CHAPTER 3

Issues and problems relevant to recruitment, deployment, utilisation and retention

3.1 Introduction

Addressing the problem of migration for individual countries needs to be part of their overall approach to human resource development. The three familiar interacting components of the process of human resource development for health, namely policy/planning, education/training and management/utilisation each have significant effects on whether staff are subsequently retained in government health services or lost through migration or to more attractive opportunities within the country. This Chapter outlines the relevant issues and problems currently facing Commonwealth countries in each of these areas.

Analysis of the reports from each of the four Commonwealth regions[3,4,10,20] indicates that virtually all countries studied were experiencing problems, for at least some staff groups. The balance of factors contributing to the problems varied between countries and regions, but there were few, if any, instances where factors were identified that were unique to any one region or country.

3.2 Policy/planning

A clear national plan, identifying the goals and objectives of the health sector in the country within the budget available, is now acknowledged as a key factor in the effective recruitment, deployment, utilisation and retention of staff [2,3]. An integral part of the national plan must be a fully developed human resource plan[3,4,10] that is based on, and integrated with, the identified service needs, covers all groups and occupations together rather than in isolation, and is based on the objective of integrated teams of health workers[43]. This allows the appropriate numbers of staff and the balance of skills (professionals and auxiliaries) required for the service both now and in the future to be determined and, following review of sources of supply and likely losses, allows appropriate decisions to be made about the numbers and types of new personnel that should be trained. Many Commonwealth countries still lack such plans[5].

There are many reasons why Commonwealth countries lack fully developed human resource plans: conditions in recent years may have not favoured planning[4], there may have been a tendency for countries to view workforce planning as a "bolt on" extra that is of secondary importance to other priorities facing their health services[10] and there may be lack of personnel with the relevant skills to carry out such planning[3,4].

Failure to develop systems for maintaining a database on skills and human resources which will provide accurate data to feed into the planning process may contribute to inadequate planning. In the Commonwealth Caribbean countries, for example, it was noted that information systems which are crucial for decision making are absent or weak[3]; in the Pacific region much indicative information is not collected because of the unavailability of experienced statisticians and epidemiologists[3].

The result is that even where some planning has been carried out, it may not be very comprehensive or appropriate to the circumstances. Comprehensive efforts may not have been made to describe and fully understand the issues of staff retention[10] or external consultants may have done the planning, leaving countries with imposed solutions and unrealistic assessments and recommendations[5].

The consequences of lack of, or inappropriate, planning are significant. In India, for example, it appears to have resulted in the continued production of doctors far in excess of the country's needs, even when the output of private medical schools is disregarded[7]. In the African region, there has been a tendency to continue to produce the types of staff who emigrate[10]. In the Caribbean the consequences have been noted to include: outdated figures for the appropriate numbers of established posts, resulting in establishments that could not be afforded even if staff were available; staff whose educational and technical preparation is unsuited for tasks required; mal-distributions of staff between urban and rural areas; and poor utilisation of staff[4]. These consequences are similar elsewhere[3,10] and contribute to the problem of unproductive and/or demoralised staff[22] who are more likely to leave the service should an opportunity arise.

3.3 Education/training

Apart from inadequate planning within the health sector for the numbers of health personnel required, some countries in the Pacific region face particular problems related to the pre-service education and training. As elsewhere, the educational level of people accepted for pre-service health professional training is largely dependent upon the secondary education system. In Tuvalu, for example, the existing secondary school cannot fully meet the demand for secondary education. Standards vary from country to country, but in some countries the output of well-educated high school graduates may be low. As a result, only a small number of eligible people may be available to enter professional training. Low educational qualifications affected recruitment in at least one country in the Caribbean[3].

In the Pacific region the tradition of sending the brightest young people to secondary schools in Australia or New Zealand[3] may encourage their subsequent entry into health pre-service institutions abroad and they may not return to work in their home countries.

Traditionally, nurses have been educated in home countries in programmes provided and administered by the Ministry of Health[2]. Where both pre-service education and delivery of health services take place in the same institution, education may be compromised by the co-existing need for service delivery to patients[3]. Partly in response to this, nurse education worldwide is undergoing review and development. Increasingly, pre-service education in some countries is being provided in "main-stream" institutions under the auspices of Ministries of Education. Within the Pacific region, Samoa is perhaps the most advanced with a three-year diploma course for nurses at the University of Samoa. One undesirable side effect of this is that graduates can readily gain registration in New Zealand, and the loss of nurses from Samoa may increase in future.

