The Labor Market for Health Workers in Africa

A New Look at the Crisis

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CHAPTER 7

Politics and Governance in Human Resources for Health

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Governance structures and political processes shape the human resources for the health labor market, determining which reforms are implemented to improve labor market outcomes. This chapter reviews recent experience in Sub-Saharan Africa to suggest how types of political regimes, state capacities to make and enforce decisions, and governance arrangements between state and nonstate actors influence health labor market dynamics and reform policies. It also illustrates the role that stakeholders often play in reform, including the ministries of health, professional associations and unions, and international agencies or donors.

Government policy can profoundly affect health labor markets, influencing market balances (such as urban-rural, public-private, and centralized-decentralized), types of health services offered, and health worker performance (provider absenteeism and responsiveness to clients, for example), among other elements. Indeed, along with a well-performing workforce, one of the World Health Organization's six building blocks of a health system is leadership and governance, manifested through such actions as planning for a country's health needs, regulating health sector stakeholders, and establishing accountability mechanisms (WHO 2010).

Largely due to political legacies, some governments in Sub-Saharan Africa have created conditions that favor health workers in the public sector, while others have overseen policies that support greater sectoral pluralism or competition between public and private markets. In the public sector, and often as part of wider political reforms, some countries provide more local control over managing public health workers than others. As Sub-Saharan countries undertake reforms to respond to the human resource crisis, they will generally focus on changing government policies to alter the labor market.

This chapter reviews recent evidence from Sub-Saharan Africa to describe how different governance structures and political processes shape health labor markets, and how health system reforms affect the health workforce. There are many definitions of governance and politics, but most address the rules and practices of decision making—such as the roles of authority, legitimacy, and power, as well as the interests of civil society, the state, and political institutions and actors, rather than specific policies themselves (Brinkerhoff and Bossert 2008).

This chapter focuses on three elements of governance: contextual state characteristics (capacity and type of political regime), state policies and organizational forms that influence health labor markets (including private sector regulation and the locus of decision making for public labor markets), and the role of stakeholder political processes in adopting and implementing health workforce policies. Although we address these three elements separately, they are interrelated.

Many chapters in this book benefit from a combination of regularly collected, quantifiable data, but similar sources of data do not exist for governance. Such limitations preclude a systematic review of governance arrangements and health labor markets in Sub-Saharan Africa, though the chapter uses evidence from a range of countries and regions. Initial hypotheses relating governance to health labor markets were therefore based on our prior knowledge, with evidence sought from Sub-Saharan countries that could confirm or reject these hypotheses. While the chapter's country evidence supports the preliminary conclusions, more systematic evidence would strengthen the evidence base for those conclusions.

Regime Characteristics

Some state characteristics are apt to influence a country's ability to make and enforce rules for health labor markets. Regime "capacity"—running the gamut in Sub-Saharan Africa from long-unstable failed states riven by civil war to fairly stable governments generally able to enforce policy—is the first important characteristic. Regime type may play a role as well, with models of governance in Sub-Saharan Africa ranging from militaristic or authoritarian regimes (or both) to pluralistic democracies. How far regimes are entrenched in power over time, thus how able to promote or block health workforce reforms is a final characteristic that can improve work place reforms affect labor markets.

Regime Capacity

Sub-Saharan Africa offers many examples of failed or fragile states that have little power to impose rules and decisions on either their own administrative structures or the rest of civil society. In these contexts producing and retaining a skilled and motivated public-sector health workforce can exceed the government's financial and management capacities (Brinkerhoff 2007). Many health workers face stresses daily, including violence-ridden environments and health infrastructures that are inadequate due to chronic underinvestment. As a result, health workers may be particularly tempted to search for a better professional and economic environment, either within the country—such as urban areas or the private sector—or outside it (Doull and Campbell 2008). These contexts may also increase absenteeism, dual practice, and health workers' demands for informal payments to compensate for irregular or unpaid salaries.

