Meeting human resources challenges: Regional experiences

Dr. Palitha Abeykoon
• Journey and destination.....
• The global and regional situation

• Major HRH issues and responses in countries of the Region

• What have been the lessons?

• Conclusions
• Start with some things that everyone knows
• HRH considered to be commonsense - all have opinions on HRH aspects – unlike the sciences
• There are some time-tested principles
• Finally no one has got everything right re HRH – it is a continuing endeavour to get the “best fit”
human resources for health mean..

......all the workers who collectively support a health service.

• work at all levels of the system from the community through to the specialist hospital or the Ministry of Health.

• work in numerous capacities including as doctors, nurses and midwives, allied health personnel, planners and policy makers.

• (WHO, 2006).
“Truisms you all know..”

• HRH (health workforce) by itself has little meaning... makes sense only when it relates to provision of health care.

• Health workforce is the most expensive single item in health services.

• Health care needs to be affordable, with universal coverage and of good quality......health workforce should therefore subserve this goal...

• Boosting Health workforce capacity is an integral part of health system strengthening...
Health workers save lives....

• People deliver health. It was investment in the world’s health workers—from community workers and barefoot doctors to nurses and physicians—that made possible the science-based health revolution of the 20th century.

• Strong links between the density of health workers and health services provided and health outcomes (PHFI and WB).

• The number, quality, and configuration of human resources shape the output and productivity of health systems.
Figure 1.2  The glue of the health system

- Financing
- Technologies & drugs
- Infrastructure
- Knowledge & information

Human resources
Two key HRH goals

1. Achieving the right balance (number, type, distribution) in a country's health workforce (quantitative).
   Also to provide the tools and supplies for them to practice effectively and efficiently. A practitioner without adequate tools is as bad as having tools without practitioner.

*(Concerns HRH Planning and management/deployment)*
Two key HRH goals (contd...)

2. Relevance of education and training programmes (qualitative).
   Important question here is relevant to what?

*(HRH Production)*
Key issues: which mix of policies?

- How do we plan how many health workers to educate, and employ?
- How can we improve recruitment, retention and return?
- How can we determine and deploy the most effective skill mix of staff?
- Which incentives are effective in motivating staff?
- How do we improve productivity?
Key questions pertaining to the context in human resources in health care

- the level of economic development in a particular country
- sociodemographic, geographical and cultural factors.
- Health care financing
What then are some of the key balance and relevance issues in SE Asia?

• Inadequate numbers of some personnel, and excesses in others
• No balance between different categories and skill mixes and No team concept in health care
• Poor quality of education and training – low skills
• No continuing professional development
• Poor supervision and support
• Low motivation
• Migration – internal and external (rule of $\frac{3}{4}\text{ths}$)
Factors affecting the development and implementation of HRH policies

- Context, including the political and socioeconomic environment, disease patterns, and the influence of various stakeholders

- Policies, including macroeconomic policies and government organizational reforms, health sector policies and reforms, and HRH policies

- Support systems, including information, human resources, and financial resources that go into HRH planning and implementation
Relationship between health system inputs, budget and expenditure categories

(Reductions of inputs are shown in parentheses)
• The slide identifies three principal health system inputs: human resources, physical capital and consumables. It also shows how the financial resources to purchase these inputs are of both a capital investment and a recurrent character. As in other industries, investment decisions in health are critical because they are generally irreversible: they commit large amounts of money to places and activities that are difficult, even impossible, to cancel, close or scale down [1].

• Human resources, when pertaining to health care, can be defined as the different kinds of clinical and non-clinical staff responsible for public and individual health intervention [1]. As arguably the most important of the health system inputs, the performance and the benefits the system can deliver depend largely upon the knowledge, skills and motivation of those individuals responsible for delivering health services [1].
Global perspectives on HRH (WHR 2006)

- Estimated shortage of almost 4.3 million health care workers worldwide.
- 57 countries, mostly in sub-Saharan Africa have critical shortages—a few in SEA also.
- Sub-Saharan Africa has only 4% of health workers but 25% of the global burden of disease (GBD).
- The Americas have 37% of health workers but only 10% of GBD.
WHR Report, 2006

