Fixing Labor Market Leakages: Getting More Bang for Your Buck on Human Resources for Health

The average share of government health expenditure devoted to the health worker wage bill in Sub-Saharan Africa (SSA) is significant at 40 percent, although lower than in many other regions (Figure 1). Within SSA, there are many variations by country.

Despite such investments, African countries continue to face a “human resources for health (HRH) crisis”—in which a small number of qualified, well-performing health workers cannot meet actual need—to varying degrees. This impedes health outcome improvements and economic growth. The problem is particularly pronounced in rural or marginalized areas. This is troubling, as there is a well-accepted relationship between health outputs, such as skilled attendance at birth, and availability of health workers (Figure 2). In many countries, the inequitable distribution of health workers stands in the way of better health for people, especially women and children.

The HRH crisis in many countries can be explained by constraints in labor market supply, labor market demand, and in performance. Insufficient labor market supply refers to a situation where insufficient numbers of health workers are produced, or numbers are reduced by labor market exit, such as outmigration.

KEY MESSAGES

- Despite significant investment in health workers, African countries face a crisis in terms of human resources for health (HRH). This deeply affects their ability to deliver health results on the ground, achieve Universal Health Coverage, and foster economic growth.
- In many countries, the HRH crisis can be explained by insufficient numbers of health workers primarily in the rural labor market (supply), lack of funding to employ health workers (demand), and/or issues related to their performance.
- Simply scaling up production of health workers is not a good enough fix, as urban unemployment, rural shortages, health sector attrition, including migration abroad, as well as absenteeism and low productivity (labor market leakages and inefficiencies) will waste investments.
- Potential solutions need to identify and address country specific labor market leakages and inefficiencies including through: (i) monetary and non-monetary incentives, (ii) innovative education models (including rural pipeline models), (iii) increasing opportunities for funding for HRH particularly in rural areas, and (iv) strengthening management and accountability systems in frontline facilities.

Figure 1: The Health Sector Wage Bill as a Share of Public Spending on Health, by Region, Mean

![Figure 1: The Health Sector Wage Bill as a Share of Public Spending on Health, by Region, Mean](source: World Health Organization.

Note: EAP = East Asia and the Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SA = South Asia; SSA = Sub-Saharan Africa)
or disproportionate job uptake in urban over rural areas. Insufficient labor market demand refers to a situation where there are insufficient resources (public or private) available to hire health workers. Finally, problems with health worker performance include insufficient skills to carry out services, lack of equipment and supplies to apply skills, or low attendance, motivation, and productivity.

**COMMON CONSTRAINTS TO LABOR MARKET SUPPLY**

**Low Labor Production:** Health training institutions often lack the physical, technical and organizational capacity to produce larger numbers of health workers. Capacity varies between countries, with Sudan producing more than 3,000 doctors a year, while Zambia produces fewer than a hundred. Health training institutions in most African countries lack teachers, teaching supplies, infrastructure, and sufficient management capacity.

**Preferences for Urban and Out-of-Country Employment:** Given comparatively lower salaries and fewer opportunities at home for post-graduate education, health workers often migrate abroad. If they remain in their own countries, they tend to prefer urban over rural jobs, as the former offer better income, better education for their children, and better working/living conditions. Figure 3 shows how the probability of rural job uptake (in this case for nurses in Ethiopia) is closely linked to the provision of different types of monetary and non-monetary incentives. There are also strong links between the socioeconomic and/or geographic background of health workers (as well as exposure to rural areas during training, for example) and their willingness to remain in the country or work in rural areas (Lemiere and Herbst et al, 2013).
COMMON CONSTRAINTS TO LABOR MARKET DEMAND

**Insufficient Funding for Wages:** Wage bill funding is considered insufficient if neither the public nor private sectors can adequately absorb health workers. This can occur when there is rapid scale-up in production, urban oversupply (a common issue), or reduction in outmigration, without concomitant expansion of wage bill allocations or private sector employment opportunities. Rural areas commonly suffer from wage funding insufficiency. Public sector funding is often disproportionately allocated towards urban areas, where most of the higher-paid health workers are employed and most of the larger secondary and tertiary level hospitals located. The private for-profit sector is also disproportionately found in urban areas.

