Human resources for health
A Case Study for Ethiopia

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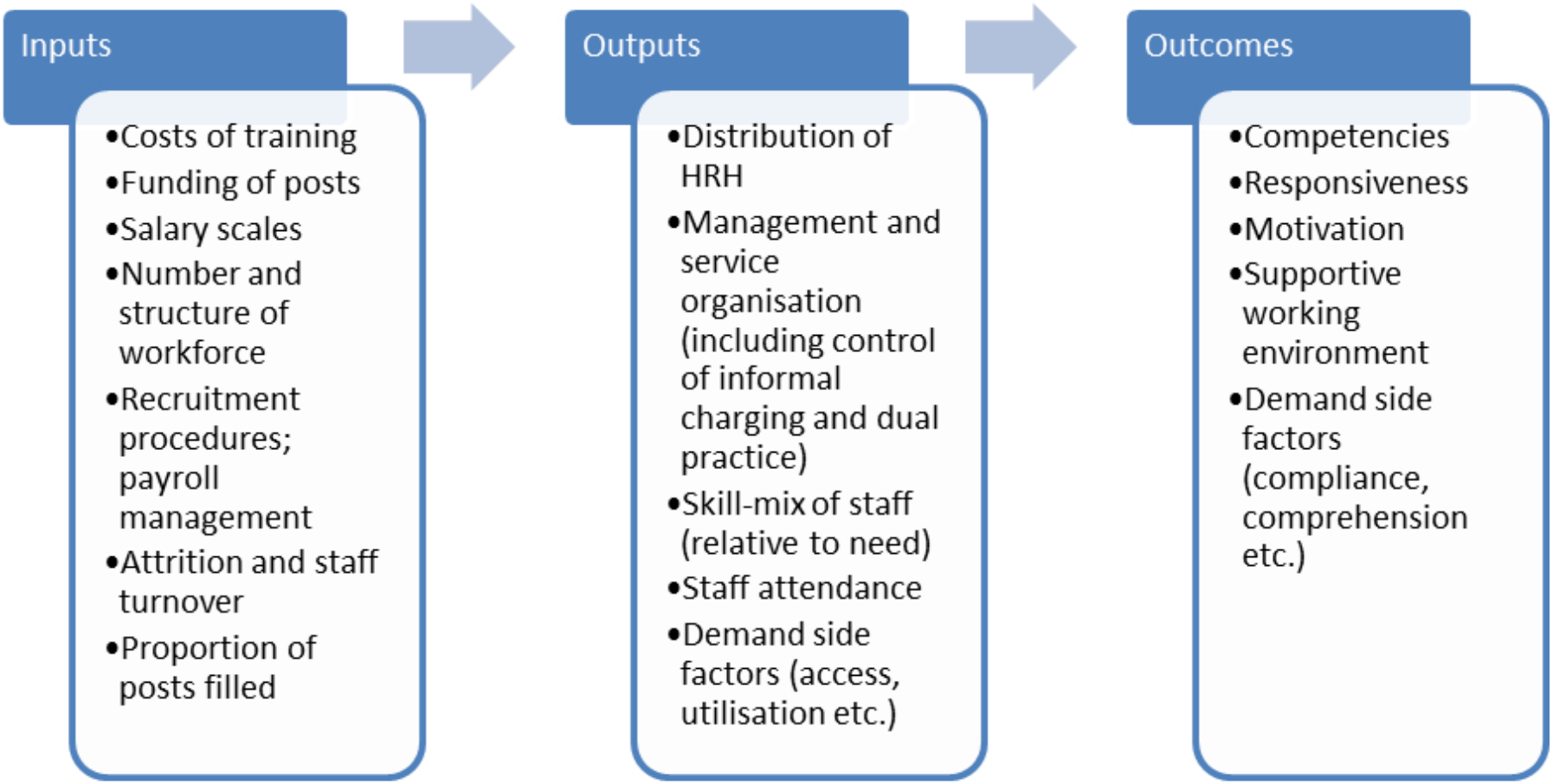
WHO WHR 2010

