

Human Resources : The Political and Policy Context

Gillian Biscoe, B.H.A., M.Sc.

The Bellettes Bay Company Pty Ltd, Australia

Abstract

At the request of WHO, this paper incorporates eight issues: donor agencies and their contribution in shaping the HR agenda; national & international agency facilitation of identifying good HR practice and facilitating networks to disseminate it; national & international successes and failures in implementing change in HR policy and practice in health sectors over last 5 to 10 years; the appropriate role for effective national level involvement in HR in a decentralised system; identification of recent trends in introduction and implementation of 'new' ideas and theories in HR; what role should be played by international agencies and national governments in appraising the relevance & applicability of new approaches to HR in the health sector; what can be done to facilitate better integration of HR policies into national level health systems planning; and what currently are the major constraints on achieving appropriate recognition of the importance of HR at this level?

The influence of the global context is briefly analysed, preceded by clarification of assumptions, based on the literature and the author's experience.

The conclusion drawn is that health leaders, managers and others do not well enough understand the strategic importance of HR to strengthening health system capacity. It seems to be still perceived by some as being at the "soft and fluffy" end of the spectrum in health (other than perhaps some formal and continuing education programmes), instead of something that is as essential to a strong health system as sound health financing, and which requires a similarly rigorous approach. There is little evidence that enough key players understand the key role of strategic HR approaches in achieving sustainable organizational change. While there are case histories of innovation and system change experiences using HR strategies, there is little *evidence* in the literature.

Key Word: human resources, donor agencies, national & international agencies, HR policy.

Assumptions

The first assumption is that within countries' health systems there are competing and conflicting goals. Three of these are society's desire for equitable distribution of health care irrespective of socioeconomic status; clinical freedom of providers to organise health care as they see fit, and economic freedom to charge prices they deem appropriate or to be paid a salary reflecting their own perceived value; and economic and budgetary controls, with health benefits at the margins justified by costs, and households, insurance agencies and governments being able to budget for the coming year and beyond⁽¹⁾.

The second assumption is that there is knowledge, values and attitude dysemmetry between different categories of health providers, between providers and consumers, and between providers and governments,^(2,3) which skew equality and rationality of communication and information exchange and subsequent policy development, including HR policies. This dysemmetry creates a market which is unlike other markets, with public sector production failure,⁽⁴⁾ and health systems consequently sometimes responding a-

typically to some human resource and other strategies that are effective in non-health markets.

The third assumption is that the goals of a country's health system are, or should be, good health, responsiveness to people's expectations, and fairness of contribution to financing the health system. And that to achieve these goals, a country needs to have effective service provision, resource generation, financing and stewardship ⁽⁵⁾.

The fourth assumption is that HR is more than simply education and training, pay, working conditions, and performance and career development. HR is multi-dimensional, involving interdependency between an individual and the organizational culture, policies and structures, and enabling strategic capacity for linkages between a myriad of issues such as information, ethics, awareness, motivation and behavior ⁽⁶⁾. HR also addresses the reality that basic knowledge is becoming obsolete at an unprecedented rate, requiring ongoing learning, updating and adaptation as new working styles and labor markets develop ⁽⁷⁾. Implicit in this fourth assumption is the author's experience that HR complexity is ill-understood with HR strategies often weak as a result and that, while health sector reform is 'sweeping the developing world, its wider implications for human resources have been largely ignored' ⁽⁸⁾.

The fifth and final assumption is that the competing and conflicting goals, dissymmetry, and sociohistorical values which underpin each country's health system, create health systems that are inherently resistant to *system* change. HR strategies are a key vehicle to achieve system change, with maximum effect when strategically linked to appropriate management, policy and financing strategies.

Global Context

The usual dot points of global trends need to be presented. However, this is done with some caution. The danger always is that because a label or concept is familiar, there is an assumption that there is shared understanding of the real issues and potential implications. If environmental scanning and analysis is not repeated regularly within organizations, is it safe to use concepts and labels learned five or eight or ten years ago and assume a shared understanding? There is a need to apply ongoing intellectual rigor to understand new or potential implications, when times continue to change apace.

Thus, with caution, some key global trends are presented below. The question is, for all of us, what do they actually mean in terms of their potential impact and influence, over time? And importantly, if these are global trends, implying that 'sooner or later' they will happen in most countries, then what are the most effective strategies to adapt and manage these trends successfully within individual countries and organizations? Some key global trends are:

- Economic globalization and integration.
- Technology and its impact.
- Structural adjustment and privatization.
- Ensuring sustainable development.
- Emerging new work systems.
- The shift from personnel administration to strategically focused HR efforts.
- Changes in leadership style from bureaucracy to entrepreneurship ⁽⁹⁾.
- Changes in organizational culture from risk averse bureaucracies to innovative and effective organizations.

Added to these are the increasing global challenges of keeping abreast with new health knowledge and its implications, from the explosion of knowledge in the genetic field to communicable and non-communicable diseases. While sophisticated technological advances continue, we are faced with the paradox of growing resistance of infectious diseases to antibiotics and the potential for uncontrollable epidemics. For this and other global health challenges, globalization provides a platform for solutions, given the magnitude of many of the challenges is greater than the capacity of one nation to successfully address.

