

What Countries Can Do Now: Twenty-Nine Actions to Scale-Up and Improve the Health Workforce



Task Force on Human Resources for Health Financing

Global Health Workforce Alliance

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Twenty-Nine Actions to Scale-Up and Improve the Health Workforce

**Task Force on Human Resources for Health Financing
Global Health Workforce Alliance**

This paper synthesizes the human resources for health financing work conducted to date and sets out the topics requiring additional academic and field research. The analysis for the paper was conducted by the Secretariat of the Financing Taskforce (FTF) under the guidance of FTF members.

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Introduction

Health workers play a critical role in the provision of health care and represent the single largest cost element in providing health services in low-income countries. Many of the poorest countries in the world have been unable to meet the pressing health needs of their populations. Millions of people die prematurely, or suffer from illness or disability unnecessarily, because appropriate human resources for health (HRH) to provide care are not available to them.

While the health workforce situation is complex and addressing it requires a long term commitment from multiple stakeholders, there are actions that countries could take immediately to alleviate the health conditions of their populations.

This document explains **seven** financing and economic issues that matter for health workforce scale-up and financing. It then states **twenty-nine** actions that policy-makers could take right away to address the issues, independent of any long-term HRH interventions in progress.

The seven issues are closely connected and interdependent. Some of them, such as fiscal space and funding health workforce employment, are relevant to *global* policymakers and development partners as well as country-level policy-makers. Others, such as in-service and pre-service training, deployment, efficiency, and resource management, are mainly for *country-level* policy-makers to tackle.

The seven issues are based on an extensive review and synthesis of the literature, research findings, and experience to date on the financing and economic aspects of the health workforce scale-up and improvement, conducted by the Alliance Task Force on Financing and documented in "*Financing and economic aspects of health workforce scale-up and improvement: Framework Paper.*"

Issue One: How can countries pay for scaled up employment of HRH?

Why it matters

Low-income countries face resource constraints and difficult tradeoffs across and within sectors when attempting to meet the basic needs of their populations, including access to trained and effective human resources for health (HRH). Countries wishing to expand the number of HRH must mobilize resources to pay the costs of: (1) HRH employment, including wages, benefits and incentives; (including in-service training/professional development) (2) HRH pre-service training; and (3) HRH management.

The long-term sustainability of HRH scale-up requires domestic resources to be mobilized, often supplemented by external resources. The availability of domestic resources depends on countries' gross national income (GNI); government's ability to capture the GNI; the share of government revenue allocated to health; and the share of health spending allocated to HRH. Frequently, the available domestic resources are insufficient to meet the government's plans for HRH scale-up. The recently renewed commitment by the international community to increase aid to help countries meet the Millennium Development Goals (MDGs) should help fill the financing gap between the needed and available resources.

While the willingness of the international community to provide aid offers opportunities for governments to accelerate their HRH programs' scope and meet the MDGs, countries also face challenges for macroeconomic management. These challenges include ensuring sustainability in the face of aid uncertainty and variability and each country's own long-term economic prospects.

What countries can do

- 1. Estimate the "fiscal space"/government funding** that is likely to be available for employment of HRH through to the end date of countries' HRH scale-up plans (e.g., 2015 if the plans are aligned with the MDGs). This involves projecting the funding that is likely to be available from government for HRH scale-up and would allow the Ministry of Health to compare the available and required funding for covering HRH costs. The Ministry can vary the assumptions behind these funding projections and estimate "optimistic" and "pessimistic" scenarios for resources that could be available to meet HRH plans. The "gaps" calculated between plans for HRH scale-up and likely fiscal space could be used in advocacy efforts within government and/or with external partners. Finally, based on the scenarios, the Ministry could re-assess its HRH plans to determine whether it is possible to adjust them while still meeting HRH needs, including achieving the MDGs and securing basic health care for all, but at lower cost, such as through additional measures to improve the efficiency of HRH (See Box 1 and charts on pages 8 and 9).