International nonstate actors and raw free-market supply and demand may particularly affect labor markets for health workers in fragile and failed states. In some contexts, especially states in, or emerging from, conflict, a relatively free and unregulated market for health services can result. Unlicensed or unregulated providers may feature strongly, as could heavy reliance on out-of-pocket payment for services and major forms of corruption, especially in the drugs and medical equipment supply chains.

Most health workers in these situations seek the safest locations, often urban areas or even abroad. After the civil conflict that began in 2002 in Côte d'Ivoire, the health workforce changed greatly as the majority relocated, fled, or could not go to work. Further, the conflict accentuated a preexisting urban bias as most health workers relocated to the relative safety of the capital, Abidjan (Butera and others 2005). Skills distribution

can also be adversely affected if the most highly educated (and therefore marketable) health workers emigrate to more secure countries. The exodus from both Angola and Sudan, for instance, led to greater use of lower skilled workers to meet demand once the conflict stopped (High Level Forum on Health Millennium Development Goals 2005). In short, a lack of central authority may shape or accentuate preexisting labor market imbalances, such as those between urban and rural workers or between worker skill levels.

International donor interventions and support may also profoundly affect health labor markets in these contexts. For weak or fragile states, donors often provide ministries of health substantial short-term budget support to enable continued provision of health services. Such support often targets personnel who remain in the public sector, providing salary incentives, for example; or to help nongovernmental organization (NGO) health providers to deliver services in the place of the public sector (Doull and Campbell 2008). Any such actions hold implications for the labor market.

In the Democratic Republic of Congo, for instance, donors supported long-standing involvement of faith-based organizations and NGOs, with the latter co-managing more than three-quarters of local health zones in the 1980s. The Democratic Republic of Congo subsequently built up public sector delivery capacity, but the violence that followed the fall of the Mobutu regime in the 1990s resulted in the near collapse of public services. Faith-based organizations and NGOs assumed responsibility for almost all the country's services—and today manage more than half the facilities (Waldman 2006).

In Mozambique internal distortions among public sector health workers were exacerbated during the civil war, from the mid-1970s until the early 1990s—both in skills (in the 1980s, unskilled staff made up about half the public health workforce, and fewer than 5 percent had a university education) and geography (such as a strong urban and hospital bias). With significant postwar technical and financial assistance from international agencies, the share of unskilled staff dropped to 36 percent 10 years later, and professionally trained staff grew to 64 percent. Geographic deployment also saw improvements (WHO 2009).

In short, donor choices in these cases—taken in the context of weak state capacity—affected the human resources labor markets. Their choices shifted the balance of provision to the private sector, making the market the arbiter of human resource distribution, even when supporting public services.

Regime Type

Most political regimes in Sub-Saharan Africa claim to be multiparty democracies, but in fact range from relatively liberal democracies to "thinly veiled personal dictatorships," with the majority somewhere in between (Collier and Levitsky 1997). The locus of power frequently lies with the executive branch (such as the president), which has historically used state resources to support networks of political clients (van de Walle 2002). Political scientists have attempted to demonstrate a relationship between basic types of regime—from authoritarian to democratic, and even more refined distinctions between—and government policies. But little evidence emerged that one type of regime is more conducive to major reform, such as for redistribution of land, and even less for specific health sector policies (Bienen and Herbst 1996).

Even so, recent reforms under two distinct types of regimes in Sub-Saharan Africa suggest that regime type may influence policies affecting health labor markets. A competitive political environment in some democracies can create conditions favoring health worker reforms.

Ghana's relative success, including that in human resources, is one (rare) example. The country's ability to maintain its democratic regime while implementing different policy reforms, without generating major ethnic or class conflict, has created a good environment for reforms. Other countries will probably require major changes to establish such environments.

But some countries with authoritarian governments have also succeeded. Such regimes emerged from military insurgencies, and are led by progressive elites interested in mobilizing international resources toward new socioeconomic policies. Like authoritarian regimes elsewhere that do not rest on democratic legitimacy, such as China, Cuba, and Vietnam, these Sub-Saharan regimes aim to offer the population services or economic opportunities as a means of retaining power.