Globalization is defined, for the purpose of this paper, as “the process whereby nations increase their interrelatedness and interdependency through the spread of democracy, the dominance of market forces, the integration of economies in a world-wide market, the transformation of production systems and labor forces, the spread of technological change and...the media revolution”⁽¹⁰⁾.

In this new world of global competitiveness, the ideal scenario is a dynamic equilibrium between wealth creation and social cohesiveness, with governments balancing the need for local, social, value-added policies (e.g. health policies) against the need for developing a comparative advantage for their country to actively participate in the global integration of the value chain. While local, social, value-added policies are seen by some to be relatively market and cost-inefficient they are essential for social development. There seems little point in a country being transiently wealthy while civil society crumbles around the pot of gold.

The policy issues that governments, and thus society, grapple with are how to finance these social policies, whether privatization and ‘free’ market forces will reduce the cost burden, and how to manage the social cost of increased efficiency (e.g. unemployment). Even where governments have sound social policies, globalization is resulting increasingly in the internationalization of previous domestic markets such as supermarkets and hospital chains, with some authors saying that this diminishes the direct power and control of government in the domestic market⁽⁹⁾.

We see some countries with health workforce policies focused on both the global and domestic markets, e.g. the Philippines’ overproduction of doctors and nurses, stimulating their ‘export’. Overseas-earned income is thus provided to the Philippines because of strong family ties and money being sent home. In other countries, there are barriers protecting domestic markets, e.g. in Australia registration for Australian-resident foreign trained doctors has traditionally been achieved with some difficulty, while there are now some changes in progress.

The migration overseas of 50% of new medical graduates from Thailand in 1965 resulted in the government implementing a three-year compulsory contract for public sector services for all new medical graduates. In 1997, as privatized, competitive health services reached their peak in Thailand, giving choice of employer to medical graduates, 22% of new medical graduates resigned from the public sector to join the private sector, even though the financial penalty for breaking their three-year contract was \$US10,000 to US\$15,000 in fines. The reasons for resignation included mismanagement of human resources⁽¹¹⁾.

In other countries, e.g. Fiji, increased outward migration of the health workforce has resulted from internal political changes. In South Africa, an acute shortage of registered

nurses is being exacerbated by a similar shortage in the United Kingdom, with the latter heavily recruiting from the former.

Health System Reform and Development (HSRD)

Health systems are thus neither immune nor divorced from the impact of the new global order. Attempts are being made in most countries of the world to adapt or transform health finance and service delivery structures accordingly. While health professionals may see merit in learning about new health technology, HR is more often seen as something that other people do elsewhere in the health system, and that is related to health workers only for “personnel administration functions” (e.g. pay), or formal and continuing education.

HR as a complex suite of strategies with the potential to strengthen a health system, including organizational and individual performance and job satisfaction, is not commonly understood ⁽¹²⁾.

There have been many lessons learned over the last decade in HSRD. Paradoxically there is little information in the literature on how HR policies and strategies relate to government and health sector reforms ⁽¹³⁾. Perhaps the one thing that is clear is that, as with computer systems, a turn-key solution, that is, one country’s human resource development approaches unilaterally applied to another country, is not the answer, both because of sociopolitical, economic and cultural differences and because of differing national internal capacity and capability. However, best practice principles can be applied with specific strategies adapted.

While precise definitions of HRDS are not internationally agreed, for the purposes of this paper a definition is proposed, given that simplistic human resource development strategies (HRDS) need to be avoided in the complex area of health systems.

HRDS can incorporate both health management reforms and health market reforms and it is useful to distinguish the differences (although some countries, e.g. New Zealand and the UK, undertook both concurrently in the late 1980’s), given that appropriate HRDS strategies differ markedly between them.

Health management reforms generally include structural changes (e.g. decentralization), health financing reforms (e.g. health insurance), policy process improvements, and strengthened management accountability through financial and HR delegations (e.g. to hospitals from the health ministry or central government agencies). HR is a key component for successful health management reforms.

Health market reforms, on the other hand, are aimed at creating market forces in the health system, through internal markets of limited or more open competition. Thailand is currently pulling back from a perceived over-competitive health system and developing instead health management reform approaches, as is New Zealand, while the specifics in each country differ. Nepal, on the other hand, is encouraging the further development of largely unrestricted internal markets as it pursues health market reforms.

The usual global pattern over the last 15 years has been health management reforms followed by health market reforms. In those countries where the latter precedes the former, e.g. Nepal, the proliferation of the private sector in the absence of the elements of health management reforms, creates inequities, quality and cost dilemmas, and policy, HR and management dilemmas, because of inadequate capacity and capability.

The starting point for HRDS in most developing countries, at macro-policy level and institutional policy level, is a diversity of non-harmonized policies, policy gaps and

capacity and capability challenges. Developing countries have the additional burden of embracing medical and other technological advances in a restricted economic environment. In developed countries, the very policies that led to success, e.g. Japan, may turn into liabilities as priorities change and institutional inertia prevents people adapting to the new requirements (e.g. Japan's care of the elderly and pursuit of higher quality).

To respond to the impact of global trends, HRDS need to be comprehensive and address priority setting, public/private mix, organizational design, research, values, information systems, productivity, performance and incentives. For HRDS to be achieved and sustained, a cross-cutting approach to modern and integrated HR strategies are essential. HRDS need to address values and attitudes, as well as skills, competencies and organizational culture, to support changes in health policy and the health system.