2. The Ministry of Health can use the fiscal space analysis for advocacy. The gap figures could be used to seek additional resources to make it possible to attain the planned HRH levels. These resources might come from government borrowing or from external support, or both. The Ministry of Health can work with other health advocates, including in civil society and members of parliament, to advocate for the necessary resources. Ministries and partners can also seek additional resources through global health initiatives such as the Global Fund. Alternatively, if additional resources cannot be raised, then the Ministry can adjust its HRH scale-up plans in the short run to reflect only those aspects that can be financed while working to secure adequate resources in the longer run. Other methods to close the gap might include efforts to improve the efficiency of HRH (see area five below), or to reduce the need for government HRH by harnessing privately employed HRH (see area seven below).

Box 1: How to estimate countries' fiscal space

Data requirements

These fiscal space estimates would be based on the following variables:

1. Economic growth
2. Government capture of GNI
3. Share of government revenue allocated to health
4. Share of health spending allocated to HRH

Data sources

The Ministry of Finance and/or Economics could provide the predicted values for item one and the current values for items two and three. Item four should be available through examination of Ministry of Health budgets and expenditure reports. The National Budget would also have data on items three and four.

Data analysis/scenarios for resource gaps

Based on the data variables above, Ministries can estimate "base", "optimistic" and "pessimistic" scenarios.

For examples, to estimate the "base" scenario, the Ministry can take the data as given from the various sources. For "optimistic" levels of funding, the Ministry can make assumptions about: faster economic growth, greater government capture of GNI, higher share of government revenue allocated to health, and greater share of health spending allocated to HRH to produce a maximum estimate of fiscal space. Similarly, a "pessimistic" scenario could be developed.

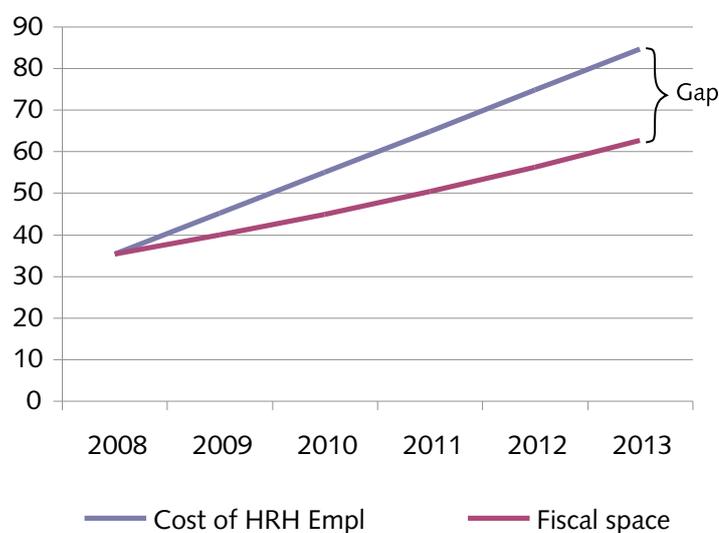
The comparison of the "base," "optimistic," and "pessimistic" scenarios of available resources could be compared against the costs of targeted/ planned HRH employment. This comparison between the available and required resources would show the gap in necessary funding to meet countries' HRH scale up plans. The size of the gap, especially at the end of the planned period, is an indicator of the long-term sustainability of the HRH plans and needs for external support.

It is recommended that countries not stop after making these initial calculations, but rather that the calculations be updated at least annually so that changes in circumstances (e.g., faster than expected economic growth, lower than anticipated government capture of GNI) can be taken into account and implications for fiscal space for HRH employment can be understood.

Example calculation of national fiscal space is shown below:

Data Category	Amount
GNI 2008 (million)	\$5 000
HRH employment cost in 2008 (million)	\$35.2
HRH employment cost in 2013 (million)	\$84.6
Expected GNI annual growth rate	4%
Government capture of GNI 2008	15%
Government capture of GNI 2013	16%
Government allocation to health in 2008	10%
Government allocation to health in 2013	14%
Share of health spending to HRH 2008-2013	47%

Projected fiscal space and cost of HRH employment:



Issue Two: How can countries fund the investment and recurrent costs of producing the needed HRH?

Why it matters

Given the initial stock, attrition rates, and targets for scaling up the numbers and attaining an appropriate skill mix of HRH, a country's medical education system needs to produce the desired HRH.¹

There are recurrent costs to the pre-service training of HRH, in terms of paying teachers; providing books, labs and supplies, equipment, and maintenance of facilities and equipment; paying for living expenses of students; and so forth. In addition, there are investment costs that must be paid (or accounted for). When the scale-up of HRH requires enough additional students to be trained that additional physical capacity is needed,² then new buildings (classrooms, teachers' offices, labs, etc.) must be paid for and built, whether as additions to existing schools or as entirely new schools. Even when no new construction is required, there is an investment cost to pre-service training in terms of the amortization of the existing schools used. The physical plant and equipment is depreciating (losing financial value and physically deteriorating), such that it will need replacement someday, even if not in the immediate financial planning time horizon.