Category of inefficiency	Details
Medicines	Underuse of generics and higher than necessary prices for medicines
	Use of substandard and counterfeit medicines
	Inappropriate and ineffective use
	Overuse or supply of equipment, investigations and procedures
Human resources	Inappropriate or costly staff mix, unmotivated workers
Health services	Inappropriate hospital admissions and length of stay
	Inappropriate hospital size (low use of infrastructure)
	Medical errors and suboptimal quality of care
Health system leakages	Waste, corruption and fraud
Intervention mix	Inefficient mix/ inappropriate level of strategies

Human Resources for Health

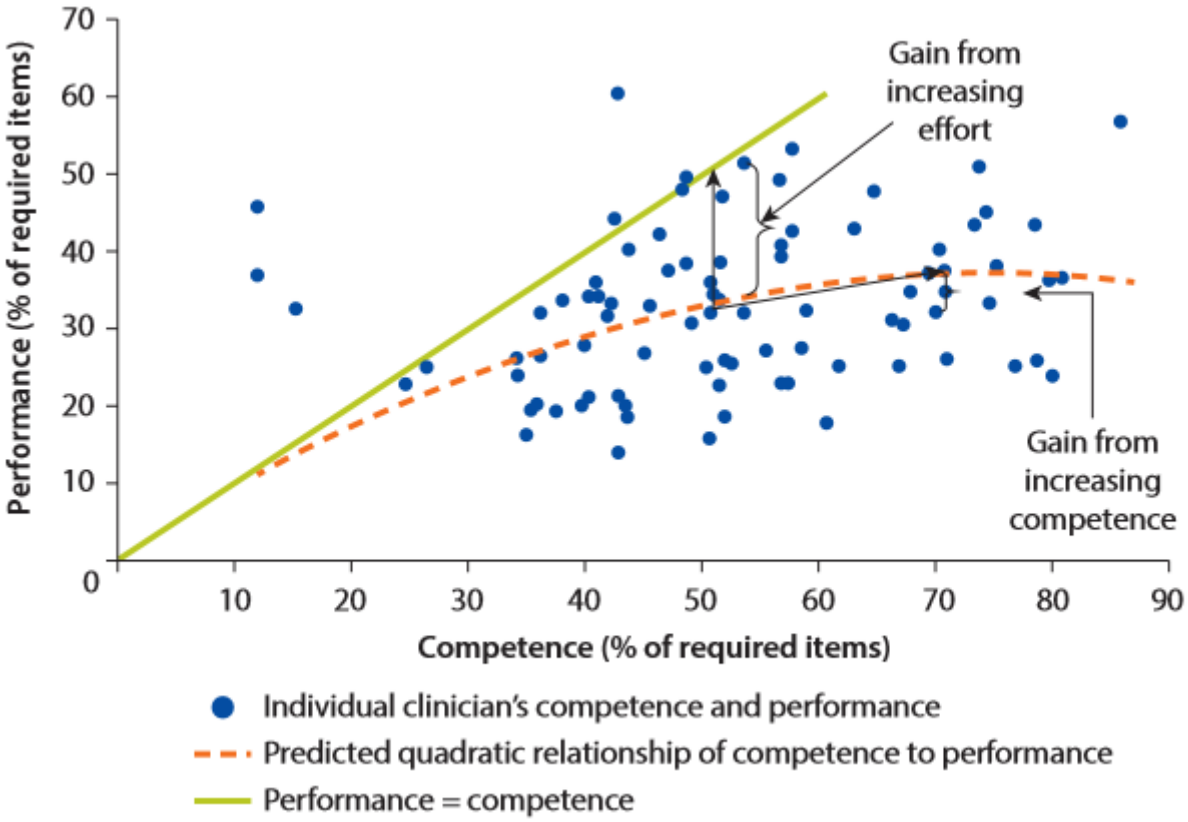


Wastage monitoring framework

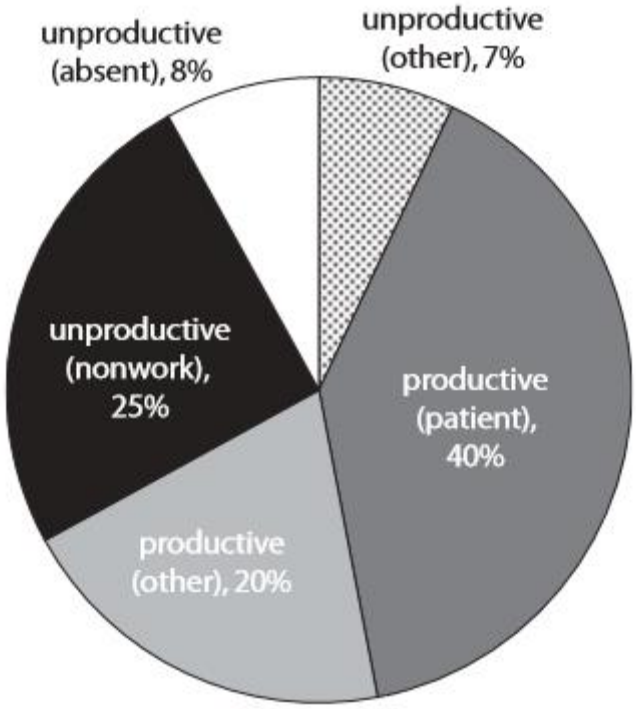
Direct wastage		
Factor	**Examples of contribution to wastage**	**Possible indicators**
Movement from health to non-health sector	Probably small: 2 – 20 staff per year (Ghana, Mozambique, Namibia)	%of job leavers exiting health work completely (exit interview)
Emigration to health sector outside country	10% of Mauritian nurses, 61% of Ghanaian doctors	Certificate verification rates Routine leaving data, e.g. resignations
Deaths, injuries and premature removal from the workforce	High significance of HIV/AIDS; Ghana 1.1% deaths compared with Malawi (<55%) of leavers	Mortality rates as % of workforce