Stewardship

As countries face the challenges of structural adjustment and transition to market economies, countries and regions are competing with each other to expand or maintain economic capacity. The International Labor Organization (ILO), recognizing that the efficiency of the public service is a key variable to success and that the image of public service personnel has been on the decline for many years, included human resource development in its 1998-99 programme of sectoral meetings.

The ILO's deliberations were based on the reality that there has been weak analysis of how the various factors contributing to successful HRDS are linked and interact. "Public service personnel" is defined by the ILO as those employed in ministries and other public administration agencies and also those working in services in the public or general interest, including health services. The ILO concluded "without qualified, committed and motivated staff, the State cannot play the role assigned to it in a rapidly changing and globalize economy"⁽⁶⁾.

In 1996 the OECD concluded, on the basis of country surveys, that more effective management of people would lead to more efficient and effective public service administration⁽¹⁴⁾. In 1997 the World Bank stated the issue succinctly: "...whether making policy, delivering services or administering contracts, capable and motivated staff are the lifeblood of an effective state"⁽¹⁵⁾. This is not always recognized in health systems in developed or developing countries. Even where it is, where overall stewardship is weak, the political and public service climate may not be conducive to its achievement.

HR responsibility within health systems is traditionally placed within a corporate services structure. While there has been for at least the last 15 years, a clear understanding at international level of the difference between the old 'personnel administration' approach and the 'new' strategic HR approach, ministries in both developed and developing countries, have been slow to adapt.

In the author's experience, HR or personnel staff frequently do not clearly understand the health ministries' core business, the complexity of its delivery, the complexities of the various sub-cultures within health, nor modern generic HRDS. Where this is the case, they are not in a strong position to develop, argue for, and implement the sort of strategic HR approaches needed to facilitate systemic strengthening of stewardship, service provision, financing and resource generation, ultimately leading to a health system satisfactory to the community and to those who work in it.

Equally, senior health managers often see HR and professionals as something separate from the mainstream activities of health. When HR practitioners are perceived as ‘personnel administrators’, strategic consultation between senior health managers and professionals with the HR practitioner is not usually part of that health systems’ culture.

However, when senior managers and health professionals have HR training integrated with best practice leadership and management development training, and are given management accountability, then some remarkable change can happen in HR approaches that support wider government and health system change. An example is during New Zealand’s first wave of socioeconomic reforms from 1989 where there was considerable government investment in experiential, multidisciplinary leadership and management development, the impact of which is still being seen ⁽¹⁶⁾.

Donors

A criticism of the donor community in some countries is that it is proliferate, uncoordinated, and follows its own agenda rather than focusing on a country’s needs. On the other side of the coin, some developing countries have no national agenda of priorities to guide donor activity, and weak donor coordinating mechanisms ⁽¹⁴⁾. This is compounded by “...too many governments know(ing) far too little about what is happening in the provision of services to their people” ⁽⁵⁾.

Donor agencies could be a significant force for systemic change. The majority of project designs do not, however, incorporate best practice HR principles and strategies. The more usual donor focus is on specific health issues, addressed often within a short time-frame (e.g. three years) with training programs tailored accordingly. While training is one aspect of HR, unless a long-term, sustained, technical assistance approach is taken with integrated, cross-cutting HR strategies, the health *system* impact of training is not high.

The problem is further compounded by there being little global agreement on what constitutes best practice HR. Some countries have developed comprehensive national HR plans (e.g. Bangladesh). Bangladesh and other countries (e.g. Tanzania, Kenya, Oman) are embracing activity standards for various staff categories, while to date no study has been conducted in any country to demonstrate the usefulness of activity standards for HR management and planning ⁽¹⁷⁾.

The relative vacuum in best practice HR strategies in donor project designs may be for several reasons.

First, for those expert in HRDS, it is a clear, obvious and essential, while complex, approach if health systems are to function anywhere near their potential. However, it appears that while insufficient people understand this, HRDS will continue to be absent from requests to donor’s for funding, and government and donor interest in, and funding for, HR will remain problematic.

Second, addressing a discrete health issue is more tangible, more easily understood than a cross-cutting HR approach, and therefore is usually more attractive to donors. Third, the political context of governments facilitates their responding to donors wishing to fund high profile health issues rather than seeking funding for the more diffuse, seemingly more abstract, and certainly longer-term, HR and system change approach.

A case history of one developing country has elements similar to many other poorer developing countries. It highlights the complexity of determining both the appropriate

starting point for HR that will facilitate sustainable HSRD and the complexity of determining the relative responsibility of donors and governments.

In this country, there are more than 250 NGOs supporting health projects. Their activities are not currently strategically coordinated. There is little private or NGO focus on the most poor areas. It is in these same areas that publicly provided services are most weak. The quality of NGO services varies and they, and the private sector, are largely unregulated.

In this country in 2000, the aim for the health system is decentralization but, despite, legislative changes, actual decentralization is minimal. While, structurally, fairly even access to health services across (country) appears assured, the reality differs. There is weak capacity for strategic planning, policy development, leadership and management, finance and other resource disbursement, analysis and decision-making at all levels. The geographical location of health facilities is not always ideal to meet population health needs. Staff availability is inconsistent and absenteeism is high.

