CHALLENGES OF RETAINING HEALTH WORKERS IN THE PNFP SECTOR: THE CASE OF UGANDA CATHOLIC HEALTH NETWORK

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Abstract

Shortage of human resource for health poses a major challenge to achieving the millennium development goals. Uganda is among the 57 countries with human resource shortage reaching critical level and the situation is worst at lower levels of the health system. The private-not-for-profit (PNFP) health sub-sector in Uganda complements government efforts to achieve the MDG, the second health sector strategic plan (HSSP II) and the health-related objectives of the poverty eradication plan (PEAP). The Uganda Catholic Medical Bureau coordinates the Roman Catholic health facilities network, one of the three PNFP networks in Uganda. This paper, presented at a conference organized by the Faculty of Health Sciences of Uganda Martyrs University in March 2007, looks at the HRH crisis as experienced by the UCMB network giving the trend, examining the reasons, the destinations of attritional cases and what the network is trying to do to improve human resource stability. The information is based on quarterly reports received by the bureau from its affiliated health facilities.

Introduction

According to The World Health Report of 2006, Uganda is among the 57 countries with critical shortage of health workforce (WHO, 2006). Yet, the high burden of disease, including HIV/AIDS, requires scale-up of some of the most labor-demanding interventions. The lean health workforce experiences heavy pressure to implement increasing range of services within the national minimum health care package (UNMHCP) and meet the targets for the second Health Sector Strategic Plan (HSSP II), the national poverty reduction strategy paper (Poverty Eradication Action Plan or PEAP) and the Millennium Development Goals (MDGs). There is also pressure to see further downward trend in the HIV prevalence which has stagnated. It has been estimated that the scale-up of antiretroviral therapy (ART) alone in Uganda between 2005 and 2012 would demand a doubling or tripling in staff time given to ART (Chandler and Musau, 2004). To scale up anti-retroviral therapy alone to meet the target of the PEPFAR would require about 10% of Uganda's doctor workforce as at 2004 level (Smith, 2004). Yet, the scale-up of ART in Uganda has even moved faster than originally planned while the health workforce remained almost unchanged. This disproportionate growth in service demand and the skewing of health workforce deployment in favour of few disease conditions worsen the functional gap with respect to implementing the range of services in UNMHCP. But this is worsened by a workforce that is increasingly becoming unstable.

Retention of Health Workers

Health worker instability is worsened by, among others, internal and external movements or losses. HIV is reported to be the leading cause of health worker attrition in developing countries (WHO 2007; EQUINET AND HST 2004). Death, for example, in 10 years accounted for 30% of the 1984 cohort of Ugandan medical school graduates, 50% of which was due to HIV (Dambisya, 2004). At a cross-sectional level the main reason for internal and external movements of Ugandan health workers is "poor working condition" (Matsiko and Kiwanuka, 2003), which often simply means poor pay. There is also desire to move out of rural to urban areas. These affect both the public and the not-for-profit (PNFP) sectors.

Experience of UCMB

UCMB is the national executive arm of the Health Commission of the Roman Catholic Church (RCC) in Uganda and coordinates the Roman Catholic health facilities. It acts as a liaison between the facilities and government and other national stakeholders. It also acts as an advocate of the mission statement of the RCC in health services in Uganda. UCMB does not own the units; they are mostly owned by dioceses and a few by Religious Congregations. Health units are recognized by the UCMB as operating in line with the mission of the RCC through an elaborate process of accreditation. By the end of 2006 there were 27 RCC hospitals, 228 Lower level units (LLUs) including

4 HC IV accredited to the UCMB (4 other LLUs had had their accreditation suspended for non-compliance with one or other requirement). There are also 12 Health Training Schools (incl. the Lab. School in Kitovu)

Most of the UCMB-accredited facilities are rural. By June 2006 the UCMB network alone had 6,845 (about 20%) of the combined 30,000-strong health workforce in the public and PNFP sectors. About 65% of the 6,845 were in the 27 RCC hospitals and the rest in the 228 accredited LLUs.