**Fiscal Re-centralization:** In many countries, non-functioning or reversed decentralization policies have curtailed local health providers’ income and ability to hire and retain health workers. This is sometimes made worse by rural health facilities being unable to mobilize discretionary resources of their own, sometimes because of the limited number of patients willing or able to purchase services. In Sudan for example, the more rural states such as North Kordofan, Kassala, or Red Sea receive much less revenue from federal transfers and own sources than more urban or centrally located states.

**Limited Patient Ability to Pay:** Limited revenues particularly from rural populations constrain private-sector demand for health workers, and/or public sector income augmentation opportunities. Assessments in SSA overwhelming show that rural populations are poorer than urban ones. Lack of health insurance for rural populations also prevents them from buying adequate health services and thus generating rural revenue and demand for HRH (including from the private sector).

**COMMON PERFORMANCE ISSUES**

**Limited Health Worker Competencies:** A critical challenge many countries face is underdeveloped competencies of health workers (knowledge and skills), often because of the limited physical, technical and organizational capacity of health training organizations. Moreover, in-service training and continuing development opportunities are often lacking or unevenly available. Specialist skill sets, especially in critical areas such as obstetrics, pediatrics, internal medicine and infectious diseases are also often highly limited by meager postgraduate medical training opportunities. Where they exist, such opportunities are often concentrated only in urban areas (with little linkage to the realities found in many rural areas).

**Challenging Working Conditions:** Equipment and supplies shortages frequently prevent health workers from delivering services adequately, especially in rural areas, where inefficient supply chain mechanisms have only limited reach. This is complicated by additional systems challenges including poor flow of information, and capacity issues such as excessive workload, limited staff and support services, and infrastructure challenges.

**Sub-par Application of Effort:** A common performance limitation in many countries is the gap between what health workers know how to do, and actually do (Figure 4). This “know-do” gap is often a reflection of low productivity levels, health worker absenteeism, and inadequate responsiveness. The gap is often linked to two main challenges 1) inadequate or
non-functioning accountability and supervision mechanisms (particularly for facility managers over health workers), 2) low motivation of health workers, due to challenging working and living conditions, few opportunities for professional advancement, and few performance-linked monetary or non-monetary incentives.

POLICY IMPLICATIONS

Identify and Address HRH Leakages. Traditional approaches to address the HRH crisis have focused mainly on increasing production of health workers, without first paying attention to labor market leaks and inefficiencies. Figure 5 shows common leakages in Togo because of outmigration, unemployment, and a large rural/urban imbalance. Only 150 out of 890 doctors trained actually end up serving 80 percent of the population. Of them, many are absent, unresponsive, unproductive and unmotivated. Fixing these inefficiencies and leakages will require identifying country-specific, cost-effective strategies and mechanisms that focus on changing health worker behavior through incentives, adopting innovative education models (including rural pipeline policies), increasing opportunities for funding for HRH (including labor market demand) especially in rural and marginalized areas, and strengthening management and accountability systems (particularly at the facility level).

QUESTIONS TO AFRICAN MINISTERS

HRH is a critical issue for low and middle income countries aiming to achieve Universal Health Coverage, achieve critical health outcome improvements, and foster economic growth.

- What is needed to scale up efforts to identify and fix existing inefficiencies and leakages in the health labor market, which will be unique on a country to country basis?
- What would it take to better decentralize health worker training to rural areas, and to adopt education strategies linked to reducing outmigration, better skill sets to address local challenges, and increasing rural job uptake?
- How can facility managers be empowered with better skills, incentives, decision making authority, and tools to raise funding, so that they can more effectively manage their health workers?
- How can the private sector play a larger role in addressing the HRH crisis (and shoulder some of the public sector funding constraints), and how can its reach and access be expanded to reach the rural poor?

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