The same fiscal constraints faced by governments concerning employment are relevant for the costs of scaling up pre-service training. Governments are limited by their tax take from GNI, by their willingness to borrow, and, in some cases, by the availability and effectiveness of the in-country risk-pooling mechanisms to generate financing from health service users. They must choose how to allocate their resources among competing sectors and among competing needs within sectors. In practical terms, the allocation of government resources for pre-service training of HRH is complicated by the fact that, in many countries, some or all pre-service HRH training is the responsibility of the ministry of education or higher education, not the ministry of health, which is usually responsible for employment of public sector HRH. This means that there must be coordination between the ministries responsible for HRH pre-service training and employment, so that adequate and matched resources are allocated to both.

What countries can do

3. Begin dialogue with ministries of education and other relevant ministries.

The estimated large cost of scaling up pre-service training (PST) means that ministries of education will be important partners for ministries of health and other ministries³ in the effort to achieve HRH scale-up. Such partnerships are

-
- 1 Alternatives are to send students to other countries for training or to recruit health workers from other countries, but most LICs are likely to train nearly all of their own HRH.
 - 2 Some countries, e.g., Sudan, have organized two shifts at schools to limit the need for additional physical infrastructure.
 - 3 Some countries place "nurse training" in a specific ministerial department under vocational education.

often not as easy as they might seem, so it is best to begin the discussions around them sooner rather than later.

- 4. Find out how much the private sector could contribute.** Many countries now have private HRH pre-service training schools, in addition to those operated by governments. The planning process should consider the graduates produced by these private schools and how many of them are likely to take government jobs. In addition, there might be ways to facilitate or stimulate investment in additional private pre-service training capacity to alleviate public sector capacity limitations that otherwise could constrain HRH scale-up. For instance, governments could provide for streamlined approvals and accreditation processes, offer tax breaks, or provide scholarship support for student tuition payments. Governments could also enter into discussions and partnerships with private schools to develop and implement strategies to ensure that graduates from these schools will contribute to meeting HRH needs in rural and other underserved areas, such as by developing scholarship programs and recruitment strategies targeted at rural and socially disadvantaged populations, developing curricula that focus on rural primary health needs, and developing mentoring and service programs that enable students to learn about and spend time in rural and other underserved areas. Also, governments could seek partnerships with private sector actors to encourage contributions to investments in public institutions.
- 5. Consider policies to require tuition contributions** from students at government pre-service training schools to help pay for the costs of the training and the needed expansion of capacity, while offering complementary student grant and loan programs to ensure access by all academically qualified applicants, regardless of family resources, to HRH training.
- 6. Estimate and project the cost of HRH PST** needed to meet HRH employment objectives as shown in Box 2 and the accompanying charts.
- 7. Use projected costs for advocacy.** Much as for employment costs, meeting HRH pre-service training needs will likely require significant new investments from governments and development partners. Health and education ministries, together with partners in civil society and parliament, can advocate for the necessary resources internally and externally, as well as through their influence on the use of global health initiative funding.
- 8. Consider innovations and strategies that may make pre-service training more cost effective.** These include use of information and communication technologies and targeted investments and strategies to reduce attrition from programs so that few resources are spent training students who do not graduate. The attrition-reduction strategies might include needs-based financial aid, improved student housing, and academic support for students with inadequate secondary school backgrounds.
- 9. Consider redesigning job roles and pre-service training methods to address country's specific needs.** Redesign of jobs, to meet the specific needs of the country, and redesign of education and training, to meet the needs of the students, can greatly reduce both the cost and the length of HRH production.

Box 2: How to estimate countries' pre-service training costs

Data requirements

Countries would need to start collecting the data below from all of its training institutions for each of the medical cadres that the institutions train.