Centralized management continues. Personnel administration, including staff deployment and transfer, is centralized. Family, economic, social and security disadvantages of working in rural and remote areas make staffing problematic. Problems in drug and other supplies, transport and financial disbursements, together with low or absent staff, compromise services including outreach services.

There are over 40 health worker cadres in (country); the majority of them have limited training.

There is a shortage of absolute numbers of nurses. There is an over-supply of doctors with increasing production of both doctors and nurses in the pipeline through private medical colleges. There are perceptions that standards of new medical, nursing and other health worker graduates are uneven. There is no overall health workforce planning to facilitate the balance between supply and demand.

There is geographical maldistribution of all health workers in favor of urban areas. Staffing levels are further compromised by poor motivation and widespread absenteeism because of poor wages in the public sector, higher wages and incentives in the private and NGO sectors, and staff not taking up positions when transferred to rural and remote areas with which they are not familiar.

Most health workers supplement their incomes in the private sector. For nurses, this often means dual employment. For doctors, it often means public sector employment and private practice, even where some private

providers provide financial incentives for them not to concurrently run a private practice.

Donors emphasize training. This translates into a myriad of discrete and non-integrated training courses, usually directed at the less-educated health cadres who frequently must leave their health center unattended and travel long distances, including on foot, to attend them.

The higher wages paid by NGOs and the proliferating private hospital sector attract the talented and able away from the public health system.

Finances are a major constraint in improving health services. Because of the weak administrative and management capacity, strategies to strengthen aspects of the health system follow an ad hoc pattern.

Staff reluctance to serve in remote areas far from home and families, where there are no financial incentives to do so, usually no accommodation (provided for doctors but not for other health workers), and security fears, means that health facilities may have no staff or ad hoc staffing patterns, constraining access. Illiteracy and poverty in a user-pays system further constrains access. Travel distance and the terrain, and perhaps no staff, no drugs and no other supplies when one arrives, complete the access constraints.

For staff, their low wages have recently been increased to a minimum living wage. This has yet to be paid. Despite the low wages, there are more applicants to study medicine and nursing than there are student positions. It is very attractive to staff to attend donor-supplied training courses, and to be paid for them, whether or not they are a priority or perceived to be relevant to their day-to-day work.

Absorptive capacity is low. 1999 data indicates that around two-thirds of external development resources allocated was released and about 60% utilized, and about 20-40% of the Ministry of Health (MOH) development budget has not been utilized. The MOH budget is heavily reliant upon donor funding including for recurrent costs, with no strategies apparent to reverse this situation ⁽¹⁸⁾.

Stewardship and donors

Leadership has been described as the ability to remove barriers, enabling people and organizations to maximize their effectiveness to achieve a common goal ⁽¹⁹⁾. Where it is clear that stewardship needs strengthening, either at the political or public service level, or both, then stronger leadership should be exercised by the international donor community to develop strategic alliances needed to support strengthened overall government stewardship, as well as that of health ministries.

Donor activity would achieve much greater return on investment if it was conducted within a clear strategic framework set by government, where priorities were determined,

including HR priorities and principles, and where there was active management and coordination within government of donor efforts.

However, where stewardship is generally weak, the myriad of training programs for specific health issues will not achieve sustainable results in the absence of higher-level HR activity. Higher-level HR activity needs to focus on national policies that address priority public service system weaknesses, as well as health system needs. Lessons learned lead to the conclusion that HR strategies should vigorously focus on strengthening national health ministries as a precursor to, or concurrently with, HR focused on strengthening health service delivery ⁽¹⁹⁾. In many environments, ministries of health have little flexibility to respond to and embrace new HR approaches. This creates a bureaucratic environment of ‘administering the rules’ when ‘managing innovation’ is needed for health systems to be successful ⁽²⁰⁾.

The bureaucratic demarcations that characterize national public service structures are repeated at the international level. Thus international donor health organizations, focus on health and health systems, when the starting point for HR development and health system change in a country may need to be the lead government agency responsible for civil service reforms (often called something like the public service commission). This leads to the conclusion, that strengthened strategic alliances and partnerships are needed between ‘health’ and ‘non-health’ international agencies and donors, to conduct joint situational analyses with countries, developing a coherent strategic approach to public sector reform. *Within* this framework, HSRD in health can be facilitated.

Cambodia provides an illustrative case history. HSRD is proceeding apace. Progress has been considerably assisted by the strengthened capacity and capability of the MOH through HR strategies, implemented with WHO support. However, progress with HSRD is now being constrained because overall public sector reform is lagging behind HSRD achievements ⁽²¹⁾.

In a climate of tightening health budgets, it can be difficult to persuade governments to spend money on health system strengthening, such as through HR strategies, when there are high profile health challenges to which to respond e.g. malaria, TB, maternal and infant mortality. In the same way as technical experts in health often have little understanding of HR and its importance, this is true too with politicians. International health agencies need to find better strategies to strengthen political understanding of the potential return on investment, social and economic, of sound HR strategies.

HR challenges

HR in other sectors

The health system is not renowned for actively engaging with other industries to share stories and lessons learned for mutual benefit. And the reverse is true. While there are some changes at international level, cross-sector collaboration at national level is not the norm. While the health ‘market’ may be atypical to other markets, there are many best practice HR practices and principles that are generalizable. Some of these are present in some health systems. However, as most health systems tend to work in isolation from others sectors, and they from health, it is not surprising to note their relative absence.

