Providing health care under adverse conditions:

Health personnel performance & individual coping strategies

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Performance, working conditions and coping strategies: an introduction

Wim Van Lerberghe, Margaret Luck, Vincent De Brouwere, Guy Kegels and Paulo Ferrinho

One of the basic reasons underlying health care reform efforts, however varied these may be in scope or comprehensiveness or speed or intensity, is the widely-shared suspicion that health services perform less well than they should and could do. As health systems are essentially made up of people, improving performance would first have to focus on them– even acknowledging that working environment plays a crucial role.

The management of human resources is one of the most important determinants of the success or failure of health sector reform. Despite management reforms and staff training efforts, many public sector organisations have had little success in improving the performance of their staff. With increasing demands for accountability and value for money from public sector services, it is at least necessary to improve our understanding of what makes health personnel perform well – and of what stands in the way of good performance.

Many governments automatically recruit all health professionals upon graduation to work in the state health care sector. All too often this means wages below subsistence level and working conditions without the basic material and equipment. Policy developments in the health care sector usually ignore these realities, either because of a lack of planning capacity at the central level or because of overriding political concerns or civil strife. In

the meantime, cities witness an explosive growth of 'wild' private health care, sometimes legal, sometimes not, but always unregulated. A characteristic of this particular private sector is that it 'shares' the human and material resources of the public sector: personnel, facilities, drugs, etc. State sector health personnel become less available to work for the public sector, but do not resign. They remain state employees, and enjoy the relative advantages of status, fringe benefits and study opportunities.

An attractive alternative, particularly for doctors, are job offers from international development agencies or (international) non-governmental organisations. Such job opportunities contribute to an internal brain-drain of human resources by reducing the number of personnel available for state sector health service provision but, on the other hand, may help to retain good and competent professionals in the country.

The predicament of the public sector health worker can be mapped as a vicious circle. Health workers with relatively high professional and material expectations are working in a resource-poor environment with little support or supervision. They have little incentive – and means – to maintain or improve their performance within the frame of their public service duties, and at the same time they have to develop individual 'coping strategies' to fulfil their professional and material expectations. This works, at least to some extent, and allows the public authorities, hard-pressed for scarce resources, to ignore unrealistic claims for salary increases, since their employees are helping themselves. The bureaucratic system is in relative equilibrium, as long as public frustration does not voice its dissatisfaction as a political challenge. And the civil servant is left to pursue his individual coping strategies, whereas his investment in his job proper becomes increasingly symbolic. This further discourages and undermines attempts to build a public service that lives up to the legitimate demand for quality care. Thus the vicious circle is complete. In the short-term it is in the interest of all actors (health workers, policy makers and donors) to behave as if it did not exist, or to discuss it either in terms of downsizing or of provider-blaming. The underlying realities or to the precise consequences for public health sector service delivery are rarely analysed.

These issues were discussed at an international conference in Lisbon (October 9-10, 1998)[1], in an attempt to stimulate a rational dialogue free of

[1] The conference was organised by the Centro de Malária e Outras Doenças Tropicas da Universidade Nova de Lisboa (Portugal), the Prince Leopold Institute of Tropical Medicine (Belgium) and the Associação para a Cooperação e Desinvolvimento Garcia d'Orta (Portugal). It was made possible through the financial support of the INCO-DC Programme of Directorate General XII of the European

the moralising finger-wagging they often seem to generate. The objective of the conference was to describe practices in a range of countries and to identify the implications for health policy makers seeking to improve health personnel performance.

The conference was attended by policy makers and researchers from international organisations and from 28 countries in Europe, Africa, the Middle East, Asia and North and Latin America. The conference participants described coping strategies and their consequences in their countries, assessed the problems and limitations with existing mechanisms of managing personnel performance in the health sector in the context of such coping strategies, and debated the positive and negative effects of the human resource policies of international organisations. This resulted in a collection of papers with very different viewpoints and formats, reflecting the different professional and geographical backgrounds of the participants. We have grouped them under three headings. First a set of papers describes the performance of health personnel in a number of countries and attempts to improve it. A second part looks more closely at the various coping strategies health care workers, medical and paramedical, clinical and managerial, actually apply to deal with difficult working and living conditions. A third part looks at how policy makers and technical assistance agencies deal with the predicament of health personnel – with the necessary distinction between policy and practice. This part ends with two field experiences, from Thailand and South Africa. They relate how practitioners have managed to find a good and pragmatic compromise between their professional and other aspirations, and their vision of a public mission for health services.

It came as no surprise that the evidence on the nature and impact of Western-style performance management systems is limited and of little relevance for the public health sector of developing countries. As several participants noted, it is somewhat academic and futile to evaluate the performance of public health staff when they do not have a minimum of supplies or equipment, nor a decent living wage. But even in more favourable environments, public sector services are not necessarily open to improvement by such management systems. These latter are potentially relevant only to the extent that performance matters in these services. A necessary condition seems to be to render the organisation performance-conscious before saddling it with a performance management system of any kind. Examples from South Africa, Spain and from quasi-governmental hospitals in Ghana seem

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Commission, BADC (Belgium), the Fundação Luso Americana para o Desenvolvimento (Portugal) and the Fundação para a Ciência e Tecnologia (Portugal).

to indicate that, on a small scale, and in adequately resourced working environments, a team approach, clarity as to what is expected of people and some incentives (e.g. financial rewards and educational opportunities) may result in more job satisfaction and better performance.

In this context it was rather intriguing to note the recurrence of references to the "inner motivation" of health personnel. Whether described as "professional ethos", "sense of belonging to a team", or "working for the public good", it was clear that fostering a sense of commitment to the public good and ensuring fairness and peer collaboration are critical elements to improvement of health personnel performance. On the other hand, evidence presented suggested that incentive schemes based on financial rewards for reaching pre-identified measurable objectives may result in a loss of professional values and may cause health care provision to become just another market item, to be sold according to the availability of material incentives. In this context the public health care sector may become merely a place for professionals to recruit clients for their private activities.

Officials of international development agencies present at the meeting acknowledged that their organisations had not always adequately addressed human resource issues and strategies in the countries in which they provide aid. They recognised that their own employment policies have at times aggravated personnel-associated imbalances and problems. On the other hand, they face a kind of prisoner's dilemma: participate in the vicious circle, and help perpetuate it, or sacrifice performance in the short term. Hence a call for more intensive deliberation and collaboration between development agencies, government officials and academics to find adequate solutions.

Government officials present at the meeting stressed the need to recognise health workers as a productive part of society, and not just as drains on scarce public resources. They pointed out that as the private sector grows the need for regulation increases, but that policing a large and sophisticated private sector may be even more difficult than managing the public sector. Mere downsizing is not a solution, if the public sector is to switch from a focus on service delivery to one of regulator and purchaser of health care.

The papers in this book show that it is possible to discuss these delicate issues without moralising. Providing evidence and documentation, will, we hope, help to manage the current impact of the health sector crisis on the performance of the health personnel. Solutions are not self-evident, but a number of points are clear as of now. First, it will not be possible to address these problems without actively involving the major international development agencies. Second, the private sector is a reality that cannot be ig-

nored: the times of exclusive public provision of health care are gone. Third, salary increases for public sector personnel are not affordable on the scale that would be necessary to redress the situation. Fourth, financial incentives are only part of the solution: professional and social value systems are poorly understood but underestimated motivators.

It would be naïve to hope for blueprint solutions that would break the vicious circle that characterises the performance of public health care providers in many countries. A few of the case studies reported here, however, show that at least piecemeal and incremental solutions are possible.

Human development challenges in health care reform

Malcolm Segall

Ethical behaviour: the jewel in the crown of health services

My central thesis rests on the belief that the most precious possession of any health service is the dedication and inner motivation of its health workers. There is rightly much concern these days about the quality and responsiveness of health care. My thesis is that, for driving patient and community centred behaviour in health workers, no system of external incentives can ever match a self generated ethic of service. This ethic develops in reasonably funded public health services in which there is a prevailing culture of professional standards. It could be observed in most health workers most of the time in the developing health services of low-income countries 20 years ago. Health system policies need to resurrect or create the conditions in which a service ethic – the 'jewel in the crown' of health systems – can be nurtured.

Primary health care, the economic crisis and neo-liberal economics

Before the movement of health sector reform, there was another interna-

tional health policy called Health For All and Primary Health Care[2]. In some circles one must almost lower one's voice these days in mentioning primary health care, for fear of being branded a sentimental wet. This was a policy of an appropriately structured, comprehensive national health system, in which the public sector played a leading role in the organisation, provision and financing of health care, and it was based on a philosophy of co-operation between the actors involved in the production of health.

However, the ink was scarcely dry on the Alma Ata Declaration before the rise in oil prices precipitated the deep and prolonged recession of the 1980s, which was accompanied in the industrialised world by the emergence of the neo-liberal economic policies of the Reagan–Thatcher era. The economic crisis extended to low- and middle-income countries, where it was accompanied by corresponding macroeconomic adjustment programmes.

European and other developed countries: the new public management, health sector reform, the swing from co-operation to competition – and back

In this market-oriented context, the public sector was characterised as being inefficient because managers lacked economic incentives to strive for efficiency. This was contrasted with private sector management that was superior because of the incentives to efficiency created by competition. Therefore, with a view to cost containment and increasing efficiency, the role of the state should be reduced by means of privatisation when possible and, where the state continued to operate, economic incentives should be introduced to motivate public sector managers towards efficiency. According to this 'new public management'[3], market mechanisms and competition should be introduced to the public sector, be this in the form of market testing of public services, contracting out to private providers, or 'internal markets' in which the competitive players would be public bodies. The market relations should be governed by contracts, which would specify performance targets and employ input/output accounting with a view to more effective monitoring and greater transparency.

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[2] WHO/UNICEF. Primary health care: Alma-Ata 1978. Geneva: WHO, 1978: Health for All Series No. 1.

[3] Hood C. A public management for all seasons. Public Administration 1991; 69 (1): 3-19.

These ideas were applied to the health sector under the rubric of 'health sector reform'. The form of their application was influenced by the work of Enthoven on managed competition[4]. Though his theories arose in the context of the need to regulate the free market health system of the United States, they were actually applied most systematically in European and other developed countries to introduce competition to their socialised health services. This was most notably the case in Britain[5], that had the most centralised health service in Western Europe.

There are many variations to the model of managed competition. Where there is a single third party payer (for example, the government), two constant features are: the separation between the needs assessment, planning and financing role on the one hand and the health care provider role on the other (the 'purchaser-provider split'); and competition between (semi-) autonomous health care providers. Where there are multiple third party payers, competition may be among the insurers, in which case (and in contrast to the single payer situation) there may be vertical alliances between the purchasers and providers[6].

In some countries, a few years after the introduction of market mechanisms to their public health services, and sometimes with a change of government, disenchantment set in with the role of competition. This disenchantment was based on: doubts about whether competition actually increased efficiency (which was sometimes already improving prior to the introduction of market relations); doubts about the extent to which competition actually occurred or was likely to occur (because of insufficient providers to constitute a viable market or because of the loyalty of commissioning authorities to previously directly managed units); high transaction costs; possible perverse effects on the quality of care, especially as a result of shorter duration of admission; and loss of health service stability and capacity for long term planning. Thus a shift back from competition to co-operation has occurred in Britain[7] (the process began even before the elec-

[4] Newman P. Interview with Alain Enthoven: is there convergence between Britain and the United States in the organisation of health services? British Medical Journal 1995; 310 1652-5

[5] Enthoven AC. Reflections on the management of the National Health Service. London: Nuffield Provincial Hospitals Trust, 1985. Secretary of State for Health. Working for patients. London: Her Majesty's Stationary Office, 1989.

[6] Van de Ven WPMM, Schut FT, Rutten FFH. Forming and reforming the market for third-party purchasing of health care. Social Science and Medicine 1994; 39 (10): 1405-12.

[7] Secretary of State for Health. The new NHS: modern, dependable. London: The Stationary Office , 1997.

tion of a Labour government[8]), New Zealand[9] and Sweden[10].

Developing countries: the impact of economic crisis and adjustment on health systems and the import of health sector reform policies

In low- and middle-income countries, it is necessary to distinguish between the effects of the economic crisis and adjustment programmes on health services and the effect of specific reform measures within health systems (sometimes in the context of wider public sector reform). The former has had by far the greater impact, especially in the poorest countries.

The austere economic environment has had a familiar catalogue of adverse effects on public health services: declines in real public health expenditure, deterioration in the physical state of facilities and equipment, shortages of drugs and supplies of all kinds, a radical deterioration in the quality of services delivered, and a disastrous impact on health workers.

Public health workers have experienced a serious fall in the real value of their salaries, to the point where their public income often covers only a fraction of household needs[11]. This has resulted in: the development of a widespread practice of levying informal ('under the table') charges on formally public patients; frank private practice by public health workers, in clinics or their own homes, in patients' homes, or in public health facilities themselves, legally out of hours or illegally during working hours; the stealing of public service drugs and equipment for use in private practice; and the undertaking of non medical commercial activities (especially in poorer areas where private medical practice is not so lucrative). In addition to

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[8] Ham C. Contestability: a middle path for health care. British Medical Journal 1996; 312: 70-1.

[9] Ham C. Reforming the New Zealand health reforms. British Medical Journal 1997; 314: 1844-5. Malcolm L. GP budget holding in New Zealand: lessons for Britain and elsewhere? British Medical Journal 1997; 314: 1890-2. Hornblow A. New Zealand's health reforms: a clash of cultures. British Medical Journal 1997; 314: 1892-4.

[10] Whitehead M, Gustafsson RA, Diderichsen, F. British Medical Journal 1997; 315: 935-9. Bergman SE. Swedish models of health care reform: a review and assessment. International Journal of Health Planning and Management 1998; 13 (2): 91-106.

[11] Ferrinho P, Van Lerberghe W, Julien MR et al. How and why public sector doctors engage in private practice in Portuguese-speaking African countries. Health Policy and Planning 1998; 13 (3): 332-8.

these private activities of public health workers, in some countries public sector downsizing has thrown on to the market a large number of one-time public health workers. These vary from medical doctors through all grades of formally trained health cadres to village health workers. Many of these health workers are practising privately. Add to them traditional healers and informal drug sellers and the total result is a burgeoning of private ambulatory health care practice[12]. Much of this practice is unlicensed and illegal and virtually all of it unregulated. As public health systems have deteriorated and patient attendance has dwindled (especially at lower levels of the service), households have had increasing recourse to over-the-counter drug purchases and the use of private practitioners, thus generating the demand for private care. This occurs even in poor and rural areas. Small-scale, informal private practices of health workers have always been present in developing countries, but the economic crisis has resulted in a great expansion of this type of activity, largely independently of any specific health sector reforms.

These developments have had a very damaging effect on the professional ethics of health workers. Their self-seeking conduct has arisen largely out of economic necessity, but has been reinforced by the 'catch as catch can' ideology of the market place. The culture of self-interestedness and the decline in community values – seen wherever marketising reforms have dominated the policy agenda – are relatively unrestrained in poor countries where regulatory mechanisms are weak. One can only shudder to think about the quality of the health care that is meted out in isolated private practice in these circumstances, especially in the poorest areas.

What have been the specific prescriptions of health sector reform in these conditions? To some extent, the policy prescriptions have failed to address these grassroots realities, being couched largely in terms of theoretical economic constructs. Put simply, international agencies, notably the World Bank but also bilateral donors, have looked to export the health sector reform theories developed in a northern context to the south[13]. The policy thrusts again included reducing the role of government (especially in provision), increasing the role of the private sector, and promoting competition between health care providers, public and private. These policies were promoted as universal economic truths, seemingly without the need

[12] Hanson K, Berman P. Private health care provision in developing countries: a preliminary analysis of levels and composition. Health Policy and Planning 1998; 13 (3): 195-211.

[13] World Bank. Investing in health: World Development Report 1993. New York: Oxford University Press for the World Bank, 1993.

for testing or piloting them in different socio-economic, cultural and political contexts. This was despite: the lack of clear evidence of greater efficiency in the private sector in the field of health care, especially in poorer countries; the frequent lack of sufficient health care providers to constitute a viable market, especially in poor and rural areas where the need for better health services is greatest; the lack of managerial capacity in provider units such that they would be able to pick up and respond to market signals by increasing efficiency, especially without reducing quality; and the lack of capacity in the health authorities of poor countries to undertake effective contracting with, or regulation of, the private sector. Contracting out services to private providers, or regulating an expanding private market, can scarcely be an answer to endemic inefficiency in publicly provided services. Especially in poorer countries, there is a pervasive lack of the necessary health service information and managerial capacity, and the transaction costs involved in large scale contracting or regulation would be considerable The problems of designing and monitoring contracts, and of formulating and policing regulations, must be greater by several orders of magnitude than the difficulties of improving public service management.

Many now accept the usefulness of separating the commissioning/planning role from the provider role in public health services. But the question is: what should be the nature of the commissioner-provider relationship and indeed the relationship between the various health care providers? These relationships should encourage patient centred behaviour – and discourage self-interested behaviour – in the providers. Relationships of a contractual kind tend to be in opposition and to stimulate self-seeking behaviour in the contractors[14]. If contracts require providers to meet financial targets, they are likely to result in increased money making activities (like high technology care) at the expense of less lucrative but higher priority health interventions that would generate better health outcomes. If contracts are monitored by performance targets based on throughput indicators (as they often are), they create incentives to maximise the quantity of outputs which can be at the expense of quality of care and health outcomes. There is the well-known revolving door syndrome, in which patients are discharged from hospital too early only to be readmitted shortly after, when they will count as another throughput statistic. Contracts lend themselves to the massaging of data by providers to meet output obligations and generally result in a concentration of activity on what can be measured

[14] Mackintosh M. Managing public sector reform: the case of health care. Milton Keynes: Open University, 1997: Development Policy and Practice Working Paper No.37.

(usually in terms of quantity) at the expense of what may be important but may not be easily measured (like quality, responsiveness and caring). Market relationships present health care providers with perverse incentives and can do violence to the professional ethos of caring. The health care product is qualitatively different from the manufacture of shoes or cars. Market incentives can replace the centrality of people in health care by profits and compassion by accountancy.