In 2006, about 60% of UCMB LLUs were able to provide the complete Uganda National Minimum Health Care Package (UNMHCP) expected of their level, up from 54% in 2003 (UCMB, 2003; UCMB, 2006). However, new demands keep coming and there is increased pressure to scale up accessibility or to introduce additional services. These include services related to the Global Health Initiatives (especially HIV/AIDS care and treatment). In June 2004 there were only 6 RCC hospitals providing ART. By June 2005 ART was provided in 18 UCMB facilities (16 hospitals and 2 lower level facilities), rising to 27 facilities by June 2006. Enrolment per facility has been increasing yet the same period did not see equivalent growth in human resource in the health facilities. Instead, for the UCMB network, the number of staff has been negatively affected in the last two years by high levels of attrition especially of key clinical staff. In 2005/06 the network lost a total of 1,487 health workers (757 from hospitals and 730 from LLUs). In LLUs the overall annual attrition rate dropped from 31% in 2003/04 to 28% in 2004/05 before shooting back to 30% in 2005/06. Overall hospital staff attrition rate more than doubled from 7.1% in 2003/04 to 16.6% in 2004/05 and 16.8% in 2005/06. On the surface, attrition did not increase much between 2004-05 and 2005-06.

However, cadre-specific rates have sharply increased, especially for enrolled nurses and enrolled midwives, yet these cadres form the backbone of patient care especially in the lower level units. LLU staff attrition in 2005/06 was 45% among the enrolled nurses, 52% among the double enrolled (nurse/midwife) nurses and 46% for enrolled midwives compared to 38%, 37% and 62% respectively for 2004/05. LLU attrition among clinical officers was 30% in 2005/6, down from 53% in 2004/05. In hospitals, attrition rates were 26% among enrolled nurses, 34% among enrolled midwives, 22% among enrolled comprehensive nurses, and 55% among enrolled psychiatric nurses in 2005/06. Double enrolled nurses in hospitals had no attrition in 2005/6. The median length of time the leavers had served in the individual facilities was just 24 months.

Where and why did the leavers go?

At least 40% of UCMB (RCC) network attrition cases were reported to have joined government employment. Another 34% did not have their destinations reported but it is likely most of these also joined government services as their departures mainly coincided with massive recruitment by government. About 35% of the attrition cases in the UCMB network clearly stated low pay as their first reason for leaving. Another 26% left "in search of better opportunities" which, basically, also means better pay. This means that at least 61% left because of low pay. UCMB estimates that at least over 60% of their leavers could have joined government services to get better pay.

Onzubo (2007) separately observed that in the remote West Nile region of Uganda, 72.9% of health workers leaving PNFP facilities in 2004/05 went to government services. Though search for better pay was the main reason given for leaving the UCMB facilities, the Bureau has established that, in reality, the total "package" of salary plus benefits offered by a number of PNFP units (including some affiliated to the UCMB) is bigger or better, at least for doctors (UCMB in this case) – but often not necessarily so for other cadres. The remuneration package includes salary, housing, light, water and other benefits often not available to civil servants especially in rural areas.