PROJECTIONS FOR NUMBER OF GRADUATES

- i. How many graduates do PST institutions currently produce per year?
- ii. How many graduates are needed to meet HRH employment objectives?
- iii. How many graduates now enter government service, enter private service, emigrate, or choose not to practice?
- iv. How much of the gap between graduates needed to meet employment objectives can be met by currently un-used pre-service training capacity?

COSTING INFORMATION

- i. What are PST institutions recurrent costs (teacher salaries, utilities, labs, libraries)?
- ii. What assets and capital investments do PST institutions have?
- iii. How old are PST institutions? What is their expected life span?

COSTING PROJECTIONS

- i. For recurrent costs:
 1. What do PST institutions plan to do that may cause them to change their current cost structure?
 - a. Plans to improve labs?
 - b. Plans to adjust teacher to student ratios?
 - c. Plans to provide more books, etc.?
 - d. Plans to change the mix of national and expatriate teachers?
 - e. Are dropout rates expected to change?
- ii. For capital investments:
 1. What capital outlays do PST institutions expect to have in the coming several years?
 2. What is the expected life span of the capital investments?
 3. What is the replacement cost of these capital investments?

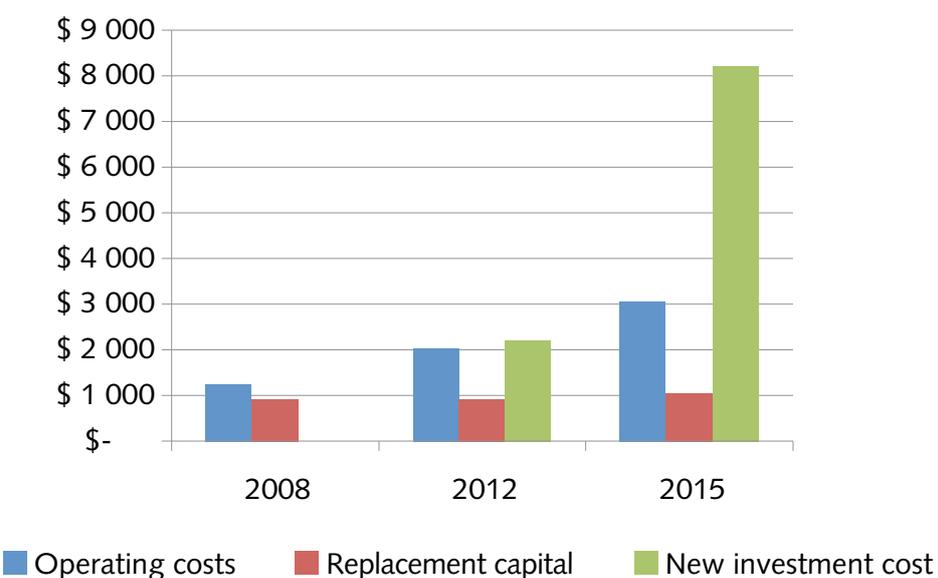
REVENUES

- i. Do PST institutions collect any revenues from their students and others? How much?
 1. Direct revenues:
 - a. From student tuition payments and fees
 - b. From donors
 - c. From the government: MOH, MOE, Other ministries (i.e. Capacity Building)
 2. In-kind contributions
 - a. Volunteer instructors
 - b. Private support for students' living costs

Example estimate of country pre-service projections:

	2008	2012	2015
Graduates	50		
Enter private employment	10	16	22
Emigrate or exit the sector	10	15	20
Graduates need to meet HRH plans	30	50	80
PST capacity in 2008	70		
Additional PST capacity needed		11	41

Assumptions	Amount
Operating costs per grad (000)	\$25
Replacement capital per capacity (000)	\$13
Investment cost per additional capacity (000)	\$200



Issue Three: What retention mechanisms have been tried, do they work, and how much do they cost?

Why it matters

When countries wish to scale up the numbers of HRH, they can do so through some combination of: (1) producing more HRH; and (2) decreasing attrition among those already in place and of new entrants into the workforce. The extent of attrition of HRH affects the needed numbers of new HRH and thus the financing needed to produce them. Attrition is categorized as: economic and natural.

Economic attrition refers to a worker leaving the health sector to pursue alternative opportunities, for both financial (higher salary) and non-financial (better training or supervision, other working conditions; better housing; etc.) reasons. HRH sometimes find those opportunities in the health sector of another country, or in other sectors in their own country. (From the point of view of Governments, a public sector employee moving to the private sector constitutes attrition.) Economic attrition could be reduced by improving the conditions in the original sector, thus making the alternative comparatively less attractive. Of course, financial and many non-financial incentives have costs.