Lessons learned from other, non-health sectors include the central premise that developing the workforce has a positive economic impact by improving the economic

condition of the individual, as well as his/her family and community. Other lessons learned include:

- Understanding that transparency and accountability play a key role in building public trust, equity, access and the social partnerships required among stakeholders for HR development (e.g. the Miami-Dade Community College in the USA);
- The importance of experiential learning in contrast to the Taylorist-like principle of knowledge and training being presented in discrete bits to be assembled together at a later date (e.g. New Zealand's former Health Services Management Development Unit);
- Developing systems thinking in ways that allow stakeholders to learn from one another and connecting systems and strategies at points that promise highest leverage for mutual benefit (e.g. Australia and New Zealand's Learning Sets);
- Understanding the basic concept of customer-oriented learning and helping people to learn skills they want to learn because they can see the potential benefits (e.g. micro-financing for poor women in Ahmedabad, India; the military retraining program in the Ukraine);
- Ensuring HR strategies are demand-driven, tied into local, regional, national and/or international needs and being able to minimize gaps between the demand and supply of skills;
- Ensuring transparent criteria for access to education and other HR strategies; seeking out groups who have not previously participated (e.g. more women in medicine; more men in nursing; those disabled being recruited into health, etc.);
- Basing HR strategies on improving competencies rather than on length of training;
- Creating multiple entry points for education programmes instead of the usual one-entry-point found in most health professional training;
- Ensuring portability of skills: local, regional or international geographic portability and portability across occupations (e.g. Schlüsselqualifikationen in Germany);
- Developing generic skills for portability across occupations include learning how to learn, plan, effectively communicate in a variety of media, budget, problem solve and generate alternatives with traits such as leadership, flexibility, curiosity and 'coachability' being even more portable (e.g. from clinical medicine to health ministry leadership; from health into other industries); and, finally,
- Exploring public-private partnerships and the linking of multiple stakeholders, key for HR development ⁽²²⁾.

There is little evidence that these principles are widely understood by international organizations and governments across many sectors, including health. Where health experts have accountability and responsibility for either seeking donor funding, or for leadership and management of health issues in-country, the absence of HR knowledge in project design and implementation is apparent ⁽²²⁾.

Two among many case histories support the premise that there is a lack of HR knowledge and expertise. In Guinea, maldistribution of health workers and low staff morale

are the critical HR issues. The HR strategies in Guinea, however, are focused on in-service training. In Costa Rica, the health sector reform plan recognizes the lack of HR policies, standards and procedures but strategies are focused on worker productivity and short-term contracts, contributing to greater grievances among public sector employees.

International strategic alliances: Turning deliberations into action

Strategic alliances among international agencies is becoming more apparent as is the swing away from the hard edge of economic rationalism to include a greater social and people focus. (For example, the World Bank and Asian Development Bank announcements in the last two years in response to the wide-spread perception that development efforts had been successful only in narrowly defined terms, with often inadequate human relevance and impact, and, the Jakarta Plan of Action on Human Resources Development in the ESCAP Region, to which WHO contributed ⁽²⁴⁾).

The challenge now for international agencies is to understand best practice HR and its *application*, not just within the HR area but also among programme directors (or similar), ensuring that expert HR design is included in all project designs for donor funding and/or national agreement. This would require internal organizational education in best practice HR and consistent best practice HR design in all donor funding requests and project designs, and their evaluation post-implementation. External to the organization, it requires a high-level collaborative network of public and private sector partners, who together analyze organizational successes and failures across many sectors, the contribution or otherwise of HR strategies, and the lessons learned for the health sector.

The lessons learned need to be communicated consistently over time through multiple channels. Given the health system and workforce challenges many countries are currently experiencing, countries may, for example, find helpful frank discussions of case histories at World Health Assembly and WHO Regional Meetings *each year*, to assist their own HSRD and HR efforts.

At national level, the same principles apply. Relative marginalization of HR areas will continue as long as the perception remains they are not integral to the success of the core business of programme areas, either in planning or implementation. The leadership of, and expertise within, corporate services areas are therefore key to changing both the perception and the reality. Also key is strengthening the HR capability of health ministries among senior health managers, across programmes, and incorporation of best practice, expert HR strategies, in health system planning.

Decentralization

It is interesting to note the frequent emphasis on strengthening financial management skills for decentralization, with the HR emphasis more often being confined to the simple mechanistic step of decentralizing delegations.

Governments across the world are reassessing their role in the health sector, with the general trend being towards various models of decentralization. Decentralization provides a potentially excellent platform for HRDS. Ideally it enables the national level to establish best practice standards and principles to guide HR management and development, requiring accountability from managers while enabling innovation. To achieve this however, the national level must have best practice HR practitioners, there must be leadership from senior management at central level to ensure HR is both organizationally integrated and emphasized, and the HR capacity and capability of managers in a

decentralized environment must be strengthened, within an organizational development (OD) framework.

In the view of the author, after extensive study in many countries over the last 15 years (e.g. Egypt, Iran, Australia, Cambodia, China etc.) and at regional level it is the national level that should be responsible for HR policy, standard setting, regulation and monitoring, and for basic education of, and macro HR strategies for, health professionals and health workers. This should include responsibility for national policies for balancing supply and demand, qualitatively and quantitatively.