Figure 1.2 Distribution of health workers by level of health expenditure and burden of disease, by WHO region

Data sources: (3, 18, 19).
Not a level playing field…… (WHR 2006)
Density of doctors, nurses and midwives in the 49 priority countries

Uzbekistan: 134
Kyrgyz Republic: 80
People’s Rep of Korea: 74
Tajikistan: 70
São Tomé and Príncipe: 24
Nigeria: 20
Solomon Islands: 15
Uganda: 14
Myanmar: 13
Vietnam: 13
Lao People’s Dem Rep: 13
Kenya: 13
Pakistan: 12
Ghana: 11
Cambodia: 10
Yemen: 10
Comoros: 9
Zimbabwe: 9
Benin: 8
Mauritania: 8
Burkina Faso: 8
Zambia: 8
Afghanistan: 7
Nepal: 7
Dem Rep of the Congo: 6
Eritrea: 6
Côte d’Ivoire: 6
Gambia: 6
Guinea-Bissau: 6
Papua New Guinea: 6
Bangladesh: 6
Central African Republic: 5
Senegal: 5
Madagascar: 5
Rwanda: 5
Haiti: 4
Mozambique: 3
Togo: 3
Chad: 3
Malawi: 3
Liberia: 3
Mali: 3
Ethiopia: 3
Tanzania: 3

Critical threshold = 23 doctors, nurses and midwives per 10,000 population
Review of Nursing Workforce

- demand for care outstripping supply
- nurse staffing difficulties in some regions/specialties
- increasing competition from other employers
- need for increased use of support workers to “free up” nurses to focus on higher level care
- need for increased emphasis on nurse retention, and returner nurses (migration high in some countries)
The percentage of foreign-educated physicians working in Australia, Canada, the United Kingdom (UK) and the United States (US) is currently reported to be between 21% and 33%. Foreign-educated nurses represent only 5% - 10% of these countries' nurse workforce. While the percentages of migrating nurses are much smaller than those of physicians, the absolute numbers are always increasing and represent an important depletion of the source countries' supply of nurses. Thousands of nurses, the vast majority of them women, migrate each year in search of better pay and working conditions, career mobility, professional development, a better quality of life, personal safety, or sometimes just novelty and adventure (Kingma, 2006).
Nurse migration

- New Zealand reports that 21% of its nurses are trained abroad, (WHO, 2006).
- In Switzerland, 30% of employed registered nurses are foreign-educated; and in at least one university hospital 70% of new recruits are from abroad.
- In 2005, 84% of the new entrants to the Irish nursing register were foreign-educated.
- Same in UK and increasingly in US.
- In 1990 nurses came UK from 71 countries, but by 2001 they came from 95 countries.
- Between 2001 and 2002 for the first time there were more overseas nurses added to the register in the United Kingdom than there were local nurses.
- US currently has a ready market of over $5 billion in nursing jobs that cannot be filled. By 2006, there will be over $20 billion in unfilled nursing jobs.
- By adding England, Canada, Germany, Japan, Norway and all the other developed economies, there will be a very high global demand for nurses in coming years.
- There is no doubt that foreign-educated nurses make a significant contribution to the delivery of healthcare in most industrialized countries and in many developing countries, with regional or sub-regional hubs, for example South Africa, attracting nurses from neighboring countries by offering better pay, working conditions, and/or professional development opportunities.
Nurse migration

• developed countries exploit ‘push’ factors, which make some nurses in developing countries willing to cross national boundaries

• Why do not more nurses migrate?
  – Lack of adequate communication skills
  – Lack of cultural reorientation
  – Lack of professional skills and training
  – Lack of a comprehensive strategic plan for the exportation of skilled manpower (including nurses).
• The Philippines is the leading country in supplying quality nurses abroad. India is rapidly catching up.

• Thailand ~ enhancing the national capacity to cope with the shortage ~

• Singapore ~ an open and transparent policy for foreign nurses ~

• PR China ~ an emerging star with strong government support ~

• The ASEAN Mutual Recognition Arrangement on Nursing Services is a small step forward to achieving the overall objective of the movement of natural persons (MNP) in the ASEAN region.
• Highly skilled workers are shifting from poorer to richer regions and from the public to the private sector.
• Two decades of health sector ‘mis-reforms’ treated health workers as a cost burden, not an asset.
Notes...

