

Human resources for health - an appraisal of the status quo in Tanzania mainland

Anna Dominick¹ and Christoph Kurowski^{2,3}

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¹ Ifakara Health Research and Development Centre

² The World Bank

³ London School of Hygiene & Tropical Medicine

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral Drugs
CEDHA	Centre for Education Development in Health - Arusha
CSD	Civil Service Department
FTEs	Full-time Equivalents
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IPP	Intramural Private Practice
MCH	Maternal and Child Health
MCT	Medical Council of Tanganyika
MDGs	Millennium Development Goals
MoF	Ministry of Finance
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTPP	Medium Term Pay Policy
MUCHS	Muhimbili University College of Health Sciences
NCTP	National Care and Treatment Plan
NMCT	Nursing and Midwife Council of Tanzania
OPRAS	Open Performance Appraisal System
PLWHA	People Living with HIV/AIDS
PA	Performance Appraisal
PM	Performance Management
PO	President's Office
PO-PSM	President's Office-Public Service Management
PPG	Potential Productivity Gain
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
SASE	Selective Accelerated Salary Enhancement
TEHIP	Tanzania Essential Health Intervention Project
TGS	Tanzania Government General Scale
TMTB	Tanganyika Medical Training Board
URT	United Republic of Tanzania
WHO	World Health Organisation
ZTCs	Zonal Training Centres

1. INTRODUCTION

In her opening address at the Joint Annual Health Sector Review in 2004, the Permanent Secretary of the MoH declared that in *the area of human resources, I believe, we have now reached a crisis point and our actions will need to reciprocate the crisis at hand.*

Action to remedy the crisis hinges on a good understanding of the nature and scope of the crisis. Over the recent years, various studies on HRH have been performed in Tanzania. These studies have addressed various HRH issues, however, the overall picture remains fragmented.

The main purpose of this report is to present the available information in a structured way to facilitate the dialogue among stakeholders in the national HRH policy arena. To structure the available information, we developed a framework of key workforce related outcomes and their determinants. We reviewed relevant documents, filled in some critical information gaps in interviews with stakeholders, summarized the collected information and structured it according to the framework. We also reviewed key issues described in country-specific literature, which were refined in a dialogue with the HRH Working Group. Based on the review of available information, we identified critical knowledge gaps in relation to the key issues.

The following section lays out the framework of workforce related outcomes and their determinants. Section 3 summarizes the results of the appraisal within the format of the framework, while section 4 discusses key issues identified during appraisal.

Given the current momentum of the HRH agenda, we expect an increasing number of analytical studies in the next months and years. We hope that this report provides the structure for regular reviews of the status quo of the workforce performance and its determinants.

