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STRATEGIC MANAGEMENT OF HUMAN RESOURCES FOR HEALTH IN THE OIL-RICH MIDDLE EAST

by

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ABSTRACT

The oil-rich middle east countries are fast developing its social infrastructure, drawing upon non-national imported human resources. This policy has led to certain un-intended outcomes and vitiated normal human resources development: cultural dissonance, limited transfer of expertise, passive managerial styles, low staff morale, etc. The nations have responded by adopting strategies of indigenisation of manpower, restriction of managerial positions to national staff only, full employment policy for 'qualified' nationals. As many of these policies have yielded both positive and negative results, scope still exists for broadening the strategic management of human resources; some of these options are elucidated in this paper.

INTRODUCTION

The oil-rich countries in the middle east generally have certain common characteristics: large geographic areas consisting of substantial desert lands, small population which vary from several thousands to several millions; high GNP with limited non-oil industrial base. Population density is low indeed. Most of these countries have high fertility rates, low mortality rates, and consequent high population growth (or natural increase) rates. Although the overall health situation, in terms of mortality or morbidity, ranges from 'fairly satisfactory' to 'extremely satisfactory' comparable to many developed countries in the west, the governments of these countries are struggling hard to make comprehensive health services available to their citizens and

residents. As most or all of these countries are endowed with rich oil reserves, and are able to exploit it, the governments are in a strong position to assure their residents a high quality of life. These nations are committed to provide the best available quality of health care to the residents, and as close to their doorsteps as possible.

Most of these countries got headstarts in their infrastructural development only after the discovery of oil reserves in their territories. Consequently, their educational development started rather late. Because of these historical reasons, most of these countries did not (or do not still) have adequate human resources for health services development. In view of this, and their ability to pay relatively more attractive salaries than that available in many other developing countries, these nations have been filling the shortfalls in their human resource availabilities through importation of qualified medical and allied manpower. It is worthwhile to review the strengths and weaknesses of such policies in the context of the middle east situation.

TYPICAL HUMAN RESOURCES POLICY FRAMEWORK

As elucidated above, an oil-rich middle east country typically has a low stock of (qualified) indigenous human resources, and a large (often 50-90% of the qualified health professionals) stock of expatriate staff. It is normal to expect in most of these countries that the majority of the senior doctors (especially medical specialists) and nurses engaged in health care delivery are

non-nationals. As these personnel are expected to play pivotal roles in the development and maintenance of health services in a country, the quality of this manpower and their commitment (to the country's health care goals) become critical determinants of the country's success in health system goal fulfilment (1).

Mobilisation: Human resources are typically mobilised through informal contacts (recommendations of senior serving staff), direct individual applications, and advertisements (direct by a Ministry or through private recruitment agencies recognised by it). Usually the recruitment drives are preceded by (but not necessarily follow from) elaborate human resources planning. It is not unusual to come across situations when supply creates demand eg., if a highly qualified candidate in a rare speciality applies for a job, he may be recruited even though no provision for it exists at that time. Most recruitments (at least at the higher levels) need be routed, at least at the final stages, through the Civil Services Council/Ministry. Though after the approved recruitment, a staff may be deployed according to the needs of the Ministry of Health, the termination procedures are again linked to those of the Civil Services Council/Ministry. Similarly, career prospects and policies regarding fairness and equity, promotion and increments etc., are also governed by the Civil Services Council/Ministry.

Motivation: As usual, the authorities of a Ministry of Health generally assume that the staff (nationals and expatriates) have been well taken care of, and are expected to be committed to MOH

objectives, and are willing to devote time and energy to the accomplishment of these objectives.

