Middle-East Journal of Scientific Research 12 (12): 1649-1656, 2012
ISSN 1990-9233
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DOI: 10.5829/idosi.mejsr.2012.12.12.16

Current Role of Human Resources in Health Sector

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Abstract: The role of Human Resources in healthcare sector and challenges it faces has always been an important area of research both in developed and developing countries. Public expectations and increasing financial pressures are requiring health services to adopt new approaches to the management of their resources, particularly human resources. This paper addresses the health care system from a global perspective and the importance of human resources management (HRM) in improving overall patient health outcomes and delivery of health care services, human resource indicators, human resource development, HR issues, characteristics of HR, HR policies.

Key words: HR · HRM · AMO · HRH

INTRODUCTION

Within many health care systems worldwide, increased attention is being focused on human resources management (HRM). Specifically, human resources are one of three principle health system inputs, with the other two major inputs being physical capital and consumables. 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.

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. As well as the balance between the human and physical resources, it is also essential to maintain an appropriate mix between the different types of health promoters and caregivers to ensure the system's success. Due to their obvious and important differences, it is imperative that human capital is handled and managed very differently from physical capital.

New pressures are emerging in most countries with public expectations and demands for health care increasing worldwide. It is evident that countries around the world are re-examining their approach to the provision of health care with the introduction of more radical solutions to the problems they face, including the recognition that health services must mobilize the resources available to them as efficiently and effectively as possible. At the centre of this resource issue are health care staff, both trained and untrained, who constitute the largest recurrent cost component of any health care service. This need for greater efficiency and effectiveness in the use of health human resources has in turn highlighted a requirement for improved management practice and more skilled managers within health systems as well as a need for a practical methodology to assess management performance and particularly the management of human resources.

Objectives of Hr Issues:

- To Share the current scenario of HR and its role in the healthcare industry
- To share some of the views that the mixed audience may have as to what does the world at large want from the HR function per say in a Hospital in the form of a group activity and presentation.
- Look at some of the issues that HR has to face today and discuss some of the main issues
- Participating in doing a test on communication to show the importance of the same.
- Come to a consensus as to what would be an Ideal HR Manager and Function

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The Impact of Human Resources on Health Sector Reform: When examining global health care systems, it is both useful and important to explore the impact of human resources on health sector reform. While the specific health care reform process varies by country, some trends can be identified. Three of the main trends include efficiency, equity and quality objectives.

Various human resources initiatives have been employed in an attempt to increase efficiency. Outsourcing of services has been used to convert fixed labor expenditures into variable costs as a means of improving efficiency. Contracting-out, performance contracts and internal contracting are also examples of measures employed. Many human resources initiatives for health sector reform also include attempts to increase equity or fairness. Strategies aimed at promoting equity in relation to needs require more systematic planning of health services. Some of these strategies include the introduction of financial protection mechanisms, the targeting of specific needs and groups and re-deployment services.

One of the goals of human resource professionals must be to use these and other measures to increase equity in their countries. Human resources in health sector reform also seek to improve the quality of services and patients' satisfaction. Health care quality is generally defined in two ways: technical quality and socio cultural quality. Technical quality refers to the impact that the health services available can have on the health conditions of a population. Socio cultural quality measures the degree of acceptability of services and the ability to satisfy patients' expectations. Human resource professionals face many obstacles in their attempt to deliver high-quality health care to citizens. Some of these constraints include budgets, lack of congruence between different stakeholders' values, absenteeism rates, high rates of turnover and low morale of health personnel.

Role of Good Hrm Practices: In recent years, it has been increasingly recognized that getting HR policy and management "right" has to be at the core of any sustainable solution to health system performance. In comparison to the evidence base on healthcare reform-related issues of health system finance and appropriate purchaser/provider incentive structures, there is very limited information on the HRM dimension or its impact. In many countries, access to health professional training and employment is controlled by standards and entry requirements determined by the professions and aspects of their work are regulated. The health sector is a major recipient of public and/or private expenditure and healthcare delivery is a politicised process. Recent research has also highlighted a so-called "prime building block" of HRM – the principle of "AMO". There must be sufficient employees with the necessary Ability (skills, knowledge and experience) to do the job; there must be adequate Motivation for them to apply their abilities; and there must be the Opportunity for them to engage in "discretionary behavior" – to make choices about how their job is done. The authors suggest that organizations wishing to maximize the contribution of their workforce need to have workable policies in these three broad areas.