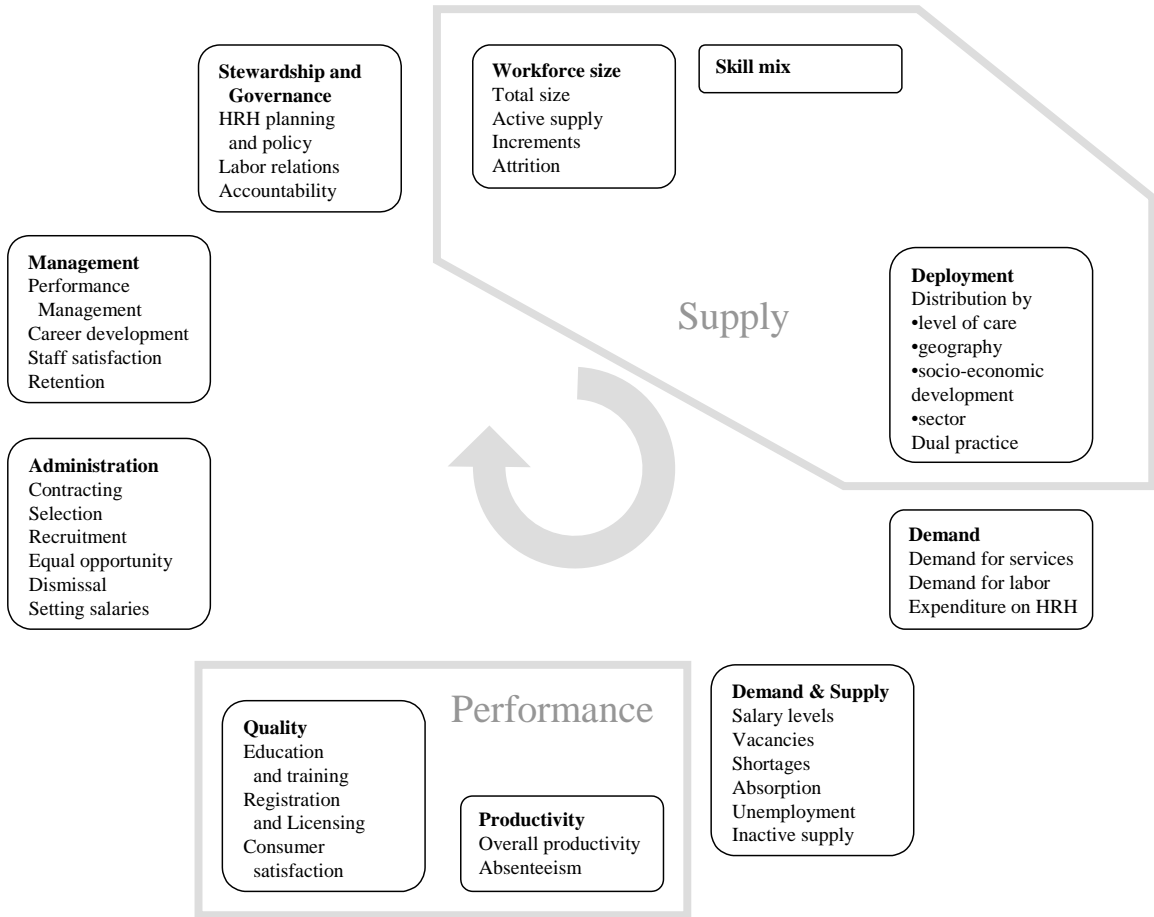
2. A CONCEPTUAL FRAMEWORK FOR WORKFORCE PERFORMANCE AND ITS DETERMINANTS

Two decades ago, human resource development seemed a straightforward task in most developing countries. Governments just needed to produce the numbers of health workers to meet the needs of expanding public health services. Meanwhile, however, service delivery systems have fundamentally changed. Decentralization processes fostered the diversification of service entities within the previously monolithic public sector. At the same time, a range of diverse private providers emerged in response to unmet needs and demands. Today, each employer represents an alternative job opportunity for health workers with varying salaries, benefits, career opportunities, and working and living conditions. At the same time, the access to information about employment opportunities increased. Previously, health workers shopped for jobs locally, today, they look increasingly for jobs nationally and internationally and sometimes even in different labor markets.

Faced with these changes, governments need to assume a fundamentally different role in the development of human resources for health. It is no longer sufficient to control training capacities, develop curricula and determine staffing rules for facilities. With the emergence of complex health labor markets, governments are challenged to ensure that the outcomes of the labor market are coherent with health sector objectives. Managing the health labor market requires a comprehensive understanding of labor supply, demand, market outcomes and other dimensions of workforce performance, such as quality and productivity. The picture, however, remains incomplete without information on determinants of workforce attributes including mechanisms and strategies designed to improve labor market outcomes.

The appraisal adopts a framework that captures key labor market characteristics and its determinants (figure 1) (Kurowski 2003). Though a differentiation between outcomes and determinants is in principal desirable, a clear distinction is impractical, as some outcome attributes are interrelated. For example, skill mix determines workforce quality.

The framework starts with attributes of workforce supply, including size, composition and deployment. It then captures health labor demand and outcomes resulting from the interplay between demand and supply. Other attributes of workforce performance follow under the headings of quality and productivity. The final elements of the framework portray key HR management and HR governance functions as determinants of workforce performance under the control of employers and policy decision makers.



3. SUMMARY OF INFORMATION ON WORKFORCE PERFORMANCE AND ITS DETERMINANTS

3.1. Supply

3.1.1. Workforce size

Total workforce size

The total workforce includes health workers who are currently employed in the health sector, unemployed seeking employment in the health labour market and those who are trained as health workers but do not work and do not seek employment in the health sector. Information is available on the number of health workers currently employed (see active supply, but not for the two latter categories). Therefore, the total workforce size remains unknown.

Active supply

Active supply refers to personnel currently employed in the health sector. According to the HRH census in 2001/02, the size of active supply is 49,900 health workers (MoH, 2004 A), which translates into a staff per population ratio of 148 per 100,000. In 1994/95, active supply was approximately 67,600 health workers (Census 1994/95). Hence, active supply decreased by 19,300 health workers over the period between 1994/95 and 2001/02.

Given conservative assumptions about increments and attrition, the size of the total workforce will continue to decline to approximately 37,900 in 2015.

It is generally assumed that the vast majority of health workers are fully employed, however, no information was available as to what extent the census data reflect full-time equivalents.

Increments

Increments result from training and immigration. No information was available regarding immigration.

The MoH collects information on the number of graduates from health training institutions under its auspices. A detailed analysis is pending. In 2000, approximately 2,420 health professionals graduated from training institutions in the country (Kurowski 2004), however, more than half of them were recruited from within the workforce. Hence, the net increment rate in 2000 was less than 900 graduates.

(McKinsey, 2004) indicated that chronic staff shortages persist in training institutions and thus limit the quantity and quality of the national capacity to training health professionals. The accreditation of training institutions depends on the ratio of qualified full-time teaching staff and students. Hence, the insufficient availability of teaching staff reinforces the capacity limits of accredited training institutions. New private training institutions

have resorted to measures such as the use of part-time staff, recruiting teachers from neighbouring countries, especially Kenya and Uganda, or even changing the semester system to reduce the need for teachers in multiple disciplines. In the case of public training institutions, it is unknown whether plans to remedy the persistent shortage of teachers and trainers exist.

Attrition

Trends in the total workforce size result from the balance between attrition and increments. Losses among the active supply result from death, disability, emigration, retirement, moves into labour markets other than health, changes in occupation and temporary or permanent withdrawals from the labour force. Empirical data on overall losses are not available. Calculated as the sum of the reciprocal of the average lengths of service and the adult mortality rate, the attrition rate would be at least 4.2% (Kurowski, 2003).

Between 1993 and 2001, losses among active supply were enhanced by wider public sector adjustment policies that included in the health sector active retrenchment of lower skilled cadres (Kurowski 2004).