Development: The situation regarding the policies of a MOH towards staff development varies a great deal, especially in regard to the expatriate staff. Some Ministries assume that the expatriate staff are already "experts", they are "temporary" (though many of them eventually spend even 10-20 years!), "they are here to work", and so on. Such MOHs naturally do not provide any opportunities to the expatriate staff for training. A contributory factor for such stances is the fact that the training load of the nationals alone is rather large. Sometimes, the rules of the Civil Services Councils/Ministries of the country do not provide for such training opportunities. In some countries, MOHs do provide opportunities to the expatriates to attend in-country seminars, etc. As far as job rotation is concerned, it is not the rule but rather an exception. It is not unusual to find an employee (nationals and expatriates alike) working in the same position (or work station) for 5 to 15 years!.

Fulfilment: Work satisfaction, as a major contributory factor to fulfilment of an employee's professional aspirations, is often assumed, but is usually not explicitly considered, by many MOHs in this region. It is only a rare phenomenon, but it does sometimes happen in some of the countries of this region, when a dynamic Minister is keen to learn about the job satisfactions of employees, commissions a study on it, and even acts on the recommendations of the study to promote fulfilment of the employee's aspirations.

Employment Practices: Most countries in this region follow "full employment" policy as far as the qualified nationals are concerned. The states are morally bound to provide employment to those qualified nationals who seek employment in a Ministry, or at least attach priority to such applications before considering recruitment of expatriates locally or from abroad (2).

PROBLEMS IMPLICIT IN CURRENT HUMAN RESOURCES POLICIES

Cultural Dissonance: The expatriate staff are recruited from a large variety of countries with diverse cultures, some of which are incongruent with the culture of the recipient country. These staff may not find it easy to adjust to the social environment of the country to which they migrate. The nationals may not also appreciate the value systems of the foreigners. Such situations sometimes lead to difficult organisational and managerial problems. Many of the expatriate staff may not know the local language. This causes communication breakdowns, and the patients' interests suffer. As a large number of expatriates are present in a country (in MOH and other Ministries and non-Government organisations), these people have substantial influence on the attitudes and behaviours of the nationals. Unfortunately, not all such influences are beneficial to a country.

Inadequate Transfer of Expertise: It is a normal practice in the health care field that the seniors pass on their expertise to the juniors over time. For example, the medical consultant in charge

of general surgery is expected to associate the junior surgeons in the operations that he undertakes. It would have been the case if all the medical staff were nationals. In a middle east country it is not unusual to find a developed country professional (with western, supposedly superior, qualifications but with extremely limited experience) occupying a senior consultant (head of a department) position, and under him some nationals and other expatriates (possibly, with non-western qualification but longer experience). In such a situation, it is difficult to imagine that smooth transfer of expertise will take place.

Yet another pathological phenomenon undermines the possibility of smooth transfer of expertise from the expatriates to nationals. It is found that some expatriate staff do not provide any on-the-job training to their junior national colleagues, as they are afraid of losing their own jobs. Many expatriate staff closely guard their own expertise so that they will be perceived as indispensable. Further, the inertia of many national colleges to exert and learn also adversely affects the possibility of the transfer of expertise. In one of the countries it was observed that the expatriate staff in a certain department functioned as "checkers" rather than as "supervisors"
or "trainers". Such a situation further depresses the low self-confidence of many national staff.

Passive Management Styles of Expatriate Managers: In view of the serious shortage of qualified senior personnel, many MOHs are forced to appoint the expatriate staff in senior managerial

positions. This compromises the national pride. Many subordinate national staff quietly resent such appointments, and do not feel comfortable to work under non-nationals. The expatriate managers, on the other hand, are afraid of asserting their authority, which is little anyway. If an expatriate manager finds that some of the nationals working under him are inefficient or indisciplined, he feels reluctant to proceed against them. This situation forces the expatriate staff under him, to exert themselves, and they are overworked as a result. The managers tend to rely more on them. And, this sets in a
vicious phenomenon of disguised unemployment or (under-employment) of nationals. Thus, a style of apathetic management continues, and it ultimately harms the very system in which it is embedded.