Natural attrition refers to workforce departures for reasons of retirement, death (especially in the face of HIV/AIDS), and so forth. To diminish natural attrition, countries can raise their retirement age, provide workers information about disease prevention and ensure their own access to confidential, comprehensive health care, and improve workplace safety.

Policy and financial choices can affect attrition and retention. Examples include policies concerning retirement age and requirements to serve in the government sector if one benefited from government-funded pre-service training. The employment opportunities, pay, benefits, and working conditions offered to HRH can affect their choices to: (1) remain in or exit the health sector; (2) choose to work in government or private employment; (3) stay in or leave the country; and (4) serve in rural or other disadvantaged areas versus in cities or other relatively privileged areas.

What countries can do

10. Examine alternative financial and non-financial incentives and working conditions that might reduce the temptation to emigrate. Ask HRH for feedback (through surveys or focus group discussions) on the working conditions and financial rewards that are important to them, to help determine alternatives that are likely to work and to be affordable. Include among the possible alternatives bonding arrangements, where HRH that have benefited from government subsidized pre-service training are required to serve in government employment for a given period of time post graduation. Choose incentives and working conditions that indicate the greatest payoff in terms of improved retention and quality of care for the lowest cost. Note that many improvements in working conditions, such

as introduction of supportive supervision also are likely to have significant impact on quality of care.

- 11. Consider tailoring pre-service training of HRH** to provide the skills needed for the country's specific situation, without necessarily providing the skills that facilitate emigration (as in Ethiopia's CHW training and in China's "chicken doctor" program).
- 12. Consider changing policies for mandatory retirement ages or full pension benefits after a given number of years of service.** Raising or eliminating a mandatory retirement age could allow more HRH to remain in the workforce. Where full pension benefits have been promised after a given number of years of service, it might be considered unfair to take them away. However, not making this promise for new hires could help with retention in the future. For those to whom full pension benefits are promised, additional pension benefits might be offered if they agreed to stay at work longer.
- 13. Find out from the country's HRH diaspora what conditions might bring them back to the country.** (Note that some countries' physician diasporas, such as Nigeria's, have associations that can act as their representatives). Consider the costs of the conditions against the likelihood of returned diaspora HRH (and what additional investment resources they might bring with them).
- 14. Measure and monitor attrition rates by area.** Areas to compare include geographic (rural versus urban) and sector (public versus private). This information will help policymakers understand how current retention strategies are working and see where action is needed, for example, to improve HRH working conditions in rural areas or increase remuneration of HRH in the public sector to remain competitive with private providers.

Issue Four: How much would it cost to achieve equitable employment?

Why it matters

Many countries have a physical distribution (or deployment) of HRH that well serves those with relatively high incomes and poorly serves the disadvantaged, in contradiction to stated health priorities. This is the case for both government-employed HRH and those employed in the private sector.

Governments face many challenges in deploying HRH to needy areas. It would seem that a government could deploy HRH wherever it wishes—to attack the major sources of morbidity and mortality, this usually would mean putting HRH in rural areas and urban slums. Nonetheless, governments face practical issues in trying to do so, such as: high attrition of HRH assigned to needy areas; the constraints of civil service protections on disciplining HRH who do not report to their assigned posts; and human resources information systems that are too weak even to allow decision makers to know where HRH are deployed.

Privately employed HRH are an important part of the overall HRH distribution. Private commercial providers respond to market demand in deciding where to locate their services (including their HRH). They tend to locate their HRH where there is a concentration of income or where government provision is lacking in numbers or perceived quality. Urban populations tend to be better off financially and government-provided services are often considered to be of unsatisfactory quality. Hence, there is a tendency for commercial private providers to locate in urban areas—though this is not to the total exclusion of poorer and more rural areas in most countries. Household surveys often show that poor people devote half or more of their out-of-pocket spending on health to paying for privately provided services. Commercial providers tend to look for underserved niches and, sometimes, this can be serving the poor.

Referral facilities and teaching hospitals are located in large population centers, thereby concentrating HRH. Thus, a “perfectly equal” deployment of HRH is unlikely to be achieved. However, a more equitable deployment than the status quo in many countries is highly desirable, especially in the distribution of basic and primary care facilities and their HRH.