Characteristics of HR Activities in the Health Sector: In HRM the two planning approaches are not mutually exclusive and can even be complementary. The rational approach encourages a recognition of the role of information, of modern analytical techniques and of decision-making tools for developing coherent policies These are necessary but not sufficient conditions. The second approach brings an appraisal of the political, economic, cultural and social context in which the development and implementation of policies take place. But there are also some specifics to the health context that need to be taken into account in the process of developing and implementing HRH policies:

- The inter sectoral nature of issues linked to HRH and the variety of participants and sectors involved. The causes of HR problems in the health sector are various and complex. Solutions depend on many inputs (financial resources, education programs, working conditions), which are in many instances outside the control of the health sector decision-makers or HRM administrators. In most industrialized countries, such as Canada or the countries of Western Europe, central unions negotiate working conditions directly with the government and sign collective agreements that leave administrators of health organizations little room for independent decisions. Responsibility for the production of personnel, for the definition of curricula and for certification criteria is usually in the hands of independent training institutions. Practice standards are generally defined by professional bodies. In other words, strategies for intervening on the health workforce cannot be decided autonomously by a single organization or single unit at the ministry of

health. They have to incorporate the viewpoints of a wide variety of institutions, participants and interest groups who have a stake in the decision-making and in implementing actions.

- The time-lag between decision-making and outcome. Contextual changes influencing the demand for health services and tendencies within the workforce cannot be dealt with in a short time. For a number of decisions relating to the health workforce, short-term or medium-term projections are not sufficient. Hall shows that a 10% rise in the number of students registering with medical schools will produce only a 2% increase in the supply of doctors after 10 years. A substantial lapse of time is therefore required to bring about major quantitative and qualitative changes in the health workforce or to rectify the adverse effects of poor decisions. Accordingly, HRH policies in reforms and attempts to expand health services should allow for the intervals needed to train and develop the workforce. They must equally anticipate the long-term impact some major trends such as ageing of the population are likely to have on the demand for services and on the workforce demand.
- Strong professional dominance. Health care systems are widely influenced by the role of professionals whose training emphasizes the value of autonomy and professional self regulation. Generally speaking, professional structures are well established, supported by laws, guidelines, culture and history. Various professional categories assume distinct roles and have their own training structures and regulatory mechanisms. These groups also tend to have a distinctive culture and a very pronounced identity that may complicate implementation of changes. Strong in the conviction of their cultural and symbolic power and in their ability to rally public opinion behind them, they may hinder the implementation of new policies if there is no clear understanding of the proposed changes, or if these changes are perceived as affecting them negatively. All these factors indicate that the process of development and implementation of workforce policies in the health sector must be an ongoing process of adjustment, not only to the needs of the population but also to the changing expectations of the personnel and that it should be conducted with their full participation.
- The interdependence of the different professional categories. Most health occupations are highly interdependent when carrying out their tasks. Problems in one professional category may spill over into another. For example, a shortage of nurses resulting from inadequate planning may have adverse effects on the work of doctors.
- The role of the state as the principal employer. The state remains the principal employer in the health sector, despite a tendency to give increasingly greater scope to the private sector in the provision of services. HRH are expensive to produce and in terms of recurrent expenditure. Any inadequate workforce policy that encourages overproduction of personnel, excess consumption of resources or poor utilization of available personnel has a direct effect on public finances and further reduces scarce resources that could have been assigned to other sectors of the economy.
- The high proportion of women employed in health services. The health sector is also recognized as being a major employer of women, who are increasingly active in the job market while fulfilling family responsibilities. As seen in Zimbabwe, women working in the health sector often receive lower salaries and have fewer opportunities than their male colleagues to rise to the higher echelons of the hierarchy. Concentrated in specific professional categories such as nursing, they often pay the highest toll when budgets are cut.
- The ambiguity of the relationship between health needs, service requirements and resource needs (human or material) in the supply of these services. Understanding of health needs is imperfect. Understanding of the services required to respond to needs is also imperfect. The relative contribution of health services is not well understood. The development of HRH policy has to deal with uncertainty and with many other factors – political, economic, social and cultural – that influence these relationships.
- Deficiencies of the market. In other sectors of the economy, the job market responds to the law of supply and demand and adjustment processes may be both more easy and less costly. But in health, where there are imperfections as in any market, the state may be required to intervene in order to see through the necessary adjustments within the

framework of the political process. The challenge here is to overcome the rigidity associated with certain institutional mechanisms (unions, professional regulations, etc.) that may restrain the implementation of the adjustments required or render them more costly.