3.1.2. Skill mix

The HRH 2001/02 census identified health attendants as the largest cadre within the health workforce (38%), followed by the group of nursing cadres (27%) and the group of medical cadres (14%) (MoH 2004 A). The proportion of skilled professionals among active supply was 49%, which is an increase of around 6% compared to the 1994/95 HRH census.

3.1.3. Deployment

Distribution by level of care

Findings in the 2001/02 census indicated that over 50% of health workers were employed in hospitals (Table 1). Information about the distribution by type of hospital (district, regional, tertiary) were not available.

Table 1

Distribution of health workers by level of care 2001/02

Health Facility	FTEs	Proportion of the total
Hospital	24,554	55%
Health Centre	5,917	13%
Dispensary	14,284	32%
Total	44,755	100%

Source Census data 2001/02

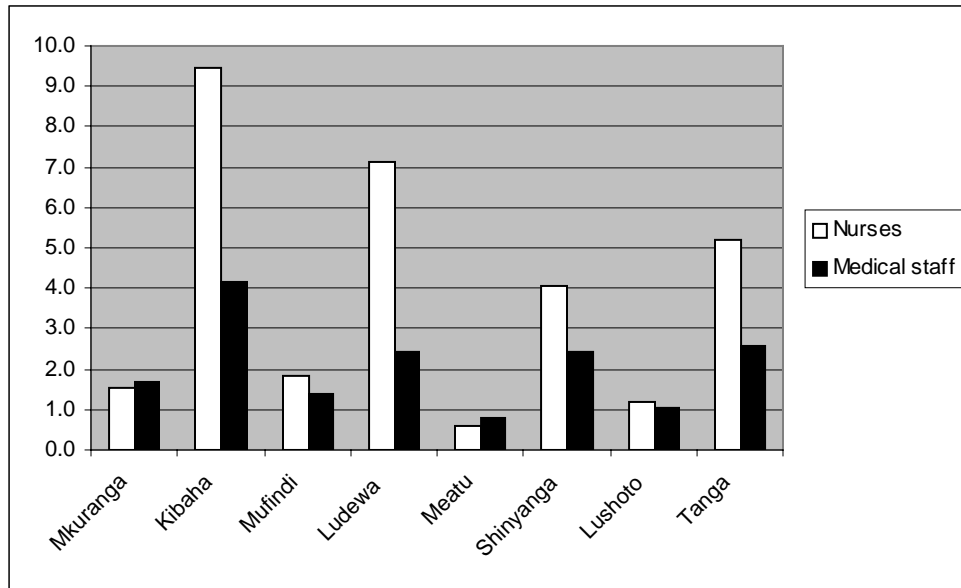
Geographical distribution

Based on a sample of the 2001/02 census data, Kurowski, et al, demonstrated substantial variations in the geographical distribution of health personnel (Kurowski, 2003).

Significant differences existed at the regional level. Disparities were even greater at the district level (Figure 1). For example, the number of nursing staff per 10,000 population varied between 1.6 (Mkurunga) and 16.2 (Ilala).

Figure 1

Staff per population ratios for nurses and medical staff –
2001/02 estimates by selected districts



Source: Kurowski (2003) Computations from census data 2001/2

Districts with the high staff per population ratios were characterised by greater numbers of health facilities and often the existence of a regional or tertiary hospital with significantly higher staffing levels than district hospitals. After corrections for infrastructure, significant staffing variations persisted - at a scale of approximately 100%.

3.1.4. Distribution by level of socio-economic development

Information on the distribution of health personnel by level of socio-economic development is lacking. The data of the 2001/02 HRH census allow an analysis at the resolution of the district level. Districts are commonly classified as urban and rural. Following this classification, roughly 40,700 (83.9%) health workers were employed in the rural areas serving 80% of Tanzanians. Approximately 7,800 (16.1%) health workers are employed in urban areas serving 20% of Tanzanians. The workforce serving in rural areas mainly constitutes low skilled cadres while the urban health facilities are staffed with high skilled cadres.

3.1.5. Distribution by sector

In 1994/1995, the workforce size was approximately 67,600 FTEs. The public sector employed 51,800 (77%) health workers while the private not-for-profit and private for-profit employed 11,500 (17%) and 4,300 (6%) respectively (Table 2).

Table 2

Health workforce distribution by sector in 94/95 and 2001/02

Period	Public	Private not-for-profit	Private for-profit	Total
1994/95 census	51,800	11,500	4,300	67,600
2001/02 census	35,400	9,800	3,200	48,400
2001/02 (Kurowski et al.)	35,000	11,700	7,500	54,200

Source: Census data 1994/95 and 2001/02

According to the HRH 2001/02 census, the workforce fell to 48,400 FTEs. Approximately 35,400 FTEs (73%) were employed in the public sector. The private not for-profit sector and the private for-profit employed 9800 FTEs (20%) and 3200 FTEs (7%) respectively. In comparison to the HRH 1994/95 census data, employment in the private sector decreased in absolute terms. The proportion of health workers employed in the private sector, however, increased slightly.

Kurowski et al estimated the workforce size and composition based on a sample of the HRH 2001/02 census (Kurowski 2003). Census sample data were employed to calculate average staffing levels by type and ownership of facilities. Workforce size and composition were computed based on the calculated average staffing levels and the number of registered public and private facilities. According to this methodology, the total workforce was estimated as 54,200, with 35,000 FTEs (65%) in the public sector, 11,700 FTEs (22%) in the private non-for-profit sector, and 7,500 FTEs (14%) in the private for-profit sector. In contrast to the HRH 2001/02 census findings, the estimates suggest an absolute and relative increase in private sector employment.