In practice, as distinct from the rhetoric, not all that much explicit use of market principles appears to have been made in the health sector reform process of developing countries, especially in the poorest. Liberalisation of the laws on private health care has taken place in countries that previously restricted such practice, but this has been mainly an after the event legitimisation of existing realities. Reports of public contracting of private (commercial) providers have been relatively few and the results appear rather indeterminate; the findings suggest that this provider mechanism may be applicable more particularly to non-clinical support services and in the cities of less poor countries[15]. Public subsidisation of the not-for-profit health services of non-government organisations has been a long standing practice in developing countries, especially in the rural areas of sub Saharan Africa. Privatisation policies, including the use of insurance mechanisms and tax incentives to stimulate the private health sector, have been followed in some countries, again mostly the less poor[16]. World Bank officials have even gone so far as to state explicitly that, at least in the context of low-income countries adopting sector wide approaches, *"the content of health policy reforms has not concerned the introduction of market-oriented experiments and financing mechanisms that dominate European reforms and the academic literature"*[17]. The latest health strategy of the World Bank is now also worded in a more nuanced way with respect to the public/private mix, especially in low-income countries, and acknowledges the need to move from blueprinting to more piloting and research[18]. Much of what is now passing under the rubric

[15] Mcpake B, Banda EEN. Contracting out of health services in developing countries. Health Policy and Planning 1994; 9 (1): 25-30. Mills A. To contract or not to contract? Issues for low and middle income countries. Health Policy and Planning 1998; 13 (1): 32-40.

[16] Bennett S, McPake B, Mills A. The public/private mix debate in health care. In: Bennett S, McPake B, Mills A (eds). Private health providers in developing countries: serving the public interest? London and New Jersey: Zed Books, 1997.

[17] Peters D, Chao S. The sector-wide approach in health: what is it? Where is it leading? International Journal of Health Planning and Management 1998; 13 (2): 177-90.

[18] World Bank. Health, nutrition and population sector strategy. Washington

of 'reform' is nothing else than standard approaches to improving public health management. It could have been taken from the pages of the WHO/UNICEF report on primary health care at Alma Ata.

Swinging back of the pendulum: from competition to co-operation

As reality asserts itself over economic theory and as a political shift takes place in some countries from the right to the centre left, I believe we are now seeing a swinging of the pendulum back from competition to co-operation in health services. This is with a view to promoting desirable provider behaviour (as distinct from self-seeking); encouraging the sharing of accurate provider information with health authorities and of technology and best practice among providers; allowing a greater focus on health outcomes (as distinct from cost and volume); constraining transaction costs; and promoting stability, joint planning and integrated delivery systems.

What applies at the institutional level filters down to apply to the individual health worker. How should we measure and reward individual performance? What is the role of economic incentives. such as performance related pay? Problems that arise with a primary focus on individual output and material rewards include: perverse effects on the quality of care; divisiveness and a negative impact on team working; and the undermining of the primacy of professional self worth and job satisfaction as motivating factors and the ultimate guarantors of patient and community centred behaviour. This is not to say that health workers should not be justly rewarded for extra effort or for working or living in difficult conditions. It is standard practice in health services to award allowances for hardship postings, night or permanent call duties, and (non-self-generated) overtime or extra workload. Team rewards can also help to stimulate co-operative methods of working. But in general the classical non- (directly) material incentives that reward all round professionalism, such as access to scholarships or post basic education and promotion (which carries with it increased remuneration), may well best serve to generate ethical behaviour in health workers. It should be emphasised that the receipt of a living wage is a necessary (though insufficient) condition for health workers to behave ethically and if governments want their health services to improve they must – if only slowly then at least surely – improve the living conditions of public health

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DC:World Bank Group, 1997.

workers.

Rehabilitation and reconstruction of public health systems and the nurturing of professional ethics

The recovery of health systems in low-income countries will take not years but decades. What is needed is not an ideologically driven process of predetermined reforms, but a developmental process based on what actually works in different circumstances. This may well include the public contracting of non-government providers, especially not-for-profit organisations. It must include accepting the reality of an expanded private health sector and of the need to regulate the private activities of both public health workers and full time private providers of all sizes and levels of qualification. But there are two ways at looking at contracting and regulatory measures. Are they part of a long term proactive policy of reducing the role of government in health care provision and of increasing the role of private or quasi private providers? Or are they simply part of an overall package of measures for health system development, in which the public sector is likely to be a major – if not the major – actor in the provision, as well as the financing and planning, of health services? Given the need for universal access to health care, the provision of integrated services, and a provider environment that nurtures professional ethics and patient centred caring, I say it should be the second way.

But I do not refer to an unreconstructed public health sector and a return to a top down, command and control bureaucracy. We need to take account of what history and experience have taught us about better ways to organise health systems and to take *some* leaves out of the cookbook of private sector management to promote efficiency. We thus need to work towards more effective decentralisation of public health systems, where possible to districts, and to give substantial management autonomy to at least the larger hospitals. (In stating this as a principle, I am not underestimating the great practical difficulties involved in implementing decentralisation, which if not done effectively can create more problems than it solves. We should also not conflate decentralisation in the public sector with the introduction of market style relations between public bodies.) In both cases managers should be given discretionary powers over budgets and staff. But we want, not only decentralisation, but also democratisation, with the active involvement of local political structures, as well as representative community based organisations, in health-related decision making and the

running of health services. Such popular involvement can also help to solve the problem of regulating the myriad small-scale private health activities that in poor countries are virtually out of reach of formal government control. Technically we need to employ appropriate computerised systems for the management of finance, personnel, drugs and information and develop the capacity to use them.

With the ambitious training programmes that have taken place in many developing countries over the last several decades, together with *laissez faire* service management, some public health systems have put on too much personnel weight, at least in the more developed parts of the service and in relation to the carrying capacity of the economy. Sometimes the problem is not so much employing too many total staff as having an inappropriate staff mix. Some countries have engaged in downsizing (or better rightsizing) of their public health services and more slimming down may be needed, if only to loose excessive or inappropriate staff in parts of the service to be able to expand with appropriate staff in underserved areas. The fewer heads there are to share a limited salary budget, the higher the salaries can be for those remaining in public service. It is better to have a smaller number of people working well than employ a larger number of people whose minds (and often bodies) are elsewhere.

From markets to public health

What is required is improved public health management in the broad sense of the term, with explicit programme goals and the use of modern management methods. To make a virtue out of necessity, one can say that the economic crisis has usefully jolted public health systems out of their previous state of routinisation and complacency and this should be built upon. But not all change is progress: as a leading policy, the original privatising and marketing thrust of health sector reform should now be considered to be a spent force. It continues to divert attention from the developmental process that is needed in publicly led health systems in rich and poor countries alike.

Part I.
Performance management under adverse circumstances: expectations and illusions

Health workers motivation in decentralised settings: waiting for better times?

Kasa Pangu

Introduction

The situation and motivation of health workers is critical to health service delivery because it affects the performance and ultimately the quality of care.

During the last decade or so, most countries in Sub-Saharan Africa have gone trough several changes that affect dramatically the life of health workers. As a consequence of falling public sector expenditures, salaries of health workers have become meaningless, as they have not kept up with inflation. The primary health care strategy, the health sector reforms and the decentralisation process are remodelling the relationship between health workers and communities, modifying the role of communities from that of passive recipients of care, to that of active partners in decision making and care delivery. The traditional balance of power between health workers and communities is changing in favour of communities. Health workers have come to consider themselves as losers in the process. With the de-linkage their job security is threatened as they no longer have a guaranteed lifetime employment as civil servant with central government. They are now hired, disciplined and even fired by national boards, local authorities or local committees, often independent from the Ministry of Health.

This paper shows that the motivation of staff and the incentive systems are linked to the approaches to health sector development. It analyses data

from Benin, Zambia and Uganda where studies on motivation of staff, health sector reforms and/or decentralisation have been conducted and shows that health workers are frustrated and unhappy with the decentralisation process. However, the dissatisfaction is not shared by all categories of health workers. In Benin for example, women staff and young civil servants are more likely to accept the changes than men and long serving civil servant. Other studies also show that civil servants leaving in urban settings are more likely to resist the change than those in rural. However, there is a common feeling among the health workers that the new changes are temporary. They expect and see better future in being re-employed by central government. As shown in the study from Uganda, decentralisation has not brought the radical changes in term of management, rational use of resources and job satisfaction as was expected. In many instances problems have only been transferred from the centre to the periphery without building capacity to solve them. New problems have also emerged that have decreased the efficiency of decentralisation and have further affected the morale of health staff. Under these circumstances, innovative strategies are needed to maintain motivation.

Approaches to health system development and impact on the health workers motivation

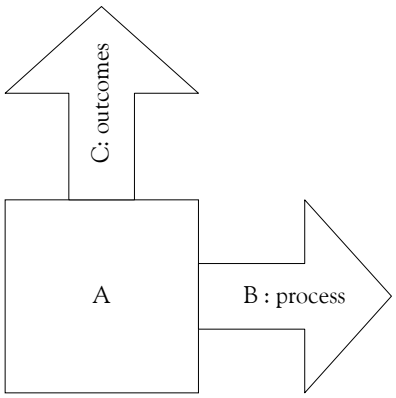
Different approaches to the development of the health sector have different impact on the situation, motivation and performance of health staff. Basically one can distinguish two approaches to health sector development: the outcome oriented model and the process model.

THE OUTCOME ORIENTED MODEL

The outcome oriented model of health system development, emphasises the achievement of outcomes and goals (C). One moves from situation (A) to the achievement of the outcome (C) through specialised and often ad hoc procedures[19]. Vertical programs are examples of outcome oriented model.

[19] Adapted from A conceptual framework for a global agenda for children, A report prepared for the Tarrytown Group by Urban Jonsson, Bjorn Ljungqvist and David Parker, 1998.

Figure 1. Models of health system development



The prototype of a vertical program is the eradication of Guinea Worm. The program aims at achieving a clear outcome: the eradication of Guinea Worm (e.g. no case of Guinea Worm in targeted countries.) A specific process has been established to achieve the objective including the detection and treatment of cases, the reporting and surveillance system and the training of appropriate workers. Other vertical programs such the smallpox eradication and to a certain extend the polio eradication programs, used the same approach.

The incentive system in the vertical programs, aimed at improving or maintaining the performance of staff, at augmenting the coverage and to a certain extend, at increasing the efficiency in the use of resources. Performances are expressed in term of number of cases detected or treated, number of children vaccinated and/or % of targeted population covered.

Various types of incentives were granted to health staff working in vertical programs, comprising financial and materials incentives such as daily allowances, training allowances and vehicles. Vertical programs ensured also better condition of work resulting in a greater job satisfaction. Through the network of relationship with international organisations, the vertical programs also offered a better career perspective for their staff.

Vertical programs have achieved remarkable results like the universal child immunisation. They also succeeded to maintain high level of staff motivation. However, the system had major limitations. First, it was highly centralised; all decisions were taken at national level. Second, it was heavily dependent on external donors. Third and most importantly, the system created dependency. Health staff were no more willing to perform their normal duties without external incentives. For example, in a dispensary in Ethiopia

with a particular low immunisation coverage the nurse was asked why was he not vaccinating the children? He replied without hesitation: *"No incentive, no vaccinations"*. The sustainability and ownership of the program was completely lost, and because the incentive was linked to performance it was not unusual that the results were doctored to comply with the targets.

THE PROCESS ORIENTED MODEL

Over time a new kind of process oriented model of health system development has emerged. It integrates the concept of a good process and the imperative of sustainable and sustained achievement of desirable goals. This has first been developed in small projects run by teaching institutions or NGOs before being adopted and applied in health sector reforms. Let us first review the experience of small projects.

The experience of small projects

In Sub-Sahara Africa, such pilot projects include Ife (Nigeria), Danfa (Ghana), Kasongo (Congo), and Pahou (Benin). The participation of teaching institutions, such as the Institute of Tropical Medicine (Belgium) and the Johns Hopkins University School of Public Health (USA) reinforced these projects.

Basically, the small projects have demonstrated that a good process was feasible and necessary to obtain sustainable result. A good process was participatory, inclusive, and empowering. It strengthens self-esteem, promotes solidarity and democracy. In other world a good process promotes endogenous development. The projects have also demonstrated the importance of involving all stakeholders including the community. In the Kasongo project for example, the first three months of the development of a health area were devoted to information gathering, sensitisation of the population on their role in the functioning of the health centre that culminates in a census of the catchment area population that offered an opportunity of direct contact between the household members and the health staff. All these activities intended to make the process as participatory as possible.

The incentives given to health staff in those projects aimed at improving equity of access and quality of care. Sometimes, like in the Kasongo project it included a special provision preventing the health workers to engage in private practice during the duration of his/her contract[20].

[20] Kasongo Project Team, Darras, C, Van Lerberghe, W, Mercenier, P (1981) The Kasongo project; lessons from an experiment in the organisation of a system of primary health care, 54p. Annales de la Société Belge de Médecine Tropicale 60,

The projects provided job satisfaction by creating a stimulating working environment in which operational research and service delivery were closely linked. They also developed also teamwork spirit through a definition of common objectives to be reached and a clear distribution of responsibilities and tasks. Finally they created opportunities for career development through in service training sponsored by the teaching institutions.

Several NGOs provided the same kind of opportunities and incentives to their staff.

By definition the system was decentralised. The motivation was maintained by regular supervision, evaluation of the work and publication of the results. The involvement of the users and the community in the management of resources at local level was considered as a crucial factor of success.

However, the system had also several limitations. It depended on external donors, although to a lesser extent than the vertical programs. There was a bias in the selection of candidates working in the projects. Only people convinced of the approaches were selected. As in the missions where religious and faith constitute the cement that creates coherence and motivates the staff, in small projects a unified philosophy on PHC was the cement that maintained cohesion among the staff and motivated most of them. These conditions are hardly replicable on a large scale.

The health sector reforms and sector wide approaches

Health sector reforms / sector wide approaches have been defined as sustained processes of change in policy and institutional arrangements, guided by governments, designed to improve the functioning and performance of the health sector and ultimately the health status of the population. It is an attempt to combine both sound process and clear goals at national level. The changes are meant to bring global development of the health sector.

As illustrated in Figure 2, in theory, the health sector reforms tries to follow the ideal path from A to D, by a balanced approach in which an increasingly good process is established with simultaneous gradual achievement of desirable outcomes. This is clearly expressed in several documents in Zambia[21]: the reform was not an end in itself but a process by which institutions and relationships would be transformed.

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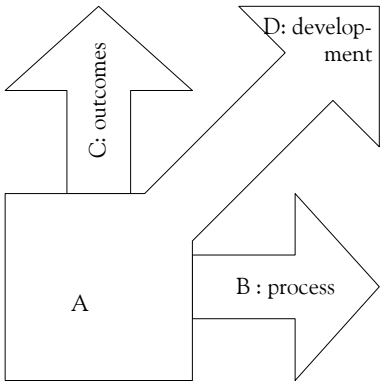
supp, 1-54.

[21] Independent review of the Zambian health reforms. MOH, WHO, UNICEF, WORLD BANK –Lusaka 1996.

Figure 2. Combining process and outcomes to achieve full development of the health sector



Impact of decentralisation on the health workers

In Zambia as in other countries, the main feature of the health sector reform remains decentralisation. As part of the decentralisation process the ministry delegates the implementation to the districts, the local authorities, the private sector and NGOs with whom a contractual relation is established. A consequence of the decentralisation is the change in accountability. The health providers are answerable to local health authorities, or health boards and committees. The local authorities or health boards are supposed to deliver services that are client and community oriented.

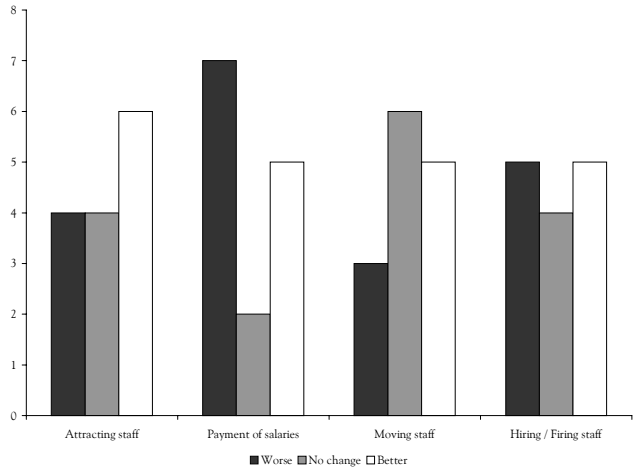
The re-organisation and the review of MOH functions under health sector reforms have had a great impact on the management of health workers. In many countries the changes included downsizing MOH, decentralisation of management functions, de-linking of health service delivery from civil services, and review of the organisation of MOH to reflect the shift from a vertical to a more integrated system.

DECENTRALISATION HAS REPLICATED A CENTRALIZED SYSTEM

The issue of personnel has become problematic after decentralisation. A study conducted in Uganda among the directors of districts health services (DDHS), who were asked about negative impact of decentralisation, showed that the most common responses focused on issues of personnel. This involved lack of flexibility in hiring and disciplining, nepotism, tribalism and other forms of favouritism, unqualified personnel, non -payment of

salaries and lack of job security. In regard to hiring of health workers several DDHS complained on problems of hiring of personnel on tribalism, regionalism, and nepotism or general favouritism rather than based on merit. *"Sons of the soil have priorities"*. An other complaint related to limited opportunities for advancement and general corruption. Finally several DDHSs reported conflicts over setting priorities; some local authorities did not consider health problems as priorities and tended to use health budget for other activities. To a certain extent decentralisation has simply replicated a centralised system in each district, with consequences for personnel (Figure 3).