Hrd Actions in the Health Sector:

- At a more operational level, the spectrum of interventions is large, but it has to be used in accordance with the particular country's economic and political context, its traditions and the particular balance of power between the various stakeholders. This section presents some examples of what can be done in relation to specific problems.
- Policies relating to staffing, are notoriously among the most difficult to implement (Hall, Mejia 1978, Mejia 1987, Barer, Stoddart 1990, De Geyndt 199739), because they are politically sensitive, as they imply jobs and because there is a lack of information about future needs. What will be the epidemiological profile, what will be the technology available, how providers will behave in terms of their productivity, what is the impact of feminization of medicine, what will be the replacement needs? Market forces do not suffice to reach an efficient equilibrium, especially when the more qualified personnel is concerned, because adjustments can occur only over long periods of times due to the time needed to educate them. Planning and intervention in education and training is thus usually required to achieve an optimal skill mix (Polaski 1998)40.
- A balanced stock of health care providers would be one in which there are no surpluses or shortages. These notions are relative: they can be defined in relation to demand and to the capacity of absorption of the country (number of positions unfilled, unemployment, underemployment) or in relation to needs. Whichever definition is chosen, it is determinant to have valid information about the current workforce situation, its composition, its distribution, its production capacity and to be able to forecast its evolution according to various scenarios, making hypotheses in relation to future intake (new graduates, immigrants), to attrition (temporary leavers, retirees, deceased, emigrants) and internal mobility of personnel.
- Due to the time lag between demand signals and supply responses in the health labor market, human resource planning is necessary to avoid "overshooting, with surpluses or shortages of particular skills" (Polaski 1998). Various planning methodologies have been developed to help set the targets. These are briefly presented in annex 2. The choice of a particular approach is value-based; if equity of access according to need is valued, then a needsbased approach is better indicated. Planning can be a technocratic exercise conducted by government alone, but it is more likely to be effective if it is done jointly with the providers and the educators, who then adhere more willingly to the conclusions of the exercise. Planning methodologies offer the advantage of presenting the policy-makers with more comprehensive scenarios of the implications of the choices they intend to make.
- To reduce surpluses of specific categories of providers, one long-term solution is the regulation of the intake (new students, immigrants). This works better when it is made on the basis of agreements with the professional associations and the education institutions. It is also more effective if the financing of educational institutions is linked to the desired number of graduates. Regulating the creation of new schools is also another strategy. Usually, this is under the responsibility of the Ministry of Education, which needs to adjust its policies to those of the health sector. If medical education is regarded as a public good (Preker, Feachem 1994), it ensues that the State can legitimately regulate their creation42. The problem, in many countries, is that this is not done appropriately; it rather serves to build up political leverage and to gain favors from private interests. The control of entry of immigrant health providers on the market is usually made through immigration laws or through requirements by the professional councils regarding qualifications. However, councils do not always have the technical and administrative capacity to play that role and their strengthening can be a fruitful strategy. The existing stock of providers is bound to diminish gradually thanks to a combination of normal attrition (deaths, retirement, emigration) and reduction of new entrants
- Shortages, such as often occurs in nursing and in some professional and technical occupations in the areas of nutrition, mental health, rehabilitation, long-

term care, can be addressed through incentives to develop new programs, to attract recruits and to retain those already in the field. These include subsidies to education institutions, scholarships, more attractive pay scales, career plans, access to continuing education, dissemination of information on these occupations, status enhancing measures, such as professional titles. In many countries, nursing remains a low status occupation and will develop only slowly, if no effort is made to valorize it. Where there is unrestricted access to faculties of medicine, dentistry and pharmacy, nursing schools have difficulty in recruiting the better-educated students. Students prefer the more prestigious occupations, which then become overcrowded; their members are then more likely to oppose the development of a strong nursing profession.