In Ethiopia, Rwanda, and Uganda, for example, regimes emerged that were committed to overcoming internal conflicts by providing better services to their populations—not only to establish legitimacy, but also to promote healing within society. Over time, relatively progressive governments have developed in these countries, growing the capacity to enforce decisions that implement reforms, including those affecting health workers. Certainly, not all authoritarian regimes are interested in this kind of legitimacy, preferring repression to services or economic opportunities: Zimbabwe is a striking example. It is also possible that these currently progressive requires may change their orientation over time. Still, such progressive authoritarian regimes are more capable of carrying out health workforce reforms than failed states or weaker democracies torn by ethnic conflicts, such as Kenya.

Political Entrenchment

Many innovations affecting health labor markets take a long time to realize their goals. Political entrenchment—the stability of a particular political elite—can thus affect not only whether reforms are attempted, but also whether they are seen through consistently, or repeatedly changed. Under authoritarian regimes or even democracies that lack true political contestation, for example, political commitment to a particular reform may be sustainable over a long period. Conversely, pluralist democracies with a highly contested balance of power may face difficulties in sustaining commitment to reforms.

Entrenched elites can also block reforms, particularly those in autocratic regimes. In addition, a lack of commitment can inhibit reforms. While governments in Uganda have generally been dedicated to fiscal decentralization, for instance, top-level leadership has not shown commitment to a planned public-private partnership in health strategy. This strategy remained dormant due to government inaction and lack of civil society pressure (Peters and others 2009). Zambia, Ethiopia, and Rwanda are three examples of countries where political entrenchment affects policies governing health labor markets (box 7.1).

Health Sector Governance

The combination of organization arrangement, political regime or legacy, and government regulatory policies can shape public-private balances in health labor markets. A sectoral balance heavily weighted toward publicly provided services, for instance, may be associated with *de facto* or *de jure* limits on private sector opportunities, dampening the free labor market. States' capacity to enforce regulations directed at private labor markets (such as dual-practice) may similarly affect the public-private labor market balance and outcomes.

State or Private

In some contexts historically left-leaning political orientations led to health care markets dominated by the public sector. In Ethiopia a long

history of socialism significantly dampened private sector development until the mid-1990s, and even today the public sector is more dominant than in other Sub-Saharan countries (PSP-One 2007). Similarly, Tanzania banned private for-profit practice in 1977. Although the ban ended in 1991 (individual clinical practice was permitted), research in the early 2000s suggested that private for-profit facilities continued to struggle to survive, inhibited by institutional norms favoring religious-affiliated operations. Often these religious-affiliated operations not only charged higher prices than for-profit facilities for a common set of services, but

Box 7.1

Political Entrenchment and Health Sector Reforms

Under democratic or authoritarian regimes the degree of political entrenchment, power, or stability can determine policies and reforms in the health sector.

- *Zambia.* In the 1990s health workers were partly delinked from employment with the Ministry of Health, and granted contracts with newly created central or district boards of health. Delinking brought greater flexibility in staff financing, including user fees. After a few years, however, the government regarded the system as a policy failure, recentralizing it in 2006 and abolishing user fees. In both the delinking and relinking decisions, politics played a role. An intended full delinking to boards of health never took place because of labor union protests, and the subsequent relinking reflected political events, including the election of a new government "intent on bringing a 'new deal' for Zambia" in health, and the departure of a minister of health who had championed the previous reforms.
- *Ethiopia.* Since 1994 the Ethiopian government has conceptualized, initiated, and driven large-scale fiscal decentralization. Its statist approach was the most important factor in promoting adherence to policies. Accompanying the continuing fiscal decentralization, a recent important health sector reform pushed a large-scale expansion of community health extension workers. With more than 30,000 health extension workers deployed nationwide, this policy affects health labor markets into the future. Just as the fairly powerful position of the ruling party helped the earlier efforts to decentralize, its entrenchment may prove important in sustaining this expansion, despite limited financial resources.
- *Rwanda.* As part of a series of health reforms the government institutionalized performance-based financing, which pays facilities based on achieving outputs instead of providing inputs. Piloted in two districts in 2001–02, and scaled up nationwide only five years later, this approach has benefited from sustained political commitment from the president downward, as well as significant donor support. Both elements are central to the push to use performance based financing. They have also contributed to the remarkable speed in going from pilot testing to nationwide implementation.

