Ethical considerations for effective health human resources planning and management

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Abstract—This paper maps out some of the ethical issues associated with effective Health Human Resources (HHR) planning and management. The key HHR topics of ethical recruitment and retention are highlighted drawing upon an ethics framework that emphasizes the principle of transnational justice. The key take-home messages are as follows: (1) ethical recruitment of health workers from other jurisdictions needs to acknowledge the effect their recruitment has on the region, province, or country they leave behind and (2) an ethical approach to HHR management requires more attention be paid to deploying existing domestic HHR to their full scope. This would include but not be limited to non-practising internationally educated health professionals already in Canada.

Effective management of Health Human Resources (HHR), is one of the most critical elements of healthcare leadership. HHR are the most important and also the most costly inputs into healthcare delivery systems. Moreover, most key healthcare decisions implicate or are directly about HHR. Thus, how healthcare leaders plan for and manage HHR is integral to system efficacy and sustainability. It is perplexing, therefore, that there is so little literature that explicitly addresses the range of ethical issues associated with effective HHR planning and management. When ethical issues are considered in the health literature, the lens tends to focus on the activities and healthcare decisions of healthcare professionals and their professional codes of ethics. This paper shifts the perspective to examine the circumstances and context within which healthcare professionals practice by mapping out some of the ethical issues associated with more effective HHR planning and management. In doing so, it draws upon the ethics framework that highlights the principles of autonomy, non-maleficence, beneficence, and justice, with reference to an HHR context. A particular focus is on Eckenwiler’s (2009) conceptualization of transnational justice, described as structural processes that result from the actions of many persons and the policies of multiple organizations that transcend national boundaries to produce either justice or injustice. The key HHR activities of recruitment and retention—inform ed by a targeted, yet systematic review of the Canadian HHR literature — are highlighted.

ETHICAL HHR PLANNING

A range of activities are covered under the umbrella of HHR planning. At its most basic level, effective planning for the health workforce involves matching the needs of the patient or population targeted for the healthcare services being delivered with the supply of health workers minimally in the spirit of beneficence and justice. Challenges arise when there is a gap between the needs of the population and the supply of HHR that can address those needs. Managing that gap is a complex process that involves both short-term and long-term strategies. When a gap arises as a result of a shortage of HHR, one of the short-term strategies has been to look elsewhere for HHR to address unmet needs. This has resulted in recruitment from other regions, provinces, and countries.

The bulk of the literature that explicitly examines ethical issues in HHR planning addresses the recruitment and integration of Internationally Educated Health Professionals (IEHPs). First, with respect to ethical recruitment, a number of commentators have problematized the increasingly prevalent practice of the recruitment of health workers from low- to high-income countries (eg, [2, 3]). For example, in Canada there are a number of nurses who trained in the Philippines and physicians from South Africa: both the Philippines and South Africa have developing health systems with a much higher acuity of population health needs and much lower density of health professionals than Canada. With many countries chasing after this limited
resource, high-income countries like Canada are better positioned to succeed in these recruitment efforts. But such activities, though not attributable to one organization, contravenes Eckenwiler’s (2009) notion of transnational justice.

As a result of such trends, HHR planning and management has gained attention not only in the scholarly literature but also in various health policy dialogues. The World Health Organization (WHO) dedicated the World Health Report in 2006 towards this issue, which initiated the Decade of Human Resources for Health. More recently, in May 2010, the WHO Global Code of Practice on the International Recruitment of Health Personnel was signed by all members of the World Health Assembly, including Canada. Briefly, the WHO Code outlines a set of principles (not solely ethical) that all member nations have voluntarily agreed to observe. These include fair and transparent recruitment processes respecting the rights of migrating health personnel (or autonomy) while at the same time promoting the sustainability of developing health systems by striving to mitigate negative consequences of health personnel migration (or non-maleficence).

The code not only addresses the ethical recruitment but also the ethical integration of IEHPs in terms of fairness of employment policies and practices and equal opportunities of access to professional practice. This has been a particularly salient issue in Canada where there is not only a concern with brain drain from source regions but also with brain waste that is, having many health professionals unable to practice their profession nor work in the healthcare sector. When health workers are recruited—whether actively to the health sector or passively through immigration policies—it is imperative that their skills be utilized at the highest possible skill level.

One of the responses to the increasing salience of these ethical issues has been an effort to strive towards “self-sufficiency,” or to rely on domestically trained health professionals to meet HHR needs. Indeed, self-sufficiency is an underlying goal of the WHO Code, which states that member nations, “should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel.” (Article 3.6, p. 4). One of the challenges with this goal is that neither is there a commonly understood definition of self-sufficiency, nor do we understand how this definition might differ for countries like Canada, for which there is a long-standing tradition of immigration, including of health workers. If self-sufficiency is to mean training all staffing requirements domestically, this would exacerbate an already difficult situation for IEHPs migrating to Canada.