Figure 1: Trend of attrition in LLUs of RCC health network

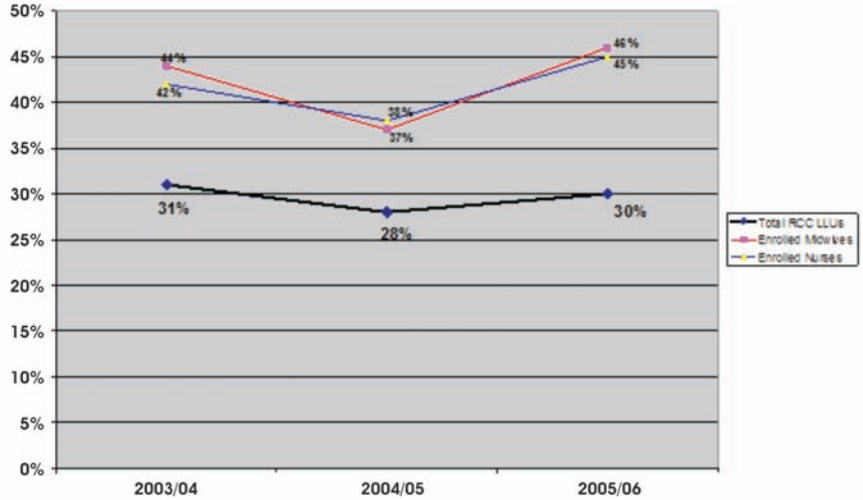
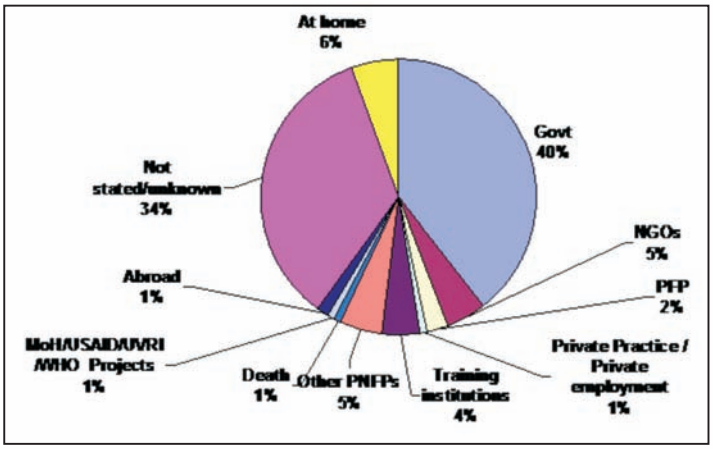
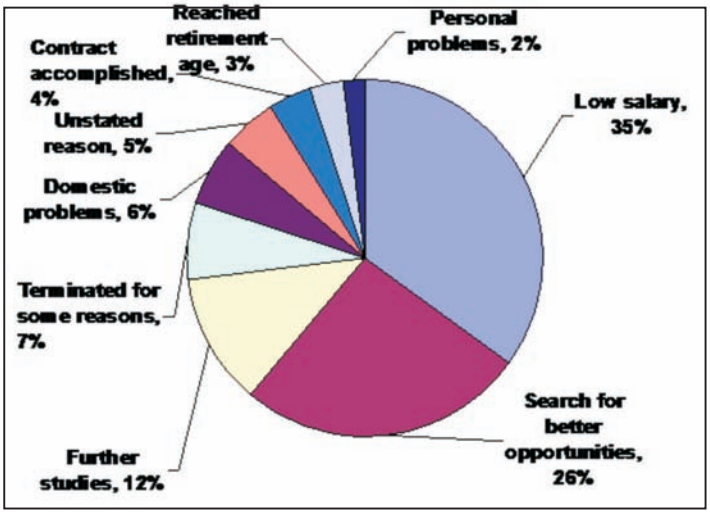


Figure 2: Destination of attrition cases of health workers from the RCC network in 2005/06



PNFPs pay National Social Security Fund (NSSF) instead of pension. Unfortunately the benefits that are not received as cash are often not valued by health workers. They do not look at remuneration in terms of "package" but rather in terms of hard cash pocketed. On the other hand even where salary / cash take home are the same with that in government for comparable jobs, health workers seem to perceive that the pay per unit of work done is higher in government facilities compared to the PNFP, because of the quite often under utilization of working hours or rather the misuse of it for personal work or additional employment while working in civil service.

Figure 3: Reported reasons for leaving RCC hospitals in 2005/06 (from exit interviews)



Second-line reasons given for attrition included heavy work load (54%), domestic problems (14%), low incentives (10%), lack of career path (4%), going for studies (2%), moving out of rural environment (2%) and need to change work environment (2%) among others. The word "incentives" is commonly used among workers in Uganda to mean "satisfactory or additional pay". Meanwhile it is not uncommon for employees in any sector in Uganda wanting to go for "better jobs" to state "domestic or personal problems" as reasons for leaving a job for fear of blocking retreat into previous employments just in case their job search efforts do not pay off.

Staff Dismissal in PNFP units

Among the first line reasons given for leaving was dismissal which accounted for 7% of the attrition in 2005/06. A common question is why PNFP facilities cry for staff and yet dismiss some of the few and hard-to-get health workers they already have. PNFP facilities are required to provide quality services. For this they also need staff not only in number but also in quality, availability, discipline, commitment and all attributes that the clients would want to see in the people expected to serve them. About 31% were reportedly dismissed due to indiscipline or unprofessional behavior, 15% due to absenteeism and / or poor performance, 11% due to theft, and 4% for having been convicted of criminal offences. Other reasons reported included disliking night duty, staff lay off due to general restructuring, irresponsibility, mental illness and other miscellaneous ones. Reasons for dismissal were not reported to UCMB in 22% of cases. By contrast there is an impression among PNFP staff that it is difficult to dismiss civil servants even when they grossly under-perform or misbehave in government facilities.