Sources: Peters and others (2009) for Ethiopia; CHESSORE and Wemos Amsterdam (2008) for Zambia; and Rusa and Fritsche (2007) and chapter 13 of this volume, for Rwanda.

also developed services specifically for patients with greater ability to pay (partly because of better access to outside investment such as donors) (Mackintosh and Tibandebage 2002).

In other contexts where underlying political leanings have not borne directly on public-private market distribution, the private sector may play a larger role in service delivery, even though regulations tilt the balance toward the public sector. In Zambia 80 percent of health workers work in government-owned health facilities, though the proportion of private health workers has grown. Fairly strict regulations help drive this publicprivate balance, such as bonding requirements for graduates of public medical schools (who must work for 18 months in public institutions after graduation), national guidelines that hinder the opening of private clinics, and policies that apparently discourage private sector expansion (Garcia-Prado and Gonzalez 2007; PSP-One 2007).

Similarly in Ghana only 65 percent of health workers are publicly employed. Part of the reason may be bonding requirements that affect cadres—nurses, for example, must either work up to five years for the Ministry of Health or repay schooling costs. While some workers obtain exemptions from these requirements, the system channels the large majority of health graduates into the public health sector after they graduate (Buchan and McPake 2007; Garbarino and others 2007).

Across all kinds of political contexts and in most countries in Sub-Saharan Africa, underdeveloped state capacity to regulate the private sector affects health labor markets. Although private health expansion is an explicit government policy in Ethiopia, poor regulatory capacity provides ample room for private moonlighting during public working hours, as well as self-referrals by public workers to private practice (Lindelöw and Serneels 2006). In these ways, the capacity to regulate and monitor the private sector affects opportunities to work there, as well as desire to do so, regardless of official regulatory policies.

Decentralization

Over the past 25 years governments in Sub-Saharan Africa and elsewhere have widely adopted decentralization in the health sector, and in the public sector more generally, shifting decision making from central to local officials. In health, fiscal decentralization aims to give local authorities greater discretion in using financial resources, while administrative decentralization confers greater local authority over a number of functions, such as managing human resources, organizing and delivering services, and targeting rules for coverage or exemption from fees. Although organizational reforms in Sub-Saharan Africa often focus on fiscal decentralization, some governments have also conferred greater authority over a range of human resource functions—from procedures for candidate selection to setting salary levels and bonus payments.

Governmental motivation to decentralize human resource functions frequently stems from a reaction to inefficiencies in central management of health personnel. In a typical central system, as in Kenya, a public sector commission (across civil service or across the health sector) is responsible for almost all human resource management, including determining local facility and area staffing requirements, allocating posts, selecting candidates, controlling staff movements and termination, and determining conditions of service, such as salary and allowances (Vujicic, Ohiri, and Sparkes 2009). Decentralizing selected health workforce is a policy option to redress deficiencies in centralized administration and, as governments hope, to improve health labor market outcomes. In terms of efficiency, local recruitment could shorten the time it takes to fill a position, eliminating many steps in central approval. Local authority over hiring could also improve the chances that candidates willing to serve across the country are matched to positions, as local units can make the selection. When such units set salaries and allowances, they can consider local labor market conditions and attract and promote the best candidates if they have sufficient financing to offer appropriate incentives. Decentralized authority may eventually improve the quality of care as well. Health personnel drawn locally and willing to serve locally may be more motivated and productive in the workplace (Bossert 1998).

These arguments are often made to support decentralization. But some evidence suggests that local authorities may not have enough knowledge, funding, or management capacity to exercise these roles, or that local political conditions and corruption might reduce the ability of even skilled and motivated local administrators to make appropriate decisions. Decentralization can take a variety of forms, involving a range of

human resource powers. Relationships between particular decentralization arrangements that affect health labor markets are often mediated by oversight capacities of officials (both local and national) and mechanisms of accountability to both national and local authorities.