• I will try to illustrate some of these and end with a few suggestions that may be relevant to Myanmar and countries in the Region.

• We must remember that no one size fits all. The solutions depend on the context, the state of the economy and the allocations to health, the goals of the health system and the way the system is managed.
What is the standard ratio of nurse to doctor?

- There is no standard ratio of nurse to doctor.

- However, the WHO and the World Bank advocate that nurses and midwives could deliver most of the minimum essential public health and clinical services, with doctors providing clinical supervision and direct care of complex issues and complications.

- As a rule of thumb, suggest that the ratio of nurses to doctors should exceed 2:1 as a minimum with 4:1 or higher considered more satisfactory for cost-effective and quality care.

- The Commission of Macroeconomic and Health (2001) also noted that many of the health care interventions provided at community level can be carried out by people other than doctors: by nurses, midwives and other paramedical staff of various degree of training.
A WHO source has noted that ‘There is no absolute norm regarding the ‘right’ ratio of physicians or nurses to population. This depends on (1) demand factors, e.g. demographic and epidemiological trends, service use patterns and macro-economic conditions; (2) supply factors, such as labour market trends, funds to pay salaries, health professions education capacity, licensing and other entry barriers; (3) factors affecting productivity, e.g. technology, financial incentives, staff mix, and management flexibility in resource deployment, and (4) priority allocated to prevention, treatment and rehabilitation in national health policies. Generally, shortages or oversupply are assessed based on comparisons with countries in the same region or at the same level of development’ (WHO 2001).

In a more recent WHO led paper examining the issue of imbalances in the health workforce (Zurn et al. 2002) the authors noted that there are both ‘economic’ and ‘non-economic’ definitions of skill imbalance, and that these imbalances may be ‘static’ or ‘dynamic’. If static, they are likely to respond only slowly, if at all, to market forces due to regulatory mechanisms, monopoly situations or wage controls, which can exist in health care labour markets.
• First, address supply side issues: improve recruitment retention, recruitment and return

• Address factors related to work environment and a decentralised style of management, flexible employment opportunities, and access to continuing professional development to improve both the retention and patient care.

• Developed countries exploit ‘push’ factors, (low pay, poor career structures, lack of opportunities for further education), which make some nurses in developing countries to cross national boundaries (see WHO 2006).
• Second, for sustainability dealing with demand side challenges needed (Buchan 2006).
• These should be based on the recognition that health care is labour intensive and that available nursing resources must be used effectively. As noted earlier, shortage is not just about numbers, but about how the health system functions to enable nurses to use their skills effectively.
Myanmar

• Doctor-population ratio stands at 1:1,722
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total health expenditure (THE) as% of GDP</td>
<td>2.2</td>
<td>2.7</td>
<td>3.1</td>
<td>3.5</td>
<td>3.5</td>
<td>3.4</td>
<td>3.8</td>
<td>3.5</td>
</tr>
<tr>
<td>Government health expenditure (GHE) as% of THE</td>
<td>28.5</td>
<td>34.7</td>
<td>48.0</td>
<td>54.4</td>
<td>41.0</td>
<td>38.3</td>
<td>47.2</td>
<td>63.9</td>
</tr>
<tr>
<td>Social security funds as% of GGHE</td>
<td>9.6</td>
<td>21.3</td>
<td>0.8</td>
<td>0.8</td>
<td>12.2</td>
<td>24.1</td>
<td>7.2</td>
<td>12.4</td>
</tr>
<tr>
<td>Private health expenditure on (PHE) as% of THE</td>
<td>71.5</td>
<td>65.3</td>
<td>52.0</td>
<td>45.6</td>
<td>59.0</td>
<td>61.7</td>
<td>52.8</td>
<td>36.1</td>
</tr>
<tr>
<td>Private households’ out-of-pocket payment as% of PHE</td>
<td>75.4</td>
<td>74.3</td>
<td>78.9</td>
<td>74.2</td>
<td>81.8</td>
<td>77.3</td>
<td>80.4</td>
<td>76.6</td>
</tr>
<tr>
<td>Prepaid and risk-pooling plans as% of PHE</td>
<td>4.3</td>
<td>6.0</td>
<td>9.0</td>
<td>13.2</td>
<td>6.6</td>
<td>12.8</td>
<td>9.5</td>
<td>15.6</td>
</tr>
<tr>
<td>External resources on health as% of THE</td>
<td>1.4</td>
<td>1.2</td>
<td>0.61</td>
<td>0.02</td>
<td>2.5</td>
<td>2.6</td>
<td>0.02</td>
<td>0.24</td>
</tr>
</tbody>
</table>