The national level should also provide leadership to facilitate appropriate linkages to enable greater complementarity and partnership within the health system. Local level HR management is then key for local attraction, recruitment, and retention, with all the system, organizational and management complexity that these imply.

Whether other HR strategies are developed and/or implemented nationally or locally depends on the purpose and type of strategy, and each country's structural levels of responsibility (e.g. centralized vs. decentralized, purchaser-provider arrangements etc.).

Ultimately there is a simple test of which level should do what. HR strategies should be initiated at the national level where it is in the national interest to do so. The national interest may range from the earlier New Zealand example of leadership and management development to support national reforms, to facilitating licensing of health professionals, to establishing policies for pay equality between the private and public sectors to reduce brain drain.

Licensing

Licensing of health professionals is one aspect of HR. Most countries have domestically focused licensing policies, e.g. for medical doctors that enables management of the supply of medical doctors and national consistency of standards. In some countries the Ministry of Health is the licensing authority for health professionals (e.g. Jordan, Myanmar). In others autonomous or relatively autonomous councils have the responsibility (e.g. South Africa's Interim Medical and Dental Council).

HR strategies by licensing authorities vary widely from little or none to, for example, the Spanish Association of Colleges of Physicians establishing the Professional Institute of Medical Education, an accreditation body for institutions offering continuing medical education. Licensing bodies can potentially be a key vehicle for HR strategies, including regional bodies, such as the European Union of Specialist Physicians ⁽²⁵⁾.

It can be argued that the European Union has, ipso facto, abolished geographical professional boundaries. In September 2000 a nursing conference of members of the Asian Productivity Organization proposed a phased approach from early to mid-21st century, for global licensing, discipline and nursing education requirements ⁽²⁶⁾.

Stewardship: Leadership and management

Those countries which responded early to the impact of global trends, in the late 1980's, focused strongly on multidisciplinary best practice leadership and management development strategies for their most senior managers and for health professionals (e.g. the UK and New Zealand). The positive impacts of these strategies are still being felt more than a decade later ⁽¹⁶⁾. In South Africa, the Oliver Tambo Leadership Development Program aims similarly to strengthen leadership and management capacity and capability.

Implicit in this is developing HR expertise. The International Council of Nurses, funded by the W. K. Kellogg Foundation, has a global initiative and conducts leadership and management development program for current and ‘next generation’ nurse leaders across the world. WHO is developing leadership and management development programmes which will initially commence in Egypt.

The increased awareness of the importance of sound leadership and management is heartening. However, the design and execution of leadership and management programmes is critical. Process is as important as content if participants are to genuinely, and sustainably, move beyond the status quo and achieve change. Also key is that programmes are multidisciplinary and that current and potential leaders are the participants. One group of participants in a ‘health leadership programme’ made a study tour to another country. The question of the host country was: “Why do you have people on such programmes who do not have now, and clearly will never have, the capacity or capability to be leaders?”⁽¹⁾.

The magnitude of the leadership and management task in health is high. The interest in, and understanding of, best practice leadership and management development to ensure real expertise in senior and middle level managers in the health sector, is uneven.

As well, discrete and disparate leadership and management development programs may assist individual capacity building but do not necessarily strengthen organizational or health stewardship capacity or capability. Organizational development (OD) strategies are as ill-understood as HRDS, notwithstanding the plethora of available literature. At the end of the day it is improved system capacity and capability that should be the aim, and OD provides the framework to achieve this. *Maintaining* the relative capacity and capability is also critical as the pace of change continues.

Conclusions

HR strategies: Budget availability

There appears to be no correlation across countries between sound and relevant HR strategies and economic status and health budget availability. Rather, the correlation seems to relate to sound and relevant *national* HR policies, and their official adoption by central government (either parliament or central agency) within which complementary HR policies for health are developed and implemented. This reinforces the hypothesis that targeting health systems in isolation from whole-of-government reform reduces chances of sustainable success through system change.

HR strategies: Stewardship

Where stewardship is weak, HR strategies to strengthen national HR policy development, and within that, health ministries, is essential to success. Without strong HR leaders with skills in managing change, the required credibility for HR is absent, political leadership is unpersuaded, and the required linkages between HR and policy and planning is weak or absent. This reinforces the hypothesis that single-issue donor and international agency support (e.g. for malaria, maternal and infant mortality etc.), in the absence of HR strategies to strengthen health ministry capacity and capability, will always struggle to achieve sustainability and influence system change. It also reinforces the hypothesis that WHO and others need to form stronger strategic alliances for country situational analyses where general stewardship is weak. Also needed, are strategies to strengthen whole-of-

government HR approaches, within which context HRDS in health ministries has greater chance of success.

HR strategies: WHO and donors

Donor projects are more often single-health-issue focused, emphasize single-health-issue training, and do not often focus on HRDS and health system change. Health experts in international agencies and national governments also having little expertise in HR and therefore not requiring its inclusion in project designs, and policy and planning probably inadvertently reinforce this weakness. Senior technical health experts need to be educated and envisioned, if more strategically oriented HR strategies are to be achieved in donor-funded projects. Donors also need education and envisioning.