3.1.6. Dual practice

There is general consensus that dual practice is common among medical officers and less frequent among assistant medical officers, clinical officers, and nurses. However, no data were available to substantiate the common perception. Based on interviews with health practitioners and experts, a McKinsey report (McKinsey 2004) found that 60% of medical officers provide services in the public and private sector.

3.2. Demand

3.2.7. Changes in the demand for services

The HIV/AIDS epidemic has caused a substantial increase in the demand for health services. More than 25% of services are provided to patients infected with the virus. A further increase of this share is expected with the implementation of the NCTP for PLWHA. The Plan set a target of treating 65,000 PLWHA with antiretroviral drugs

(ARVs) by the end of 2005, and at least 400,000 by the year 2008. The WHO suggests an even more ambitious scaling up of care and treatment, aiming to treat 220,000 PLWHA with ARVs by the end of 2005 (MoH, 2003 D).

3.2.8. Changes in the demand for labour

Assuming that information on active supply reflects the demand for health labour, demand for health labour decreased over the last decade. The significant reduction in demand for health labour in the public sector outweighed, by far, increases in the private sector. Should the NCTP be implemented, the demand for health labour would significantly grow. The provision of antiretroviral treatment to approximately 500,000 PLWHA in 2008 would require approximately 9,300 FTEs (URT 2003D).

3.2.9. Expenditure on HRH

The demand for health labour critically depends on the availability of resources for health care, and in particular, personnel emoluments. The PRSP identified health as a priority sector, and as such the sector is expected to benefit from increases in both the absolute level of government spending on health and the relative share of the budget. However, the actual government expenditure on health has been falling. Recent Public Expenditure Reviews (PER) (2003) showed that the share of the health sector remained at a level of approximately 8.7% of the total budget. According to the MTEF, personnel emoluments, as a share of recurrent expenditure in the sector, will fall from 32% in the financial year 2003/04 to 24.7% in the financial year 2004/05. The decline is the result of only slight increases of personnel emoluments (on average 4% per year) in comparison to significant increases in other expenditures (MoF, 2004).

3.3. Market Outcomes

3.3.10. Salary levels

Health workers in the public sector are civil servants. They receive benefits in the form of salaries and pension contributions. Only few additional benefits exist, such as the travel allowance. It is a wide-spread belief that compensation in the public sector is poor.

Salaries of public sector health workers are set according to the Tanzania Government Scale with few executive scales for senior/political positions and a different arrangement for government agencies/departments whose salaries are influenced by the market. A preliminary analysis by the authors shows a highly compressed wage scale for health professionals. For example, the basic salary of a nurse or clinical officer exceeds the salary of an unskilled worker who was trained on the job by merely TShs 10,000 per month. However, a thorough analysis of salary rates within health and across labour markets is pending.

Under the SASE scheme, personnel critical to management and administration functions are on an accelerated pay scale. Salary increases serve as a reward within the PM scheme (see SASE).

3.3.11. Vacancies

It is important to distinguish between two types of vacancies. The first type entails positions that were budgeted, and for which employment permits were granted, by PO-PSM, but employers failed to recruit. The Health Sector Review (MoH, 2004 C) indicated that such vacancies persist mainly in rural areas due to a lack of information and insufficiencies in the recruitment process within the specified three month period. Second, vacancies can be defined as the number of unfilled positions according to the recommended staffing levels. In this case, vacancies are not established positions. Given the 1999 staffing levels, the MoH estimates that a total of 17,500 unbudgeted vacancies persist.

3.3.12. Shortages

Vacancies, as discussed above, reflect shortages between supply and demand. However, in resource poor settings, health needs do not translate into demand for services and consequently for health labour. Therefore, it is important to estimate HRH requirements based on health needs in comparison with their availability.

As discussed above, it was estimated that the implementation of the NCTP requires an additional 9,500 FTEs. (Kurowski et al, 2003) estimated that an expansion of priority health interventions necessary to achieve the MDGs would require approximately 120,000 FTEs by 2015. Given the current HR development policy framework, only 38,000 FTEs will be available by that time.

3.3.13. Absorption of the health labour market

Currently, graduates from medical colleges have an employment guarantee. The absorption of other cadres into the health labour market is unknown.

It is generally assumed, that under the employment freeze between 1993 and 2001, the number of training graduates in key professional cadres (except physicians) was greater than the demand in the national health labour market (MoH, 2004 B).

3.3.14. Unemployment

The level of unemployment among health workers is unknown.

Under the employment freeze, the medical education system tended to produce more graduates than the public sector absorbed. Substantial surpluses are likely for the cadres of nurses and clinical officers. Given the slow expansion of the private sector, it can be assumed that approximately a few thousand nurses and clinical officers are trained but not employed in the health sector. They are either unemployed or working in other labour markets.

3.3.15. Inactive Supply

Inactive supply is defined as the proportion of health professionals that is employed in labour markets other than health, or not active in any labour market. Apart from the assumptions discussed under unemployment, no information on inactive supply is currently available.