Table 3: Summary population, service coverage, and financial protection in seven countries in southeast Asia in

Figure 2: Fiscal space in the context of insurance coverage and general government expenditure
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaysia</td>
<td>4.4</td>
<td>44.4</td>
<td>55.6</td>
<td>6.9</td>
<td>0.0</td>
<td>0.4</td>
<td>40.7</td>
<td>307.2</td>
<td>604.4</td>
</tr>
<tr>
<td>Thailand</td>
<td>3.7</td>
<td>73.2</td>
<td>26.8</td>
<td>13.1</td>
<td>0.3</td>
<td>7.1</td>
<td>19.2</td>
<td>136.5</td>
<td>285.7</td>
</tr>
<tr>
<td>Philippines</td>
<td>3.9</td>
<td>34.7</td>
<td>65.3</td>
<td>6.7</td>
<td>1.3</td>
<td>7.7</td>
<td>54.7</td>
<td>62.6</td>
<td>130.2</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2.2</td>
<td>54.5</td>
<td>45.5</td>
<td>6.2</td>
<td>1.7</td>
<td>8.7</td>
<td>30.1</td>
<td>41.8</td>
<td>81.0</td>
</tr>
<tr>
<td>Vietnam</td>
<td>7.1</td>
<td>39.3</td>
<td>60.7</td>
<td>8.7</td>
<td>1.6</td>
<td>12.7</td>
<td>54.8</td>
<td>58.3</td>
<td>182.7</td>
</tr>
<tr>
<td>Laos</td>
<td>4.0</td>
<td>18.9</td>
<td>81.1</td>
<td>3.7</td>
<td>14.5</td>
<td>2.3</td>
<td>61.7</td>
<td>26.9</td>
<td>83.9</td>
</tr>
<tr>
<td>Cambodia</td>
<td>5.9</td>
<td>29.0</td>
<td>71.0</td>
<td>11.2</td>
<td>16.4</td>
<td>0.0</td>
<td>60.1</td>
<td>36.8</td>
<td>108.1</td>
</tr>
<tr>
<td>Low income</td>
<td>5.3</td>
<td>41.9</td>
<td>58.1</td>
<td>8.7</td>
<td>17.5</td>
<td>4.6</td>
<td>48.3</td>
<td>26.8</td>
<td>67.0</td>
</tr>
<tr>
<td>Lower middle income</td>
<td>4.3</td>
<td>42.4</td>
<td>57.6</td>
<td>7.9</td>
<td>1.0</td>
<td>15.8</td>
<td>52.1</td>
<td>80.2</td>
<td>181.0</td>
</tr>
<tr>
<td>Upper middle income</td>
<td>6.4</td>
<td>55.2</td>
<td>44.8</td>
<td>9.4</td>
<td>0.2</td>
<td>21.0</td>
<td>30.9</td>
<td>487.9</td>
<td>757.0</td>
</tr>
<tr>
<td>High income</td>
<td>11.2</td>
<td>61.3</td>
<td>38.7</td>
<td>17.2</td>
<td>0.0</td>
<td>25.6</td>
<td>14.0</td>
<td>4405.2</td>
<td>4145.0</td>
</tr>
<tr>
<td>Global</td>
<td>9.7</td>
<td>59.6</td>
<td>40.4</td>
<td>15.4</td>
<td>0.2</td>
<td>24.6</td>
<td>17.7</td>
<td>802.3</td>
<td>862.5</td>
</tr>
</tbody>
</table>

Data from the World Health Statistics, 2010. In accordance with National Health Accounts conventions, external finance is included within government and private shares (which sum to 100%). Private health expenditure includes out-of-pocket payments, private social insurance, and other private insurance. International dollars are used when comparing across countries. US dollars are used when looking specifically in one country. THE=total health expenditure. GGHE=general government health expenditure. SHI=social health insurance. PPP=purchasing power parity. int$=international dollar. NA=not available.