Figure 3. Changes to personnel under decentralisation: perception of district directors of health services in Uganda. (Source: Impact of decentralisation in Uganda, 1998)



DECENTRALISATION HAS EXACERBATED THE TENSION BETWEEN HEALTH STAFF AND COMMUNITY BOARDS OR LOCAL AUTHORITIES

Since Alma-Ata, the movement of community empowerment, translated in the health sector by the development of community health workers, has been viewed by health workers, especially at basic level, as an attempt to usurp their technical prerogatives and give them at cheap cost to untrained community members.

The recent movement of decentralisation and transfer of management power to local authorities and local committees have exacerbated the frustration. The decentralisation has changed the position of communities from that of passive recipients to that of active partners in health care delivery,

modifying the traditional balance of power in favour of communities. Health workers consider that their transfer to local authorities has not contributed to improving their living conditions. On the contrary, the situation has worsened. Salaries have remained unchanged and often have become meaningless, as they have not kept up with inflation. Financial allowances from local authorities are usually low. When national authorities propose higher rates, local government do not necessarily implement them, for lack of resources.

THE SITUATION OF HEALTH STAFF AT NATIONAL LEVEL

At national level the health staff in vertical programs are the most affected by the changes. Their positions have been abolished, or they have been given a period of transition during which their role and function will be redefined. The situation is further complicated by the fact that vertical structures have not totally disappeared from the MOH. Because the new structures to channel the funds are not ready yet, some donors and governments still support vertical programs or even create new one. The case of AIDS control programs and the Integrated Management of Childhood Illness (IMCI) are examples that illustrate the tension existing between the need for good process development through integration and the need to achieve deliverable outcomes through specialised programs.

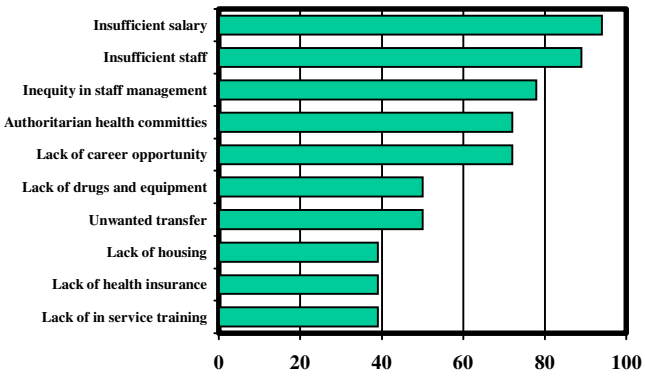
In short, decentralisation has left many health professionals in vertical programs and health staff at district levels frustrated and unhappy. In some countries this has resulted in prolonged situations of social unrest, in other most dynamic staff have left the public for the private sector or have migrated to other countries.

The reasons for staff de-motivation

To understand the various factors affecting the motivation of health workers one has to look not only on the process of health system development, but also on the internal functioning of the health system. Figure 4 gives the results of a study done in Benin on the reasons for decreasing motivation of staff. The ten top causes of staff de-motivation are: insufficient salaries, insufficient staff, inequity in staff management, authoritarian health committees, lack of drugs equipment and supplies, unwanted transfer, lack of housing, lack of health insurance and lack of in service training opportunities. The study also highlights some internal factors such as lack of drugs and equipment and lack of in service training. It also underlines some other factors linked to comfort and security of health workers, such as lack of

housing and lack of health insurance.

Figure 4. Ten top reasons of staff de-motivation in Benin



Why do health workers remain?

With so many causes of frustration and de-motivation, why do health workers do stay in function? The same study in Benin showed that despite this unfortunate situation, health workers were willing to assume their duties for the following reasons described in Table 1.

Even if not mentioned, the lack of opportunity for an alternative job is probably one of the major factors maintaining people in their position, as well as the unofficial advantages (financial and others) they get from their position. Nevertheless, the survey showed that most of the reasons to remain in function are related to internal personal and professional motivation (vocation, morale satisfaction, and professional conscience). These factors are important to know because often these internal positive aspects of motivation are often neglected. Specific motivation strategies should be designed to strengthen address these specific aspects. In the same study, it was observed that female staffs (midwives) were better acceptors of the change, perhaps because their performances were directly visible and appreciated by the community. They often received compensation in kind from the community.

Table 1. Reasons that motivate health staff to stay in function in Benin

Reasons	%
Health work is our vocation	94
The work gives us a morale satisfaction	83
Professional conscience	67
The hope that tomorrow will be better	50
Moral obligation towards the population	39
As a civil servant I'm inhibited to look for an other job	17
Because I'm honoured through my job	17
The good atmosphere at work	05
Opportunity to do other activities	05

Strategies for improving motivation and morale

The study in Uganda showed the majority of District Directors of Health Services estimated that decentralisation has worsened the salary situation. However, for other issues their judgements were rather inconclusive indicating that there was room for improvements. What kind of improvements is needed?

The study done in Benin gave some indications on the kind of changes the health workers would like to see happen at district levels. Table 2 describes the strategies proposed for the five top priorities.

Table 2. Health workers top problems and strategies to solve them in Benin

Factors	Strategies
Insufficient and irregular salaries	Salaries paid centrally, incentives by local authorities. Banking system with possibility of credit for health staff.
Insufficient staff	On job training / Intersectoral collaboration.
Inequity in staff management	Clear description of function and task at each level. Training of leadership and role of managers.
Authoritarian health committees	Targeted training on management and communication, action for a better integration of health staff in communities.
Lack of career opportunities	Linkage between national and local services. In service training.

Conclusion

To achieve the objective of staff motivation sound process of decentralisation should be put in place, including capacity building at peripheral levels.

If the health sector reforms integrates the concerns of health workers, it could cease to be seen by many as "a pretext for downsizing health staff". It could become a real opportunity to deal with the issues of personnel in a comprehensive manner.

To do so, the health reform process should integrate the concept of a good process and the imperative of sustainable and sustained achievement of desirable goals for health staff. Objectives to achieve the motivation of staff should be integrated to the process.

The Philippine has carried out such process with the devolution and the Magna Carta for Health Workers Act that defined series of legal benefits to health workers. The process is also being reviewed in Ghana with the recognition of the need to compensate staff working in rural and unpopular areas, the establishment of a common grade, title and career pathways which should allow all cadre to reach the highest level of remuneration.

This is the kind of process that will reassure health workers on their future. Without that health workers will always consider the new changes as temporary and will see better future only in being re-employed by the central government

The performance of medical doctors in Tunisia

Abdallah Bchir and Vincent De Brouwere

Introduction

Most developing countries are confronted with an increase of the cost of their health system. Rationalisation of health expenditures and improvement of the health care system performance become priority objectives. Health care reform implemented to achieve these objectives should nevertheless take into account the specific context of the country. In the field of human resources management this requires an analysis of the factors promoting or hindering health personnel performance. This paper proposes such a preliminary analysis for Tunisian medical doctors.

The Tunisian health services

Tunisia has a population of 8.8 million inhabitants (1994) and a population density of 56 inhabitants per square kilometre. The birth rate has dropped to 22.6‰ in 1995; this contributes to the decrease in the natural growth rate of the population (from 2.58% in 1984 to 1.7% in 1995). About 35% of its population are less than 15 years old, but the proportion of people older than 60 years is increasing (6.7% in 1984, 8.3% in 1995). Life expectancy at birth is 71.4 years.

Somewhat more than a quarter of the Tunisian population is economi-

cally active. GDP was US$1,607 per inhabitant in 1995. The average health expenditure per inhabitant was US$109[22]. The proportion of the government budget devoted to health represents 5.9% of the total budget[23]. In 1994, the private sector was responsible for 54% of the total health expenditures, while the public sector was responsible for 42% and the para-public sector for 3%[1].

Three health care delivery sectors coexist in Tunisia: public, para-public and private sectors.

PUBLIC SECTOR

The public sector is the main provider of care in Tunisia especially with regard to preventive and hospital care. It is organised in a pyramidal way according to three integrated levels. For each level the mission, the technical specifications and the geographical responsibility are well defined.

The first level consists in "gathering points" where a mobile team of health personnel periodically provides curative and preventive care, basic health centres and district hospitals (including maternity wards). The "gathering points" and the basic health centres are the interface between the population and the health care system. They respond to the basic needs of the population in terms of curative and preventive care. At the end of 1995, there were 1,777 health centres spread over the country (1 health centre for 3,954 inhabitants on average: minimum 1 HC/18,735 inhabitants in Tunis; maximum 1 HC/2,487 inhabitants in Kebili). It is important to note that only 21% of the HCs offer a daily curative consultation: 40% have only one consultation per week. District hospitals are the first referral level for the HC. Generally speaking, there is one district hospital per administrative delegation. In 1995, there were 110 district hospitals with a total bed capacity of 2,606 beds (16.4% of the public beds).

Regional hospitals are the second level of care. They admit patients referred by district hospitals and patients referred by first line health services located in their administrative territory. These hospitals are located in the regional capital towns. There are 29 regional hospitals with a total bed capacity of 5,550 beds.

Specialised institutions and university hospitals constitute the third level of care. They provide specialised care for patients referred from regional hospitals and their staff teaches at the Faculty of Medicine. There

[22] Source: Ministère de la Santé Publique, commission sectorielle de la santé, analyse de la situation actuelle et objectifs du IX° plan, August 1996.
[23] Source: Loi de Finance, exercice 1997.

are 20 university hospitals and specialised institutions (12 of which in the capital, Tunis) with a total bed capacity of 7,752 beds.

For the whole country, there are 18,672 hospital beds (2.09/1,000 inhabitants), of which 90% are managed by the public sector. Universities own about 50% of the public beds.

Besides these facilities, the public sector comprises military health services (3 hospitals of 800 beds and a few dispensaries) and health services belonging to the Ministry of Interior (one hospital of 70 beds and 65 dispensaries). They cater for their personnel and their families (military, police, security personnel).

PARA-PUBLIC SECTOR

This sector comprises six facilities (no hospitals) belonging to the Social Security Fund and the health services belonging to some national enterprises. These facilities provide primary care and specialised care for their members (insured people from private and para-public sectors).

PRIVATE SECTOR

Since the 1980s, the private sector has expanded rapidly in response to the increase in demand for health care.

The private sector comprises general practitioners (1,468 clinics) and private specialists (1,305 clinics), 49 private hospitals (with a total of 1,874 beds) and support services (50 haemodialysis centres, 141 laboratories). The private sector possesses 549 (80%) of the 681 haemodialysis machines and 20 of the 28 scanners available in the country. Private facilities are mainly located in urban areas.

Health personnel

At the end of 1995 there were 5,965 medical doctors in Tunisia (1 medical doctor per 1,500 inhabitants). General practitioners represented 54% of the total (55% in the public sector and 53% in the private sector). The Ministry of Health employs 42,825 technical and administrative workers, and among them 3,191 medical doctors (53.5% of the total number). The distribution of the technical health personnel is clearly uneven (Table 3).

Table 3. Ratio of inhabitants/personnel in Tunisia, 1995 (public and private sectors)

	Medical doctors	Pharmacists	Dentists	Nurses
District of Tunis	778	3184	704	283
North East	1879	5244	10399	427
North West	2774	9976	18260	359
Central East	1305	4270	7618	282
Central West	3283	11996	25377	542
South East	2233	6881	18805	413
South West	2400	8815	26605	314
Total Tunisia	1500	5310	8473	351

Financing

Health expenditures amount to 6.2% of the GDP in 1996, up from 4.3% in 1980. This corresponds to US$ 109/inhabitant year.

There are three sources of funds for the health sector: the government contributes 34.4%, the social security fund 14.9% and the households 50.7%. The proportion of direct financing by the households is increasing; it was 37.5% in 1980.

The MOH gets its resources from the government (81.6%), from the social security fund (10.8%) and from its own income (7.6%). The social security fund participates by a) a direct payment (a lump sum) to some public hospitals and b) by a payment to the state treasury.

There are 1,640,975 affiliated people (plus their families) to the social security fund. They have access to the public system. In counterpart, the social security fund pays the MOH, but this payment is clearly insufficient as compared to the expenditures.

The direct income for the MOH comes from the contribution of households under the form of co-payment fees (lump sum of US$1 for each consultation) for those who are insured or from the fees paid by those who have no insurance scheme and no social coverage. Free of charge social coverage is given by the government for people with low income.

The performance of medical doctors

In Tunisia the performance of medical doctors is considered 'good' when they do well what they are supposed to do (the notion of quality and of quantitative achievement of an implicit or explicit objective) at a low cost

(the notion of efficiency). In other words, improving performance means improving both the productivity and the quality of care delivered by the medical doctors.

The performance of the medical personnel is influenced by several interrelated factors: individual capacity (one knows what s/he has to do, how to do it in the best way and at the lowest cost); career structure and how it is managed; organisation of the health care system; and socio-cultural and economic context

After a short description of the medical career structure in Tunisia, we will discuss the factors influencing the productivity and the quality of the medical doctors.

Career structure

PUBLIC SECTOR

In the public sector, there are three career tracks: the university-hospital career, the "hospital-public health" career, and the hospital career.

The university-hospital career

This career comprises three grades: university-hospital assistant, "*Maître de Conférence Agrégé*" and Professor.

The recruitment of the assistants is organised through a national competitive examination. This examination is open to so-called residents, i.e. medical doctors having completed a specialist degree (4 years). The selection committee takes into account the teaching activities, the clinical work and the research activities. The access to the grade of *Maître de Conférence Agrégé* is also regulated by a national competitive examination. This examination is opened to university-hospital assistants who completed at least 4 years in the grade. Professors are nominated among the *Maîtres de Conférence Agrégés* according to the results of a national competitive examination opened to those who completed 4 years as *Maîtres de Conférence Agrégés.*

Getting a higher grade means an increase in salary: an *assistant* earns 960 US$/month; a *Maître de Conférence Agrégé* 42% more, 1364 US$/month, and a *Professeur* US$1500 per month, double the *assistant*'s salary. Some are Head of Service, and receive a bonus in kind, as car fuel (equivalent to 120 US$/month). The jump to a higher grade is a real incentive for the university staff to achieve a better performance.

If the salary in the university career is higher than in the other public

tracks, it is nevertheless lower than what can be earned in the private sector. This explains partly why many university staff leave the public for the private sector. In order to reduce this leakage MOH has allowed the professors and the *Maîtres de Conférence Agrégés* to combine their work with a private practice in the hospital – but with a significant salary cut.

The hospital-public health career

This track concerns all the general practitioners and specialists who are working in public non-university facilities (first line health services, district hospitals, regional hospitals).

The general practitioners' career structure comprises three grades: public health medical officer (US$730 per month); public health principal medical officer (US$910 per month); public health major medical officer (US$1,090). The specialists' career structure comprises only two grades: public health medical officer, specialist (966 US$) and public health medical officer, principal specialist (1200 US$).

There are no fringe benefits. The promotion to a higher grade for general practitioners is organised through a national competitive examination, organised every year, for those who have already completed 5 years in the lower grade. The selection committee consists of 5-6 members: a representative of the MOH, a representative of the university, a representative of the national medical trade union, and 2-3 public health major medical officers. The selection committee takes into account the clinical activities (mainly the level of responsibility, the seniority and the place where the candidate works, giving favour to those working in remote areas), the scientific activities (communications in scientific workshops, publications) and a written test on theoretical medical knowledge. There is however no objective criterion as far as clinical performance is concerned. The number of posts to be filled varies every year. In 1997, there were 110 posts for 240 candidates (success rate: 46%), while in 1998 there were only 85. As the number of candidates increases every year, the probability to get a post tends to decrease.

There are bridges between the hospital-public health career of general practitioners and of specialists. General practitioners who completed 5 years in the public health career can participate in a national competitive examination in order to be accepted for training as a specialist. The MOH guarantees their salaries during the training. It is also possible for those who have been working in specialised services to participate in a national examination leading to the university career.

The career of hospital medical officers

This career structure has been created for the university-hospital assistants who were not successful in the national competitive examination (and therefore have to stop their university career), for those who decided not to go further in this career or for whom no post was available. This career structure comprises two grades: hospital medical doctor and hospital principal medical doctor.

They can practice in university or regional hospitals and essentially carry out clinical duties. They are not supposed to teach in the Faculty of Medicine.

PRIVATE SECTOR

Medical doctors who chose to practice in the private sector have no career structure. If they decide to enter the public sector, the length of service as private practitioners is not acknowledged.

Income taxes are levied as a lump sum, but this lump sum is at least equivalent to what the public sector medical doctors pay. We don't know to what extent the private career is attractive, but it seems that the market base for private practice is becoming smaller. The number of private practitioners increases, the more so since only few medical doctors are nowadays recruited by MOH. Also, demand is finite. Only a small proportion of the population can afford private doctors fees, and in most case social security will not reimburse private practitioner's fees.

Productivity and performance appraisal

PRIVATE SECTOR

The private sector is responsible for about 16% of the total number of hospital admissions, 40% of consultations and 10% of preventive care but productivity in the private sector is not known. It is however obvious that private practitioners are more available than public doctors (they all work mornings and afternoons). In urban areas, specialists have on average more patients than general practitioners.

PUBLIC SECTOR

In the public sector as a whole, health personnel are subject to disciplinary measures in case of malpractice in clinical activities and for administrative reasons (late arrival, absence). Sanctions range from reprimand to striking

off the roll of civil servants. The Medical Council (association of medical doctors) is responsible for the respect of professional ethics.

University staff

Performance appraisal for university staff is organised for heads of services since 6 years through a periodic evaluation every 5 years. An *ad hoc* committee assesses their performance in the field of research, clinical and teaching activities. As a result, some heads of services have lost their post.

A productivity premium is given to the university staff depending on their performance. Every semester, university medical doctors have to produce a report about their scientific activities. This report is the basis on which performance of university staff is assessed. The career structure and the periodic evaluation are the main pressures on university staff performance.

Hospitals

There is no information on hospital productivity as such. Available statistics concern hospital utilisation indicators: average bed occupancy and number of patients in out-patient clinics. These indicators, however, are not used for institutional evaluation but serve as a basis for resources allocation. They are not very useful for assessing health personnel performance.

In university hospitals, bed-occupation rates are on average higher (75.6%) than in regional hospitals (55.4%) and in district hospitals (36.8%). Waiting time may be up to several months for a specialist consultation in university hospitals.