- Many countries have tried to solve the problem of unbalanced geographical deployment, by requiring that health care providers to do some sort of "social service", after graduation, in less attractive regions. The effectiveness of this strategy is debatable and would have to be assessed. It can even be an incentive to migrate out of the country; and, if the process of posting is not transparent, it opens the door to corruption. It also has a greater impact on women, who are less mobile than men and more preoccupied by security concerns. Alternatively, a mixture of economic, organizational and professional incentives can be used to improve the deployment of the workforce. These incentives can be devised after having analyzed the expectations of providers, which are likely to be a mix of economic, professional, personal and family related ones.
- Reforms in education for the health professions are necessary because needs have changed and new knowledge and techniques are available. Changes are needed to make the education and training of health providers more community and needs-oriented. In Latin America, the W.K. Kellogg Foundation has been financing, since 1994, the UNI Program (Una Nueva Iniciativa-A New Initiative in the Education of Health Professionals: Partnership with the community), which supports universities and professional schools in shifting their programs from discipline/profession oriented to community oriented (Chaves, Kisil 1994). There are now 20 projects in 10 countries, which have achieved different degrees of success in modifying the way doctors, nurses, dentists, pharmacists, nutritionists are trained and interact with the health services and with the communities. The emphasis is put on the joint participation of the community, the services and the educational institutions in the process of planning and organizing the services. Students participate in the identification of problems by doing field surveys, part of the learning process is conducted in the services and interdisciplinary approaches are emphasized. In various parts of the world, many institutions now describe themselves as community-oriented. There is a WHO Network of community-oriented educational institutions for health sciences48 which has 58 institutions as full members and 131 as associate members. Although this is still a very small proportion of all health sciences education institutions, the Network proposes a new model of education which is now influencing the more traditional institutions.
- To better guarantee the quality of education, two types of mechanisms can be used. The first one, accreditation, is a process of assessment which recognizes that a service, a program, an organization is meeting the standards defined by peers or by independent evaluators. Examples in the area of education for the health professions are presented in Box 5. Accreditation applies to activities and institutions, whereas certification, the second mechanism, applies to individuals. Certification is the formal professional recognition of the competency to execute certain tasks. When it is legally enforced, it takes the form of licensure. Traditionally, certification was acquired for good; re-certification is a process whereby the recognition of competency is renewed periodically. The requirements can go from proving that a minimum number of hours of training have been completed or by passing a written or oral exam. In Canada tests evaluating the clinical skills are used to certify specialists, but the costs of the "Objective Structured Clinical Evaluation", at slightly more than 1000 $ per individual assessed, is prohibitive in most countries. Licensing procedures, which mean to restrict access to practice to qualified providers, can be made more effective. In many countries, licensing is a simple bureaucratic procedure whereby the Ministry of Health, some other public agency, or a professional council issues a permit, usually for life,

to anyone presenting a diploma from a recognized education institution. No assessment of quality is made, as if all institutions provided equal quality education and if all graduates were adequately competent. To overcome this problem, the licensing body could conduct a general exam or delegate that function to an independent agency, to guarantee that all licensees meet minimal standards of competency and do not put the health and well-being of the public at risk. To play their role, licensing bodies must first have a clear mandate of quality maintenance and have the technical and financial capacity to do so. They should also be made accountable in order to avoid that they use their powers to create rigidities which would advantage their members, such as by artificially creating barriers to access to practice.