3.4. Performance

3.4.16. Productivity

Overall productivity

(Kurowski, et al., 2003) defined staff productivity as the time health workers spent on patient care, outreach activities, administrative tasks, in meetings, in training activities, on cleaning, preparatory and maintenance activities, and research. In time and motion studies in 10 public facilities in the Rufiji district and Kinondoni and Ilala Municipalities, staff productivity was found to be on average 57.5%. The study describes further the potential productivity gain (PPG), the proportion of time spent in breaks, waiting for patients, on social contacts and unexplained absences. Thus, the PPG reflects the potential increase in productivity through improved staff management and optimized staffing levels. The observed PPG was almost 30%.

Absenteeism

No information on absenteeism was available. In general, public service regulations stipulate that cases of chronic absenteeism are reported to the respective employer who is authorized to take disciplinary action. The general perception is, however, that no comprehensive monitoring on absenteeism is in place and reports about chronic absenteeism are a rare event.

3.4.17. Quality

Education and Training

The MoH has made continuous efforts to update training curricula. Further, significant investments have been made to upgrade the skills of health workers. For example, thousands of MCH Aides have been upgraded to enrolled nurses. A systematic review of these efforts and their impact, however, is lacking.

On average, health professionals spend 25% of their time on the care and treatment of PLWHA. Current plans for the expansion of care and treatment propose, in addition to guidelines and manuals, in-service training for all health professionals in public service. Such a proposal casts doubt on the qualification of currently employed health professionals to respond appropriately to the increasing demand for care and treatment of PLWHA.

Registration and Licensing

Nurses in Tanzania register with the NMCT. Registration requirements include the successful completion of a prescribed nursing course in an institution approved by the NMCT, the passing of an additional examination administered by the NMCT and a probationary period of two years.

Medical doctors register with the MCT following medical training in a registered medical school and complete a one-year internship and a probationary period of two years.

Though legislation authorizes the TMTB, there is no regulation in place for the registration and licensing of Clinical Officers and Assistant Medical Officers.

Foreign trained nurses can register with the NMCT. Registration fees for foreign trained nurses are at TShs. 30,000 compared to TShs 20,000 for locally trained nurses.

Consumer satisfaction

Patient satisfaction has yet to be comprehensively assessed. A recent study was performed at Muhimbili National Hospital (MNH) (Muhondwa et al. 2994). Overall, patients were satisfied with the service and care provided at MNH. Few respondents complained about long waiting times, high fees for services, in particular investigations, poor levels of hygiene on the wards, poor standards of nursing care and inappropriate behaviours and attitudes of staff towards patients.

3.5. Administration

3.5.18. Contracts

According to the Public Service Management and Employment Policy (URT, 1999), all public service employees must have a written contract of employment. The contract shows his/her duties and responsibilities. There are four types of employment contracts. The vast majority of health workers in the public sector are on permanent contracts that entitle health workers to a variety of benefits including pensions. Fixed-term contracts are also common. Other forms of contracts include operational and daily service contracts. It is not known; however, to what extent the government uses the various types of contracts.

Permanent contracts are offered to personnel that are engaged in core tasks of an ongoing nature, in particular if there is a continuing need in the foreseeable future. Fixed term contracts are used under the following circumstances:

1. When urgently required skills are in short supply and tasks are of limited duration.
2. When policies seek to bring people with fresh skills and talents from outside the Public Service.

The decentralisation of the recruitment and contracting task to the district level has impacted contractual practices in the public sector. Contracts with local governments or agencies are not transferable. Employees who want to change their locality of employment from one district or agency to another must resign and apply for employment with the respective authority (PO-PSM, 2004). Consequently, there is no employment guarantee other than with the local employing authority.

3.5.19. Selection

Selection of candidates in different posts in the Public Service is based on merits through an open competition. Applications for appointments to vacant posts are invited by public advertisement in such manner as may be determined by the respective authority (URT

1999, URT 2003A). The president is conferred with the powers of appointing the executive posts, for example, permanent secretaries and departmental directors.

Criteria for selection are based on qualifications and experience, proved merit and suitability for the post in question. These criteria maintain an appropriate balance between academic and professional qualifications and ensure skills relevant to the job at hand. If candidates are equally qualified, preference is given to women.

3.5.20. Recruitment

The public sector employment freeze was abolished in 2003. Over the last years, new positions have been increasingly established. However, recruitment efforts, dependent on location and cadre, remain frequently unsuccessful (MoH, 2004 C). A thorough review of the recruitment process is underway. Early results indicate that the recruitment policy has been carefully designed to prevent ghost workers, nepotism and other drawbacks. However, in practice, the employment procedures are lengthy. Within the decentralization process, the responsibility for hiring has been transferred to the local governments dependent on approval of the Presidential Office for Public Service Management and a budget guarantee from the MoF.

According to discussions at the Health Sector Review (MoH,2004 C), Local Government Authorities are often not fully aware of the details of the employment procedures, a fact that contributes to delays in the hiring process and eventually results in the expiration of permits before vacancies can be filled. The technical capacity to recruit is likely to differ between urban and rural locations, further aggravating the geographical imbalances. Communication challenges contribute to the limited capacity to recruit in rural locations. For instance, the Nkasi District in the Rukwa Region cannot be reached at all during the rainy season. Here, information flows depend on the message system of the police.

3.5.21. Equal opportunity

The Public Service Management and Employment Policy (URT,1999) stipulates that men and women, marginalised/vulnerable groups such as orphans and disabled individuals, are given equal chance of employment provided that the applicant has the required skills and competency for the job. For the disabled, recruiting panels have the authority to judge whether the applicant's physical disability may hinder the performance.