Recently, MOH organised a hospital reform. It is supposed to improve working environment, resources management and hopefully productivity. Specialists are encouraged to open outpatients clinics in the afternoon.

First line health services

Medical officers are expected to work full time, 36 hours a week, and are not allowed to have another job. However, those who are living in so-called underprivileged areas are allowed to undertake private activities.

Every medical officer is given an annual premium, but the amount varies according to the productivity, on the basis of a report from the hierarchical authority, but criteria used to appreciate productivity are not explicit.

In order to encourage medical officers who demonstrated an interest in public health activities, the Ministry of Health may grant them a fellowship to study abroad. Public health medical officers are supposed to provide curative care (daily clinics in health centres and periodically duties in dis-

trict hospitals), to participate in preventive activities (school medicine) and to take action in the general field of public health (epidemiological surveillance, programme evaluation). In actual fact, curative care takes up 90% of the medical doctors' time.

On average, a public health medical officer has a workload of 21.7 patients per workday. This average hides large variations between regions, and in a particular region between health facilities and/or individuals. Some medical officers have 80 patients per day while others have only 10. A study carried out in the Tunis region reported that 61% of medical officers had less than 15 patients per day, 28% had between 16 and 20 and only 11% more than 20. The distribution of medical officers contributes to the variability of the workload: some health centres have three medical doctors although the number of patients is low, while in others there is only one medical doctor for a higher number of patients. The variations in workload create dissatisfaction among the medical doctors who have a high number of patients. They feel that they are doing too much compared to their colleagues, without getting any advantage for the additional workload. They also feel that the distribution of posts is not fair, as newly appointed medical doctors may be posted in health centres with a few patients.

There is no systematic information on the real number of hours spent by medical officers in health centres. However, a survey carried out in one region reported that medical officers spent an average of 2:30 hours (± 60') in curative clinics. This means an average of 5.16' (± 4.2') per patient, for a total of 30 patients. Whatever the number of patients, curative clinics take place only in the morning. The MOH has tried to make the medical doctors working morning and afternoon, but the medical staff opposed huge resistance to this attempt.

As a whole, the productivity of medical officers in clinical activities seems remarkably low considering the lack of staff in the health centres. As a consequence of such a relatively poor productivity at first line health services, patients go consulting specialists and emergency departments of hospitals. The ratio of the number of consultations at public first-line health services on the number of consultations by specialists and emergency departments in public hospitals is 1.25. This reflects the extent of the underutilisation of health centres. Of course, other factors play a role. They are related to the motivation of medical officers, the pattern of health system organisation and the comparative (dis)advantages of the public health services (Table 4).

Table 4. Determinants of the motivation of public health medical officers

Perception from general practitioners	Pattern of health system organisation	Comparative (dis)advantages of the public health services
- No incentive for the medical doctors to increase the number of patients (they are not paid according to the workload) - No valorisation if quality of care is improved - No adequate training in general practice (doctor-patient relation is poor) - Poor working environment - No real technical support (supervision) from the health authority	- No systematic feed-back from specialist to general practitioner after referral - Direct access to specialist is tolerated, although it is formally forbidden - No compulsory continuing education for practitioners and no incentive for those who spend time on it	- Insufficient technical equipment at health centre level for the management of patients (so that patients prefer to go directly to the specialist or to the hospital) - After the increase of the fees at health centres, private practitioners became more attractive - Shortage of drugs in public health centres

To understand the relatively poor performance of the public health general practitioners in Tunisia one should take into account two components: the general practitioner's motivation, and the consumer's perception of the public health general practitioner.

CONSUMER'S PERCEPTION. The well publicised development of medical technology has spurred the demand for high-tech medicine. The increased number of specialists is ready to respond to this. This further contributes to the poor image of general practice. In cities, public general practitioners are used by poor people who cannot afford a private doctor or just as a means to obtain a referral to the specialist. Without a culture of family practice there is little hope to go beyond that role of automatic referral.

THE MOTIVATION OF THE GENERAL PRACTITIONER. At the outset the motivation of the general practitioner is conditioned by the image of the function he has and by the place he thinks he has in the health system. There is a crisis in the professional identity in Tunisia. One does not speak about "general practitioner" but of "public health doctor". This is related more to the status – the public sector pays the salary – than to the professional identity. The latter is, however, essential if one is looking for professional

performance through individual development.

Being a general practitioner does not refer to family practice but to the established fact that this particular doctor failed to become a specialist. During their studies, the general practitioners never learned the family practice model. Their role model is rooted in the hospital practice. Professional satisfaction in such a model comes from the beauty of a diagnosis or from the use of technology. In hospitals, quality of care is assessed through clinical meetings referring to accuracy of diagnosis. Norms of good practice acquired as a student has little relevance to family practice in first line health service: there is no sophisticated technology at this level and the general practitioners often work alone. That partly explains why a Tunisian general practitioner feels so frustrated to work in a health centre. The poor image of a general practitioner – someone who failed to become a specialist, who is just good enough to screen out patients who need a specialist – is implicitly and sometimes explicitly transmitted by the hospital university staff throughout the curriculum.

This feeling is re-enforced by their first experience. Technical diagnostic tools are few and the working environment is poor. They have to see patients at the curative clinic: s the more, the better. They have to show up at work and send reports to the Ministry of Health. When they refer patients, they hardly get feed-back from the referral hospital. Continuing education is organised at regional level but is not compulsory and does not play any role in the career structure.

There is no objective to be achieved. The important thing is that no patient complains about the length of waiting time or the absence of the medical doctor. Their chief is an administrator who only cares about the formal aspects (reports in time, no absence, good vaccination coverage figures), whatever the quality of the care provided.

After a few months in a post, they realise there is no incentive to work harder than the other colleagues do. If they want to take initiatives, they are confronted to the sluggishness of the system and that makes hard to implement any improvement. The simplest attitude in such a context is just to behave as the others: see the patients and that's it. And indeed, why would they try to do more? Their salary is guaranteed and the premium is roughly the same whatever the output and the basis on which it is allocated is not known. Their career structure does not take into account the quality of their outputs: the important thing is to present abstracts in conferences and to publish. Nobody asks them to define objectives or to assess the quality of care. Except if they make a big professional mistake, nobody would call them to account about their clinical performance. Finally, many doctors

do not live where they work. In order to alleviate this discomfort, they ask to be transferred in a health centre near the place where they are living, which is obviously not possible for everybody. Transfer does not depend from performance but the refusal of transfer is felt as another disincentive.

Since a few years, however, the MOH tried to remedy this situation. Indicators for following up national programmes were developed in order to help general practitioners to monitor their performance. A new programme designed to stimulate provision of quality care was set up and defined criteria to certify health centres and health districts performing well (i.e. filling the criteria). In 1998, a law concerning the health district organisation defined criteria for the nomination of medical officers as heads of health districts. These medical officers will be appointed according to their performance in clinical and public health activities. They will be periodically evaluated every five years.

The political priority seems to be to improve the performance of the general practitioners in public service. They work at the periphery of the health system, close to the population. Their influence may be crucial to better meet the needs and demand of the population and they can do it at a cost far less than hospitals.

A better performance, however, cannot be achieved without addressing several issues such as the construction of a positive professional identity, the emergence of a quality of care culture, and a performance appraisal system that clearly promotes quality of care initiatives and productivity instead of mere bureaucratic compliance.

The internal brain-drain in the Angolan health sector

Evelize Fresta, Mário Jorge Fresta and Paulo Ferrinho

Introduction

With its 13 million people, Angola is one of the poorest countries in the world, despite its wealth in natural resources. About one third of the population lives in cities and towns, and two thirds of these are concentrated in the capital Luanda. In Luanda about three quarters of the population is concentrated in peri-urban slums (the *musseques*). Over 80% represent recent arrivals from the war-torn rural hinterland.

The current situation in the country can at least partially be explained by the long civil war, the slow process of political transformation, the painful structural adjustment programme, a survival economy with a huge informal sector and the lack of clear policies in the fundamental sectors for the development of the country, including health. In the health sector the resulting niche has been filled by a growing and unregulated private sector, as well as by an ever increasing involvement of non-governmental organisations (NGO) in all aspects of the day to day life of the country.

This paper is a review of as well as a reflection on the Angolan Health Care System in order to contribute for the current debates about its reform. Our focus will be on the behaviour of the human resources in the health sector *vis à vis* the three major providers of health care: the government, the private sector and the NGOs.

The Angolan health care system

According to the 1992 legislation, the Ministry of Health (MOH) is responsible for the provision of public sector health care and for the co-ordination of the health care provided by other non-public-sector providers. These other providers include: the army, the missionary sector, the private for profit sector, the NGOs, the international development agencies and the traditional healers. None of these receives financial or methodological support from the MOH. Actually they are the major investors in the health sector over the past decade.

The MOH is the largest employer of health care workers in the country: 21,910 workers, of which less than 1,000 have university training. It owns 31 hospitals (9 in Luanda), 233 health centres and 1684 health posts. During 1995, 2,5% of the government budget was allocated to the MOH (less than US$2 per capita per year). Pharmaceuticals are among the scarcest resources; they are channelled to the largest hospitals, to the detriment of the smaller hospitals and PHC units. Drug supplies are often interrupted despite an internationally supported essential drugs programme[24].

Because of the political situation in the country, the management structures of MOH and the public sector have become dysfunctional, with a growing loss of accountability of all managers at all levels. All decisions depend directly of the Minister. The current status of the health care facilities is not well known. The resources are not inventoried. The facilities themselves are classified without uniform standards: what is considered a urban health centre in some provinces is in others called a district hospital and what is a health post in one district is a health centre in another. The personnel allocated to a facility often had to flee for the war. MOH may expect a nurse or doctor to be working in a particular health facility, whereas they are actually living and working hundreds of kilometres away, in the capital (In 1995 there were 180 doctors in Luanda, displaced from their provincial posts as a result of the war), most frequently without the knowledge of MOH.

The human resources situation

As far as investment in the training of qualified personnel, the health sector

[24] Björck M, Johansson E, Kanji N. (1992) Improving the quality of primary care services in Angola. Health Policy and Planning; 7(3): 290-295. Björck M, Johansson E, Mancas A, Teca P. (1997) Quantitative monitoring of quality of care in Angola. Essential Drugs Monitor: 14: 11-12.

has been in a privileged position, but still short of the country's needs. The human resources in the health sector, excluding non-technical personnel, can be divided into community-based workers and basic-level, mid-level and higher-level personnel. The ratio of human resources per inhabitant is summarised in Table 5.

Table 5. Health personnel and ratios of inhabitant per health personnel per province - 1987 and 1988

	Doctors (1988)	*Nurses and Paramedics (1987)*	*Health Promoters (1987)*	*Inhabitant per Doctor*	*Inhabitant per Nurse and Paramedics*	*Inhabitant per Health Promoter*
Bengo	11	173	54	14 191	887	2 841
Benguela	62	934	60	10 108	637	9 918
Bié	22	506	312	49 714	2 014	3 267
Huambo	48	455	209	32 189	3 039	6 617
Huila	50	518	183	17 048	1 550	4 387
Cabinda	24	808	65	6 391	177	2 202
K. Kubango	10	65	28	13 956	1 920	4 457
Kuanza n.	14	363	179	25 436	964	1 954
Kuanza s.	18	433	203	37 018	1 439	3 069
Kunene	7	126	59	36 633	1 723	3 680
Luanda	362	2 673	73	3 853	487	17 834
Luanda n.	11	244	173	25 390	1 130	1 594
Luanda s.	7	172	95	21 629	875	1 584
Malange	31	409	19	27 933	2 009	43 247
Moxico	13	250	26	24 608	1 155	11 119
Namibe	26	217	145	3 950	457	684
Uige	31	546	346	25 370	1 351	2 132
Zaire	10	300	80	15 550	486	1 824
Angola	757	9 192	2 309	12 850	1 004	3 999

The community-based workers (health promoters and traditional birth attendants) have been utilised inadequately and their role needs rethinking. The basic technicians (nursing aides and other auxiliary personnel: radiology, laboratory, pharmacy, statistics, physiotherapy, orthopaedics) are trained in Angola after six years of basic schooling. They receive their 18 months training in one of the 21 schools in the provinces. The production capacity of these schools is 800 technicians per year.

Thirty percent of the mid-level technicians (nursing, midwifery, laboratory, pharmacy, speech therapy, audiometry, occupational therapy, dietetics, dental, orthopaedics, optometry, radiotherapy, radiology, neurophysiography, cardipneumography) are trained outside the country.

Higher level technicians have all received university education. Since the mid 1980s, the *Centro de Ensino Superior de Enfermagem* offers BA level post-graduate training to nurses with at least five years of field experience. Although it is a regional WHO centre for Portuguese and Spanish speaking African countries, most of its trainees have been nationals.

The Faculty of Medicine of the Agostinho Neto University, under the Ministry of Education (MOE), offers undergraduate training in Luanda and in Huambo. Since after independence and until 1995 the Faculty trained 824 physicians. About 200 to 300 were trained abroad, namely, in order of frequency: Portugal, Zaire, Benin, the Soviet Union, Cuba, Germany and Rumania. The Huambo branch is currently inactive because of the war. In 1998 there are 506 physicians-in-training[25].

There is no national medical registry and no precise information is available on the number of doctors undergoing post-graduate training abroad: the 1996 estimate of 96 is a gross underestimate. Since 1980 the post-graduate training of physicians has been thought of in terms of four broad lines of differentiation: basic sciences, hospital specialities, public health and general practice. A post-graduate college was established in 1986 as a joint inter-ministerial (MOH and MOE) body. This body confers and recognises post-graduate courses. Since 1988 there have been local speciality examinations for hospital specialities and public health. In Angola this training has been done in the national hospitals in Luanda. Outside the country it takes place in several countries, namely, in order of frequency: Portugal, Spain, Italy, Germany, France, Belgium, United States of America, Canada, Brazil and the United Kingdom.

Although official policy acknowledges the "general practitioner as an important agent to promote the provision of primary health care to the population", specialisation in general practice has not developed and it is seen as the option of the "failed clinician" or for the "just-out–of-school doctor". In practice, the result is that most postgraduate training in the country and abroad[26] does not contemplate opportunities in general practice and public health.

Once trained, 60% of the physicians are recruited by the MOH, 20% by the University and 20% by the Army, with some overlap between the different sectors. Since 1980 MOH employed doctors are exclusively placed in hospitals. The exception is Luanda where doctors can be placed in health

[25] Anonymous. Março de 1998. Relatório de Actividades. Ano Civil de 1997 e Plano de Acção – 1997-*2001*.Universidade Agostinho Neto, Luanda.
[26] Ferrinho P, Bäckström B. (1998) A educação médica além-mar. Ordem dos Médicos; 14 (6): 24-25.

centres.

In 1990 there were 413 foreign doctors in the country. The precise number in the past and currently are unknown. The number of NGOs and their (human) resources are also unknown.

In 1988 67% of Angolan and 40% of foreign doctors were located in Luanda with a ratio of 3843 inhabitants per doctor compared with the national ratio of 12,850. Currently the situation is even worse.

As a result of this situation, morale amongst health personnel is low and human resources management and development is one of the most complicated issues in the current health sector. One of the most visible signs of the discontent of health personnel in the growth of the non-governmental health care sector, namely the private sector.

The private sector in Angola

In Angola, particularly in Luanda, there is a bustling private sector. Since 1992, legislation enables doctors with more than three years of training to work in the private sector. Further, this legislation regulates the processes of legalising private health care institutions and defines the State's role *vis à vis* these private providers.

This represents a significant departure from the 1975 post-independence policies, when non-state health care could be provided only in large industrial enterprises. In 1985, the posts of occupational health doctors were officially recognised and legalised. These doctors could then provide health care to workers and their direct families, on the basis of part-time (twice a week) contracts with their employers. Slowly these industrial health facilities started to be converted in private surgeries, health centres or hospitals. Parallel to these developments, since the 1980s, and very insidiously, even non-medical health personnel started developing private consulting rooms, health centres and facilities with inpatient care. Already in 1984 4% to 7% of the Luanda population sought health care in the private sector[27]. More recently, also in Luanda only 28-38% of the sick seek care with the public sector health services[28]. The situation in the rest of the country is undeniably worse.

[27] Bernardino D. (1985) Alguns indicadores de saúde no município de Rangel. Acta Médica Angolana; 4 (1): 13-25.

[28] Anonymous. Relatório Sítios Sentinela. Município do Cazenga. Luanda, Novembro de 1990. Anonymous. Relatório do Inquérito Sobre Malária. Sítios Sentinela. Municípios de Cazenga, Simbizanga, Kilamba Kiaxi. Luanda, Maio de 1991.

Gradually, with the deterioration of the salaries paid by the State, breaks in supplies and deterioration of existing facilities, a growing number of health personnel started seeking for opportunities in the private sector or, even, outside the health sector[29]. The typology of this private medicine is summarised in Table 6. In Luanda alone there are more than 400 of these units of private provision of health care.

Table 6. Typology of private practices in Angola

Grouping of Doctors	*Contractual Relation*	*Facility*	*Physician payment*	*Care Provided*
Individual	none	own surgery	fee for service	ambulatory
Individual	none	renting consulting room	fee for service	ambulatory
Individual	contract with factory managers	factory	salary	ambulatory, occupational health
Individual	contract with private clinic	private clinic	fee for service, fee for session	emergencies, outpatient and inpatient care
Group practice	contract with private clinic	private clinic	fee for service, fee for session, profit-sharing	emergencies, outpatient and inpatient care
Group practice	private practice within the public facility	public sector hospital	fee for service	outpatient and inpatient care

It is rare for a doctor to depend entirely on his public sector activity. Some 75% of doctors working for MOH also work in the private sector, only one in five with official authorisation. But the dependence on an income generated in the private sector is growing: while in 1991 the median of the percentage of working time spent on private sector activities was 0% in 1996 the median was 50%. This generated 78% (median) of the doctors income[30] in Angola.