Table 2: Key indicators of health financing in seven countries in southeast Asia in 2007
Gap ratio between highest and lowest province HRH densities in 4 countries

- Indonesia: 19.92 (10.5 Nurse) to 18.58
- Cambodia: 18.58 (3.86 Nurse) to 15.72
- Thailand: 12.51 (5.74 Nurse) to 6.77
- Vietnam: 4.63 (2.36 Nurse) to 2.27

Maldistribution of doctor > nurse except in Vietnam
How the countries responded to the challenges

• Shortages
  – Increase production quickly to compensate for the shortages but may compromise quality
  – Up-graded assistant doctors to be doctor (Vietnam)
  – Rotate high qualified staff to work in rural area (Vietnam)
  – Role of private sector (Philippines and Indonesia)
  – Skill-mix, professional mix, task shifting

• Point for consideration
  – Quality VS quantity (in resource poor countries, scale up lower cadres may have to take into consideration—shorter time, lower costs)
  – Employment opportunity for newly graduated
How the countries responded to the challenges

• Maldistribution
  – Incentive (financial and non-financial)
  – Compulsory placement
  – Rural recruitment for education

• Point for consideration
  – Comprehensive strategies
  – Sustainability
Average Monthly income of doctors with different working experience in different settings, Thailand, 2010 ($US)

Source: Tinnakorn Nori
• Another critical area for policy intervention is to achieve effective skill mix-through clarity of roles and better balance of nurses, physicians, other health professionals, and support workers.

• The evidence base on skill mix is developing, and many studies highlight the scope for effective deployment of clinical nurse specialists and nurse practitioners in advanced roles.
### Geographical distribution (Nepal)

<table>
<thead>
<tr>
<th>HRH indicators</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total medical doctors</strong></td>
<td>5,869</td>
<td>6,739</td>
<td>7,616</td>
<td>8,575</td>
<td>9,596</td>
</tr>
<tr>
<td>(% in private )</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td><strong>Doctor per 1,000 pop : total</strong></td>
<td>0.24</td>
<td>0.28</td>
<td>0.30</td>
<td>0.34</td>
<td>0.37</td>
</tr>
<tr>
<td>Doctor per 1,000 pop: capital</td>
<td>1.41</td>
<td>1.47</td>
<td>1.52</td>
<td>1.58</td>
<td>1.66</td>
</tr>
<tr>
<td>Doctor per 1,000 pop: outside</td>
<td>0.11</td>
<td>0.13</td>
<td>0.14</td>
<td>0.1</td>
<td>0.17</td>
</tr>
<tr>
<td><strong>Nurse per 1,000 pop : total</strong></td>
<td>1.72</td>
<td>1.88</td>
<td>1.00</td>
<td>1.16</td>
<td>1.26</td>
</tr>
<tr>
<td>Nurse per 1,000 pop: capital</td>
<td>3.40</td>
<td>3.84</td>
<td>4.15</td>
<td>4.44</td>
<td>4.69</td>
</tr>
<tr>
<td>Nurse/ 1,000 pop: outside capital</td>
<td>0.40</td>
<td>0.50</td>
<td>0.57</td>
<td>0.66</td>
<td>0.73</td>
</tr>
</tbody>
</table>
## Sri Lanka

<table>
<thead>
<tr>
<th>HRH Indicators</th>
<th>2006</th>
<th>2008</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor per 1,000 pop: total</td>
<td>0.57</td>
<td>0.68</td>
<td>0.72</td>
</tr>
<tr>
<td>Doctor/ 1,000 pop: capital city</td>
<td>1.4</td>
<td>1.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Doctor /1,000 pop: outside</td>
<td>0.4</td>
<td>0.7</td>
<td>0.8</td>
</tr>
<tr>
<td>Nurse per 1,000 pop: total</td>
<td>1.2</td>
<td>1.5</td>
<td>1.4</td>
</tr>
<tr>
<td>Nurse per 1,000 pop: capital city</td>
<td>1.8</td>
<td>2.1</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Indonesia