While the employment policy framework stipulates equal opportunity for all Tanzanians, the current practice remains unknown.

3.5.22. Dismissal

Procedures for dismissal of public health workers are laid out in the Public Service Regulation and Scheme (URT, 2003A). A public servant may be dismissed after due process at any time under the following circumstances: criminal prosecution, fraud or embezzlement, dereliction of duty, persistent absenteeism and gross incompetence. Mechanisms for appeal differ between medical personnel, nurses and public servants in the operational services. Information regarding dismissal remains confidential between the employer and employee, and information is sent to the MoH, PSM, and MoF only to

initiate the deletion from the payroll. No information was available on prevailing practices. However, there is general consensus that the dismissal of a public health worker is an extremely rare event.

3.5.23. Setting Salaries

Salary levels of the TGS are set by the CSD in collaboration with the MoF. In this process, health worker representatives play a negligible role; however, details of the process have yet to be investigated. The Public Service Staff Circular No. 2 (URT, 2003 B) acknowledges insufficiencies of the current salary levels but does not specify remedies.

3.5.24. Incentives

Incentives provide a policy mechanism to align health worker behavior and health workforce performance with health sector objectives. A thorough review of incentive mechanisms is pending. According to information from the MoH, the compensation framework in the public sector lacks monetary incentives that are explicitly linked to performance attributes. For example, health workers do not receive rewards for serving in hardship areas.

3.6. Management

3.6.25. Performance Management

Performance Management (PM) is about measuring, monitoring and enhancing the performance of the staff, as a contribution to overall organisational performance (Martinez and Martineau, 2001). In Tanzania, there are only two separate tools to enhance performance of health workers, one implemented at MUCHS¹, the other in form of SASE. The latter mainly applies to staff in various ministries.

The SASE implementation began in 2001. The scheme provides stop-gap enhancements of pay for those with critical skills and high-performance in the public service. SASE targets senior administrative staff and a few non-senior staff who performs special tasks to achieve medium term targets as stipulated in the MTPP (URT, 2003 C).

A mid-term review of SASE was performed in late 2003. Final results are pending. Studies on HRH judge SASE as a setback for HRH development in Tanzania. For example a McKinsey report (McKinsey, 2004) claims that the impact of SASE has been far less than desired and potentially counter-productive. The program appears to have demoralized many front-line workers, as the benefits were limited to higher-ranking officials.

MUCHS introduced an Intramural Private Practice (IPP) to enhance salaries and performance of medical doctors. However, the financial reward is not linked to any form of performance appraisal. Medical doctors in other public hospitals are entitled to IPP,

¹ See section 9.2 for details

however, it is not known to what extent the practice has been adopted in other public health facilities.

There is wider confidential performance appraisal (PA) conducted annually. It is not clear to what extent the PA is linked to other elements of performance management systems such as support functions, rewards, or sanctions.

3.6.26. Career Development

Career development implies two dimensions; continuous education and promotion. Quality continuous education is important for attaining individual and organizational performance objectives. The MoH has established 6 Zonal Training Centres (ZTCs). The McKinsey report (McKinsey 2004) noted that only two ZTCs – Arusha (CEDHA) and Iringa - are functional. Their success is partly the result of support by the TEHIP. TEHIP programme managers have leveraged and expanded capabilities in the ZTCs to conduct tool development and all training for the TEHIP pilot districts. However, there is no systematic review of candidate's pre-entry training needs. Anyone who applies and meets entry qualification is admitted for training. No monitoring and evaluation system for training inputs, outputs and outcomes is in place.

3.6.27. Retention

The general perception is that internal migration is a significant problem with migratory flows from rural to urban areas and from the public to the private sector. However, no data are available to substantiate this claim. In contrast to the general perception, there is no particular policy in place to foster retention among health professionals with the exception of SASE. SASE has been adopted by few ministries to accelerate salaries of senior administrative positions. Regarding international migration, the McKinsey report (McKinsey 2004) noted a high out-migration rate of doctors to countries in the region, mainly Kenya, Uganda, South Africa and Botswana. The report claims that these countries are able to offer 3 to 9 times the compensation offered in Tanzania.

3.6.28. Staff Satisfaction

Stakeholders, in general, assume low morale, satisfaction and motivation among public health workers. Low morale is commonly associated with unsatisfactory compensation levels and poor working conditions. Overall evidence is scarce but tends to support this assumption. The Baseline Study Report from Muhimbili National Hospital (Mwahonda 2004) indicated that the overall motivation level among staff is low. Roughly 50% of doctors and nurses were not satisfied with the working conditions. Dissatisfaction was attributed to a lack of clear job descriptions, lack of performance management, limited opportunities to participate in decision making, poor information flows between management and staff, poor supervision, low salaries and poor staff welfare. Similar findings are reported by IHRDC (2004) for public and faith based health facilities. Low motivation was linked to staff shortages, low salaries, poor working conditions (equipment and housing), favouritism and lack of transparency in human resource management practices (e.g. transfers, selection for training and upgrading), limited supervision and monitoring; weak disciplinary procedures, limited and slow opportunities

for promotion that are based on seniority rather than merit, rigid employment management policies that discourage labour mobility, slow decision-making across the public service, and conflicting lines of accountability at district level.

