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. But the situation is even worse at micro levels. The private-no-for-profit (PNFP) health sub-sector complements government efforts to achieve the MDG, the health sector strategic plan II (HSSP II) and the health related poverty eradication plan (PEAP) indicators. Uganda Catholic Medical Bureau coordinates the Roman Catholic health facilities network, one of the three PNFP networks in Uganda. This paper looks at the HRH crisis as experienced by the UCMB network giving the trend, examining the reasons, the destinations of attrition 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

Uganda is among the 57 countries with critical shortage of health workforce (The World Health Report 2006). 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 (UMHCP) and meet the targets for the Health Sector Strategic Plan II, the Poverty Eradication Plan (PEAP) and the Millennium Development Goals (MDGs). There is also pressure to see further downward trend in the HIV prevalence. 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 (Rudolf Chandler and Stephen Musau, 2004). To scale up anti-retroviral therapy alone to meet the PEPFAR target would require about 10% of Uganda's doctor workforce as at 2004 level (Smith O. 2004). But scale-up of ART in Uganda has even moved faster than originally planned while health workforce remained almost unchanged. This disproportionate growth in service demand and the skewing of health workforce deployment in favour of few diseases conditions worsen the functional gap in respect to implementing the range of services in UMHCP. 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 (Yoswa M Dambisya, 2004). But at a cross-sectional level the main reason for internal and external movements of Ugandan health workers is "poor working condition" (Charles W. Matsiko and Julie 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.

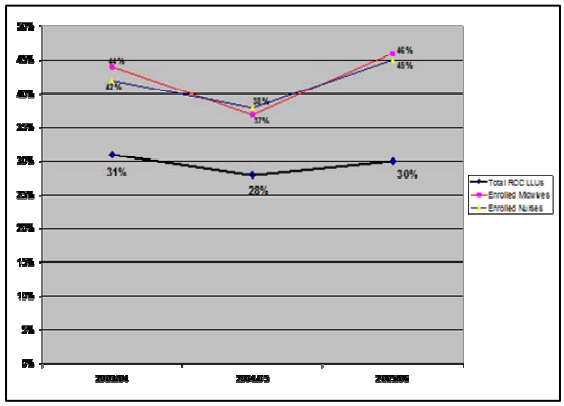
Experience of UCMB

UCMB[1] 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 also acts as a liaison between the facilities and government and other national stakeholders. UCMB does not own the units; they are mostly owned by dioceses and a few by Religious Congregations. By the end of 2006 the UCMB had 27 RCC hospitals, 228 Lower level facilities (LLUs) including 4 HC IV accredited to it (4 other LLUs had got suspended accreditation for one reason or the other). There are also 12 Health Training Schools (incl. the Lab. School in Kitovu)

Most of the UCMB facilities are rural. By June 2006 the UCMB network alone had 6,845 (about 20%) of the 30,000 health workers in public and PNFP combined. 65% of the 6,845 were in the 27 RCC hospitals and the rest in the 228 accredited LLUs.[2]

UCMB LLUs have increased their completeness in provision of Uganda minimum health care package (UMHCP) from 54% in 2003 to 60% in 2006 (UCMB 2003, 2006). At the same time there is increased pressure to scale up accessibility to or introduce more / additional services. These include services related to the Global Initiatives (especially HIV/AIDS care and treatment). By June 2004 there were 6 RCC health facilities (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.

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



Instead, for the UCMB network the trend in number of staff has been further affected in the last two years by high levels of attrition especially of the key clinical staffs. In 2005/06 the network lost a total of 1,487 health workers (757 from hospitals 730 LLUs). In LLUs the overall 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 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. These