Deconcentration, delegation, and devolution. One aspect of decentralization policy is determining who receives greater decision-making power. Some forms of decentralization focus power on local health administrators: the deconcentration of authorities to line-ministry officials at lower levels of the system, for example, or delegation to semiautonomous institutions.

Other forms are more political, such as devolving of authority to local governments (Rondinelli, Nellis, and Cheema 1984). In practice, systems of decentralization can be hybrids. Mozambique, for example, has devolved some responsibility to provincial governors—primarily decisions on health workers with preuniversity training—who may then delegate it to provincial directors of health. During the 1990s, these arrangements kept the management of physicians fairly centralized (Saide and Stewart 2001).

Human resource functions. A second aspect is how much authority is granted for various decisions. Subnational authorities may get power to decide on human resource functions, including hiring and firing, tenure (salaried or contracted), compensation, transfers, performance management, skill mix (such as establishing jurisdictional staffing and facility staffing patterns), and training. Many countries decentralize only some health workforce power, and corresponding human resource functions, such as those involved in primary health care or lower level cadres. Our review suggests the following five generalizations for Sub-Saharan Africa.

First, governments can decentralize fiscally without doing the same for human resources. Although Ethiopia, Kenya, and Mali devolve budgetary decisions on health to local governments, the centers keep control of most health workforce functions.

Second, consistent relationships between the official form of decentralization (deconcentration, delegation, or devolution) and decentralized health workforce authority are hard to discern. A deconcentrated context such as Namibia's may tend toward even greater local decision making than more extensive forms of decentralization, such as delegation in Ghana or devolution in Kenya.

Third, decentralization may affect only some (often lower) health cadres and institutions. Districts in Tanzania take the lead in recruiting and contracting lower staff positions, but only initiate these procedures for higher levels. In Uganda nearly all hospital workers are exempt from decentralized management (Ssengooba 2005; Steffensen and others 2004).

Fourth, the decentralization of human resource functions is often limited to basic administrative functions (such as transfers, training, and maternity leave) and not the myriad other functions previously cited. In Tanzania and Uganda base salaries largely follow civil service norms, but nonsalary remuneration comes under local government authority. Fifth, health worker decentralization does not seem systematically related to regime type. The traditionally authoritarian regime in Rwanda covers a range of health workforce functions, while those in Ethiopia (another traditionally authoritarian regime) or Mali (heralded for its democratic institutions) are limited primarily to fiscal matters.

These trends show exceptions, but decentralization for human resource functions is limited. One reason for this limitation is that historical practices hinder local-authority innovation, relying on promotion by seniority, deferring to national civil service standards rather than performance

or other locally relevant criteria (Das Gupta, Gauri, and Khemani 2003; Olowu and Wunsch 2004).

Evidence on Decentralization and Health Labor Markets

Designing studies that persuasively demonstrate decentralization's impact on health sector performance, including health labor markets, is difficult. Lacking such studies, we make the following three points, drawing on specific observations.

First, decentralization can improve some conditions that affect health labor market outcomes while worsening others, or leaving them unchanged. In Uganda most management functions are under district authority, while salary scales and payroll management remain centralized. Reflecting on that divide, interviews with 800 health workers in 2005 suggest that health personnel supply improved (interviewees felt that district employment processes were generally much faster than previously centralized ones), distribution may have improved (poorer districts usually had higher levels of workers in their home districts than in wealthier ones, which can help retention), and motivation may have improved (75 percent of interviewees expressed satisfaction at receiving salary more predictably and quickly under a decentralized process). Box 7.2 describes a stakeholder account of salary consolidation in Ghana.