Where there is much to be done from a low base in a complex environment, a realistic time line is also needed to develop and implement HRDS to achieve system change. More realistic time-lines for donor technical support to countries should therefore be encouraged.

HR strategies: The learning curve

Given the challenge of change management that many countries are experiencing with HSRD, WHA and WHO Regional Meetings, and other critical international meetings, should provide better fora for countries to frankly share lessons learned from HSRD case histories, following the principle that people learn what they see they have a need to learn.

HR strategies: Organizational cultures

In-country, best-practice, experiential leadership and development programmes for senior and middle managers, which incorporate HR expertise, should be designed and implemented to develop organizational cultures of innovation, and provide the mechanism for strengthening health ministries and integrating HR in policy and planning. Rigid bureaucracies remain the norm in most health ministries, a far cry from the global trend of moving to organizational cultures of flexibility and innovation.

HR strategies: the public/private sector and access

While there is ample literature on aspects of HR there is little on HSRD in environments of health system reform, nor is there obvious cross-fertilization on knowledge between other public sectors, the private sector and health. There needs to be better international and national leadership in convening public/private sector global, regional and national management groups, not only of HR practitioners but also of senior general managers from the public and private sectors, to meet over, say, the next three to five years, to analyze best practice HR strategies across sectors, and *widely* disseminate findings for the mutual benefit of all parties.

Given that many WHO and other international publications reach national ministries but do not reach further, and given that HR practitioners tend to talk to other HR practitioners, more innovative strategies need to be found to increase access to new HSRD knowledge by other people working in health.

Conversely, HR practitioners need to be exposed routinely to the thinking of other groups who work in health. The Internet is one obvious media. Another is for HR experts to both listen and learn, and present HSRD issues and findings at the multiplicity of health

conferences convened for other health purposes (e.g. specialist orthopaedic conferences, physiotherapy conferences, public health conferences, professional organization conferences, licensing board conferences, etc.). Health management education programmes, conferences and meetings should also be targeted. In particular, health ministry leaders need to gain strategic level expertise and interest in HRDS.

HR strategies: Country experiences

An analytical framework for HRDS should be developed and globally agreed, to enable robust country situational analysis leading to real in-country understanding, quicker development of a body of knowledge in HRDS, for in-country application, inter-country comparative analysis and research.

And so...

The conclusion drawn is that health leaders, managers and others do not understand well enough the strategic importance of HR in strengthening health system capacity. It still seems to be perceived by some as being at the “soft and fluffy” end of the spectrum in health (other than perhaps some formal and continuing education programmes), instead of something that is as essential to a strong health system as sound health financing, and which requires a similarly rigorous approach. There is little evidence that enough key players understand the key role of strategic HR approaches in achieving sustainable organizational change. While there are case histories of innovation and system change experiences using HR strategies, there is little *evidence* in the literature.

Some conclusions on HSRD are that:

- Appropriate, system-oriented HR strategies are as critical to achieving a quality health care system as health financing and health policy strategies.
- Strategic HR is ill-understood, including often by those holding formal HR positions in health organizations, with more evidence of traditional personnel functions being prevalent than cross-cutting HR strategies.
- Strategic HR is also ill-understood by managers in the health system: where they have a management challenge with staff, with team building, or with their organizational culture, they too often do not know there may be a solution, on which a skilled HR practitioner can advise. Alternatively, the manager may know there is a strategy to assist, but finds skilled advice lacking in the HR area.
- Strategic HR approaches, that target health system change, are more usually not an integral part of designs to achieve health system reform.
- HR strategies often do not address the core HR issue (e.g. ‘brain drain’, geographical maldistribution, motivation, innovation, risk-averse organizations, productivity, quality, job satisfaction).
- Donor activity often incorporates discrete training functions but there is little evidence of strategic HRDS to achieve system change.
- Donor project time lines are often too short for sustainable change, even where they are strategically focused.
- Weak stewardship needs to be reversed for sustainable health system reform and HRDS are key to strengthening stewardship.

- HR lessons learned from non-health public sectors and the private sector are not widely evident in HRDS in-country.

To ‘fill the gaps’ we would do well to strengthen:

- Private and public sector collaboration and frank exchange for mutual benefit.
- National level HRDS capacity even in a decentralized environment.
- The utilization of multi-various global, regional and national non-HR health meetings to emphasize HRs strategic importance in a focused, systematic, sustained strategic approach over the next five years, and for HR practitioners to listen and learn from these meetings, adapting their HRDS strategies accordingly.
- The utilization of formal international meetings, such as WHA and WHO Regional Committee Meetings, to frankly share and discuss country case histories and lessons learned, to assist countries’ efforts in health system reform and change management.
- Collaborative country situational analyses to enable whole-of-government HR reform, within which health ministry HR strengthening is implemented.
- HR expertise as a core competency in non-HR senior health managers and health experts, to influence countries’ understanding of the essentiality and complexity of HR strategies, in the same way as financing policies are essential and complex, and the inclusion of HRDS in national health plans.
- The development of an HR analysis and implementation framework to guide global thinking, develop in-country understanding, quickly build a body of knowledge from which lessons learned can be drawn and enable strengthened in-country analysis of sustainability issues in HR, leading to HRDS being incorporated in all donor requests.
- The development of global, regional and in-country, multidisciplinary, experiential leadership and management development programmes for senior and middle level health managers.