Negative Environment context

All these difficulties of improving salaries in PNFP facilities occur at a time when, despite increases in the health spending, budget support to PNFPs from government is stagnant on the whole and actually reducing in real terms (NB: The Ministry provides a fixed or reduced total amount for PNFP units over time, and yet continues to register more units as being PNFP. This, together with rapidly increasing population, means that, in real terms, their actual contribution to individual units is declining). Yet, the cost of providing services amidst increasing demand for services is also increasing. Meanwhile the country is also experiencing brain drain to other countries, especially in Europe, although there seems to be no data on the magnitude. This is probably inadvertently promoted by training that increasingly prepares the health workers to fit into international demands, for example the introduction of degree nurses. The appreciation

of Ugandan health workers internationally is a good thing and many may be happy about their migration or export, not worried about the loss to Uganda of capacity built by years of experience and intensive expenditure. Like the PNFP networks currently are to the government, sooner or later Uganda will become a production and internship center for developed countries with the idea that it may increase income and improve remuneration of remaining health workers while actually becoming unable to build a stronger experienced health workforce. The vacuum left by such migration gives government and other agencies more incentives to recruit from PNFP which are generally seen to have more committed personnel. In the meantime agencies are recruiting nurses and midwives for "export".

Doing less for more

Reported practices in government facilities are creating unbalanced preferences. Many staff who have left PNFP units for the government units (often in the neighbourhood) informally talk of freedom to report late to work at their new jobs and to leave early each day, thus doing less for the same or more money; some report of starting weekly duties on Tuesday and/or starting weekends on Thursdays. It is also common knowledge that many government health workers move out for personal business at will for hours and days, shuttling between personal business and official jobs but still get full pay. There are informal reports of some personnel preferring to be "permanently" on night duty or day duty in order to do other work for additional income during day or night in another employment.

The perceived unwritten job security in government services therefore appears to be security of job and salary even when one works less and the difficulty to get dismissed once recruited, even for the laziest and the most undisciplined. On the contrary in modern practice, job security is based on performance and productivity – effectiveness, quality, and efficiency – some kind of "pay for performance" (P4P). That is what PNFPs try to follow which tends to alienate some health workers who prefer the easy option. The question is if demotivated UCMB network staff get "motivated" to work for government because of the complacency there, is that what government wants?

The increasing Scale-up of services

Many of the GHI project grants pay comparatively hefty salaries and cause more attrition from both government and PNFP. But whenever PNFPs are supported, often so-called "support to human resource" actually targets training workshops, equipment and allowances. It is not systemic institutional support. The allowances are paid to the few staff attached to the projects. One effect of this is the demotivation of those not attached to the projects but who are equally working very hard to handle other health conditions. Another effect is that because additional personnel are not recruited, the few staff handling the Global Health Initiative interventions soon become overwhelmed, less productive and even more demotivated. GI projects, no matter the source of funding, are therefore having negative effects on PNFP systems, especially on human resources.

Efforts to reduce and mitigate losses

Recruiting to replace

The biggest loss to RCC health facilities was not in numbers but rather in quality of the workforce as the first reaction has always been to recruit and replace. Overall the hospitals lost 730 but also recruited 737 new staff, while the LLUs lost 730 and recruited 839 in 2005/06. On a regional consideration, replacement was 100% in the north, 96% in the west, 133% in the east and 101% in the central region. Overall these meant 102% replacement for the network. Over-replacement was done in some cases as a proactive measure to increase the chances of retention. However, the overall quality of staff was affected because some of the critical cadres were not fully replaced. Among the enrolled nurses and enrolled midwives, hospitals lost 239 but replaced only 204; the LLUs lost 168 and replaced only 112 enrolled nurses and midwives combined hence a net loss for these two cadres.