Yet decentralized recruitment proved frustrating and costly for many job applicants, potentially affecting the future stock of workers. Many workers felt geographically isolated due to new administrative obstacles to cross-district transfers. And many felt that local selection was prone to nepotism and capture by local governments (Ssengooba 2005). Similar evidence has been documented in other Southern African countries (Tanzania) and worldwide (Indonesia, China), suggesting that such experiences may not be uncommon either in Sub-Saharan Africa or internationally.[1]

Box 7.2

A Stakeholder Account of Salary Consolidation in Ghana

Ghana's effort to consolidate salaries illustrates the impact of political influence on the shape of reforms that affect health labor markets. In 1999, lobbying by the Ghana Medical Association to address a lack of overtime compensation culminated in the Additional Duty Hour Allowance scheme for doctors. The scheme was administratively cumbersome, incurred ballooning costs, and was opposed by the Nurses Association for creating unequal pay. To address these problems, the public workforce's formal employer—the Ghana Health Services—hired an outside consultant (a Ghanaian national residing abroad) to work with a team of mid-level technocrats to reform the job evaluation process and recommend a new salary structure.

It became clear that the proposed reforms would lead to major changes in procedures for compensation and promotions, replacing the discretion granted to local managers with a more merit-oriented process. At that point, the Ministry of Health wrested control of the reform from the Ghana Health Services, delegating negotiations to higher level stakeholders from the Ministry of Health, Ghana Health Services, Ministry of Finance, staff of the Presidency, IMF advisors, and Chief Executives of the main Teaching Hospitals, along with the hired consultant. Pockets of opposition surfaced, including chief executives of the teaching hospitals (who reported directly to the Minister of Health and resisted being equated with heads of regional hospitals who reported to the Ghana Health Services) and the Ministry of Health's director of human resources (who reportedly objected to sharing responsibility for implementing the reform with other departmental directors). A personal rivalry among key officials further complicated agreement over the plan.

The Ministry of Health took ownership of the reform when the Minister of Health, upon recommendations of others, removed the consultant so that reform could be done "within Ghana." After hiring an in-country Ghanaian consultant to

work with their officials, the Ministry of Health abandoned the scheme developed by the original consultant and the Ghana Health Services in favor of one developed using "their own intuition" about appropriate salaries. The new, consolidated salaries were offered to the professional associations as "take it or leave it" offers. Much turmoil ensued when the government proceeded to pay the wage bill for health workers according to these new salaries. Nonphysician health workers banded together to protest what they viewed as an unfairly large gap between the salaries of doctors and other workers. Nurses in particular complained that the government had abandoned the objective process put in place by the consultant, and some initially went on strike (but eventually accepted the salaries reluctantly).
Source: Blanchet 2009.

Second, the capacity to exercise authority often mediates relationships between labor markets and the decentralization of human resource functions. Such decentralization can be administratively costly and require basic organizational changes, taxing national resource capacities.[2] Those charged with managing human (and other) resources rarely have the training (Uganda) or the staff (Rwanda, with only 35 people at the central Ministry of Health office). Rwanda's central office has responded by deconcentrating management functions—for example by giving district health facilities sole responsibility for district staff management—but it is unclear whether these staff possess the skills to manage all aspects of human resources at their level (Vujicic, Ohiri, and Sparkes 2009). In Kenya, even though districts are expected to manage performance of the public health workforce, they do not have the legal mandate to do so (Steffensen and others 2004). And in Tanzania a study of health workers in two districts found that poor recordkeeping and management undermined the employee appraisal system, and few appraisals were carried out (Manzi and others 2004). Capacity constraints in carrying out decentralized powers can therefore affect a variety of labor market outcomes, from the local active stock to individual motivation.

Third, accountability mechanisms matter—an aspect that is important from the perspective of political economy as well. Reports from countries where locally elected governments play a role in decentralized health workforce management suggest that employment procedures can be vulnerable to local capture. In Tanzania weak local institutions overseeing human resource management are reportedly "easily manipulated" by local elites (Munga and others 2009). Qualitative data suggest that some health workers there feel that political interference in recruitment by district officials—including threats against health managers if they do not select local politicians' candidates—resulted in selecting unqualified workers. Indeed, even though the government reduced the powers accorded to district politicians to address such concerns, there are indications of continuing politicization (Munga and others 2009). Such problems have also been reported in Uganda, where health workers have complained of favoritism in employment toward "sons and daughters of the soil" (Ssengooba 2005).

