6 Support the workforce

Knowledge Summary: Women's & Children's Health

Boosting the capacity of the health workforce is an integral part of health systems strengthening, and has to be a priority for achieving MDGs 4 and 5. A strong health workforce helps countries to uphold women's and children's rights to health and quality care. Countries and their partners have to commit to long-term support, coordinate across the public and private health sectors and forge inter-sectoral links.[1] In the short term, some countries have made significant progress through innovative approaches, such as task-shifting and incentive-based programs for the health workforce.[2]

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The Partnership for Maternal, Newborn & Child Health

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The problem

Midwives, nurses, doctors and frontline health workers are a crucial part of any health system, but currently, in many places, there are simply too few.[3] A study of 198 countries found that maternal and child death rates were higher in those with fewer health workers.[4] The Global Health Workforce Alliance asserts that: "One decade into the 21st century, the world continues to face a health workforce crisis of unprecedented proportions."[1]

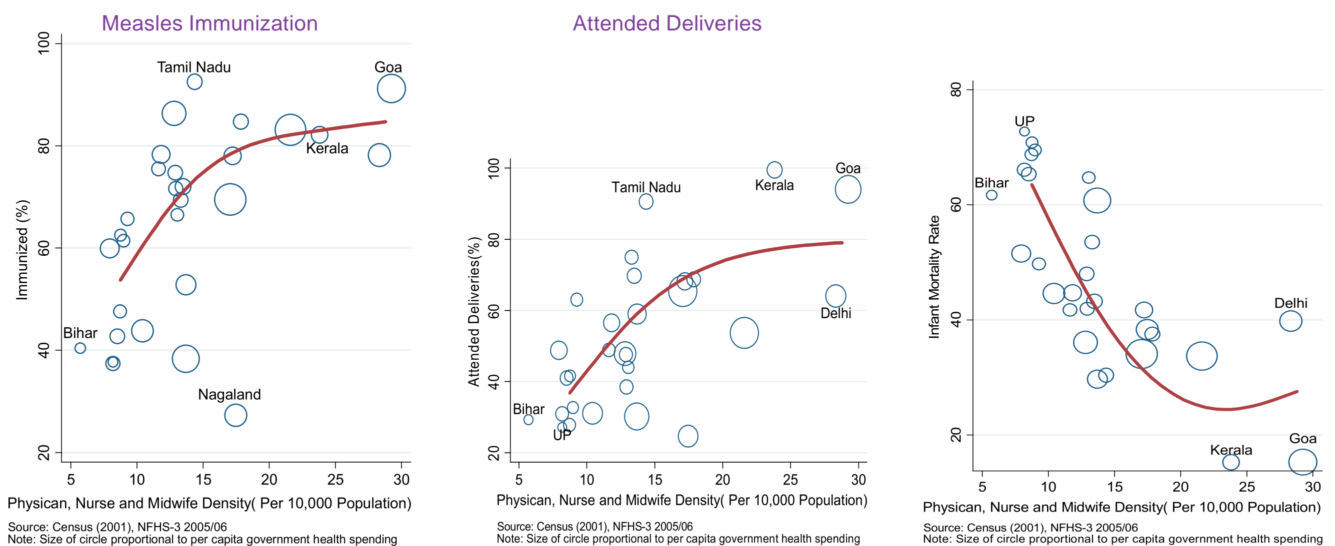
What do we know?

The shortage of health workers worldwide is the result of multiple, complex factors, including too few people being trained in the relevant skills. There is an uneven distribution of health workers within and across countries. Highly skilled medical workers, such as obstetricians, pediatricians and other specialists, tend to be concentrated in urban areas and are more likely to seek employment in other countries, contributing to the so-called "brain drain".[4] Health workers face problems such as lack of opportunities for further training and career progression, low salaries,[5] poor work environments and unsupportive supervision/management. These factors affect workers' motivation and performance, which adversely affect both the quality of care and health outcomes.

Recent analyses emphasize the strong link between the number of health workers, the use of health services and health outcomes in different Indian states.[4, 5] A 2008 study by the Public Health Foundation of India and the World Bank shows that higher worker density is associated with higher measles immunization, more attended deliveries, and lower infant mortality (see Figure 1). However, variations in these outcomes indicate that: "there are several factors other than the workforce density which are influencing health and service utilization. This includes, among other things, the efficiency of health workers, their quality, their distribution and composition."[6]

Figure 1

Health workers save lives: India's health workforce, service utilization and health outcomes



Source: PHFI and the World Bank (2008). "India's Health Workforce: Size, Composition, Distribution." *www.hrhindia.org/Paper1/Health_service_utilization_and_the_health_workforce.html*

What works?

Countries need to train, employ and effectively deploy adequate numbers of health workers. However, while scaling up is essential, it is not always enough. Countries also need to build the capacity of existing workers so that they perform better, and create an environment that encourages them to stay in areas where the need is greatest. This has already been shown to work in some contexts.

Improving skilled attendance through different recruitment methods

Countries need to prioritize active recruitment of more midwives and nurses. In some places (e.g. Ethiopia, Ghana and Pakistan) however, recruiting more frontline community health workers is helping to ease acute shortages in the immediate term, and is aiding deployment of workers to

Box 2 – What countries can do now: 29 actions to scale up and improve the health workforce

The World Health Organization and the Global Health Workforce Alliance have recently identified seven key issues to strengthening the capacity of the workforce, and proposed 29 actions to address these.