Also, recruitments did not replace lost experience. Overall 30% of staff attritions were people with over 3 years experience at the PNFP facilities. About 47% had 1-3 years of experience and 23% had less than 1 year of experience. These lost years of experience were replaced largely (53% of cases) by new inexperienced fresh graduates. In this way the RCC health facilities have become some sort of internship centers from which government and others with more money recruit.

Attempt to increase salaries

Efforts made to harmonize salaries and wages with government workers through budget support from government have been hampered by government financial regulations. PHC recurrent non-wage conditional grants, by law, can not be used to pay "salaries". This is in spite of the acknowledgement, even by the law makers and financial technocrats, that there is need to help PNFPs improve salaries because they complement rather than compete with

government. This has also been hampered by the prolonged delay in passing the Public Private Partnership for Health Policy, which caters for this arrangement. Local efforts to raise PNFP salaries closer to that of government and NGOs without support from government has greatly increased the cost of service delivery to the detriment of many PNFP facilities.

Deployment or posting by government

The government at national and local levels has been deploying some of its staff to PNFP facilities, or accepting to include some staff recruited by PNFPs onto its payroll. This practice, which was initially limited to doctors, has been abused. While there are a number of civil servants with exemplary records of work in PNFP facilities, many seconded staff tend to behave as "government staff" in PNFPs. Some of them insist on obtaining salary top-ups from PNFPs before they can work. Others want to work for the same duration or to do private clinical practice or other business, even during working hours as their counterparts in government health units. Consequently they become demotivators to non-seconded staff and become another cause of attrition. Civil servants posted to PNFP facilities have been seen as trigger agents for dual employment among hitherto committed PNFP staff, a practice not allowed in PNFP facilities if it interferes with staff performance and availability for *bona fide* clients.

Agreement on Terms and Condition of work at recruitment

The presence of a Manual of Employment is now mandatory in each UCMB-accredited hospital and diocesan health department. Health workers must be made familiar with the content of the manual in order to, preferably, decide at the outset whether they wish to continue to take up the RCC employment or not. This, it is hoped, can help to sieve out from the outset those much less committed to work with PNFP units.

Improving management –through training of managers

The UCMB offers scholarships for personnel of the network with greater preference for management training. A number of health services managers in the network have been trained especially at Uganda Martyrs University to obtain Masters, Diplomas and Certificates in the management of health services.

Opportunity for Professional Development

Sponsorship of personnel in the network is part of the motivation package, based on the institutional need matching with the professional need of the staff. It is accompanied with a bonding agreement between the staff and hospital. (Although the scholarship scheme is operated by the UCMB, the interested individual applies to the health unit board which, in turn, presents it to UCMB. This is meant to ensure that the agreement signed is between the individual and the sending institution. UCMB is just the grantsman). This is contrary to common impression that there is little opportunity for professional growth through training in PNFP units. This excludes other sponsorships offered directly by the individual hospitals with the help of their benefactors. The number of people trained in the UCMB may only appear small simply because of the much smaller denominator compared to the public service.

Conclusion

The PNFPs, including UCMB network, are genuine partners to government. They complement government health services. However, the increasing level of attrition in the PNFP network is threatening its capacity to complement government efforts to serve the people of Uganda. The attrition is mainly due to differences in salaries and other conditions of service between government and the PNFPs, including UCMB. Any effort that strengthens the PNFPs is of advantage to government in delivering on its promises to the people of Uganda.

Recommendation

Terms and conditions of service need to be explained and understood by both PNFP employers and health workers. Especially, the notion of benefits as being beyond the simple salary needs to be clarified. Concrete efforts need to be taken to have these harmonized with those of government. This will require that government increases budget support to PNFPs. It will also entail allowing them to manage government support in a way that enables them to harmonize salaries with government. Among the conditions of service needing urgent correction are those that create the perception that the civil service is a refuge for lazy people to get money with the least effort while NGOs and PNFPs are seen as the opposite. All the aforementioned should be done under observance of true principles of partnership as stated in the draft PPPH policy, which, too, needs to be passed soon.

Government needs to revitalize, enhance and protect the sector-wide approach (SWAp), since most of the initiatives to scale up health services are currently coming in through vertical projects, thus destabilizing the health system. Such distortions, including destabilizing the workforce and work culture in the country, cause long term damage yet the initiatives are short-term measures.

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