Where skilled personnel are needed in relatively small numbers, governments are frequently unable to provide in-country training[3]. For example, there is no University in the Seychelles so that a number of doctors, nurses and pharmacists go abroad for continuing education. In the past, people from the Seychelles were educated in Eastern Bloc countries, Russia and Cuba. Since the Seychelles became a democracy, trainees have been educated in Australia, New Zealand, Zimbabwe and South Africa. An emerging problem is that, whereas people always returned from the Eastern Bloc as they were not permitted to register there, they do

not always return form Western countries which permit registration. A further disadvantage of educating doctors and nurses abroad in developed countries is that the education provided is not necessarily suitable for public health initiatives and rural health services in home countries[3].

In small countries, where the main need is for public health initiatives and rural health services, some specialist practitioners are required to deal with secondary and tertiary referrals. When specialist training is undertaken overseas, this can bring additional problems. For example, until recently, doctors in the Pacific region needed to study abroad to obtain post-graduate specialist qualifications[3] and donor agencies frequently fund post-graduate studies in developed countries[3]. On completion of their courses, doctors often wish to practise for a period before returning home. On return, however, they may find there are insufficient patients to maintain their specialist skills. Salaries may be low, and the country unable to offer increases. The doctors may not be able to meet their financial commitments and may choose to emigrate. There are also the attractions of a better life elsewhere[44,45].

Education in country may not obviate all the problems outlined above, particularly if the curriculum is not tailored to the needs of the country. In the African region, for example, it was noted that specialist training tended to be devised from curricula initially borrowed from developed countries, resulting in graduates who may not function well in their own less developed environments[10]. In the Asian region, it was noted that it is the doctors trained to international standards who migrate[10]. This has high economic costs, and may result in countries being less able to afford to train other health workers, which may be more suited to their health needs.

3.4 Management /utilization

The management and utilisation of personnel within health services is important as it affects working lives and individual decisions to remain in or return to government service[21,46]. The implementation of the public sector reforms currently being introduced in many Commonwealth countries, however, requires new management skills both centrally and locally and there is evidence that there has been a failure of managerial skills to keep pace. Decentralised decision-making forms part of these public sector reforms, and requires new performance management skills centrally, yet in many countries in the African region, with the possible exception of South Africa, personnel administration is still generally centralised and inefficient[10]. In the Caribbean, where there has been some decentralisation, the decentralised units are unable to assume management of transferred responsibilities, as those in management positions do not have the required knowledge and skills[4]. In the Pacific, there has also been some decentralisation, and a need for new knowledge and skills[3]. The failure of managerial practices and skills to keep pace with current requirements is reflected in poor human resource policies that contribute to poor retention and utilisation of staff[3].

These management shortcomings may be manifested in various ways:

- Recruitment procedures may be cumbersome, leading to considerable delays and frustrations even for staff trained within the country. The period of recruitment in Ghana (from application to receipt of first salary) averages one year[10]. The result of similarly drawn-out recruitment procedures in Lesotho was that none of one batch of newly qualified nurses from the National Health Training College were employed in the public service, despite the existence of vacancies[31]. Most were thought to have found employment either in the private sector or in South Africa. Slow recruitment and appointment of qualified staff is also a problem in the Caribbean[4]. Other

personnel practices such as conflict management and improving industrial relations may also be poor[4].

- Salary scales for professional groups may be perceived as inequitable. In the Caribbean, salary scales are developed within public service procedures and negotiated with trade unions that do not exclusively represent health workers, and the salaries do not necessarily reflect educational preparation or performance of health sector personnel[4].
- Terms and conditions of service and working conditions may be poor, particularly in rural areas. The responses to questionnaires sent to Caribbean countries implicated low remuneration, inflexible working hours, lack of educational opportunities, limited training, shortage of supplies and equipment, and poor working environments among the factors contributing to loss of health professionals[4]. In rural areas of the Caribbean these factors may be exacerbated by separation of staff from their families, poor housing with lack of electricity and clean water, and inadequate security. In the Pacific region, health workers in rural areas also experience problems related to the living environment and to educational opportunities for their children[3]. A further problem noted was that if relocation costs were paid, staff may be expected to stay for a given number of years that further reduced their opportunities for continuing education and for maintenance of skills. It may then be difficult for a health worker to "re-skill" even if the opportunity of relocation arose.
- Staff may be utilised poorly. Highly qualified staff may be required to undertake tasks below their level of skill/expertise. There may also be inadequate supervision of lower grades of staff[4]. Both situations can lead to low morale.
- Opportunities for promotion and career advancement may be limited. In the Caribbean, top-heavy management structures in certain professions, such as nursing, may create bottlenecks in the organisation/management structure, blocking opportunities for career advancement[4]. Promotion is often slow and in most instances tied to age or years of service rather than education, training, or performance. At the same time there are limited incentives for good performance and poor use of the performance appraisal system not sufficiently used to guide for staff development.

The consequences of these management weaknesses are significant. Not only do they lead to poor retention and utilisation of staff, but they also result in higher costs of turnover and replacement, the remaining staff may become overburdened and demoralised, quality of care may suffer and the amount of healthcare which could be provided is reduced[4].