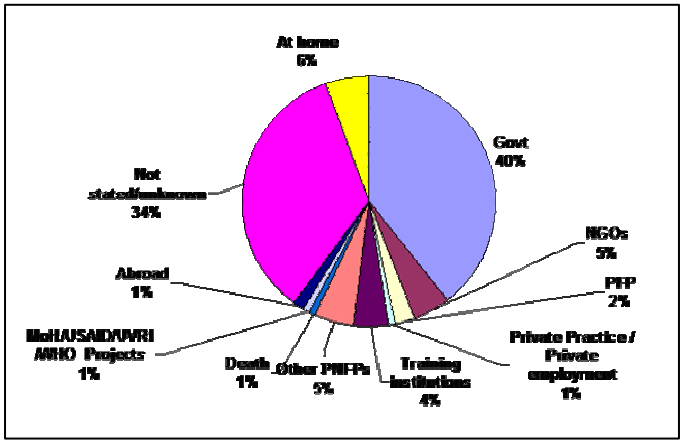
[1] The others are the Uganda Protestant Medical Bureau (UCMB) and the Uganda Muslim Medical Bureau (UMMB)

[2] Source: HR reports from health facilities to UCMB

cadres form the backbone of patients care especially in the lower level Units (LLUs). LLUs 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 these together being 46% attrition among the enrolled cadres in LLUs in 2005/06. LLU attrition among clinical officers was 30% 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 inn 2005/06. Double enrolled nurses had no attrition in hospitals in the same period. The median length of time the leavers had served in the individual facilities was 24 months.

Where and why did the leavers go?

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



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. 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 at least 61% left because of low pay. UCMB estimates that at least over 60% could have joined government services to get better pay.

Paul Onzubo (UMU 2005)[3] separately observed that in the West Nile region 72.9% of health workers leaving PNFP facilities in 2004/05 went to government services.

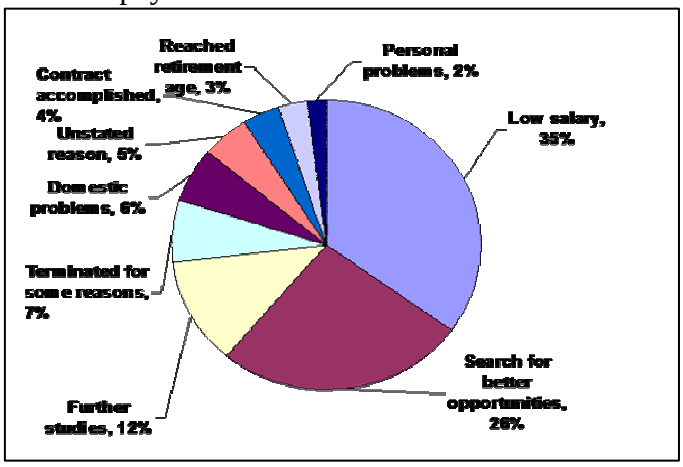


Figure 3: Reported reasons for leaving RCC hospitals in 2005/06 (from exit interviews)

Though search for better pay was the main reason given for leaving the UCMB facilities, in reality total "package" of salary plus benefits may be bigger or better in a number of

[3] Paul Onzubo; Turnover of Health Professionals in the General Hospitals in the West Nile Region, Uganda Martyrs Univerrsity, 2005 (Unpublished).

PNFP facilities including that of UCMB, 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. 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.

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%), 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.

Dismissals

Among the first line reasons given for leaving was dismissal which accounted for 7% of the attrition in 2005/06. It has sometimes been questioned what a "contradiction" it is that PNFP facilities cry for staffs 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. 31% were reportedly dismissed due to indiscipline or unprofessional behaviors, 15% due to absenteeism and / or poor performance, 11% due to theft, 4% having been arrested for criminal offences. Other reasons reported included hating of night duties, 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 that civil servants apparently feel it is difficult to be dismissed 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 while actually reducing in real terms (falling allocation per health facility as more health facilities get enrolled by ministry of health as "PNFP". There is also increased cost of providing services amidst increasing demand for services. Meanwhile the country is also experiencing brain drain to other countries especially Europe although

there seems to be no data on the magnitude.[4] 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. Like the PNFP networks, 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 foreign agencies are recruiting nurses and midwives for "export" here in Kampala.[5]

Reported practices in government facilities are creating unbalanced preferences. Many leavers informally talk of reporting late to work at their new jobs and leaving early each day, thus doing less for the same or more money; some report of starting weekly duties on Tuesday and starting weekends on Fridays. 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 job but still get full pay. There are informal reports of some personnel preferring to be "permanently" on night duties or day duties 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. That is what PNFPs try to follow which tends to alienate some health workers who prefer the easy option.