- 2010 = 42467
- 2009 = 51789
- 2008 = 44759
- 2007 = 38600
Sri Lanka (workforce predominantly in govt)

• **Positive Factors**
  1) **Government Policy - Mahinda Chinthana Vision for a new Sri Lanka** - shows the political.
  2) **Incentives - Leave for training**
     • Government sponsorship for training courses
     • Low interest loans: distress loans; car loans; duty free concessions
     • Concessions to work in difficult areas:
  3) **Development Partners and HRH networks**

• **Barriers**
  1) **Lack of Coordination**
     no overall human resources policy and development plan existing in the country
  2) **Poor Motivation**
     • Next to salary and incentives are training and
     • Training are not universally
     • Performance management activities have to be improved
  3) **Labour relations**
     • The role of Trade unions as an influencing factor in determining HRH.
Indonesia

**Barriers:**

- Planning HRH is not yet supported by the accurate and timely HRH information system.
- Mismatch between supply and the HRH requirement due to inadequate HRH review.
- Training curricula of HRH education mostly have hospital orientation rather than Primary Health Care.
- Maldistribution of HRH, while career development, reward and punishment system has not been fully applied.
- Positives are there is capacity in HRH management and is that HRH production is relatively well funded
Vietnam

Three positive factors:
• Commitment from high policy makers
• Good coordination among HRH stakeholder
• Good resources for HRH

Three barriers:
• Poor accreditation system
• Inappropriate remuneration, incentive for health workers, especially for rural and remote areas
• Weak HRH information for policy makers
HRH in China

Positive factors:

- Abundant medical and health educational resources for health professional production in China.
- The importance of health workforce development has been gradually recognized by the health policy-makers and the whole society.

Barriers:

- Mal-distribution of HRH between urban and rural areas, between public and private sector, and between under developed areas and developed areas.
- Income and benefits for health professionals still at low level in contrast with the and effort they dedicate to improving people’s health status.
The challenges for ensuring appropriate human resources for health

- The lack of overall investment in the health system.
- A shortage of staff especially in the more isolated or rural areas.
- A lack of appropriate strategies or a longer term vision for human resources, including staff training and development initiatives.
- Low levels of general education, especially of women, which restricts the numbers which can be trained up to join the health workforce.
- Low levels of staff pay, often lower than other professions, and poor administrative structures to ensure the payment of salaries on a regular and timely basis.
- The use of unofficial measures by health staff to compensate for their low salaries. These measures may include working in private clinics or other employment to top-up their wages or attending training workshops and sessions to collect on the per diems. Staff may resort to charging fees to patients for drugs, tests and treatments, and retaining some of these payments for themselves.
HRH policies and strategies – can group them into three categories:

- **Context**, including the political and socio-economic environment, disease patterns, and the involvement and degree of influence of various stakeholders;

- **Policies**, including macroeconomic policies, health sector policies and reforms, and HRH policies themselves;

- **Support systems**, including information, human and financial resources that go into HRH planning and implementation
7 Barriers to HRH development: summary from the region

1. HRH planning capacity poor, information base weak

2. Poor HRH management and inadequate performance appraisal

3. Weak career ladder, Incentives planning and skill-mix

4. Poor accreditation systems and HRD institutions lack accountability.

5. States/regions with greatest human resource needs also have the lowest capacity of producing them

6. Mushrooming of private hospitals / training institutions

7. Brain drain of trained manpower.
Notes

• distribution of medical and nursing colleges across the country highly skewed. Continuing political instability with frequent change of governments
• How do countries address these issues?
• How well?
Rational Utilization, e.g. redistribution of health workers

**Indonesia**

- Change from mandated service to contracts for MDs, nurses in remote areas who get higher pay with new graduate placement

**Sri Lanka**

- Relax rules in order to allow publicly employed doctors to engage in private practice.

**Myanmar**

- Mandatory 3-year public service for all general doctors before entering private practice. Train voluntary health assistants and TBAs (only pay is from patients).

