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Repoa Brief

Enhancing the Distribution and Performance of Health Workforce in Kenya

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Key messages

- The country is facing acute shortage of human resource in the health sector
- The problem is even more serious in the Northern Arid and Semi-Arid lands (ASAL) counties and rural areas, where working conditions are bad
- Human capital flight to other countries to look for green pastures in very high among workers in the health sector

Introduction

Health workers are the cornerstone and drivers of health systems and must be adequate if the country is to achieve her health targets as articulated in the Kenya Health Policy (2014-2030), Kenya Vision 2030 and Sustainable Development Goals. There is a strong positive correlation between health workforce density and service coverage and health outcomes in general including the immunization levels, child survival, and primary care outreach (WHO 2007). Thus, maintaining an adequate number and quality health workforce is important and requires the careful management of attraction, retention, and training frameworks of the required human resources.

Health workers are effective if the system in which they function is able to: adequately educate an appropriate and sufficient number of health workers; provide sufficient financing for their salaries, supplies and transportation; effectively motivate and manage the administrative, information, logistics and supply needs and working tools of health workers; establish appropriate physical infrastructure and delivery models; and provide safe working conditions.

To achieve a health workforce which is adequate, competent, responsive and productive, actions are needed to manage the dynamic labour markets that address entry into and exits from the health workforce. Actions are also required to improve the distribution and performance of existing health workers.

Although the numbers and distribution of human resources for health is important, Kenya has had health worker gaps based on global cadre norms before and even after devolution. The country has on average 2.5 medical officers per 1,000 people compared to the WHO norm of 30 in 2013. In 2015, it was estimated that the respective shortfalls in clinical officers and nurses stood at 6,696 and 40,468.[1]The mal-distribution of health human resources worsens these ratios in many counties. In addition, training institutions are poorly distributed and in favour of urban areas and curative care. Besides the human resource gaps; the health sector has experienced recurrent unrests among health workers as a result of perceived poor remuneration and poor conditions of work.

Findings

The brief presents findings from the recent studies on "An Assessment of Health Care Delivery under Devolution" and "Understanding Devolution in Kenya and Tanzania: Case for Kenya" undertaken by KIPPRA indicate that: Like in most countries, health workforce supply in Kenya is affected by gross under-production of health workers. There is more emphasis placed on training high status, high income occupations, leading to shortages of technical and support staff in some cadres.

Among the main challenges facing the health system in Kenya include acute shortage of health care human resources in some of Kenya' counties. The shortages are particularly more acute in the northern Arid and Semi-arid lands (ASAL) counties and rural areas where households cover long distances to access healthcare. Health workers are often reluctant to relocate to remote areas that offer inferior amenities for health professionals and their families. Owing to their more attractive amenities, urban areas attract health care professionals. These advantages include: more opportunities for career and educational advancement, better employment prospects for health professionals and their family (especially spouse), easier access to private practice, lifestyle-related services and amenities, and better access to education opportunities for their children.

The observed shortages are likely to get worse since most counties are experiencing an expansion of healthcare infrastructure without a concomitant increase in human resources. Only 25 percent of the counties acknowledged that medical staffs were generally adequate in health facilities. There are also glaring gaps in effectiveness of training, capacity building and general workforce development. The above findings motivate the need for more healthcare human resources; ensuring effective deployment and institutionalized effective training and capacity building programmes; and professional management.

In addition, a sizeable number of physicians, nurses and other medical professionals are lured away to developed countries in search of better working conditions. The main factors driving this problem have been identified and these include: insufficiently resourced and neglected health systems; poor human resources planning and management practices and structures; and unsatisfactory working conditions – which is characterized by: heavy workloads, lack of professional autonomy, poor supervision and support, unsafe workplaces, inadequate career structures, low and disparities in health worker's remuneration, differences between those employed by the County Government, former Municipal Boards and the National Government. Limited technically trained staff to manage sophisticated health equipment across most facilities especially at sub national level, poor access to needed supplies, tools and information; and limited or no access to professional development opportunities. There was also minimal emphasis on medical

[1] ROK/MOH (2014c: 35-6)

research perhaps due to limited financial provision.

Conclusions and recommendations

A number of interventions are recommended for improving human resources management in health care. These include:

Mechanisms for informing workforce planning

Establishment of research mechanisms for provision and update of evidence on health workforce requirements currently and into the future. This shall inform the health policy planning process. Specific needs include research and dissemination on: strategies to better retain health workers that include attention to both salaries and working conditions and differential effects on male and female staff and ways to monitor health worker performance. Evidence can also be built on: managing size, skill mix and organization; use of incentives to improve performance; institutionalizing up-skilling, educating and training; impacts of legislation and regulation; and influence of political and macroeconomic contexts including devolution of human resource management. The roles of national and county governments in health human resource management should be clarified and adequate resources dedicated for such functions as training, medical research and skills development.

Reforming medical training, recruitment and retention

Introduction of reforms in medical training, recruitment and retention to address scarcity of health workforce in the rural and ASAL areas. These include: locating Health Training Institutions in rural areas; implementation of special incentive or welfare package to health workers in the rural areas such as provision of housing; in-service training and career development opportunities and an increase in hardship pay/allowances. The national and county governments should commit to: introduce more flexible pathways into health education in order to encourage the recruitment of students without traditional qualifications and from under-represented populations; implement incentive systems and regulatory measures to influence physicians' location choices; and create a formal support structure which may be a department, working group, or observatory that facilitates the design and implementation of recruitment and retention interventions.

Improving incentive structure

Improving salaries and other incentives for health workers. Available information indicates that financial incentive is an option to aid recruitment and retention in under serviced areas. Multiple incentives and motivation to make working in unattractive areas more appealing can be introduced. There is need to align remuneration schemes since these are not harmonized owing to the fragmented nature of negotiated CBAs between various categories of medical staff. As an example, in recent years, both Doctors and Nurses have bargained their respective CBAs resulting in relatively higher pay for these staff relative to Clinicians (who are not unionized). There are indications that this may affect the morale and productivity of the staff excluded from the CBAs. This is also likely to ignite additional worker unrest within the medical workforce.

Management of health workers migration

Instituting measures for the management of health workforce migration. These include measures to: improve monitoring of health worker migration; direct migratory flows; and improve human resource policy and practice. Policy-makers should ensure that the two main indicators required for assessing the relative importance of migration and international recruitment is available: trends in the inflow of workers into the country from other source countries (and/or outflow to other countries)

and the actual number of international health workers in the country at any point in time.

Finding point to the need for implementing measures to improve human resource policy and practice. Poor retention of health workers is usually a symptom of deeper problems in health systems, such as the challenges of improving workforce planning to reduce over- or undersupply.

Attention must therefore be paid to more general human resource practice in health systems, and specifically to fair and equitable treatment for all health professionals and efficient deployment.

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