Stakeholder Influence

A common thread through the preceding discussion is that the interests of different stakeholders shape policy for the health workforce, from designing and adopting new policies to implementing them. Those with such a stake often have a strong interest in maintaining the system, while others see opportunities to benefit from reforms. Developing political strategies to work with stakeholders to address the power of various actors can be crucial for the success of reforms affecting health workers and their labor markets.

Because health policy reforms usually seek to either alter or entrench

the balance of power between stakeholders, political challenges are common—particularly for workforce reforms. To push through reforms, decision makers must assess the political feasibility of a policy, manage policy design and acceptance, and create strategies that improve the prospects for implementation (Reich 1996). Such assessment involves evaluating the positions of different stakeholders on the proposed changes, the power they can exercise in deciding on those changes, and the opportunities and obstacles that the governance context offers. Health policy reform generally involves common sets of stakeholders, with often similar roles in, and positions toward, specific policy reforms (table 7.1).

The ministry of health leads many reforms, but civil service rules and other ministries affect the types of reform that it can initiate. In Swaziland it had to negotiate with the Ministry of Public Works to lift a ban on recruiting foreign nurses to address in-country shortages (Kober and Van Damme 2006). Similarly, reforms and policies for preservice education of professional health workers often fall under the purview of the ministry of education (see chapter 16).

Still, committed political leadership can overcome significant opposition, as the recent decision by Ethiopia's prime minister to increase substantially the production and deployment of physicians—against the resistance of medical schools and professional associations—demonstrates.[3]

Professional associations and unions also play an important role, often initiating salary-related reforms while blocking initiatives that affect labor market structures, such as changing a country's skill mix, task shifting, or introducing nonphysician health workers. Associations in Ethiopia strongly resisted junior physician health officers, managing to suspend the program for several years (Bossert and others 2007).

International donors are increasingly involved in making and supporting policies on human resources for health. Their influence in extremely weak states, where they are often the dominant source of public financing, can shape labor markets. In other contexts, they work in conjunction with each other and with the national government, to varying degrees of comfort.

In sum, although stakeholder positions may be similar across countries in Sub-Saharan Africa, as elsewhere, their powers and roles vary considerably depending on the regime characteristics, nature of reforms, and reformers' skills in building coalitions of support and reducing opposition. Since political processes are not easily determined by generally observed rules, each case requires careful analysis and testing of different strategies.

Conclusion

This chapter's analysis suggests the following in Sub-Saharan Africa:

- Experiences in fragile and failed states that are unable to enforce state policies can lead to an exodus of skilled health workers, unless donors intervene heavily.
- States with relatively stable political regimes can demonstrate capacity to spearhead policy reforms and marshal international financial assistance in ways consistent with improving labor market outcomes. These may include democratic states that have avoided political polarization or fracturing, as well as those founded on a history of authoritarianism or insurgent military coalitions, but dominated by an elite committed to reforms that improve service delivery.
- State-dominated health systems appear to be moving toward more market-oriented systems, and greater regulation is likely to depend on overall state capacity.
- The impact on labor markets of decentralizing heath workforce functions is generally limited because of continued centralized salary

levels, which also create accountability issues affecting labor market outcomes.
• Stakeholder analysis highlights the political and governance issues that arise among key stakeholders in reforms affecting health labor markets.

This brief review suggests that more systematic study of the constraints and opportunities of different governance structures, processes, and stakeholder interactions would provide evidence-based guidance for recommendations on improving human resource policies in different country settings. In a field dominated by wish lists of technical recommendations for human resource policies, many never adopted or implemented, we need to pay attention to the political processes and the structural constraints that require careful strategies if we are to change policies in a positive direction.

Notes

1. See Dominick and Kurowski (2004); Kimaro and Sahay (2004); Munga and others (2009); Tang and Bloom (2000); Thabrany (2006); and Turner and others (2003).
2. Evidence from outside the region suggests that the financial implications of decentralization can be heavy: Mexico spent an estimated $450 million in administrative costs to transfer its federal health employees to the states (Homedes and Ugalde 2005).
3. Interviews of officials in Ministry of Health by second author 2008.

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