This private practice is financially very rewarding. In 1996, the public sector income of a doctor could be easily duplicated with less than one hour

[29] Roenen C, Ferrinho P, Van Dormael M, Conceição MC, Van Lerberghe W. (1997) How African doctors make ends meet: an exploration. Tropical Medicine and International Health; 2: 127-135.

[30] Ferrinho P, Van Lerberghe W, Julien MR, et al. (1998) How and why public sector doctors engage in private practice in Portuguese-speaking African countries. Health Policy and Planning; 13: 332-338.

of work in the private sector. This is particularly important in view of the very low purchasing power of the public sector salary to the extent that a couple with two children could hardly live for more than one day on the public sector salary (Table 7).

Table 7. Purchasing power of a doctor's public sector monthly salary

Goods acquired with a monthly salary	*median*	*lower quartile*	*upper quartile*
Colour TV	1/500	1/500	1/10
Kilograms of rice	5	4	16.5
Number of chickens	1.5	1	4
Kilograms of beef	1	1	3
Number of eggs	20	10	90
Kilograms of powdered milk	2	0	10
Litres of cooking-oil	3	1	10

Other coping strategies of health personnel

Private practice is only one of the many survival strategies that health personnel use to supplement their income and increase their job satisfaction. Teaching, attending training courses, supervision activities, research, trade and agriculture are some of these other strategies[31]. With the exception of the income derived from private practice all other activities have, on average, little financial impact, except in the rural areas, where the private sector is underdeveloped and collaboration with NGO and international development agencies become an important source of income[32].

The role of NGOs and development agencies

At the time the peace process was initiated in 1991, the government agreed with the Catholic and Protestant Churches to return all their property seized immediately after independence, acknowledging their important role as providers of health care. Besides these churches, in 1991 there were already 30 officially registered NGO working in the Angolan health sector.

[31] Roenen C, Ferrinho P, Van Dormael M, Conceição MC, Van Lerberghe W (1997). How African doctors make ends meet: an exploration. Tropical Medicine and International Health 1997; 2: 127-135.

[32] Bäckström B, Gomes A, Yussuf Y, Fresta E, Dias F, Gonlçalves A, Macq J, Lerberghe WV, Ferrinho P. (1998) The coping strategies of rural doctors in Portuguese speaking African countries. S Afr Fam Practice; 19 (1): 27-29.

The current number far exceeds this but it is unknown. The extent of their resources and the nature of their activities are also unknown.

Besides the private sector, health personnel, particularly doctors, are also enticed by job offers from international development agencies and NGOs.

International development agencies recruit differentiated personnel, full-time, for long periods (over two years). The MOH encourages this type of recruitment in order to ensure some influence in the development of these agencies' policies and activities. These recruitment practices result in an internal brain-drain of the best human resources, that become unavailable for service provision but, on the other hand, this may help to retain in the country good and competent professionals.

NGOs focus more on community-based projects. For these they recruit, for short periods (less than two years), less differentiated personnel, many times on part-time contracts. These personnel still keep their public sector link, and this experience enriches them with skills that may be useful for the functions they perform in the public sector.

The edge of chaos and internal brain-drain

Since 1975 there have not been major policy changes in the Angolan health care system. As a consequence, it has slowly drifted to the edge of chaos. Rather than planning for the future, the State has been reacting to emergent strategies of their own personnel and to the imposed strategies of NGO and international development agencies. The persisting war, the vacuum in the decision-making structures - with strong centralisation of decision-making in the minister himself - the erosion of the public sector salaries, the physical degradation of facilities and the frequent break in supplies, all contributed to a situation where the State does not *de facto* govern the health sector and where the State does not have the financial capacity to sustain service provision at the level necessary to meet essential needs.

The limited services in existence do not meet the desired quality standards; waiting times for patients have increased and their satisfaction with the services provided is low; job satisfaction is also low for professionals; and the break in supplies is aggravated by the transfer of pharmaceuticals and equipment from the public to the private sector.

In this context health personnel look for alternative sources of income and job satisfaction outside the public sector. Even so, they retain their formal links with the public sector: it gives them access to positions of social

prestige; it ensures professional credibility and long term employment stability; it is a source of social contacts; and it gives access to resources still not available in the private sector.

The emerging private sector, mostly in urban Luanda and the ubiquitous NGOs, also with a strong rural presence, have become important stakeholders in the health care system. Currently they draw human resources from the public sector, work independently and many times in competition with it, draining the public health care facilities of its more essential resources - the health personnel.

In the context of this internal brain the State has to define for itself a clear role, where provision of essential health care to the poor majority of the population is not neglected and where the role of other providers is regulated and supervised. Personnel, a key resource to all players, must be carefully planned, trained, deployed and their performance sustained at acceptable levels of quality. Although the State has a central role to play here, it is not the only player: besides the private sector, NGOs and international development agencies, the health professionals themselves have to contribute, in part through professional organisations, with solutions to strengthen the inner motivation of health personnel, as the most important means of ensuring their continuing commitment to the public good.

Not many solutions are apparent. Salary-based incentives may not be affordable on the necessary scale. The private sector is a reality that cannot be ignored, but what to do with it is still not clear. Employment policies and public service regulations need to be studied. Issues associated with professional ethos and internal motivation need to be better understood with particular attention for health workers who deal directly with the public.

Strategies to respond to health manpower needs in rural Thailand

Sanguan Nitayarumphong, Supattra Srivanichakorn and Yongyuth Pongsupap

Introduction

Shortage of health manpower in Thailand has been recognised since the early days of the development of Thai health care system. Many strategies to solve this problem have been introduced and implemented up till now. Some strategies were modified to be more appropriate to the situation, while some were later dropped out. The shortage problem has been much improved, but a gap of health manpower distribution between Bangkok and rural areas still exist. One main activity of early health system development was to establish schools for production of health workforce. The first medical school was established in 1888. Later on the schools of Dentistry, Pharmacy and Nursing Colleges were also established. These professional health personnel were placed mainly at the central level and very few at the provincial level. The government at that time realised the difficulties and high costs of expanding health services by using only high level health personnel, thus lower level personnel were also produced to deliver basic health services such as immunisation, maternal and child care, diseases control and care of common illness to the people in rural areas.

Several strategies were implemented by the government to achieve a balanced distribution of health personnel in rural areas, for example; a compulsory service for medical professional after graduation, the establish-

ment of a health manpower production centre, the expansion of health service infrastructures throughout the rural areas of Thailand, the increase in remuneration and the improvement of living conditions including the career promotion for those professionals who work in rural areas etc. Some strategies were found to be quite effective later, while some found to be limited. The effectiveness of these strategies is dynamic and depends on the interaction of all the interventions with the overall social and economic development and on the strong political intention of the government.

This paper reviews the measures and strategies which were developed and implemented to meet the need of health manpower in rural Thailand.

Historical background and development

Several policies and measures have been developed and implemented to improve rural health services and to meet the need of health manpower in rural areas for over a last century. Most of the earlier development was focused on the increase in the overall number of health manpower, especially medical doctors, for rural health services and on the expansion of rural health care facilities to district and sub-district levels. Since the mid twenties as a issue of brain-drain among the medical doctors became very critical for the rural health delivery system, a focus has been shifted toward a system development in order to keep health manpower longer in rural areas through incentives and a unique recruitment mechanism (Table 8).

Only by the early 1950s every province was covered with one provincial hospital. During that time medical students were offered scholarships with the contract that they would work for the MOPH after graduation. Not many medical students requested the scholarship.

Table 8: Policies and measures dealing with the distribution of health manpower in rural areas

1888	Established the medical schools to produce medical doctors.
1936	Started producing lower levels of health personnel, namely midwives and junior sanitarians, mainly for rural health centres.
1950	Expanded health facilities to the rural areas. Every province was covered by one provincial hospital. Started a scholarship program for medical students. The government started to attract medical doctors to work in rural areas by offering scholarships to medical students with the contract that they would work for the MOPH after graduation.

1967 - 1971	Increased a tuition fee of medical education and intruded a voluntary contract system for public services. Because of the external brain-drain (a rapid migration of Thai medical doctors to the United States). The government increased the tuition fee of medical education to be 10,000 baht per year for 4 years. Those who did not want to pay the fee had to sign a contract to work in public services for 3 years, on voluntary basis. If they broke the contract, they would have to pay a fine of 120,000 baht, but later, the voluntary contract system for working in public services was changed to be a universal compulsory contract system for every newly enrol medical student and the fine was increased to 200,000 baht.
1973	Increased the fine up to 400,000 baht.
1975	The government started to give incentive to maintain rural doctors to stay longer in rural areas by providing special allowances for district hospital doctors. For regular districts 1,500 baht per month for the first year and 1,700 baht from the second year onward. For more remote districts, 2,000 baht and 2,200 baht respectively.
1976	Evolved social transformation movement. Changes in Thai political system created the awareness for social transformation and called for responsibilities of university graduates, including medical students, to work for the society.
1978	Set a goal of Health For All by the year-200. Declaration of Alma-Ata was adopted by the Royal Thai government. Initiated a special project to recruit rural students and a curriculum was adapted in such a way that half of the training was provided in the rural hospitals and after graduation these rural students had to work in the place where they were selected.
1977-1986	Extended rural health facilities to the district level. With the Alma-Ata Declaration and the social transformation movement which encouraged an environment for more equitable health care system. In the 4th-5th National Economic and Social Development Plan, the rural health facilities had been much extended. The government declared that every district must have at least one district community hospital equipped with at least one doctor. Posts of rural doctors were increased and their career paths were upgraded. Housing and living conditions for these personnel were also improved.
1979	Established a co-ordinating centre and developed a project to increase the number of medical students. The co-ordination centre was set up to co-ordinate between producers (medical schools) and users (MOPH) on the planning and production of medical doctors. The project to increase the number of medical students produced in a year (200 students per year) was developed and proposed to the cabinet by the centre, so that there would be more available doctors in district hospitals.
1979, 1986	Introduced a concept of basic doctors. The resolution of 4th and 5th National Medical Education Conference stated that the medical schools should produce basic doctors that are appropriate to work in rural hospitals. They should be good clinicians, administrators, primary health care supporters and trainers.
1983	Increased the special allowance for rural doctors to 2,000 baht and 2,200 baht for regular and 2,500 baht and 2,700 baht for remote districts.

1984	Implemented the first compulsory contract for dentists and pharmacists to engage in public services.
1991	The government initiated more financial incentives for public rural doctors, as the rapid economic growth resulting in high internal brain-drain from public sectors to private sectors.
1994	Started another project to accelerate the increase in the number of medical doctors. The MOPH initiated a 10-year project to solve the problem of doctor shortage in rural areas, intended to produce 300 doctors more every year, with a target to achieve the proportion of doctor per population of 1: 3000 in 2005 from 1: 4,280 in 1990.
1994 – 1995	Improved a remuneration system for health personnel. The remuneration for rural doctors, dentists, pharmacists and nurses were increased, for example; on call payments, travel per diems, non-private practice incentives, workload related fees etc.
1997	Improved the allowance system for rural doctors: 2,000 and 2,200 baht per month for general rural districts; 10,000 baht for more remote areas and 20,000 baht for the remotest districts (more than double the salary).

After graduation, those who did not receive a scholarship stayed mainly in the medical schools and those who received a scholarship were sent to provincial hospitals and some large rural health centres. Due to the limited number of health facilities, most of the available posts for medical doctors were filled. However the high demand for doctors in the United States during the early 1960s opened great opportunities for well trained Thai doctors to migrate. It was noted in the U.S. congressional report that the first few batches of a north medical school graduates chartered flights to the U.S. This period of large migration, so called the external brain-drain, lasted about a decade and resulted in approximately 1,000 Thai doctors staying in the U.S at present.

This rapid external brain-drain prompted the government to enforce a rule in 1967 that every newly enrol medical students who refused to pay high tuition fees must sign contract to work for 3 years in public services after graduation. If they broke the contract they would face a high fine of 120,000 baht, which later on was increased to 400,000 baht in 1973. Due to the high tuition fees and little opportunities for private jobs, most of the medical students signed the contract. This voluntary contract system lasted for 4 years before it was turned into a universal compulsory contract system in 1971. This compulsory contract system continues up till now. The first batch of contracted doctors started their jobs in 1972. It was the time of social transformation which called for high social responsibilities of university graduates. The high social concern during early 1970s, followed by the Alma-Ata declaration of Health For All (HFA), had encouraged a social

environment to support equitable health system.

In 1978 the government targeted a universal coverage of at least one district hospital and one rural health centre in all districts and subdistricts (tambons). This increased the demand for rural health personnel both in quantity and in their optimal quality to serve the rural poor. This movement prompted several measures to improve health services and a distribution of health workforce. Hundreds of new district hospitals were built, the number of medical doctors produced was increased, and curricula of medical education and work in the district hospitals were adjusted to the concept of PHC/HFA. The resolutions of the 4th National Medical Education Conference in 1979 stated that the medical schools should produce basic doctors with the characteristics of being good clinicians, supporters of PHC, administrators, and trainers for the paramedics. A special project for recruiting rural medical students to study in the rural hospitals was also initiated in 1979. The compulsory contract, the economic recession with low growth in the private health sector, and social consciousness movement resulted in the large increase in the number of rural doctors from 300 in 1976 to 1,200 in 1986, a fourfold increase in 10 years. The government then aimed for having at least one doctor in every district hospital.

Although the social consciousness movement continued, the rapid economic growth and the rapid growth of private health sectors in the decade later created a second wave of brain-drain. This time it was internal brain-drain from the rural district and provincial hospitals to the rapidly growing private hospitals. While the number of beds of the district hospitals kept increasing, the number of doctors increased slowly and came to a halt and even decreased during the past decade. On the other hand the number of private hospital beds increased along with the doctors. The number of private hospital doctors increased from less than 1,000 in 1985 to more than 3,000 in 1995.

This internal brain-drain with a severe shortage of doctors in rural public hospitals, prompted the government to seek more financial incentives to attract doctors to work in the public sector especially in the rural districts, and to increase the number of medical doctors produced from 880 per year to 1,200 per year in 1992 and to 1,500 in 1997.

Along with the strategy to solve the shortage of doctors in the rural area, paramedical personnel, who had been produced to work at the health centres since 1936, were also received more attention from the government when the government initiated a long term programme, so called "Decade of Health Centre Development". It was started in the 7th National Health Plan (1992-1006) with the aim to improve the quality of the health centres

in curative activities by providing at least two more health personnel, one of which was a qualified nurse and the other was a dentist assistant.

Meeting health manpower needs in rural areas

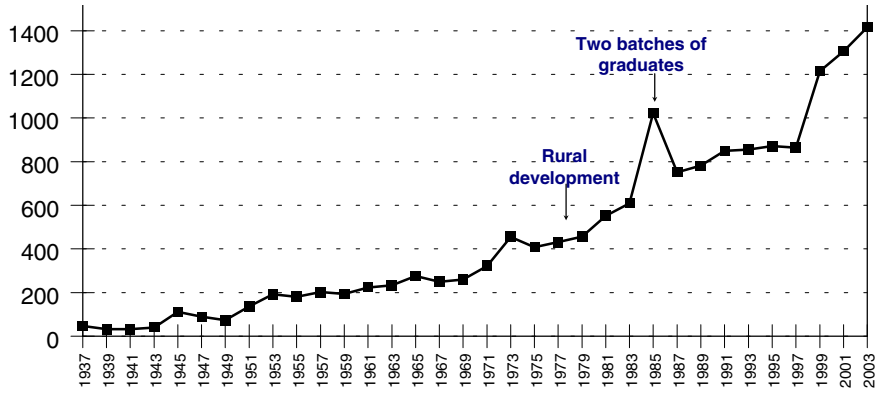
Although the government had tried to meet the health manpower need of rural areas in Thailand, it was very difficult because the problem of health manpower was complex and related to many other problems, such as health infrastructure, the socio-economic situation, the working environment and motivation. There were many attempts to improve the health manpower need in rural areas:

- Increase the production, reorient the curriculum towards rural services, and increase the proportion of rural student recruitment.
- Develop and extend the rural health services
- Improve careers, living conditions, housing for health personnel in district hospitals
- Launch a compulsory service program for every medical doctor, pharmacist, dentist, nurse and junior sanitarian under the Ministry of Public Health scholarship
- Increase financial incentives
- Social transformation and social support

1. INCREASE THE PRODUCTION AND REORIENTED EDUCATIONAL SYSTEMS

To have more available health personnel for public health services, the first step was to increase the production. The number of medical doctors had been increased rapidly since 1960s, and especially during the rural development in 1970s (Figure 5). Most of the health personnel e.g. nurses, junior sanitarians, and dental nurses, were produced by the colleges under the MOPH in response to the expansion of public health services and the external brain-drain. Since 1990, started the internal brain-drain from public to private services, the production of health personnel also had to increase to respond to the demand of both public and private services.

Figure 5: Trends in the number of doctors produced in Thailand



This method was very expensive. The operating cost for production of one medical doctor was 72,000 US$ in 1995. This total cost might go up to double.

To prevent this problem of health personnel distribution and at the same time to supply more health graduates in rural areas, a strategy of rural provincial recruitment and a hometown placement for those graduates from nursing and paramedical schools had been implemented. This contributed to the better distribution of graduated nurses, midwives, junior sanitarians and other paramedics in rural areas, especially in the rural health centres and the district hospitals. They are now the backbone workforce for the rural health service system in Thailand. After being recruited through a provincial selection mechanism which requires provincial residency and an examination, these graduates have to sign contracts with the provincial health office to engage in 2-4 years of public works after graduation. They are graduated from the colleges under the Ministry of Public Health which are distributed throughout the country. They receive free clothing, accommodation, food and study materials during the school years. Practical training programs are carried out mainly in the rural provincial and district hospitals and the rural health centres where they will work after graduation. Thus they can be very familiar with the rural facilities and environments.