What countries can do

15. Recruit pre-service HRH likely to serve in under-resourced areas. Identify students using the following criteria in addition to academic qualification: (1) those with a positive attitude toward rural service and (2) those who come from rural areas, so that once-trained, the new HRH will be more likely to accept and remain in rural posts. Also, take other measures through the education system that could impact willingness of HRH to serve in under-resourced areas, including through curriculum reform to focus on rural primary health needs, and developing mentoring and service programs that enable students to learn about and spend time in rural and other underserved areas.

16. Examine alternatives and then **provide financial and non-financial incentives to HRH posted to hardship areas**, such as financial bonuses, provision of housing, access to children's education, provision of water and electricity, security for female HRH, etc. A part of the process should be to ask HRH (again, through surveys or focus groups) what the most important incentives are to them. Another part of the process could be to study what incentives private providers, especially faith-based NGOs, offer to HRH in hardship posts. Finally, it would be important to carefully monitor and evaluate the cost and degree of success of the incentives in attaining higher retention.

Issue Five: What efficiency measures for HRH performance work? How much do they cost? What are the gains in efficiency and effectiveness and how do they affect the need for HRH?

Why it matters

Estimates of need for HRH implicitly make assumptions about HRH productivity—that is, how many people can be served effectively by each type of HRH. If productivity can be increased, then the same health impact could be achieved with fewer HRH. Clearly, it is in the interest of health systems to try to maximize HRH productivity.

To make a net gain in health financing, efforts to increase productivity must produce more value than the costs of the programs. When productivity increases, the financial gains for the systems stem from the need to employ and train fewer HRH to achieve a given target for service provision.

Two methods to increase productivity are (1) management improvements; and (2) mechanisms to hold workers accountable for performance. Many government health systems give little attention to management of HRH. Thus, motivation and morale are often low and productivity suffers. Similarly, accountability for performance within the government is weak. Civil service rules limit the ability to offer incentives for good work or to sanction poor performance or the abuse of resources. There are few mechanisms to hold government HRH accountable for the quantity or quality of their work or for the diversion of either work time to private practice or drugs and supplies to sale for private benefit. The health sector has seen an expanding number of experiences in using performance-based approaches to health financing in the early 21st century. These efforts have focused on increasing the number of services provided and maintaining or improving quality of care, but have given little attention to the specific effect of performance-based schemes on HRH.

What countries can do

- 17. Examine alternative methods to improve accountability of HRH**, then choose and apply the ones that look most promising given the country's situation. These might involve performance-based management and contracting, decentralization, greater citizen oversight of performance, and setting up systems where funding follows patients. Accountability systems also should consider measures for discipline and sanction for poor performance.
- 18. Ensure that HRH are provided with adequate support and tools to do their jobs well.** This would include providing supportive supervision and ensuring that non-HRH inputs are available, such as drugs and consumable supplies and working equipment.

19. **Engage HRH trade unions and professional organizations** (such as doctors, nurses, or midwives associations) to be partners in developing accountability mechanisms, since unilaterally implemented accountability systems are likely to be considered “imposed” and provoke opposition.
20. **Conduct a task-shifting analysis to study whether the skills of HRH are well-matched with the jobs that they are assigned.** Where current assignments show over-qualification, shift the tasks (with appropriate re-training where needed) to HRH with only the needed qualifications. This might entail an up-front expenditure for the re-training, but a savings over the longer term in employment costs.
21. **Draw lessons from experiences like Village Reach to find and eliminate waste and inefficiency in the use of HRH in the supply chain for health inputs.** This might mean out-sourcing some functions, such as transport of inputs or provision of services such as food and laundry to hospitals.

Issue Six: What are the key elements needed to strengthen HRH management and how much do they cost?

Why it matters

The efficiency and effectiveness of HRH are affected by the quality of human resources management. Traditionally, ministries of health have given little attention to and allocated few resources for HRH management. In some countries, HRH are not managed by ministries of health, but rather by overall ministries of civil service. Hence, even the minimal functions of managing HRH workforce numbers, skills, and deployment are done poorly, if at all. The best ministries of health focus on even more comprehensive “human resources development” that includes planning and formulation of human resources policy; education, training and skills development; managing the migration of skilled health personnel; and advocacy.