3.7. Stewardship and governance

3.7.29. HRH Planning and Policy

The scale and scope of the insufficiencies in the production, recruitment, deployment and performance of health workers are well known. Discussions about the HR crisis in health are common. However, concerns about the state of the health workforce did not translate into significant policy action. Since the human resource plan for the health sector expired in 2000, a coherent and comprehensive national strategy is lacking. Moreover, it was never evaluated whether previous policies achieved their stated objectives. At the same time, HRH plans are lacking at the level of Local Government Authorities.

The reform processes in the public sector, local government, and health sector have led to confusion about the responsibility and authority for policy decision making on HRH. The Public Service Regulations specify that each Minister and Ministry within the Public Service is responsible for the design and effective implementation of the regulations and policies governing the Public Service. Section 5.2 of the Public Service Management and Employment Policy (1999) stipulates that every Public Service Organisation has to draw a medium term (3 year plan) and annual human resource plans, based on its strategic objectives. The human resource plan has to be an integral part of the organisation's MTEF. In contrast, the second Health Sector Strategic Plan asserts that the critical aspects of appropriate remuneration, motivation, incentives and retention of the staff have to be dealt with directly by the CSD.

Similar ambiguity prevails in the Ministry of Health. The responsibility for HR policy is shared between three Directorates, each pursuing a rather traditional role. However, managing human resources for health is not the straightforward task it used to be. The health labor market has fundamentally changed and policy makers face new challenges. Today, it remains unclear which Directorate has the responsibility and authority to respond to the various new policy challenges (Kurowski 2004).

Today, the capacity of the MoH seems insufficient for an appropriate response to the growing HRH challenges. Some of the most skilled and experienced staff have left the Ministry. The Directorate for Human Resource Development is particularly affected. Units of the Directorate are understaffed and lack critical skills (Kurowski 2004).

Strategic planning depends on reliable information about the workforce performance and its trends. A database based on the results of the 2001/02 census is planned, however, the results of the census have yet to be finalized (McKinsey, 2004).

The MoH and partners have taken some important first steps to address the workforce deficiencies. In 2003, the MoH created the National Human Resources for Health Working Group, which brings together representatives of the Human Resource

Development Department of the MoH, the Presidential Office for Public Service Management, academia and development partners. While the concept of the Working Group provides an important vehicle to facilitate policy decisions, significant limitations need to be resolved. The objectives and goals of the Working Group remain vague. Its role is commonly misinterpreted as a coordination mechanism between the MoH and development partners rather than across Ministries. Some key stakeholders have been left out, most importantly the Directorate of Establishment under the PO-PSM. No resources are available to perform policy analysis. An extensive action plan, crafted by the group in few, infrequent meetings, requires prioritization among objectives.

HR issues were extensively debated during the Annual Sector Review 2004 (MoH, 2004 C). The review identified HR shortages, cumbersome and ineffective recruitment procedures, and geographical imbalances as the key HR issues and recommended the following activities to be implemented over the next 12 months:

- A high level decision to radically increase employment with consecutive changes in the mid-term expenditure framework
- The improvement of the recruitment effectiveness
- The implementation of a strategy to ensure equitable deployment
- The development of a mid-term HR strategic plan

In response to the mandate of the review, the MoH proposed and negotiated the hiring of an additional 2,000 health professionals in districts with staff per population ratios below average. Letters of agreement between the MoH and MoF have yet to be finalized and signed. The proposed recruitment wave, however, will take place in the absence of an incentive scheme to attract personnel to socio-economically deprived areas.

In addition, the MoH proposed an allowance package for health personnel to the Cabinet. The content of the proposed un-targeted package is confidential.

3.7.30. Labour Relations

Despite the general perception of low moral and satisfaction among health workers, labour relations have been unproblematic with few exceptions. In 1992, medical doctors at Muhimbili Hospital went on strike, demanding reasonable compensation. The government responded by introducing an on-call allowance for physicians practicing in government facilities. The stipulated rates range between TShs. 2,500 and 3,000 per night. Due to budget constraints, the allowance was restricted to 15 days per month. Recently, the on-call allowance was increased to TShs. 10,000 per night. However, the government has not been able to allocate sufficient resources to pay allowance claims.

3.7.31. Accountability

Health workers are primarily accountable to their employers. In the absence of performance management systems and sanctions in the case of negligence and other forms of malpractice, this line of accountability remains weak in the public sector.

Health workers are, in principle, also accountable to the patients. To date, there are no mechanisms in place to establish and strengthen this line of accountability.

Within the decentralisation process, Community Health Boards were established to hold the personnel in local facilities accountable. The impact of this new line of accountability on personnel performance has yet to be investigated.

4. KEY HRH ISSUES - WITH A FOCUS ON THE PUBLIC SECTOR

4.1. Supply and demand mismatch

Despite the lack of data on sub-categories of supply, data suggest a significant mismatch between the supply and demand for health labour. Approximately 17,500 vacancies persist in the public sector. Today, the production of health professionals does not compensate for the losses among the employed. Mainly driven by the HIV/AIDS epidemic, need and demand for services and labour will grow. Hence, the supply-demand mismatch will increase from day to day.

However, demand for health labour is, to a large extent, ineffective, as vacancies are not backed by resources. Public expenditure on health falls short of the Abuja target. In international comparison, the share of recurrent expenditure spent on personnel emoluments is very low. This situation may rapidly change with the anticipated injection of resources into the sector in the wake of the initiatives supporting the National HIV/AIDS Care and Treatment Plan.