Lack of Confidence of Top Management in Young Nationals: Top level (national) managerial personnel tend to rely on expatriate staff, as they lack confidence in their own young national staff. Whenever a problem is faced, or a decision is to be made, many top-level managers prefer to assign the related tasks only to certain expatriate staff. Some nationals tend to feel that they can do the job (in fact they only do the work behind the scene), but higher management prefers to ignore them. The veracity of such impressions is difficult to establish. Nevertheless, this phenomenon depresses the morale of the nationals. It also seriously affects the development of these nationals into responsible administrators.

Low Morale of Staff: The staff of many MOHs lack enthusiasm, even though they do undertake the duties assigned to them. The expatriate staff are under constant threat of termination unless they work hard. They cannot afford to make any complaints about their work. So, many of them work like robots. They even agree to undertake activities which, strictly speaking, do not pertain to their professions. They are unwilling to utter a word about it, lest they should lose their job. Many expatriate personnel, even though well qualified and experienced, are required to work for years at a junior level, and undertake the same type of work for years.

In some of the countries in the region, the expatriate staff are denied the facility of promotions to higher positions. In some other countries promotion facility is available, but it is too slow. Some expatriates prefer to leave a country in the region to go to another country in the same region, so as to get a higher position.

Although the national staff do get opportunities for training within the country and abroad, such facilities are not normally extended to the expatriate personnel. This means that some of the professionals are unable to update their knowledge, and their efficiency suffers.

Many of the above situations lead to low staff morale and performance motivation, although the work goes on because of the

expatriates' fear of losing their jobs. Some of them are unable to bear this situation too long, and decide to look for greener pastures elsewhere(3).

SOLUTIONS ATTEMPTED AND THEIR OUTCOMES

Policy of Indigenisation: Many of the countries have adopted a policy of giving priority to nationals in recruitment, and for this purpose embarked upon large scale human resources development through establishment of professional educational institutions (such as medical colleges, nursing schools etc.). This policy, which is strongly supported by political will, is bearing fruits, in terms of production of doctors and nurses etc. In case of some of the countries, this means reduced importation of expatriate personnel. In case of some other countries, at more advanced stages of human resources development, the indigenisation policy entails substitution of expatriates by nationals educated locally or abroad. Although reasonable efforts are made in the national medical colleges, nursing schools etc., to produce high quality professionals, there is inherent resistance by health services institutions to accept national replacements for expatriate personnel. Their logic is that the expatriate staff being replaced are more experienced and skilled, and often more qualified too. Such inadequacies in personnel, they argue, will affect adversely the quality of health care. When working together in an organisation the staff to develop affinity to each other,

irrespective of nationality differences, and find it difficult to let go a competent colleague, who is replaced by a national new recruit. The expatriates, in view of their constant fear of being replaced, often engage in some sorts of dysfunctional behaviour. Some of them try to maintain strict secrecy of their method of work, so that at least no nationals can master their techniques. Other expatriate senior staff (supervisors) make sure deliberately (or because of their lack of confidence in the national junior staff) that the national subordinates are given only simple tasks, so that the need for the services of senior expatriate (supervisory) staff is not obviated. The indigenisation policy itself becomes difficult to implement, in some countries, when there are ambitious infrastructural expansion plans.

Policy of Assigning Managerial Positions to Nationals Only: In many of the countries in the middle east, a deliberate policy has been adopted to ensure that most of the managerial positions are assigned to nationals. This has raised national pride, as the power of managerial decision-making has become the exclusive right of the national staff. Consequently, it has become necessary to appoint many under-qualified inexperienced nationals in managerial posts. This policy has thus diluted the quality and depth of the decisions, in view of the fact that many national managers woefully lack managerial competence. Further, the aspirations of young (national) graduates have been so aroused that all of them expect to be appointed straightaway to managerial positions. This has caused attenuation in the significance of managerial designations

such as Head of a Section, Director, Director-General etc.