This strategy was also introduced in medical schools, but with various degrees of success. In 1978 the first attempt started in one of the central medical schools. Students were recruited from rural provinces by the selection mechanism which includes interviews by provincial health administrators and medical lecturers instead of a general entrance examination. The number of students selected by this mechanism was about 10 - 20 % of

total medical students in each year. They spent the first 3 preclinical (1st-3rd) years in medical schools and the second 3 clinical (4th-6th) years in the designed provincial hospitals. After graduation they were sent to the provinces and districts where they came from. Although they were exempted from high tuition fees, they received no subsidy for food, accommodation, clothing and study materials. This system was expanded to other medical schools during the 1980s with some variations. The students had the same curriculum as general medical students, but during the summer they had to go back to practice and get experience in provincial and districts hospitals in the provinces where they came from. Empirical evidence from the experience of the medical schools indicated that this strategy could increase the rural services of those health graduates. Two thirds of the graduates still worked in the 4th year after the compulsory period (Table 9). The Northeastern medical schools found that if the recruitment wanted to be more effective, the recruited students need to be restricted to those who grew up in the rural areas and exclude those who moved from their residence into rural areas for few years before the enrolment.

Table 9: MERSRAP graduates serving in rural areas, among the 13 batches of 1978-1991

	First 3 years	*Immediately after the first 3 years*
1-9	83%	69%
10	69%	69%
11-13	85%	-

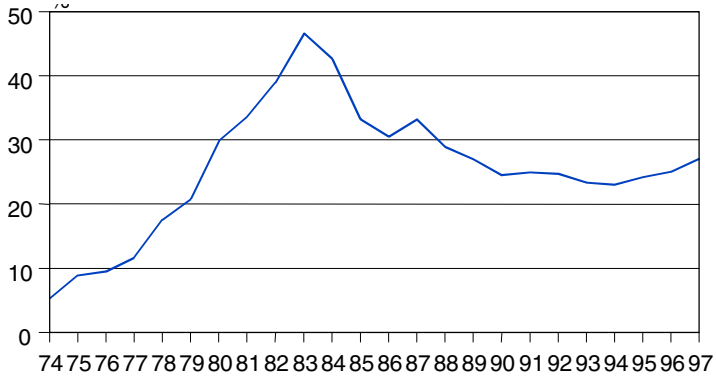
Source: Faculty of Medicine, Chulalongkorn University

However, there had never been any systematic evaluation of its success at the national level. Due to the problem of selection, i.e. some rural areas which were selected were not really rural and the problem of the placement system, i.e. some of graduates could not be placed in their hometown because there were other provinces which have a greater need of doctors, the system was terminated in most central medical schools later. Only three regional medical schools still use this strategy but in different methods. They have special quota of enrolment for the students with the residents in rural provinces in the region where these medical schools are located. There was no provincial mechanism of recruitment and the whole curriculum was the same. There was some success through the course of implementation of this strategy. A study showed that the proportion of rural medical students went up to 47 % in 1983, but it went down to 23 % in 1994 (Figure 3). The later phenomenon might be resulted from the de-

creased attention and concern to the rural areas by the government and the society during that period.

In 1994, the Ministry of Public Health, in response to the internal brain-drain and the severe shortage of doctors in rural areas, proposed a 10-year project (Collaborative Project to Increase Production of Rural Doctors - CIPRD) to produce 300 more doctors annually specifically for rural areas. The students are recruited by transparent and participatory mechanisms at the provinces. They spend 3 pre-clinical years at the medical schools (both central and regional) and the 3 clinical years at 12 regional and district hospitals. They have to sign a contract which requires 3 years of rural public services. This project started to accept 30 students in 1995 and increased to 250 students in 1998. It will later affect a larger proportion of rural medical students. These students will work in rural facilities of MOPH, mainly in their original provinces.

Figure 6: The proportion of students of rural origin



The location of the medical schools in rural provinces is another important strategy to distribute doctors in rural areas. These medical schools act as medical centres in rural areas to support rural doctors and rural health development. If medical schools are located in Bangkok, mostly they will drain doctors from the rural to the central areas. Therefore, "new establishment of medical schools should not be placed in Bangkok" and this was put in the resolution of the 5th National Medical Conference in 1986. The Chiengmai medical school, the Khon-kaen medical school, the Princes Songkhla and the Naresaun medical schools were established in 1969, 1972, 1972 and 1995 consecutively in different parts of Thailand.

Several learning experiences in the medical schools are also used to increase social awareness and responsibilities among the medical students. All medical schools created community medicine programs in their curricula. They send their students to learn community medicines or to gain medical practice experience in rural districts and provincial hospitals for 3-6 months. Some schools try to give them more knowledge and practice e.g. hospital management, community diagnosis and research, to be ready for working in the district hospitals Rural doctors are invited to teach in the medical schools. Some of them also receive honourable Master or Ph.D. degrees from the university.

Experiences in rural public services are a prerequisite for residency training programs. At least one year of rural services is required for most training programs except for rare specialities, e.g. family medicine, pathology, forensic medicine and psychiatry (Table 10).

Table 10: Prerequisite years of working before qualifying for speciality training, 1996

Category	*Years*	*Specialities*
Speciality gr. I	0	8 specialities e.g. general practitioners/family medicine, pathology, forensic, psychiatry etc.
Speciality gr. II	1-3 *	5 specialities, i.e. obstetric/gynaecology, internal medicine, paediatrics, surgery, orthopaedics
Speciality gr. III	1-3 *	13 specialities, e.g. anaesthesiology, rehabilitation, radiology, preventive medicine, neuro-surgery, urology, neurology, haematology etc.
Speciality gr. IV	at least 3 *	3 specialities, i.e. ophthalmology, otorhinolaryngology, dermatology
Speciality gr. V	at least 3*	8 specialities, e.g. thoracic surgery, plastic surgery, cardiology, nephrology etc.

Source: Thai Medical Council, 1996. * Those with a longer period of working years receive higher priority of acceptance.

2. DEVELOPMENT AND EXTENSION OF RURAL HEALTH SERVICES

To distribute health personnel to rural areas, health infrastructures of the rural areas need first to be developed. In 1979 the Thai government started rural health development as a part of integrated development project. This contributed to the shift of resources from urban districts to rural districts and the rapid increase of the number of rural district hospitals.

This rural health infrastructure development forced to increase the annual production of 200 medical students in response to the rural demand and also allowed more equitable distribution of doctors. As a result, the gap of population to doctor ratio among the different regions narrowed. Nevertheless, the distribution of rural hospitals is not well balanced,. The distribution of doctors in the district hospitals and provincial/regional hospitals differs in terms of number and quality which affect to the gap of doctors between in the rural districts and the capital districts in a province. Although there has been an increasing trend in the number of doctors working in the district hospitals, it is much slower than that of provincial hospitals. Therefore the absolute number of doctors in district hospitals is rather stable or very little increase, which often create additional workload of health personnel (Table 11). This increase in workload was one of the driving forces which push district doctors to leave the district hospitals.

Table 11: Workload of doctors in district hospitals, Thailand, 1991-1997

Year	N Doctors	Beds per Doctor Ratio*	Population per Doctor
1991	1,592	8.1	21,870
1992	1,681	8.2	23,456
1993	1,766	8.5	21,617
1994	1,411	11.9	27,689
1995	1,574	11.5	25,227
1996	1,653	na.	24,273
1997	1,665	12.3	24,118

Source: Rural Health Division, MOPH. Beds adjusted by occupancy rate

Apart from the rapid increase of district hospitals in the 7th National Health Plan (1992-1996), the "Decade of Health Centre Development" resulted in the rapid increase of health centres and health personnel in rural areas. This contributed to the larger proportions of out-patients who came to seek services from the health centres when compared to the past which mostly patients chose provincial/regional and district hospitals.

3. IMPROVED CAREERS, LIVING CONDITIONS, AND HOUSING FOR HEALTH PERSONNEL IN THE DISTRICT HOSPITALS

The number of staff at the district level increased, and the district hospitals were staffed with various types of health personnel. So the overall situation of rural health services at the district level improved. This is mainly due to the improved conditions for health personnel in the district hospitals. Staff housing has been built for all the staff in the district hospitals. At the same

time, the government has put large investments for basic infrastructure such as; roads, electricity, water supply, telephone and radio systems; these attempts made rural districts more comfortable place to live in and more attractive to the health personnel. However, the living conditions in most of the rural districts are still very different from those of the central districts in terms of education, communication, and transportation. This is still the limitation of health manpower distribution to rural areas.

The careers of doctors and health staff in district hospitals have been much upgraded. Now the doctors in district hospitals can promote to the same level as those who work in provincial hospitals and the central office of the MOPH. This is also the same for dentists, pharmacists, nurses and paramedical personnel in the health centres.

Logistic supports for drugs and equipment supplies are also greatly improved. Most of the health centres and the district hospitals are now very well equipped. These improved conditions contributed to maintain those who are willing to work in rural area stay longer.

4. THE COMPULSORY SERVICE PROGRAM FOR EVERY MEDICAL DOCTOR, PHARMACIST, DENTIST, NURSE AND JUNIOR SANITARIAN UNDER THE MOPH SCHOLARSHIP

This policy started in 1967 in response to the external brain-drain and the first batch came out in 1972. In the early years, it was a voluntary scheme. The medical students chose to work for three years in the rural public facilities or paid a high tuition fee. If they broke the contract, they would have to pay a high fine of 120,000 baht. Since 1971, this scheme became compulsory for all medical students and the fine was increased to 200,000 and 400,000 baht in 1971 and 1973 respectively.

This strategy, which combined with the rural service expansion and the economic recession with low growth rate of private sector, became the main factor contributing the rapid increase in the number of rural doctors during 1980-1990. This approach of applying compulsory contract later was also used for nurses, midwives, and junior sanitarians under the MOPH, but with different rates of fine. Combined with the provincial recruitment and the placement of these personnel only in the MOPH, this strategy contributed to the better distribution of the health personnel in rural areas. For example, in 1979 there were 17 times more nurses per population in Bangkok than in the Northeast, but in 1987 the ration dropped to 10 and to 6 in 1995.

The compulsory contracts for the medical students and rural health centre personnel later expanded further to cover dentists and pharmacists

in 1984. This also resulted in a better distribution of dentists and pharmacists in the district hospitals. At present, almost all district hospitals have at least one dentist and one pharmacist.

5. FINANCIAL INCENTIVES

In order to give incentives for doctors who delivered rural services, the government started special allowances for district hospital doctors since 1975 and this was improved in 1997 as stated in part of sequential policies.

This had not much given effect to district hospital doctors up till the period of economic growth and the boom of private sectors and more materialistic society. This period had the problem of internal brain-drain from public to private sectors. Before 1991, doctors in provincial hospitals got only salary (same rate as other government officers) and overtime payment which was very low (400 baht/night regardless of workload). Doctors in district hospitals got only salary with the special allowance (2000-2200 baht/month) and they were not allowed to get per diem allowance for travelling. This made the income of public doctors less than private around 3 times up to 10 times according to the type of specialities.

In 1991, the government started to use more financial incentives for those working in district hospitals and provincial hospitals as summarised in table 11. The salary of newly graduated doctors is 226 US$.

This financial incentive can maintain provincial specialist in provincial hospitals not resign for private and also give an effect to district hospital doctors who prefer to work in rural areas work there longer and happier. But it can not lengthening the years of working in district hospitals of most of newly graduates. Most of them worked in districts hospitals for 2-3 years and then they leave for specialist residency training and afterward come back to work in provincial hospitals (bigger and located in central town) not in district hospitals. This dues to the payment rate is no much different for those work longer in district hospitals and no preference for district hospitals more than provincial hospitals. The other important factors are the trend of specialisation. The prestige of specialists is higher than general practitioners/family medicine which is needed for rural hospitals. The value of district hospital doctors is still the second class doctors.

Table 11: Additional payments for health personnel, 1998

Types of Additional Remuneration	*Rates (baht/month)*	*Total Budget per year*	*Sources of Budget*	*Rationale*
1. Administra-	5,600 - 21,000	500- 600	Government	To attract compe-

Types of Additional Remuneration	*Rates (baht/month)*	*Total Budget per year*	*Sources of Budget*	*Rationale*
tive post adjustment		mil. (for both 1 and 2 combined)	budget	tent people to work with the public sector
2. Post adjustment for certain posts or certain types of services[33]	3,500 - 15,600		Government budget	Same as 1 with different rate
3. Supplementary payment for 8 priority medical specialities and certain services	4,000	NA	Hospital revenue	Set by MOPH with concurrence from MOF.
4. Non-private practice compensation for doctors, dentists and pharmacists	10,000	Total 255 mil. From government budget	Government budget with additional budget from hospital revenue	To encourage public servants to dedicate full time to the work in the public services.
5. Monthly supplement for district health system HRH (doctors, pharmacist and dentists, nurses in district hospitals and nurses in health centres	2,000-2,200 for regular district for all except nurses, Level 1 and 2 districts: 10,000-20,000 for doctors and dentists. 5,000-10,000 for pharmacists. 1,000-2,000 for nurses. 2,000 for nurses in health centres	271 mil. for district level and 7.5 mil. for health centre	Government budget	To encourage HRH to work at the district level. First introduced in the mid '70 wit revision of rate and criteria for payment periodically, last revision 1997 with big jump for Level 1 and 2 districts and newly introduced payment for nurses in health centres
6. Flat rate for overtime services	Doctor and dentists 800/8 hr shift	NA	Hospital revenue	latest revision of rate payable as of 12 September 1992.

[33] psychiatric department, drug addict rehabilitation and social medicine

Types of Additional Remuneration	*Rates (baht/month)*	*Total Budget per year*	*Sources of Budget*	*Rationale*
	Pharmacists 500 nurses 400			
7. Night shifts overtime for nurses	RN 200 TN 150 PN 100 per 8 hr. shift	192 mil. for regional and general hospitals. 200 mil. for district hospitals.	Government budget with possibility of hospital revenue supplement	To encourage nurses for the night shift duty in the public hospitals as they tended to go for better paid jobs in the private sector when the previous rate of payment was lower
8. Payment for OPD during extra working hours	Doctors 30/case; Dentists fee schedules; both guaranteed minimum of 100/hour Pharm. 90/hr RN 80/hr TN 60/hr others 50/hr	NA	Hospital revenues	To allow those working in the public services to have better earning from their extra hour work so that they will remain working in the public sector.
9. Fee schedules for surgery during extra working hour	Payment for doctors & surgical team	NA	Hospital revenue	To encourage timely surgical services during emergency and extra hour work

6. *SOCIAL TRANSFORMATION AND SOCIAL SUPPORT*

The 3 years compulsory contracts rapidly increased the new blood of young rural doctors since 1972. This was also the same period of social transformation which called for democracy and high social responsibilities. Therefore, these doctors were educated in this atmosphere which made them had high responsibility to the society and willing to work in rural areas. The society gave high value to those worked in rural areas.

These early rural doctors faced many administrative and logistic problems. They were not trained to be mangers but they had to become hospital directors since the first day of graduation. Many of them unintentionally

breached several government financial rules. Some were cheated by the accountants. and some were suffered from failure in personnel. With pressures from their inexperience in management and inadequate support from the MOPH, they finally set up a society of their own called "The Rural Doctor Society" in 1978 to help each other among rural doctors and to co-operate with the MOPH to solve their problems. The society started several management training, developed management handbooks, and created innovative activities to support rural district doctors, e.g. rural doctor journals/newsletters, study visits to rural hospitals and also other public activities to campaign for health of rural people. In 1982, they also established a "Rural Doctor Foundation". Their activities boosted the crusading spirits among themselves and their pride of belonging to the "rural doctors" group.

The society became widely accepted in the health activities, among medical professionals and by the public. The rural doctors were voted to be of the Medical Council Committee and influenced several change in medical education and residency training to improve doctor distribution. The success of the society boosted the morale of the rural doctors.

Moreover, in 1976 the oldest medical school, Siriraj hospital, established a special annual reward to "the outstanding rural doctor of the year". Several medical school also give recognition for their alumni working outstandingly in the rural districts. Many rural doctors are invited to become full time lecturers in medical school, mainly in the community medicine departments. All these social movement and support encourage the morale of rural doctors and some are lengthening to work in the rural district hospitals.

Discussion and lessons learnt

In Thailand, the geographical distribution of health manpower has much improved and health personnel working in rural districts including community involvement in rural villages has increased in numbers. This confirmed that the strategies of the government reached some achievement. The overall effect of this improving distribution was due to the combined strategies rather than only one single strategy. Moreover, many of these strategies were reactionary strategies in respond to certain crisis rather than being the long term plan. Some of them were fragmented, not well co-ordinated, sometime inconsistent, rarely evaluated systematically and no continuous monitoring system. Therefore, it could not result in the better achievement as expected and some successful result also could not be sustained.

Lessons which could be learned and recommendations which can be proposed to improve the present situation are:

The health care system should be oriented to give priority to primary care, especially those served in rural area, budget and other resources should be allocated to support this development.

The location for the production of health personnel should be in the rural area and there should be specific manpower recruitment of students with working conditions after graduate which favour the fulfilment of health manpower in the rural area, these are measures proved to be effective in mobilising manpower to work in the rural area.

There is a need to reform the attitude of health manpower towards rural health care development, starting from the level of education to continuous training, including creating favourable environment which will promote their work at the primary care level in rural areas.

Financial incentives including some other social support, for examples; high prestige for those who work in rural areas, have proved to be favourable condition which could bring health manpower to stay longer in rural areas, this should be maintained and adapted properly in the future.

To make the availability of health manpower possible, the availability of health infrastructure to maintain and support their function is one of the pre-conditions to guarantee the success.

The efficiency of the planning, co-ordination, and systematic monitoring and evaluation system are the key of success in implementing strategy to solve health manpower shortage in rural areas.

The main constraint to the solution of health manpower shortage in rural area is the inequitable socio-economic development of rural compare to urban area, without solving this problem of disparity between rural and urban areas. It is very difficult to expect the success of the implementation in the long term.

Health sector reform and human resources in Bolivia: the perspective of an NGO

Carlos J. Cuéllar

The crisis of the early 1980s

From 1980 to 1985 Bolivia suffered a profound economic crisis which resulted in a severe recession that has eroded the Bolivian Government's ability to adequately finance the health sector, and has fundamentally changed the financing of the Ministry of Health.