- In relation to performance management, various actions are possible. Some are directed to institutions, others to individuals. The accreditation of health care institutions, is a strategy that can help maintain and improve the quality of the services by stimulating efforts to achieve higher standards. This procedure is well established in some of the richer countries such as the USA, Canada, Australia and New Zealand, though philosophies and approaches may differ. It is more prescriptive and top-down in the United States, where it is done by the Joint Commission on Accreditation of Healthcare Organizations. In the other countries, it is a voluntary process of quality improvement based on self-evaluation and peer-assessment. The introduction of accreditation of health care institutions is currently being discussed or made in places as diverse as France and Italy and Latin American countries (PAHO 1997). Accreditation only functions as a performance improvement mechanism where institutions and their members are really committed to improving the quality of services. Also, to be accredited must bring some form of recognition and make a difference for the institutions. Otherwise it would be de-motivating to observe that institutions which are not accredited are treated exactly the same as the accredited ones.
- Quality assurance and improvement mechanisms, such as clinical and management guidelines and protocols, performance review and analysis and evidence-based practice have become common in the richer countries and are now penetrating the other. Woodward (1997) reviews the various mechanisms available to help individuals to enhance their capacity to produce better quality services. She first insists that a favorable environment is necessary for making behavioral change possible, which implies that strategies for quality improvement need to be comprehensive; they need to include the reinforcement of the educational, professional and administrative environments in particular. She also suggests that to be more effective, change strategies should consider the various stages of behavioral change: the pre-contemplative stage, when people do not perceive the need to change; the contemplative stage, when the need is perceived and information is sought on the costs and benefits of changing; the decision stage, when people start preparing themselves to change; the action stage, when they engage into activities leading to change, such as learning new skills; and the maintenance stage, at which point the support of the environment to maintain the gains already made is determinant. Accordingly, actions in favor of change of behavior should include pre-disposing (educational materials, conferences, field trips, self assessment, using opinion leaders), enabling (care maps, guidelines, practical exercises, computer supports) and reinforcement (audit, feed-back, peer review) actions. Each type of action has its strengths and weaknesses which are reviewed by Woodward (1997), who notes that change is more likely to occur as a result of sets of actions, rather than of specific individual actions.
- The improvement of efficiency is related to the elimination or to the softening of certain labor rigidities and to the improvement of decision-making. Examples of rigidities are laws which give a monopoly of practice to a specific category of providers and labor contracts which limit the flexibility in the use of personnel. In many countries, the professional laws are restrictive and they exclude some providers from the market, by virtue of the monopoly granted to doctors, dentists and pharmacists. For many years, chiropractors, denturists, midwives, homeopaths and others have been relegated to clandestinity by such laws. New approaches, which only restrict the practice of specific tasks to some categories of providers,

instead of granting the monopoly of some segment of the market, have been adopted. This was done in the province of Ontario (Canada), where it took 7 years of discussions to bring the health professions to agree to a new regulatory framework of professional practice, which was radically different from what had existed for more than 140 years. Monopolies of practice were replaced by a procedure restricting the practice of 13 categories of procedures to one or more occupational groups. This was done with a view to better protecting the public and to improving access to health services. From the beginning, representatives of the public were involved in the policy formulation process, which was conducted openly, which was said to have been a facilitating factor in making such a radical change possible.

- Better decision-making depends on the availability of competent managers and of access to valid and relevant information. In Canada, a strategy of systematic collection and dissemination of information and of promotion of research on improving the quality of health care has been adopted in 1992 with a view to supporting better decision-making. Healnet (Health evidence application and linkage network), a network of centers of excellence has been created to produce new knowledge on themes such as "making evidence-based health care choices in the clinical setting, the organization and performance of health care organizations, the equitable distribution of health care resources across regions, harnessing rapidly developing computer technology for improved health". There is also a new Canadian Institute for Health Information, created, with the support of the government, as a non-profit organization. Its mandate is to collect, process and maintain health databases and registries, covering health human resources, health services and health expenditures, to set national standards for financial, statistical and clinical data as well as standards for health informatics technology and to produce value-added analysis. Obviously, lower income countries may not have the resources to take such initiatives, but they can easily take advantage of the easily accessible knowledge and information produced by these organizations50 and similar ones developed in North America and Europe, particularly.

CONCLUSION

Since all health care is ultimately delivered by and to people, a strong understanding of the human resources management issues is required to ensure the success of any health care program. Further human resources initiatives are required in many health care systems and more extensive research must be conducted to bring about new human resources policies and practices that will benefit individuals around the world. The relationship between human resources management and health care is extremely complex, particularly when examined from a global perspective. Our research and analysis have indicated that several key questions must be addressed and that human resources management can and must play an essential role in health care sector.

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