The Capacity Project identifies the following challenges for HRH management by governments in low-income countries: (1) inaccurate or incomplete data about the health workforce; (2) inadequate numbers of qualified health workers; (3) mismatches between needed and available health worker skills; (4) retention problems; (5) slow and ineffective recruitment, hiring, and deployment processes; (6) lack of supportive policies; (7) weak planning and management systems; and (8) poor use of available financial and material resources.

What countries can do

22. **Budget for and then upgrade the staffing of HRH departments** in Ministries of Health and **build or develop HRH information management systems**.
23. **Obtain guidance about the essential functions of a strong HRH management system** and implement them. The USAID-funded Capacity Project is one good source for this kind of guidance, another is the University of Western Cape Free Courseware Project.
24. **Involve HRH managers in strategic decision-making processes of Ministries of Health**, including analysis of the HRH implications of all strategic choices. Examples include scale-up of (1) anti-retroviral treatment, likely to draw on scarce skilled HRH, or (2) malaria prevention programs, such as ITN distribution and IRS, that might reduce demand for curative care.
25. Work with schools of business administration and private providers of health services to **develop modules on HRH management to add to curricula for HR management**, so that both government and private health service providers can employ graduates with knowledge of and skills for HRH management.

Issue Seven: How do HRH in private employment affect the availability and use of health services? How can health financing policy affect the numbers, distribution, and performance of privately employed HRH to contribute to national goals and objectives?

Why it matters

In much of the developing world, the private sector is the most important source of medicine and medical care, and yet planners at ministries of health frequently give little attention to privately provided services. Private sector actors can be categorized as: for-profit companies, nonprofit organizations, social enterprises, insurers, providers, and drug and other health equipment manufacturers. These private sector actors account for as much as 50 percent of health care provision in sub-Saharan Africa (Conway et al., 2007). Estimating the exact share of HRH working in the private sector is difficult due to “moonlighting.”⁴ There are no global estimates and the numbers vary by country, from as little as 20 percent to as much as 70 percent.⁵ Private commercial providers of health services are concentrated in urban areas, and their HRH are similarly concentrated. In many countries, nonprofit private providers seek to serve the underserved, so their HRH likely are found mainly in rural areas and urban slums.

Thus, few governments have a comprehensive picture of the numbers and distribution of privately employed HRH, despite their importance in delivering services.

In addition to working parallel to government in offering health services, private providers are competitors with government for the employment of HRH. Some of the economic attrition of government HRH is to domestic private employment. Private employers have more flexibility than government in offering wages, working conditions, and benefits to HRH. Government employment often has advantages over private employment in the form of greater job security, the offer of pension benefits, and, sometimes, access to more and better equipment. “Moonlighters” try to obtain the advantages of working for both government and private employers. Government retention strategies could benefit from examining what is offered by private employers both to stem attrition to those employers and to learn how private employers seek to reduce their attrition losses to emigration.

4 Moonlighting refers to the practice of public sector HRH working in the private sector in parallel with their public sector appointments.

5 These estimates have different approaches to estimating the number of HRH in the private sector: in some cases, the HRH cited work only in the private sector while in other cases, they work in both sectors.

What countries can do

26. **Monitor employment data** concerning the private sector, including the numbers of HRH employed, geographic distribution, productivity, compensation, the services they offer, and the populations they serve. These kinds of data would provide a comprehensive picture of the overall HRH situation, allow the monitoring of trends, and provide useful information to devise policy initiatives to influence the direction of private HRH activities.
27. **Use data on private employment of HRH** in making decisions concerning scale-up of pre-service training (see Area Two above).
28. **Study and learn from private providers** concerning what they do to: (1) retain HRH in the face of incentives to emigrate and (2) successfully post HRH to hardship geographic areas.
29. Specifically, **consider assisting in or stimulating the development of private initiatives** in the following areas:
 - a. Pre-service training of HRH (e.g., creation or expansion of private medical, nursing, midwife, and other schools).
 - b. Private payment of tuition fees for pre-service training (complemented by government-sponsored student grant and loan programs to ensure access for all qualified students).
 - c. Provision of health services under performance-based contract, where the private contractor hires, manages, and ensures the working conditions needed for appropriate HRH.

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