Inappropriate administrative systems and policies	Affects other losses. Delays lose work input and may increase likelihood of emigration.	Average recruitment duration Staff recruitment rate versus vacancies

Indirect wastage		
Factor	**Examples of contribution to wastage**	**Possible indicators**
Wastage as unemployment	Not well documented in Africa. Estimates of “ghost workers”?	Unemployed health workers as % of total workforce (for each category)
Wastage as underemployment	Data is routinely collected, but staff/workload indicators may help.	Staff workload indicators, e.g. outpatient and inpatient staff per cadre
Wastage as misuse	Significant in countries with senior medics and nurses as managers	% of staff: technical or professional full-time managerial/administrative function
Wastage as inappropriate categories	4-6 categories to deliver package of services in Ghana	Workforce composition of skilled and semi-skilled staff
Absenteeism, low outputs	2.3 days’ sick leave per staff member versus 1.65 days off for all staff (Ghana)	Number of days off per staff member, per annum.
Misdeployment and maldistribution	Distribution differential: Doctors (Ghana): best 1:16201, worst 1:66071	Doctor/nurse population ratios in different parts of country.
Wastage from misadministration of HRH	Difficult to assess quantitatively: e.g. 100% of new Lesotho nurses not recruited in 1998	Recruitment and retention rates of new graduates of health training schools.