Acknowledgements

Acknowledgement is given, and thanks are extended, for assistance with research material for this paper, to the staff of WHO Headquarters in Geneva, and to Janet Barron, Dr. Jane Bryson, Lorraine Kerse, Debra Hill, Brian Lewis, Katherine Lewis, Dr. Alan Sandford and Losalini Tavaga.

Acronyms

EMRO	WHO's Eastern Mediterranean Regional Office
EURO	WHO's European Regional Office
ILO	International Labor Organisation
HR	Human Resource(s)
HRDS	Human Resource Development Strategies
HRH	Human Resources for Health
HMR	Health Management Reform
HSRD	Health System Reform and Development
HQ	Head Quarters

OD	Organisational Development
SEARO	WHOs South East Asian Regional Office
UK	United Kingdom
WHA	World Health Assembly
WHO	World Health Organization
WPRO	WHOs Western Pacific Regional Office

References

1. Dunlop D, Martin JM, Eds. An international assessment of health care financing. economic development institute seminar series. Washington DC: World Bank, 1995.
2. Degeling P, Kennedy J, Perkins R, Zhang K. A comparison of the impact of hospital reform on medical subcultures in some Australian and New Zealand Hospitals. *Australian Health Review* 1999;22:173-88.
3. Kahssay HA, Oakley P, Eds. **Community involvement in health development: a review of the concept and practice**. Public Health Action 5. Geneva: World Health Organization, 1999.
4. Preker A, Feachem RGA. **Market mechanisms and the health sector in Central and Eastern Europe**. Technical Paper Series No. 293. Washington DC: World Bank, 1996 (Translations in English, Russian, Hungarian, Polish, Romanian and Czech.)
5. World Health Organisation. **Health system: improving performance**. The World Health Report 2000. Geneva: World Health Organisation, 2000.
6. International Labour Office. **Human resource development in the public service in the context of structural adjustment and transition**. Report for discussion at the Joint Meeting on Human Resource Development in the Public Service in the Context of Structural Adjustment and Transition. Geneva: International Labour Office, 1998.
7. Bargellini M. Libraries: A key role in lifelong learning. (on-line). Available from: URL: <http://www.jrc.es/pages/iptsreport/vol41/english/ICT2E416.htm>.
8. Kolehmainen-Aitken RL. Defining human resource responsibilities in the era of health sector reform. APHA conference. 2000. In-press. (on-line). Available from: URL: http://apha.confex.com/apha/128am/techprogram/paper_2922.htm.
9. Prokopenko J. Globalization, alliances and networking: A strategy for competitiveness and productivity. Enterprise and Management Development Working Paper EMD/21/E. International Labour Organization, 2000. (on-line). 2000 September. Available from: URL: <http://www.ilo.org/public/english/employment/ent/papers/emd21.html>.
10. Gonzalez Block, M. Comparative research and analysis methods for shared learning from health system reforms. (on-line). 1999 February. Available from: URL: <http://www.insp.mx/ichsri/ch/index.html>.
11. Wongwatharapaiboon P, Sirikanokwilai N, Pengpaiboon P. The 1997 massive resignation of contracted new medical graduates from the Thai Ministry of Public Health: What reasons behind? *HRDJ* 1999;3:147-56.
12. Bryson J. Medical and managerial ethics in decision-making. Doctoral thesis. University of Victoria, New Zealand, 1998.

13. Biscoe G. WHO consultancies in Cambodia and Nepal for WHA49.1. 2000.
14. OECD. **Integrating people management into public service reform**. Paris: OECD, 1996.
15. World Bank. **World Development Report 1997: The state in a changing world**. Washington DC: World Bank, 1997.
16. Final presentations by discussion groups at the Health Management Exchange, Australian and New Zealand Health Management Network, Australia. 1998, drawing links with the work of New Zealand's Health Services Management Development Unit (HSMDU) established in 1988.
17. Hoassain B, Alam A S. Likely benefits of workload indicators of staffing need. *HRDJ* 1999;3:99-111.
18. Biscoe G. Analysis of country 'x'. 2000.
19. Dearden R. The interconnectedness of system change. Paper presented to senior executives of the Tasmanian Department of Community and Health Services, Australia, 1996. In press.
20. Lewis B. Managing Change. Paper prepared for 1998 Health Exchange, Canberra, Australia, 1998. In press.
21. Biscoe G. Analysis of WHA49.1 in Cambodia. World Health Organization, SEARO, 2000.
22. Compass to Workforce Development: "What Works". (on-line). 2000 September. Available from: URL: http://www.edc.org/CWD/s_works.htm.
23. Biscoe G. Analysis of 36 WHO consultancy reports from 1989-2000 and 10 donor project designs from 1997-2000 for preparing this paper.
24. ESCAP. Background of the Jakarta Plan of Action. United Nations ESCAP, 1997-2000.
25. Maronde J. Certification of healthcare professionals globally. A compilation of perspectives from five countries: Jordan, South Africa, Spain, United Kingdom, United States. A presentation for the Second Annual Summit on International Managed Care Trends. 1997. (on-line). 2000 September. Available from: URL: http://www.cphq.persp_compil.htm.
26. Harrifan R, et al. **International cooperative workforce projection model**. Community Initiative of Nursing of Hawaii. Asian Productivity Organisation Conference. 2000. In press.