During this period democracy was restored after years of military dictatorship. In October 1982 a democratically elected government took office. This coalition government had difficulty controlling political parties and trade unions as these exercised their rights in this new democracy. The government rapidly gave in to political pressure. In the meantime the unstable internal situation combined with the regional crisis of the 1980s produced a hyperinflation process. This reached a record inflation rate of 40,000% at the end of 1984. This led to a significant deterioration of the Social Sector. MOH per capita expenditures dropped to 38 percent of their 1980 levels. MOH no longer had the means to provide free services to the extend it had done before. The public sector was forced to institute a fee system. By 1987, 88 percent of all MOH funds were spent on personnel, leaving a meagre 12 per cent for all non personnel costs such as supplies, equipment, materials and drugs. Nevertheless, public salaries fell by an average of 43 percent in real terms during the 1980s. This resulted in a high rate of absenteeism and tardiness, an average annual staff turnover rate of

30 percent, and a cut in the official work day from eight to six hours.

Although no formal studies on the subject are available, it is safe to say that the quality of the care provided suffered significantly in the eyes of the public. Poor motivation and dissatisfaction of employees was one important cause of all this. An important segment of the population started to look for affordable alternatives to satisfy their health needs.

The new democratic government succeeded in efforts to re-establish democracy but failed to manage the economy of the country. On August 28, 1985 the new government passed a law that changed the structure of the economy from a centrally planned, heavily subsidised economy to that of a free market. As part of this new economic order, adjustments in the structure and the role of the state were implemented. These included a reduction of the number of public employees and elimination of subsidies. At the end of 1985 the crisis was so profound that it forced the President to shorten his presidential term by one year to allow a democratic succession. Partly as a consequence of this crisis, new problems and realities effected the Bolivian situation: migration to cities, demographic transition, and new diseases such as cholera and AIDS.

The results of this process were the introduction of new paradigms in the Bolivian Society and its health sector. There was a new emphasis on local realities: decentralisation and reallocation of resources. The social sector modernised and new structures and roles for MOH were defined. The scarce resources were concentrated on priority problems. Central government contributions decreased due to implementation of fee-for-service schemes and insurance plans for maternal and child care. There were new incentives to the private sector to develop into providers of public services, with increased competition among providers, better awareness of high quality services, and the emergence of prepaid and health insurance schemes. External Aid now focused on results and sustainability of cost-effective interventions.

The 1989 health sector reform

In practice, all these structural changes developed into the so-called Health Sector Reform that started in 1989. The main characteristics to date include: further decentralisation; enhanced community involvement; more action by new public and private entities: municipalities, local governments, NGOs and private providers; improved targeting of health provisions: insurance schemes and subsidies for cost-effective interventions; increased

strategies for sustainability: building capacity of local organisations, innovative financial mechanisms; separation of the finance and service provision functions and changes in the governance by the state.

Once the contents and strategies of the needed reform had been decided, it became evident that something important was missing: human resources. Who would implement HSR? What would motivate people to undertake the reforms? What kind of participation should they have in the decision-making? What kind of training and skills would they need to effectively participate?

There was no escaping from the fact that the **existing** human resources would largely be responsible for implementing all the changes necessitated by the reform. Questions about motivation, participation, training, and skills remained unanswered simply because human resources were assumed as "obvious" in the planing phase of the HSR.

In 1989 a survey conducted by the Ministry of Health among Bolivian public health professionals[34] listed the main human resource issues in order of importance:

- Selection and recruitment
- Equal job opportunity
- Job stability
- Compliance with labour laws
- Working conditions for performance
- Participation in decision making
- Training opportunities
- Career opportunities
- Compensation and incentives
- Unionisation

It is not surprising that selection and job stability enjoy higher ranking than compensation and incentives. The reason is simply because public health professionals are heavily affected by political changes in a country were political instability is a constant.

On the basis of this list of concerns, the study compared the performance of the government, the donors and NGOs as employers.

THE GOVERNMENT AS EMPLOYER. The government continued to base selection and recruitment on friendship and/or political affiliation. The influence of trade unions usually interfered with any effort to improve the system. Jobs were unstable, particularly because of the frequent political

[34] Most Bolivian health professionals work in the public sector and use their private practice as a complementary source of revenue.

changes. Government consistently failed to comply with its own labour laws. There were fewer career opportunities, low salaries and incentives, and poor work performance conditions. On the other hand, there were many decision-making opportunities and good training opportunities for obtaining degrees.

LOCAL NGOS AS EMPLOYERS. Local NGOs were more systematic and objective in selection and recruitment, but depended heavily on budget constraints. Trade unions did not interfere. Stability was contingent on project duration and financial possibilities. The NGOs were compliant with labour laws, offered better career opportunities, relatively good salaries and incentives and better opportunities for decision making. Work performance conditions were good, but there were no training opportunities for obtaining degrees;

DONORS AS EMPLOYERS. Donors had a selection and recruitment process designed to maximise a limited market. No trade unions were permitted. Stability was contingent to project duration. Donors were compliant with labour laws. They offered fewer career opportunities but good salaries and incentives. There was little room for decision making, and no opportunities to train for a degree, but conditions for working performance were good within the limits of the projects.

Coping mechanisms

Over the course of the last twelve years there has been an increase in changes to both the overall context and the health sector. The structural adjustments to macroeconomic policies led to dramatic and sudden changes that affected the health sector and, therefore, health personnel. The mechanisms to cope with this new environment varied according the employer incentives and perspectives. Government, donors and local NGOs were forced to emphasise efficiency and short term results in order to be consistent with the new order. Each designed and implemented different human resources policies that did not necessarily respond to the health sector reform's long term objectives.

The Government created special units to deal with reform. Highly qualified personnel are now paid with donor funds or resources from loans. Topping-up is common but still underground. The creation of parallel bureaucracies contradicts the ability to strengthen the public sector.

Local NGOs maximised compensation to keep highly qualified person-

nel, but their number was reduced. There was increased pressure from donors to get results, and management was often unable to face the change.

The Donors organised their recruiting system in response to market competitiveness, with high compensation to keep and attract highly qualified personnel, and topping-up practices to ensure public health key personnel inputs. The consequence was an increased capacity to provide short-term results.

Lessons learnt

Changes in policies and practices are necessary in all institutional actors of the reform. Human resources are the driving force for change. The change in the health scene should be accomplished with essentially the existing staff, but without leaving them to free-market forces. Open competition for human resources among donors results in long term weakness of the health sector. Strengthening of the state is a necessary step to insure success of HSR efforts, but attaining an effective state requires an alliance between civil society and co-operating partners. The regulatory function is inherent to the modern state and should be supported by donors. The state must not regulate less, but better. The problem of having qualified human resources for conducting the reform exemplifies this.

Performance management and health care reform in Guatemala

Angel Sanchez Viesca, Enrique Rodriguez Enriquez and Leiser Silva Sical

Framework

The conceptual framework that we have adopted to make sense of the reform process in Guatemala stems from two conceptual proposals, one by Pettigrew[35], the other by Katz and Green. To study organisational change, Pettigrew proposes an approach called contextualism. This considers organisational change as influenced not by internal processes but also by context. In analysing the reform of the health sector in Guatemala we focus on the series of events and particularly on the processes within organisations. Those processes occur in a political, social and economic context.

The management performance was approached by drawing oil the work

[35] Mumford, E. and A M. Pettigrew (1975) Implementing strategic decision. London. Longman. Pettigrew, A.M. (1977a) The, creation of organisational cultures. European Institute for advanced studies in management. Pettigrew, A.M. (1977b) Strategy formulation as a political process. International studies of management and organisation. 2(2): 78-87. Pettigrew, A.M. The politics of organisational change. The human side of information processing. N. Bjorn-Andersen. Amsterdam. Elsevier North-Holland: 39-47 Pettigrew, A.M. (1985) Contextualist research and the study of organisational change process. Research methods in information systems. E. Mumford. Amsterdam. Elsevier Science Publisher. 53-78. Pettigrew, A., E. Ferlie et al. (1992) Shaping strategic change. London., Sage Publications.

of Katz and Green[36] They propose a model called *'The Blue Print For Performance Management'*. This framework centres on what the authors call three domains: service, practice and governance. Furthermore, the blue print model suggests that in studying organisations researchers should focus on three levels of analysis, structure, outcome and process. This will allow us to describe management performance in those terms. In building our theoretical framework (Table 12) we have combined these two models to describe and analyse the reform of the health sector in Guatemala. The way we interpret our model is by regarding context as composed mainly of structure and governance while processes comprise principally services, practices and outcomes.

Table 12. Conceptual Framework

	Context	*Process*
Incentives	Peace agreement	Acquisition of pharmaceuticals
Disincentives	Lack of social and community participation	Lack of a normative frame for medical practice

We attempt to link the context and processes of the reform with management performance. In this case we see the influence of context and process on management performance in terms of incentives and incentives. For example, in considering context we regard as incentives some structural changes such as the peace agreement while we think of lack of social and community participation as a disincentive. We believe that the enhancement of the administrative processes for acquiring medicaments have had the effect of incentives for management of health services providers. However, as will be discussed with more detail in the sections below the lack of a normative frame for medical practice have hindered the management of the organisations involved in the Health sector.

Incentives and disincentives for performance

CONTEXT: INCENTIVES

The RSS starts in 1995 as the result of several factors, economic, financial,

[36] Katz, J and E Green. (1998). Management Quality. A Guide to system-wide performance management in Health Care. Second Ed. Pp,. 29-31

political, ideological and epidemiological.[37] In this context a loan with the Interamerican Development Bank (BID) was subscribed,[38] the origin of the *Programa de Mejoramiento de los Services de Salud* (PMSS, Program of Improvement of Health Services). In 1996 a new government was installed. This affected not only the contractual terms of the PMSS but also its mission, philosophy, policies and goals.[39]

The changes of the UMSS occurred according to the new plans of the government[40] and the political and social processes implied by the Peace Agreement that provided strategic and programmatic guidelines.[41]

As the result of analysing the health situation, the RSS has formulated objective image for the year- 2000 that is to deliver-. *"an integrated Health sector oriented to the improvement of the health conditions of the Guatemalan population within a participative planning process. with au efficient and effective offer of health services. with a Ministry of health regulating and ruling the health sector. and with a public expenditure tending to the permanent increase oriented towards populations at biological risk and favouring social auditing, community participation and a decentralised managerial and delivery of health services systems with the participation of public and private actors".*[42]

The PMSS organises the RSS according to three strategic and programmatic guidelines of actions- (1) The reorganisation of the central level of the Ministry of Health. (2) The extending of health set-vices coverage. (3) The reorganisation of the Hospital system.[43]

As preliminary results regarding context that favours the current processes it is worth to mention the approval of the new Guatemalan Health Code in October 1997. Among other things the code gives form to the organisation of a new model for- the delivery of health services and establishes the basis for health regulation as well as social and community participation. Furthermore, it establishes new modalities for the funding of health and the basis for- integrating the health sector audits institutions.[44]

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[37] Finkelman, Jacobo et al. (1997). Transformacion del Sector Salud en Guatemala. OPS/OMS. 98 p.
[38] MSPAS. Convenio Gobierno-BID. (1995). Proyecto de Mejoramiento de los Services de Salud. Documentos originales.
[39] Guatemala, MUSAS. 1996. Proyecto PMSS.
[40] Guatemala. Programa de Gobierno 2000. (Junio 1996). Secretaria General de Planificacion. Pp. 66-80.
[41] Guatemala. Acuerdos de Paz. (1996). Acuerdos socioeconomicos.
[42] Guatemala. MSPAS. (Junio 1997). Lineamientos policos, estrateficos y programaticos para la Reforma del Sector Salud en Guatemala. Fotocopia. P.30
[43] Guatemala . MSPAS. PMSS. (1997-1998). Evaluaciones semestrales.
[44] Guatemala. Congreso de la Repubica. (1997). Codigo de Salud. Decreto 90-97.

At the same time the government issued a new law for the executive power that in allow the Ministry of Health to be internally reorganised accordingly to the Health Code.[45]

The process of extending the coverage of the primary health services has been favoured by the incorporating *Prestadoras de Services de Salud* (health service providers) and *Administradoras de Services de Salud* (health services administrators) which are non-lucrative private organisations. As a result of this strategy it is expected that at the end of 1998 the total of inhabitants with access to health services would be increased in 20%.[46] This is remarkable taking into account that the population with access to health services, reaches a 46%.

Public funding for health has been increased in 32% between 1995 and 1997.[47] This has favoured the process of extending the coverage of health services through the hiring of *Prestadoras* and *Administradoras* that have cost to government approximately 57 million of Quetzals (US$9 million)[48].

As a result of international co-operation the Ministry of health has increased its financial resources. The amount and execution of the funds shall be evaluated in the future.

The surveillance of the compliance of the peace agreements has been a contextual incentive for the development of the RSS. The effect of this should be evaluated later particularly in its implications on social and financial policies. Finally It is worth to mention the participation in this process of institutions such as La Procurador de Derechos Humanos (human rights agency) and other private organisations.

It is worth to mention that in the period of 1997 and 1998 a salary increase has been approved. This amounts to approximately 60%. Finally, there has been an increase in the number of professional nurses.[49]

CONTEXT: DISINCENTIVES

The country continues showing a health situation characterised by persistent double epidemiological profile. On the one hand poor people suffer

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12 dic. 167 p.

[45] Guatemala. Diario de Centroamerica. Ley del organismo ejecutivo. Decreto 114-96.

[46] Guatemala. PMSS. Informe Evaluativo del primer semestre de 1998. Fotocopia.

[47] Guatemala. MSPAS. (Julio 1998). Avances en el cumplimiento de los compromisos de Paz.

[48] Guatemala. MSPAS. (1998). Informe de la Gerencia Administrativo-financiera. Sept.

[49] Guatemala. MSPAS. (1998). Direccion de Recursos Humanos. Informe.

most of the diseases and under-development. On the other hand the delivery of Health services is disorganised and fragmented. This causes low coverage, non-access of population to health services and an inappropriate orientation of public spending on health matters.[50]

In 1998 the tendency in the increase of the Ministry of Health stopped. Currently there is a trend to increase the budget of the Ministry of Health and the structure of the spending does not agree with the primary Health care programs.[51]

The integration and co-ordination of the Ministry of Health with other organisations and institutions of the health sector such as the Social Security (IGSS) have not been yet reached as it was expressed in the strategic planning.[52]

In the area of human resources it is noticeable that for years there is a deficit in the amount and quality of professionals and technicians to answer what is required for the organisations and the delivery of services. Furthermore, there is still the tendency of human resources working for the Ministry that after while obtain a job in other organisations, mainly the private sector that most of the times offer better work conditions and better salary.[53] This factor must be taken into account when analysing workers participation in the RSS, since according to some actors the degree of involvement and commitment is not yet satisfactory.

The policy of social and community participation in the processes of planning, management, monitoring and evaluation of the RS S are not yet fully developed.[54] This is definitively an area of further research. But one should note the involvement of NGOs in the delivery of health care.

It is also worth mentioning that there is a lack of proposals regarding the implementation and compliance of government health by other political and social actors such as trade unions, universities, professional associations and political parties. This again would an interesting issue for further research.

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[50] Guatemala. MSPAS. Lineamientos politicos, estrategicos y programticos. Op. Cit.
[51] Guatemala. MSPAS. (Julio. 1998). Informe de cumplimiento de los compromisos de Paz.
[52] Guatemala. MSPAS. (1997). Plan estrategico conjunto para la atencion de la poblacion guatemalteca. Fotocopia.
[53] Guatemala. MSPAS. (1997). Plan estrategico de desarrollo de los Recursos Humanos en Salud.
[54] MSPAS. Politicas, etrategias y logros. (1996-1998). Fotocopia.

PROCESS-INCENTIVES

In conduction the RSS and to support managerial and delivery of services actions, the Ministry of Health has decided to incorporate technical assistance and bias hired professionals of very high calibre. These have supported both the central and the operational level.

The central level of the Ministry of health has experienced new processes towards the decentralisation and disconcertion of technical, financial and administrative actions. Furthermore, there are initiatives to implement modern systems in different areas such as finance, administration, management, epidemiological, surveillance, the acquisition and procurement of both medicaments and other products and management of human resources.[55]

The Integrated System of Financial Administration (*Sistema integrado de Administracion Financiera SIAF*) has been instrumental in the processes of decentralisation and desconcentration of financial resources from the central level of the Ministry of Health to the local health areas. The processes that have been decentralised thanks to the SIAF are.- the provision of goods and services, procurement of medicaments and other goods such as 'open contracts'. The latter is a modality that allows the buying of some medicaments without tendering. This has favoured the reduction lit the spending. Furthermore, the Ministry of health, in order to reduce spending, has decided to procure medicaments Jointly with the Social Security.[56]

Among other ongoing process are: the signing of managerial commitments between the central level of the Ministry of health and the local operational level (*areas de salud*); the strengthening of the capacity of the local for analysing and making sense of information, the creation Of the position of managers for the administrative and financial functions in health services and the initiative to provide incentives to managers of local services.

Other meaningful managerial process is the development of a management information system. This system is composed of several modules, yet the only one being implemented now is that of health statistics which also reports the production of health services.

There have been achievements in developing human resources. The University of San Carlos, the national university, is about to recognise four qualifications a technical level.. laboratory, X-rays, radiology and physiotherapy. Likewise, the national university is reviewing a new course for professional nurses, The Ministry of health is sponsoring and carrying out a

[55] Guatemala. MSPAS. Politicas., estrategias y. logros. Op. Cit.
[56] Loc. cit.

course for technicians in anaesthesia. A private university, the Universidad Rafael Landivar, has opened a new faculty devoted to health sciences. This increases the offer of education for those who would like to pursue a career as health professionals or technicians. Finally, the Ministry of Health is also supporting a strategy that win train its personnel while they are performing their duties.

PROCESS: DISINCENTIVES

It has begun a process for the yearly programming of activities for hospitals and regional offices. However, this process has not resulted in developing strategic thinking and acting at the local level.