But if UCMB network staffs who are "not motivated" get "motivated" to work for government because of the complacence there, are government-employed health workers actually motivated and is that what government wants?

The increasing Scale ups of services

Many of the GI project grants pay hefty salaries and cause more attrition from both government and PNFP. But the additional problem is that when PNFPs are supported, often what is called "support to human resource" targets training workshops, equipments and allowances. These allowances are paid to a few staffs that get attached to the projects. One effect of this is the demotivation of those not attached to the projects but equally working very hard to handle other health conditions. The second effect is that

[4] 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 and the regarding of especially the nursing with international nomenclatures.

[5] Hence the legitimate question "Is the 'quality training' agenda indigenous or exogenous and who is actually benefiting from higher level of trainings for example BSC Nursing or Comprehensive Nursing?

because additional personnel are not recruited, the few staffs handling the Global Initiatives interventions soon become overwhelmed and less productive and demotivated as well. GI projects, no matter the source of funding, are therefore having negative effects on systems especially 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. 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. But 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 facilities. 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 graduates. 47% of recruits were from previous services. 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 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" when even the law makers and financial technocrats agree 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 Policy by Parliament. But the 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

This "double-edged knife" was initially limited to doctors posted by Ministry of Health but is increasingly also being used by district local governments and getting extended to other cadres of staff in an attempt to support staffing in PNFP facilities. However, while there are a number of civil servants with exemplary records of work in PNFP facilities, many seconded staffs seem to behave as "government staffs" wanting to do less for

higher salary and be considered as some sort of undisciplined "Saviors". Consequently they become demotivators to non-seconded staffs and another cause of attrition. Civil servants posted to PNFP facilities are also seen as trigger agents for dual employment among hitherto committed PNFP staff, a practice not allowed in PNFP facilities.[6]

Agreement on Terms and Condition of work at recruitment

The presence of a Manual of Employment is now mandatory in each UCMB 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 to continue / take up the RCC employment or not. This can help to sieve out those much less committed to work from the outset.

Improving management –through training of managers

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 health services management.

Opportunity for Professional Development

Sponsorship of personnel in the network is part of the motivation package. But it is based on institutional need matching with need of staff and not as a "buying" of the staff. It is accompanied with a bonding between the staff and hospital and not UCMB. Contrary to common impression that there is little opportunity for professional growth through training in PNFP compared to civil services there is actually a lot more. In 2004/05 the opportunity for scholarship was 1.4% in UCMB compared to 0.7% in government health employment i.e. 150 out of 20,000 (AHSPR 2004/05 page 72). This excluded other sponsorships offered directly by the individual hospitals with help of their benefactors. The number of people trained in the UCMB may appear simply because of the much smaller denominator.

Conclusion

The PNFPs, including UCMB network are genuine partners to government, complementing government health services. PNFPs use budget support from government to produce more than what government gives it. However, increasing levels of attrition in the network is threatening its capacity to complement government efforts to serve the people of Uganda. The attritions are mainly due to differences in salaries and other conditions of service in government and that of 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.

[6] PNFP facilities do not object to an employee doing another job outside official working hours provided it does not cause negative effect on performance at the primary place of employment.

Recommendation

It is important, as a starting point to recognize what it means in terms of health service output if UCMB and other PNFPs are crippled, more so as an outcome of among others, government actions or failure of actions. Terms and conditions of services need to be understood by both employers and health workers beyond the simple idea of salary and work to have these harmonized. Nonetheless this should start with what catches the heart first and fast. Government needs to increase budget support to PNFP or develop a mechanism of letting PNFPs meet the cost of care to enable them harmonize salaries with government as a move towards harmonizing terms and conditions of service comprehensively. Among the conditions of services needing urgent correction are those that create the perception that 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. Parliament needs to pass the PPPH Policy.

Government needs to revitalize and protect the sector-wide approach (SWAp). Most of the initiatives to scale up health services are coming in through vertical projects. Over-reverticalization of health initiatives may have significant short term outputs but is already having detrimental effects on health systems including distortion of the workforce and work culture in the country. These short term outputs or trends may not only themselves become unsustainable but difficult to rebuild because the systems will have gone below the initial starting point.

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