**Thailand**

- Recognition of rural service
Health Personnel Compensation and Management Strategies

Indonesia
• Test a "reward and incentive system" in some areas, to encourage greater "professionalism”

Sri Lanka
• Develop recruitment scheme and promotional grades for all categories. Develop incentives linked to performance, in-service training, service in remote or conflict areas, and opportunities for professional advancement.

Bangladesh
• Reconstitution of the Bangladesh Nursing Council
Rational Production, e.g. HRH educational development

**Indonesia**
- Center for National Education for HRH has authority to accredit health prof. education programmes.
- Decentralized production in Provinces
- Retrain some doctors in family medicine.
- Coordinate CE via Centre for Training & Education, with focus on management.

**Myanmar**
- Upgraded health prof. schools to Institutes & Unis & develop post-grad courses. Offer training in disease management and in-service training for nurses.

**Sri Lanka**
- Strengthen training facilities and create new ones.
- Develop P.G.new in-service training programmes.
Strategies for Attracting and Retaining Skilled Human Resources in Rural Areas

• Preference in postgraduate admission for those serving in rural areas of Thailand. Seems to be effective to attract doctors to rural areas for a fixed period as PG admission seems to be a priority for many young doctors; additional weightage is being given for each year of rural service.

• Higher gross emoluments on contract to doctors willing to serve in rural areas.

• The three-year Rural Health Practitioner course in Assam and the Rural Medical Assistants program in Chhattisgarh are initiatives to be scaled up for implementation throughout the country.

• The continuous efforts at skill development among the ASHA’s and systems of getting them priority admission to ANM and nursing schools.

• New courses like the 18-week emergency obstetric and life-saving anesthetist skills and training programs to skill MBBS doctors with select specialist skills are innovative solutions to find specialist skills for rural areas.
Assessment of HRH policy implementation and impacts

• Indicators of progress vary widely across countries, making it difficult to accurately compare relative progress. Only a rough measurement tool could be devised to assess each country.

• The major factors contributing to the success appear to be:
  – Securing sufficient financial resources
  – Obtaining high-level political endorsement of HRH policy and strategies, and
  – Effective use of the four HRH policy development processes (listed above).
  – Rural-urban distribution
  – Retention and and external migration
  – Ratios of doctors to nurses
Myanmar

HRH indicators 2006 2008 2010
• Doctor/1,000 pop : total 0.34 0.38 0.41
• Doctor/1,000 pop: capital* 0.67 0.76 0.83
• Doctor/1,000 pop: outside 0.19 0.22 0.24
• Nurse/1,000 pop : total 0.36 0.38 0.41
• Nurse /1,000 pop: capital 0.71 0.77 0.82
• Nurse/1,000 pop: outside 0.20 0.22 0.23
# Distribution of selected categories of township level HRH

<table>
<thead>
<tr>
<th>Category of HRH</th>
<th>(HRH per 10,000 population for year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
</tr>
<tr>
<td>Medical doctors</td>
<td>2.96</td>
</tr>
<tr>
<td>Nurses</td>
<td>2.73</td>
</tr>
<tr>
<td>Health Assistants (HA)</td>
<td>0.49</td>
</tr>
<tr>
<td>Lady Health Visitors (LHV)</td>
<td>0.63</td>
</tr>
<tr>
<td>Public Health Supervisors grade1</td>
<td>0.15</td>
</tr>
<tr>
<td>Midwives</td>
<td>2.43</td>
</tr>
<tr>
<td>Public Health Supervisors grade2</td>
<td>0.31</td>
</tr>
</tbody>
</table>
Ratios between selected categories of HRH in Myanmar (2004)

<table>
<thead>
<tr>
<th>HRH categories</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses per Medical doctor</td>
<td>1.2</td>
</tr>
<tr>
<td>Health Assistants per Medical doctor</td>
<td>0.25</td>
</tr>
<tr>
<td>Midwives per HA</td>
<td>8</td>
</tr>
<tr>
<td>Midwives per LHV</td>
<td>6</td>
</tr>
<tr>
<td>PHS-2 per HA</td>
<td>0.5</td>
</tr>
</tbody>
</table>

*Source: Department of Health*
Myanmar- some HRH issues

• **numbers very impressive**
  • The Universities of Medicine gradually increased the intakes since 2000 - from about 550 to 1300 l students in 2001. dental 300; 300 pharm, technology 300).