Three strategic options carry the potential of remedying the situation on the short run. First, little is known about unemployment among health workers and inactive supply. However, after a decade of an employment freeze in the public sector, the general perception is that a stock of trained nurses and clinical officers remains unemployed in the health sector. Second, the production of graduates could be quickly amplified by shifting from in-service to pre-service recruitment. Finally, data suggest the potential for huge productivity gains due to improved HR management.

4.2. Inefficient recruitment

Even if the supply-demand mismatch were corrected, the recruitment of health professionals would remain a challenge. At present, the probability of filling a budgeted vacancy is, on average, less than 50%.

A review of recruitment policies and practices is underway. Early results indicate room for improvements of the recruitment process. At the root of recruitment failures, however, are compensation levels and working conditions that hamper not only recruitment, but retention of health professionals and on-the-job performance.

4.3. Imbalances in the geographical distribution

Substantial imbalances in the geographical distribution of health personnel persisted over the last decade. Research indicates that these imbalances are partly driven by the unequal distribution of infrastructure. In addition, they are compounded by the failure to recruit and retain personnel in underserved areas. The latter suggest that the reasons for deficient recruitment and retention differ in underserved areas in terms of quantity and quality. A thorough analysis of the causes of geographical imbalances is lacking. At present, no policy is in place that attempts to redress such imbalances.

4.4. Deficient on-the-job performance

Though a comprehensive assessment of on-the-job performance is lacking, research indicates significant shortcomings. Most outstanding is an overall productivity level in the public sector below 60%. The large proportion of unskilled workers among the health workforce suggests that unskilled staff continues to substitute for health professionals. In addition, the plan for the re-training of all health professionals in the care and treatment of HIV/AIDS implies that current skills are inadequate to respond to the health care needs of PLWHA. Hence, shortcomings are likely not only in terms of public workforce productivity but also quality.

Performance shortcomings are solely a symptom of more fundamental issues that also impact on recruitment and retention of health workers. First and foremost, is the absence of a performance management system, including support systems (e.g. continuous education), appraisal and rewards. Performance deficiencies are further aggravated by a general lack of accountability, confounded by factors that create wide-spread dissatisfaction such as limited career opportunities and low, compressed wage scales.

4.5. Policy inertia

A policy response to the all too often evoked “health workforce crisis” is pending. The latest human resource strategic plan expired four years ago. At the same time, the relative share of the resources allocated to human resource development is declining.

Confusion prevails about the responsibility and authority for HRH policy decision making. Some uncertainties evolved in the wake of reform processes in the public sector, local government and health sector, confounded by the fragmentation of HRH policy responsibilities across three Directorates in the MoH. In addition, the capacity of the MOH to respond to the challenges has been undermined by the departure of the most skilled and experienced staff.

A strategic response will depend on reliable information about workforce performance, trends and determinants. Today, significant information gaps remain. For example, the results of the 2001/02 HRH census have yet to be finalized and critically evaluated.

5. REFERENCES

- IHRDC (2004), Exploring the Influence of Workplace Trust over Health Worker Performance, National Overview Report: Tanzania; Ifakara Health Research and Development Centre.
- Kurowski C (2004), The state of the health workforce in Tanzania – supporting solutions to burning issues. Memo. The World Bank
- Kurowski C et al., (2003), Human Resources for Health: Requirements and Availability in the Context of Scaling-Up Priority Interventions in Low-Income Countries, Case studies from Tanzania and Chad. London School of Hygiene & Tropical Medicine.
- Martinez J and Martineau T (2001) Introducing PM in National Health Systems: Issues on policy and implementation.
- Mboya R (2004) Personal Communication
- McKinsey (2004) Tanzania HR Report
- Mliga G (2004) Personal communication.
- Mmbaga (2004) Personal communication
- MoF (2004) Guidelines for the preparation of medium Term Plan and Budget Framework for 2004/05 – 2006/07.
- MoH (1999) Staffing Levels for Health Facilities/Institutions
- MoH (2000) Department of Human Resource Development, Information Bulletin on School Data Base.
- MoH (2003) Health Sector Public Expenditure Review Update
- MoH (2003) Report of the 3 by 5 Mission to Tanzania: On Scaling up Antiretroviral Treatment as part of the Global Emergency Response to HIV/AIDS.
- MoH (2004 A) Results of the HRH census 2001/02. Forthcoming
- MoH (2004 B) The human resource crisis in Tanzania – a proposal for immediate action
- MoH (2004 C) The Health Sector Review
- Moyo (2004) Personal Communication
- Muhondwa et al (2004), Baseline Study of Muhimbili National Hospital: Unpublished Research Report
- Mwakaluka E (2004) Personal communication
- Njau F, (2004) Personal Communication

PO-PSM (2004) Selected Issues on Human Resource Management in Health Sector: A presentation to Joint Health Sector Review, 16th March, 2004.

Swai E (2004) Personal Communication

Tawale (2004) Personal Communication

URT (1999), Public Service Management and Employment Policy

URT (2002), Staff Development Circular no. 23: Public Health Cadres under the Ministry of Health.

URT (2003A), A The Public Service Regulations, and the Public Service Scheme

URT (2003B), President's Office, Public Service Staff Circular no. 2

URT (2003C), Public Service Reform Programme: Revised Medium Term Strategy, Action Plan and Budget 2003/04 – 2005/6).

URT (2003D), HIV/AIDS Care and Treatment Plan 2003-2008

Yambesi D G (2004) Personal Communication