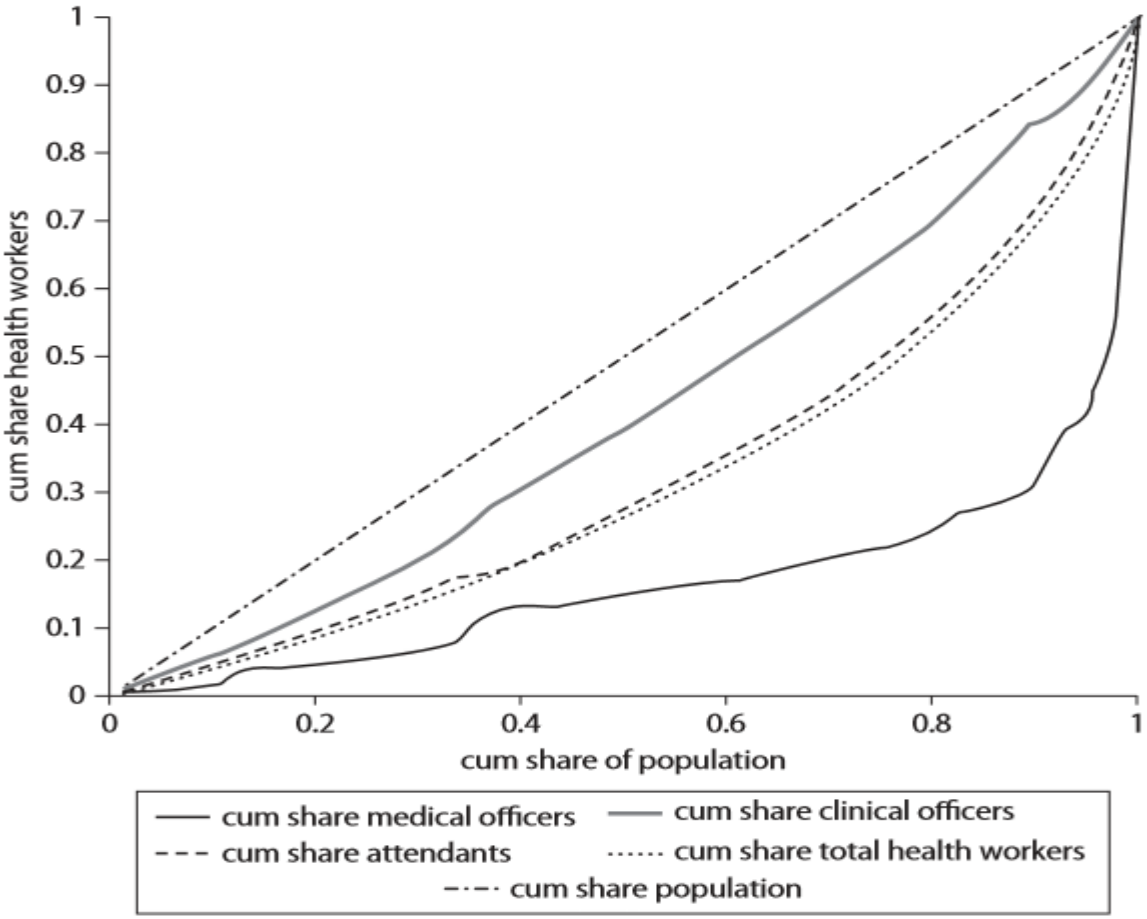
Can-do gap


Performance (% of required items)
70
60
50
40
30
20
10
0
10
20
30
40
50
60
70
80
90
Competence (% of required items)
Gain from increasing effort
Gain from increasing competence
Individual clinician's competence and performance
Predicted quadratic relationship of competence to performance
Performance = competence

Time use


unproductive (absent), 8%
unproductive (other), 7%
unproductive (nonwork), 25%
productive (patient), 40%
productive (other), 20%

Distribution



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Context

- HRH recognised to be critical component in BPR (Business Process Reeingineereing) and HEP (Health Extension Programme)
- Issues with availability, distribution, competence and motivation

Policy question

- Recognising the complexity and time it takes for HRH reform to be implemented, what are the priority questions that deserve attention?

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Approach

- Wide-ranging HRH study with focus on VfM

Table discussion

- Tables of 5-6 people
- Read the case study
- Discuss the questions
- Prepare for presentation of answers in plenary
- Total time: 60 min

Plenary discussion: 45 min

Thank you

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