ETHICAL HHR MANAGEMENT

Intricately linked to the issue of the ethical recruitment and integration of IEHPs, alluded to in the WHO code, is effective and ethical HHR management. Addressing the active recruitment of health workers to the UK in the early millennium, Bach makes this connection explicit: “governments and employers … [have relied] on the relatively straightforward panacea of international recruitment rather than focusing on underlying problems of pay and working conditions. Improvements in these areas would ensure increased recruitment and retention amongst the existing health sector workforce.” (p. ix). Recruitment of IEHPs can be considered by some to be a quick and cheap fix for the persistent problems that plague particularly hard-to-fill positions and sectors, this is seen notably in the rural/remote and older adult care sectors (c.f., [7]). Although IEHPs contribute considerably to such positions, their disproportionate representation can be seen as a symptom of the broader challenges to the quality of work in those sectors. It is generally agreed that challenging sectors are best addressed with targeted attention to the HHR management issue of promoting healthy workplaces.

Effective HHR management can be considered an important element of organizational ethics, that is, deploying health workers in a way that furthers the mission of the organization. Indeed, attention to supportive work environments and human resource practices have been found to be key factors supporting increased organizational efficiency and effectiveness, and improved patient care (Quality Worklife–Quality Healthcare Collaborative, n.d.). According to the pan-Canadian Quality Worklife–Quality Healthcare Collaborative (n.d.), a healthy work environment can be defined as “a work setting that takes a strategic and comprehensive approach to providing the physical, cultural, psychological and work conditions that maximize the health and well-being of providers, improves the quality of care and optimizes organizational performance.” (p. 3). Increased attention is being paid to these issues through such initiatives as the Canadian College of Health Leaders (CCHL) LEADS in a Caring Environment framework (2010), and the CCHL Code of Ethics, which encourage healthcare leaders to create healthy work environments.

Two key features of a healthy workplace to be promoted amongst health professionals are a manageable workload and job decision latitude. Related to these two features is the more effective deployment of the health workforce. A key element of this is having health professionals work to full scope—deploying the skills for which they have been trained. That is, just as it is ethically imperative to utilize the skills of IEHPs at their highest skill level, so too is it relevant for domestically trained health professionals, some of whom work below the full scope for which they are trained and regulated, to be competent practitioners. This gap between competency and practice can be linked to historical legacies of professional turf, which can in turn be framed as “community standards”. The lack of full scopes of practice result in serious inefficiencies in the healthcare system.
Initiatives that explicitly promote retention through return after leaves of absence are also critical; these may include refresher or retraining options. Related to this, when there are reforms in the delivery of health services, such as shifts from institutional to clinic or to community or long-term care, there is a similar imperative to retain skills and redeploy them into new or expanded organizational healthcare delivery structures. Redeployment is a particularly promising area for improvement given a history of few successes. 13

Such potential improvements to the health of the workplace have been linked to a positive effect on the retention of the workforce, including reduced absenteeism and turnover (Quality Worklife–Quality Healthcare Collaborative, n.d.). Taken together, approaches that foster a healthier workplace and the retention of this highly skilled and sought after set of workers better enables a sustained health workforce, which, in turn, supports the goal of self-sufficiency in HHR planning, a key principle in the WHO Code.

CONCLUSION

In conclusion, this brief analysis lends support to the argument that the planning and management of HHR should be informed by the principles of an ethical framework. The implications of applying such an ethical framework are evident for a number of actors and audiences at the local, regional, provincial, and national levels.

Ethical HHR planning requires the use of a number of policy levers at the national level in terms of immigration policy, but in Canada this also includes the ethical integration of IEHPs at the provincial level, which must be balanced with less active recruitment at the local and regional level. The ethical principles with respect to IEHPs also need to distinguish the circumstances in which they are recruited, distinguishing between those recruited to fill specific shortages in the workforce versus those who migrate to Canada and then subsequently seek work that recognizes their professional qualifications. Although the autonomy of the migrating health worker is recognized at least in so far as the national level of immigration policy, the ethical principles of justice and equity in terms of access to their profession (which is framed more at the provincial level) are more obscure. But as Eckenwiler 14 argues, there is no one single level or set of institutions or organizations that are solely implicated in this problem.

In terms of the issue of working to full scope, it also involves a balance between the provincial regulatory level and implementation at the local and regional level. That is, employers and decision makers at the local level often reflect on which parts of the provincially defined scope would be best utilized at their local service. Moreover, although the issues of licensure and regulation are distinct from the issue of scope, a thorough discussion of the issue of “working to full scope” also needs to recognize the “legitimate” scope of the recognized credentials of an individual professional from unrecognized credentials, and the inappropriate delegation of tasks to workers at the local level who do not possess the requisite competencies. In the case of IEHPs, it is difficult to discuss working to full scope if their credentials have not been fully recognized if or if they are not licensed to practice.

Given the nascent state of the literature on the ethics of HHR planning and management, perhaps a productive task would be to develop a Code of Ethics for HHR that would parallel and contextualize various ethical codes of practice of health professionals. Such a set of principles could draw and expand upon the principles in the WHO Code and those more directly relevant to an ethical framework.

REFERENCES