Posting and Transfer in the Health Sector – What's in a Name?

The things we don't talk about in global health escape our attention perhaps because they don't have a name – the unnamed subject being, in effect, a non-issue. From 3 to 7 February, a group of 19 researchers, decision-makers and policy advocates from 12 countries gathered for a meeting at the Rockefeller Foundation Bellagio Centre in Italy to give one such issue a name and place it firmly on the global health agenda. Organised by the Health Governance Hub of the Public Health Foundation of India, and the Averting Maternal Death and Disability programme at the Columbia University Mailman School of Public Health, the meeting deliberated on the problem of posting and transfer of the health workforce (frontline staff and managers), especially in the public sector of low- and middle-income countries. The importance of posting and transfer cannot be overstated.

We know there are major inequities and mal-distribution of all cadres of health staff across rural and urban settings – this is particularly felt in the most remote communities where grossly insufficient human resource for health remain a challenge to achieving good health outcomes. Yet, given that staff in such postings are known to face challenges (over-work, inadequate equipment, lack of career progression opportunities, being 'forgotten by the system' and access to good schools for their children and jobs for their spouse) it is not surprising that some health workers prefer to work in more comfortable urban areas, and locations where they will have the opportunity of earning additional income, whether legitimately or not. They tend to avoid or reject postings and transfers to serve more disadvantaged populations, and when posted to these places, a tendency for absenteeism exists. However, well beyond the challenge of supply, retention and distribution of health workers and managers, posting and transfer could also be done to punish, as a favour or reward for political loyalty, or even as part of a strategic move to get an incorruptible manager or administrator out of the way. Whether policies and guidelines exist or not, it is clear that posting and transfer practice is never straightforward; the processes are channelled by power, trust (or distrust), and discretion at all levels of the health system. Important as it is, this issue of posting and transfer has hitherto been poorly discussed, analysed and studied. The following is a synopsis of our discussions.

What is posting and transfer

Once named, it becomes apparent that posting and transfer can be viewed through multiple lenses – as a human rights issue (the rights of health workers, managers and users), about service delivery (which depends on how facilities are staffed), as a human resource management issue (to avoid skewed usage of relatively scarce health workers and managers), about the dynamics of power (who decides who gets posted or transferred where and when), as a gender issue (most health workers are women), about the governance of health systems (e.g. how centralised are decision-making processes, and how much autonomy is granted to decentralised units), and about public administration (i.e. the rules and procedures by which a government civil service operates). In all, posting and transfer provides a window into the 'software' of health systems – that is, their human and social dimensions – and the extent to which health systems are people-centred, for health workers, managers and users. Given these varying perspectives of posting and transfer, the layers of complexities seem near-endless.

How to study posting and transfer

Given that posting and transfer in the health sector happens within entrenched systems of individual interests, patronage and power relations, the mere act of studying posting and transfer practices has the potential to enhance transparency. Negotiations surrounding posting and transfer can be characterised by reward, retribution, or even whimsy. There is ample room for corruption in posting and transfer decision-making. This may be either through direct financial gain, or more opaque interactions of clientelism or

patronage. Exchange of favours may flow through kinship or social networks. These factors have the consequence of making posting and transfer difficult to study. In different settings, there are people in the system who are quite happy with the way the system works, namely those people who benefit by the status quo. Thus researching posting and transfer requires tact and diplomacy. In addition, interventions at multiple levels to make posting and transfer more fit for purpose require a recognition that such interventions may not result in unequivocally positive outcomes, given the emergent, non-linear and self-organising character of health systems. To gain the audience and participation of policymakers, it is important to frame posting and transfer in a non-threatening way.

There is recognition that posting and transfer failures are also a result of health system weaknesses, including the way the system is organised, insufficient fiscal arrangements, inadequate oversight, low capacities for generating and utilising human resource management data in long-term planning, and so on. In aid-dependent countries, there is a tendency for donor projects to skew the distribution of public sector health workforce, and local salary scales in the implementation of vertical programmes. When such programmes exclude the most rural and remote communities, they also worsen the urban-rural distribution of health workers and managers. In addition, it is important to understand the mechanisms by which appropriate posting and transfer practice may lead to improved delivery of public services, service coverage, patient outcomes, and inclusiveness of health systems. Many hypotheses are possible. Investigating potential causal pathways by which different contexts influence posting and transfer should be a central concern for research and advocacy. These necessitate using interdisciplinary and multiple research perspectives such as participatory methods, policy analyses, case study approaches, historical analyses, legislative analyses, complexity approaches and implementation analyses to understand current practice. Such qualitative understanding can also benefit from being placed in a quantitative context, by assessing scale and costs of poor posting and transfer practices.

Going forward with posting and transfer

Posting and transfer is likely to continue to underpin many of the challenges we currently observe in the functioning of the health workforce and service delivery. As educational systems in many countries are not producing the required levels of human resource for health, and many governments are not able to employ and sufficiently renumerate the optimal mix and distribution of human resource for health required, the unbalanced demand-and-supply which drives the dynamics of how and where (and why) to post and transfer staff will continue. The demand for health workers and managers will only continue to increase in urban areas as global populations become increasingly urbanised, the consequence being an emergence of undesirable urban postings (e.g. slum areas) co-existing with the remotest rural areas which will remain under-served. Even with commensurate levels of the workforce, posting and transfer issues will still exist, because they are also about personal aspirations, value judgements and issues of power. Naming such a pervasive issue is therefore both important and timely. Without a name, it is difficult to pin down an issue so pervasive, yet overlooked as posting and transfer. Not only did we attempt to frame posting and transfer during the three working days we spent in Bellagio, we also sought to define strategies for research and advocacy on the issue. We look forward to seeing posting and transfer take its rightful place on the global health agenda.