.

Annex I Human resources for health development: changing concerns in relation to WHO's work by 10 year period

Year	Education & Training	HRD Components Management	Policy & Planning
1950-1960	• Increased numbers of doctors and nurses • Reaching academic excellence and standards of highly developed countries • Cross-national equivalence (credentials)	• Equitable geographical distribution (conventional health personnel)	• Increased quantity • Improved quality • Cross-national equivalence
1960-1970	• Increased numbers of doctors and nurses • Increased relevance (curricula adaptation to local needs & development of social & preventive medicine)	• Equitable geographical distribution (auxiliary personnel)	• A reliance on norms and standards • Emphasis on physicians and specialization
1970-1980	• Improved methodologies (planning by objectives) • Management training	• Improved efficiency (team building; use of auxiliaries)	• Integration of health systems and manpower development
1980-1990	• New cadres of providers in developed countries • Networks of community oriented schools • Problem based learning	• Cost-effectiveness (new categories of health providers) • Incentive schemes	• Growth in modelling techniques • Development of master plans
1990-2000	• Education institutions as an active partner in health policy development and implementation • Greater congruence between population and individual health	• Monitoring of performance • Improved working conditions • Performance pay systems • Management of change	• Appropriate legislation and regulation for the private sector • Modelling enhanced by computer technology • Strategic and contextual policy formulation • Better skill mix in relation to service needs • Improved symmetry between individual and public health services

Annex II Overall policy formulation processes and implementation methods with a special focus on human resources for health

Country assessments: learning from experience

Scope of work

For the country assessments, a case study and questionnaire approach, building on the work of HQ and the regions, will be used. The focus of the individual assessments will vary according to the particular situation of each country.

In addition to providing country-specific information on the overall context and the health sector, the assessments will contribute to defining directions of change, identifying points along the way that constitute progress towards comprehensive approaches for human resource development, and highlight issues arising in the course of moving towards this approach. In other words, these assessments will focus more on process than final products.

The dimensions of human resource development policies are shown below together with a list of questions which will have to be adapted to the individual circumstances of each country. Emphasis will be placed on elaboration, especially with regard to section 2.

1. Context, Stakeholders, Negotiation

In this section only information which clearly relates to health and human resource policy development is to be provided, both in a descriptive and analytical way. The links and interaction with health and human resource policy development have to be made explicit. It might therefore be useful to give some very concrete examples to better illustrate these different points.

- What key factors influence the direction of the health sector: changes in the political system (democratization, popular participation, elections), macro-economic trends (structural adjustment, growth patterns), political and administrative decentralization, public sector and civil reforms (downsizing the government work force, restructuring, performance orientation)?
- What other factors (demographic trends and/or epidemiologic changes) influence the direction of the health sector in relation to service delivery?
- What has been the relationship between the Ministry of Health and relevant central agencies and financing institutions, in particular the Ministries of Finance, Planning, Education, Public Service, and Local Government?
- How do professional associations (medical/nursing associations, trade unions for health workers) influence policy directions?
- What has been the behaviour of different international and bilateral agencies in supporting the identification of overall national priorities for health development, including human resources, the design and implementation of reforms, and institutional capacity building?
- What are the key issues around which extensive bargaining has taken place?

2. Health and Human Resource Policy Development, Planning and Resource Allocation

- When does the last health policy and plan date from?
- When does the last policy and strategy for human resource development date from?

- If the current health and human resource policies are not the first ones:
  - ⇒ Why was it necessary to review or formulate a new policy on human resource development?
  - ⇒ Have there been recent significant changes in the approach to health and human resource policy development, planning and resource allocation, considering both processes?
- What has been the process for formulating the current human resource development policy plan?
- Are there any explicit or implicit links between the policy for human resource development and the overall national health policy both in terms of contents and processes?
- What are the top priorities for human resource development and how have these been determined and negotiated?
- Do these priorities include a policy/strategy for education and training? If yes, could you specify its content?
- Have there been significant shifts in human resource priorities and are these shifts reflected in the policy documents, as well as in the budgetary/ expenditure programme (as submitted, approved and disbursed by the Treasury or donors)? What are the areas of recent or ongoing major changes of policy content?
- Who has been involved and at what stages in priority setting and strategic planning for HRH?
- What difficulties did you encounter in priority setting and strategic planning for HRH?
- What is the role of donors and technical assistance in priority setting and strategic planning for HRH? To what extent are recent developments donor-driven? To what extent are recent developments due to strengthening of your own institutional capacity?
- What have been the major supportive or impeding factors in priority setting and implementation of your HRH strategies?
- What approaches and/or tools have been used in support of policy development?
- Is there a plan to build human resources capacity to support the implementation of the policy?

3. Institutional Reforms, Organizational Structures, Regulation

In this section only information which clearly relates to human resource policy and strategy development is to be provided. The implications of institutional reforms for human resource development are to be clearly explained and analysed. It might therefore be useful to give some very concrete examples to illustrate these different points.

- Is there a good fit between existing organizational structures and agreed human resource development policies and strategies?
- Have there been any major institutional reforms in recent years in relation to human resources for health (review of central ministry role and structures, including the HRH Department)? What is the relationship of the central ministry with decentralized levels of institutions (e.g. district health boards, training/ education institutions for health)?
- How significant is the private sector in health, and have there been changes in the public policy toward private sector financing and provision? What is the share

between public and private health expenditures? Please describe the relationships between the public and private sector. Are the relations formal or informal?

- What recent developments have taken place with regard to legislation, regulatory mechanisms and incentives to ensure implementation of policies and priorities in the public and private sector in relation to health personnel?
- How have recent institutional reforms affected the effectiveness of health service delivery at all levels of the health system? Please specify in which way effectiveness has been affected.

4. Financial flows

- To what extent does the actual flow of funds (from both domestic and international sources) support the implementation of priorities for human resource development, as set out in policies, plans and budgets?
- Have there been any recent reforms in the financial management system and payment procedures for health personnel?
- Do externally funded projects have separate banking and accounting systems and/or separate management structures?
- How have recent changes in financial flows affected the effectiveness of health service delivery?
- Are there conditional grants/earmarked funds (from donors, local governments) for human resource development activities, including education and training? How are decisions made regarding earmarking?

5. Performance Monitoring

- How is progress in HRH policy development and implementation monitored in general (all priority areas mentioned in the policy and/or human resource development strategy)?
- What are the current approaches/recent developments regarding the definition and monitoring of health personnel performance?
- Are existing information systems capable of providing key performance indicators for health personnel at different levels of the system? Are any changes envisaged in the information systems?
- What is the role of donors and technical assistance in monitoring and evaluating performance? To what extent are recent developments donor-driven?

6. Technical Assistance and Expertise

- What is the percentage of technical assistance of the total health budget (including external aid)?
- How does the health sector currently access expertise from other relevant countries and situations? What support is provided for reviewing policy options?
- How, by whom and on what basis are needs for technical assistance defined, terms of reference agreed, and technical assistance chosen and assessed?
- Is there any coordination between the suppliers of technical assistance and expertise to avoid duplication and confusion? Is it needed?

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