• Nursing student intake had increased to 100 in 2001. Starting from 2003, it has been increasing up to (1200) nursing students from previous intake of (500) students. In the Midwifery Training Schools, student intake is (900) to (1000) annually.

• Postgraduate diploma courses, ( Department of Medical Science has produced (4103) nurses holding BNSc degree, (24231) nurses holding diploma degree and (31143) midwives at the end of 2010. In some disciplines difficult

• At present, doctor and nurse ratio is (1:1.2). It is planned to increase this ratio up to (1:3) in line with that of ASEAN countries.
Myanmar- some HRH issues

• Shortage, inappropriate balance and mix of skills, and inequitable distribution, common to most developing nations.

• Private health sector booming - Doctors and nurses working in the public sector also practices in private clinics - there could be double counting of the HWF.

• Migration not excessive but +.

• Definite need of reliable and updated HRH data base
HRH Research needed in Myanmar...

To determine:

- dynamics of HRH movements within the country as well as between countries;
- utilization of existing township and rural health facilities;
- how the tasks could be distributed between rural health team members;
- determinants of productivity of these HRH;
  - how an effective staff increase can be achieved by changing personnel and operating policies that lead to higher productivity and motivation of rural health staff
  - what should be a cost-effective skill mix for equitable coverage with essential health services in rural areas.
What of the future...........
Major trends in health care...determining HRH needs and demands

• Globalization
• Changing demography and epidemiology – ageing is crucial
• New technologies
• Rise in consumer sophistication
• Emphasis on costs and benefits
• Changing professional roles
• Ethical concerns
SEAR/ASEAN: Relative advantages

• Region trains own health workers to good standard-doctors, nurses, pharmacists
• Nursing relatively strong in Region
• Strong prof ethics in workforce in most countries/most cadres
• Intra-region and inter-country collaboration and support strong
As a priority WHO will address:

- The global shortage of all types of health workers, including support workers. This is especially critical in 57 developing countries -a few in South and South east Asia-
- The fact that insufficient HRH capacity and poor workforce performance will slow progress towards the health-related Millennium Development Goals (MDGs).
- The fact that the investments of Global Health Initiatives, private foundations, multi- and bi-lateral development agencies have had a reduced impact because of a lack of human and institutional capacity
- HRH international migration issues.
• What needs to be done.....
HRH planning

• Involve all stakeholders
• Try to have “stable” policies
• Make medium term and long term projections of demand and supply
• Plan for entire Health workforce and not singly
• Develop reliable HRH data base
• Use the IT systems now available for HRH planning - as Winston Churchill said "We have the tool[s], we must do the job."
HRH production

• Work closely with the health system managers and HR planners
• Develop accreditation systems for all training institutions.
• Design systematic continuing education programs
• Pay attention to stressing ethical values
• Emphasis on staff development
• Train local as much as possible; in “right place”
HRH management

• Effective HRH management strategies crucial to achieve better outcomes
• Close gaps between HRH polices and their implementation
• Develop rational policies for recruitment, deployment and retention
• No single strategy to all countries –HRM interventions can improve health workers' performance, but that different contexts produce different outcomes. e.g. Improving rural access to care in Thailand, India and Indonesia
Summary Conclusions:
Major Initiatives to overcome issues...

• Development of national strategic plans for HWF:
  “Every country, poor or rich, should have a national workforce plan shaped to its situation and crafted to address its health needs”

• Development of capacity in HRM – understand the health workforce and labor market dynamics

• Development of good HWF information system,

• Use regional and global partnerships optimally...

• Think global- act local.....
partnerships

• South East Asia Network of Nursing schools
• South East Asia Regional Association for Medical Education
• South East Asia Public Health Institutes Network
• Asia Pacific Action Alliance on Human Resources for Health
• World Federation of Medical Education
• WHO
• World Bank
Final comment.....

• All health care is ultimately delivered by and to people, and a strong understanding of human resources management is essential to ensure the success of any health care program.
Thank you very much.....