Two illustrative examples are:

Issue One: How can countries pay for scaled-up employment of Human Resources for Health (HRH)?

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).
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.

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

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: e.g. The USAID-funded Capacity Project.
24. Involve HRH managers in strategic decision-making processes of ministries of health.
25. Work with schools of business administration and private providers of health services to develop modules on HRH management.

Further information on the other issues and action statements can be found at:
www.who.int/workforcealliance/knowledge/publications/taskforces/actionpaper.pdf

Source: World Health Organization and the Global Health Workforce Alliance (2009). Taskforce on Human Resources for Health Financing.

the areas of greatest need[7] (see Box 1). The recruitment of local residents and training of married women in rural areas as nurses or midwives helps to improve retention.[7] To meet short-term needs, task-shifting could also be a cost-effective way to train, retain and strengthen the workforce.

The private sector may be able to help countries reduce health worker shortages in some places.[8] In other cases, decentralized recruitment and financing has been used, alongside special allowances and other incentives, to improve the efficiency of hiring and retaining frontline health workers on flexible short-term contracts.[9] However, decentralization may not be effective for recruiting higher cadre workers, or to effect an equitable distribution of workers across districts, as found in Tanzania.[10]

Continuing education and training helps, particularly when supervision is good

Evidence shows that health workers who continue their education, training and professional development enhance not only their knowledge and skills, but also their motivation.[11] However, this has to be accompanied by good management and continued supervision, if any short-term improvements in performance are to be maintained. For example, high workloads in India[12] and poor management techniques in South Africa[13] adversely affected performance, despite training.

Education and training that raises awareness of health systems issues and problems helps health workers to develop a solution-focused approach to their work, thereby improving their performance and patient relationships.[7]

Financial incentives help when combined with non-financial incentives

Performance is improved by higher salaries or additional payments and allowances (for example, higher salaries linked to remote locations, housing benefits and school fees), because they motivate staff and increase job satisfaction.[14] In Rwanda and Cambodia, linking financial rewards to health facility performance has helped to improve quality and uptake of care. However, to retain staff, strategies that combine financial incentives with non-financial incentives appear to work better.[10, 15, 16]

Box 1 – Lady health workers in Pakistan

Pakistan has faced serious problems retaining skilled health care practitioners. So, in 1994, it began training a cadre of "lady health workers" (LHW). They were tasked with providing essential primary health care services to the communities where they lived. Working in tandem with local health authorities and clinics, each LHW is responsible for 1000 individuals living within her area. The target is to deploy 150,000 LHWs by the end of 2011. The total cost per year is only US$745 per LHW, or less than 75 cents for every individual that a LHW is responsible for.

Source: The Global Health Workforce Alliance. "Catalyst for Change." 2009 Annual Report (PDF)
www.who.int/workforcealliance/knowledge/resources/ghwa_annualreport_2009.pdf

Good supervision and management, and supportive colleagues, help motivation; while performance is influenced by patient satisfaction, positive feedback and collegial environments.[10]

However, financial incentives are typically much smaller than salaries in major urban areas, in developed countries or in the private sector, so they do not affect migration patterns unless other work-related issues exist.[17] In Samoa, for example, doctors preferred to migrate despite being well-paid. Reasons included long working hours, high workloads and links with families who lived overseas.

Some terms explained

Task shifting: "A process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications." *(WHO & GHWA, 2008:7)*

Skilled attendant at delivery: is an accredited health professional — such as a midwife, doctor or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns."

Source: Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO. Geneva, World Health Organization, 2004.
www.who.int/making_pregnancy_safer/documents/9241591692/en/index.html

Conclusion

Evidence shows certain strategies work, but are very context specific. A review of 55 studies on attracting and retaining staff in remote and rural areas concluded that no single solution could be applied across countries.[18] Usually, a set of interventions is more effective than a single intervention, but this has to be determined by local needs. For example, Thailand was able to improve access to care in rural areas by recruiting local people, training them in rural areas and assigning them to places close to their home towns. In Indonesia, doctors in rural areas were paid twice as much as those in urban areas, and were also given specialist training.[19]

Ultimately, improvements have to occur across the health system to enable health workers to deliver effectively (see Box 2). Governments and international organizations have to provide the required funding, coherent health workforce plans, and policies to manage global migration as an integral part of global accountability.

Useful resources

- WHO and GHWA (2008): Scaling Up, Saving Lives (PDF). www.who.int/workforcealliance/documents/Global_Health%20FINAL%20REPORT.pdf
- UNFPA and University of Aberdeen (2004): Into Good Hands: Progress Reports from the Field. www.unfpa.org/public/site/global/lang/en/pid/2048
- Human Resource Projection Tool for maternal and newborn health. www.who.int/making_pregnancy_safer/countries/hr_projection_program/en/index.html
- WHO (2010): Models and tools for health workforce planning and projections. *Human Resources for Health Observer.* www.observarh.org.br/nesp/upload/arquivos/models_tools_hwf_eng.pdf

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3 *Countdown* to *2015* decade report (2000–10): taking stock of maternal, newborn, and child survival, (PDF) www.*Countdown*2015mnch.org/documents/2010report/*Countdown*ReportAndProfiles.pdf
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