Policy of Full Employment of Nationals: This policy has led to wide-spread recruitment of national staff, through filling of all available staff vacancies whether necessary or not. Because of the failure to assess genuine manpower needs disguised unemployment of nationals has resulted. Low productivity of human resources has thus led to wastage of precious financial resources, and is thus indirectly affecting the real indigenisation of human resources. This policy has yielded, however, good political mileage in terms of assuring the people that the governments are bent on keeping the interests of nationals above everything else.

POSSIBLE STRATEGIES

The countries in the oil-rich middle east region may embark upon or strengthen the implementation of one or more of the policy options listed below:

1. Raise resource allocation for education of nationals in the country or abroad.
2. Remove or soften the bureaucratic and/or budgetary constraints on travel or deputation of nationals for overseas studies.
3. As an interim measure, set up local educational/training institutions with expatriate faculty members, to conduct crash

(condensed) courses for nationals.

4. Undertake long range human resources planning especially for optimal replacement of expatriates over time.

5. Monitor human resources productivity as a routine, with a view to checking unnecessary import of expatriate manpower.

6. Undertake periodic studies on job satisfaction of personnel and initiate corrective actions for keeping employee morale high.

7. Extend in-country training (continuing education) opportunities to all employees including expatriates.

8. Assure time-bound lateral promotions (gains in pay) to all employees including expatriates, and out-of-turn merit-based vertical promotions (gains in status) to employees with exceptional performance.

9. Set firm educational and experience criteria for recruitment of nationals to positions based on job evaluation, and adhere to these for recruitment decisions.

10. To facilitate desirable transfer of expertise from seniors (usually expatriates) to juniors (usually nationals) consider:

(a) preparation of job manuals (detailing administrative process descriptions),

(b) development of teaching learning materials such as video recordings of complicated surgeries etc.,

(c) use of (senior) expatriate staff as 'trainers' and 'supervisors' rather than as 'checkers',

(d) inclusion of counterpart training in the job descriptions of expatriate staff, and

(e) frequent interaction with nationals to ascertain the situation and take corrective actions.

11. To ensure that the expatriate staff appointed to managerial positions do not adopt passive management styles, consider:

(a) delegating to the expatriate managers adequate authorities commensurate with their responsibilities,

(b) monitoring managerial performance through independent information or performance audits of different departments, and,

(c) impressing on the expatriate managers the need for enforcing discipline among the staff irrespective of nationality.

12. To promote the managerial skills and competence of nationals, higher echelons of health administrations may:

(a) demonstrate greater trust in the nationals' abilities, and (b) organise in-house management training for national staff.

CONCLUSION

The oil-rich middle east nations are in a state of quick transition from 'developing' to 'developed' world. The health care systems of these countries have expanded very fast in recent years, with the help of importation of expatriate human resources. As

these nations slowly move towards self-reliance in human resources, it is essential for the health administrations of these countries to adopt suitable strategies, which will optimise the utilisation of the indigenous and imported human resources, as well as expedite the process of indigenisation. It is necessary to attempt a realistic appraisal of the human resources policies adopted in each country, in response to the problems typically encountered there, and to adopt strategic human resources management as elucidated in this paper.

NOTES

1. The first ever WHO Expert Committee on Management of Human Resources (TRS 783) endorsed 'the definition of health personnel management as activities that mobilise and motivate people and that allow them to develop and reach fulfilment in and through work aimed at the achievement of health goals'. The key concepts here are: mobilisation, motivation, development and fulfilment (WHO 1989).
2. A WHO-EMRO Consultation in Nicosia, Cyprus has reviewed the policy and leadership development for Human Resources for Health (HRH), identified problem areas and outlined important guidelines for policy investigations (WHO 1991).
3. A case study of the Sultanate of Oman has presented a policy analysis of that country (Ghosh 1991 a). In another working paper an approach has been discussed for the study of HRH policy making mechanism (Ghosh 1991 b). WHO-HQ is

developing a HRH Policy Analysis Kit based, inter alia, on these approaches.

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