The management information system still lacks fundamental modules such as those of human resources, administration, finance and medicaments.[57]

There is an initiative to restructure the organisation of the Ministry of health.[58] Although there is a proposal for the new organisation and regulations these have not been implemented yet. This has created avoid between the new and the old organisation. As a consequence ad-hoc forms of organisation has taken place. The problem is that these are in the process of being institutionalised so those involved in these ad-hoc structures are resisting the implementation of the new organisational chart and regulations. Furthermore, the metaphor to describe the organisation structure would be that of a feudal system, in which each Lord only bothers with what happens within his feud disregarding the collective goals. Thus administrative and managerial processes tend to be vertical, fragmented and disintegrated.

There has been also an attempt to design and to implement technical norms for treating different health problems. Likewise there have been a process to elaborate and implement protocols for primary health care and those treatments offered in hospitals.[59] However, both the technical norms and protocols have neither been standardised nor completed. These obviously can se uncertainty and confusion when treating and facing either traditional or newly emerged diseases such as diarrhoea or cholera as well as tuberculosis and HIV.

The delivery of primary health services through the strategy of hiring PSSs has meant a change in the way health services are administrated.

[57] Silva. Leiser. Propucsta de Plan para los sistemas de in forinaci6n del MSPAS. Fotocopia. 35 P.
[58] Guatemala. MSPAS. (4 agosto de 1998). Reglamento organico interno del MSPAS. Propuesta sujeta a aprobaci6n. Guatemala. Fotocopia. 43 p.
[59] Guatemala. MSPAS. Politicas, estrategias, y logros. Op. Cit.

These changes and transformations have not been properly interpreted or adopted by workers of those health services that provide primary health care. Moreover, in the process of implementing this strategy two important factors were looked over: the experience of those public workers at the local level and the reorganisation of the Ministry of health as it was mentioned above. In addition the because of this strategy some asymmetries in salaries have occurred. For example, two workers doing the same job may receive very different salaries, those hired by the PSS earn significantly more than public workers. Without any doubt these are issues that have to be studied in the long and short term.

The issues that act as incentives for both context and processes allow us identify different possibilities for the development and implementation of the RSS in Guatemala. Those issues that were regarded as disincentives should be a matter of careful consideration in order to adopt corrective measures.

Managing staff performance in Guatemala

Walter G. Flores M.

The purpose of this study was to document how different service delivery organisations try to manage and improve the performance of their staff. The specific objective was to identify methods used to measure, monitoring and enhancing staff performance in one private organisation and one public organisation working in the health sector.

Two organisations in Guatemala, one private and one public were selected for this study. The organisation's interest for the topic and willingness to provide information were the main factors that influenced the selection. Respondents were selected on basis of their relation with the organisation's performance management system/process. Research methods used include individual semi-structured interviews and document analysis.

The private organisation

The organisation studied is the national branch of an international non-governmental organisation working in development in more than 45 countries world-wide. It has 350 employees and it is the largest private organisation working in the development field.

TOOLS USED TO ASSESS PERFORMANCE. The organisation has been implementing a formal performance management system for the last 4 years. This system is used in most of the 45 countries where the organisation has a presence. It contains three tools that are used to measure staff performance.

THE JOB DESCRIPTION: every employee has a description of his/her position which includes a summary of the job purpose, the responsibilities and tasks, the key contacts and relationships, the levels of authority and autonomy, the required competencies, the educational and experiential qualifications and the reporting relationship. The job description is the starting point for determining the time-bound activities in a performance plan.

THE INDIVIDUAL OPERATING PLAN (IOP): this is the individual's action plan. An individual IOP has two major sections: (a) Prioritised Objectives and Activities (i.e. specific, time-bound actions which are directly related to the fulfilment of the job responsibilities, as well as new initiatives which may be agreed by the supervisor and employee); (b) Personal Professional Development Objectives and Activities (i.e. activities intended to expand or improve skills and abilities required in the position). All goals contained in the IOP are defined in mutual agreement between the employee and his/her supervisor at the beginning of every fiscal year. It gives a sense of ownership and responsibility towards those goals. Theoretically, there is a cascade process to identify the key goals that should be included in the IOP. For example, the organisation has a five years strategic plan. From this plan, every project defines an annual operation plan (AOP) that should include the strategic goals of the organisation and the specific goals of service delivery agreed with donors. Every staff should have in turn his/her goals in concordance with his/her project AOP

THE ANNUAL PERFORMANCE APPRAISAL (APA): every supervisor must evaluate each staff under his/her supervision individually. The annual appraisal is carried-out using a specific format. This format evaluates performance in three key areas: (a) achievements of results in relation to one's IOP; (b) performance of key organisation-wide competencies (leaderships, problem solving, organising, planning and others.) and (c) fulfilment of primary job responsibilities. The criteria to evaluate the above key areas are results-oriented and behaviourally based. Individuals are being appraised on what they produce and on the overall impact "outputs" or achievements of their effort, as well as on verifiable behaviours and actions which define qualities like "creativity", "initiative", "dependability".

Despite the use of these tools there are still some gaps and issues that are not properly solved by their use. This situation is particularly evidenced in the projects where the purpose is to strengthen and develop public health services by the provision of technical assistance. This implies a change in the kind of service delivered by the organisation: from direct provision of health care (whereas the client is a consumer of health care), towards the provision of technical assistance (whereas the client is another health

worker from the public sector). The main limitation is that this change has not been reflected in the goals / indicators of the IOP. The lack of the appropriate indicators to measure the performance of those who deliver technical assistance has had some negative effects.

It is also important to note that to make a proper use of the IOP, the supervisors and their staff must have a good sense of the relationship between inputs-outputs-outcomes. Without this sense of planning, the goals and indicators included in the IOP are not realistic and in many case over-optimistic.

The lack of a systematic process to collect information on staff's performance along the year results in biases during performance appraisal. These biases diminish the credibility of the annual appraisal.

Another important limitation of the current tools to measure performance is that it appraises individual work only. This is an issue for those projects whose products are highly dependent on teamwork and for those whose main activity is to deliver technical assistance. Transferring abilities for teamwork and co-ordination are essential in any programme of institutional strengthening and development. One should question whether the organisation could appropriately transfer this kind of abilities when they are not formally reinforced within the organisation itself.

MONITORING STAFF PERFORMANCE. Consistent supervision, coaching and mentoring are the mechanisms that the organisation's PMS requires to carry out an appropriate monitoring of staff performance. However, ongoing monitoring becomes complicated in practice because it requires specific abilities that many supervisors either do not have or have not properly developed yet (i.e. problem analysis, effective feedback, planning, counselling and listening). This situation has resulted in supervision, coaching and mentoring not being as systematic as it is expected.

ENHANCING STAFF PERFORMANCE. The provision of training is the most used mechanisms within the organisation to influence staff performance. Training provided by the organisation to staff is of several types and for different purposes (skill development, training towards technical qualifications and as a prize) and offered either locally or internationally. However, there is not a clear criterian within the organisation regarding when and how to provide such training. Interviewees reported that training is sometimes provided in contradictory situations.

The systems also regulate performance-related payment (PRP) as a reward to enhance performance. Nonetheless, implementing it has had sev-

eral unwanted effects to the point that neither managers, nor staff is supportive of such mechanism. This is why the organisation has been reducing the importance of PRP in the decision of annual increments on salary.

BENEFITS/USE OF PMS WITHIN THE ORGANISATION. As far as known, the information produced by the organisation's performance management system has had four concrete and verifiable uses: (1) main input to define an annual training plan for the staff, (2) key criteria to decide promotions within the organisation (high performance), (3) criteria to end up an employee's contract with the organisation (low performance) (4) one of the variables taken into account to decide annual increments on salary. Despite the above, it is still uncertain how PMS has contributed to the organisation's effectiveness. However, all staff interviewed said that they think that performance management is important and that they strongly support its implementation within the organisation.

The public organisation

The other organisation we studied was the Ministry of Health (MOH). It has more than 20,000 employees and it is the main provider of health services within the country. The MOH does not have a performance management system reward, the sanctions are not regulated. Nonetheless, interviewees mentioned several tools and mechanisms that are used to manage the staff performance.

TOOLS USED TO ASSESS PERFORMANCE. There are monthly reports of health service delivery: immunisation coverage, number of deliveries attended, etc. However, this tool is not considered effective for measuring the performance of staff because not all staff elaborates monthly reports. Whenever there is more than two staff of the same category in a health facility (more than two nurses for instance), only one, usually the most senior, submits reports.

Performance is also monitored during field supervisions in the health posts and health centres. However, there are many health facilities that are not visited as often as needed.

Supervisors use the provision of basic resources to carry out fieldwork (petrol, per-diem, training and in some cases vehicles) to enhance staff performance. The field staff identifies the availability of basic resources to carry out fieldwork as the main factor influencing their performance. How-

ever, the connection between the provision of resources to carry out fieldwork as a reward and the expected performance is not clear. Sometimes resources are offered because a district has a low coverage of health services. Other district may develop considerable lobbying and pressure to receive resources. In general, basic resources to carry out fieldwork are not allocated to staff as a reward for good performance.

Conclusions, emerging issues and concerns

The two case studies show that the availability of resources is considered a key influence on staff performance. Providing resources to carry out fieldwork and a salary that is competitive within a national labour market were perceived as having the greatest influence on the staff performed. In the case of the public organisation, performance of staff seemed predominantly affected by the availability of basic resources to carryout fieldwork. Therefore, assuring a minimum of resources for staff in the public sector appears to be a more basic requisite than implementing a PMS itself. Nonetheless, some performance appraisal mechanisms can be well combined with the delivery of the above resources. For example, new vehicles and *per diem* can be implemented along with the commitment from employees to use the individual operating plan. Using the provision of basic resources as a reward to enhance performance (as in case of the public organisation) is an issue that has several inconsistencies and it is prone to the development of pervasive incentives because the reward in itself should not determine the ability to achieve a goal.

Job description and the individual operating plan are two tools that can help to clarify expected performance and objectify accountability among staff. However, its implementation is not straightforward and requires specific analytical and planning skills from both supervisors and supervised. Job descriptions should have a margin of flexibility to respond to the particular characteristic of health districts. Having a balance between appraising individual and teamwork performance needs to be addressed.

Supervision is a key element of performance management. Therefore, any process implemented must assure that the supervision is carried out effectively and systematically. Availability of qualified staff to administer the performance management system is essential. The case on the private organisation showed that implementing a performance management process requires basic skills from supervisors. Developing those skills may not always be easy. The provision of training aimed at developing skills in effective su-

pervision and human resources management can have potential benefits in supporting the staff performance management process.

The performance management system is usually led by Human Resources departments/divisions. This is not the case for the public organisation studied here.

Due to the decentralisation policy that is underway in Guatemala, it is expected that any managerial process, including human resource management and performance appraisal should be organised and overseen by the regional directors. However, the scarcity of qualified and trained staff in performance management is already a matter of concern.

Performance management in the Portuguese National Health Service

Aldina Gonçalves, Maria Claudia Conceição, Isabel Craveiro and Paulo Ferrinho

Introduction

"Performance management" is a concept that started to appear more frequently in the management literature in the mid-1990s, but has only rarely been associated with the management of professionals in public sector health care services and institutions. The performance management concept has been associated principally with job-satisfaction of professionals and, in some contexts, improvement in indicators of performance. But the application of the concept to public sector professionals has been hampered by a lack of conceptual clarity on one hand and by poor documentation of its effectiveness, particularly in service-oriented institutions, such as health care services, on the other.

Performance management can be broadly understood as behaviour at work that is dependent on knowledge, motivation, skills and opportunities and with consequences that go beyond productivity. Using this definition, there is some evidence that performance management may, on a small scale, and in the private or quasi-public health care institutions result in performance gains. It may even work in the public sector of the developing countries if attention is paid to the process – it should be participatory and if the focus remains on the patient-clinician interface.

On the other hand, the evidence is that under conditions of extreme

resource constraints, as it is the case in the public sector of many developing countries, performance management *as an isolated intervention* is not the most appropriate intervention.

Portugal is a country where the National Health Service is a relatively recent institution (late 1970s). As part of development of the Portuguese National Health Service, health centres (HC) first made their appearance in the early 1970s, and the family physician in the early 1980s. Until recently Primary health care services were managed as a central vertical programme, in parallel with another vertical programme, hospital services. It is only in the last five years that a major effort is being made to merge all directorates in a single one, which acts as a central focal point of policies, strategies, norms, and guidelines to be adapted and implemented by decentralised Regional Health Authorities (RHA) – five in total. These RHA will in future co-ordinate and supervise the activities of the district health care services (*Sistemas Locais de Saúde)*, where HC and district hospital services will be managed by a single district health authority (DHA). The budgets for these DHA and their associated health care services will be negotiated with Region based *Agências de Acompanhamento*, according to explicit objectives, criteria and indicators. At the moment there are only five functioning DHA, one of which in the region where the study reported here took place.

Literature review

The first step in this study was a review of the literature available on staff performance in Portugal, in the Portuguese language. Since performance is dependent on knowledge, motivation, skills, and opportunities, and with consequences that go beyond productivity, we extended the search to articles on motivation, job satisfaction, stress and burn-out of health personnel and quality of services.

Some journals were searched manually for the period 1993-1998[60].

[60] The journals searched manually included: Acta Médica Portuguesa (Portuguese Medical Journal); Acta Pediátrica Portuguesa (Portuguese Pediatric Journal); Arquivos do Instituto Nacional de Saúde (Archives Of The National Institute Of Health, Portugal); Cadernos de Saúde Pública (Journal Of Public Health Of Rio De Janeiro, Brazil); Coimbra Médica (Journal Of The Health Administration Of Coimbra, Portugal); Enfermagem (Nursing, Journal Of The Portuguese Nursing Association); Enfermagem em Foco (Focus On Nursing, Journal Of The Portuguese Nursing Trade Union); Entre Tanto: ARS Do Norte (In The Meantime Time, Journal Of The Health Administration Of The North Of Portugal); Reflectir Saúde

Relevant bibliographic references in the articles identified during the manual search were obtained for review. In addition to this, the MSDGSA data base of the *Direcção Geral de Saúde - Ministério da Saúde* (Ministry of health), which includes Portuguese titles and authors since 1988, was searched for relevant keywords[61]. Lastly, the data base of the *Escola Nacional de Saúde Pública de Lisboa* (National School of Public Health, Lisboa) was also searched. This data base includes all the titles and authors available in the library of this school. It also includes the dissertations submitted as a partial requirement for post-graduation courses in Public Health, Hospital Administration and Occupational Medicine. A great number of these works were "missing" or not available[62].

Most of the literature found is about the Portuguese situation. No African papers in the Portuguese language were found. Some Brazilian publications and articles were found and are included. Not all articles are research reports. Also included are review articles that characterise the human resources situation in Portugal and Brazil.

All works found are about health problems in the public sector. When the private sector is referred to it is to remind us that human resources are shared by both sectors and that the relationship between the two is not clarified. However, the impact of this overlap on performance of health personnel has so far never been studied and reported upon.

We did not find original articles on methods of assessing performance. The research work reviewed here is mostly descriptive, frequently without clarifying the underlying theoretical model. None of the articles refers to interventions resulting from the findings.

The Portuguese health care system is characterised by a shortage of nurses relative to doctors, but with doctors showing the greatest maldistribution of all health human resources. These imbalances and contribute to poor performance in the public sector that is compounded by a legal frame-

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(To Reflect On Health, Journal Of The Health Administration Of Setubal, Portugal); Revista Portuguesa de Clinica Geral (Portuguese Journal On Family Medicine); Revista Portuguesa de Pediatria (Portuguese Journal Of Paedriatics); Revista de Saúde Pública (Journal Of Public Health Of São Paulo, Brazil); Saúde Infantil (Child Health, Journal Of Paediatrics Of The Paediatric Hospital Of Coimbra, Portugal); Sinais Vitais (Vital Signs, Nursing Journal).

[61] These included: recursos humanos, motivação, desempenho, satisfação profissional, satisfação dos utentes (human resources, motivation, performance, job satisfaction, patient satisfaction).

[62] Key words: *recursos humanos, satisfação profissional, satisfação dos utentes* (human resources, job satisfaction, patient satisfaction). The key words motivation and performance don't exist in this data base.

work that encourages career progress through the curricular evaluations that ignore the performance and the productivity criteria.

Most of the literature is on GPs working in public sector HCs. This literature identifies high levels of job dissatisfaction related to insufficient salaries, inadequate systems of incentives, inadequate work environment and low level of skills of the HC managers. Factors such as continuing education and teamwork increase job-related satisfaction. The self-perceived low status of GPs further aggravates their unhappiness.

Performance management practices

The second step in the study was a descriptive study of performance management practices. The information obtained was of a qualitative nature.

The objective of the study was to identify to what extent performance management is part of the management *armamentarium* of public sector managers in the Portuguese National Health Service and to identify areas of the possible positive impact of these management practices on the performance of Family Physicians.

In the study Region there are one RHA and three Sub-Regional Health Authorities (SRHA) The region includes one of the two largest metropolitan areas in Portugal. The research tool was an open-ended questionnaires applied to the 9 members of the management boards of the RHS and SRHA. They were contacted by letter with a copy of the questionnaire, followed by a telephone confirmation of the appointment and then a face-to-face interview. Seven of the nine members of the RHA and the SRHA were eventually interviewed by AG.

INTERVIEWS WITH RHA AND SRHA

The first part of the interview tried to identify manager's perceptions of what is considered good performance of a manager and good performance of a family physician (Table 13), as well as what is considered good management of a RHA/SRHA and good management of a HC (Table 14).

Table 13. Manager's perceptions of what is good performance

Good Performance of a Manager	*Good Performance of a Family Physician*
Fulfils pre-defined goals and objectives	Manages of his/her patient list well, administratively and ensuring the code necessary access
Provides leadership	Makes efforts for continuing education
Handles competently interpersonal conflicts	Participates in community-oriented activities
Is able to work in a team	Has clear good-practice guidelines
Has clear criteria for the evaluation of results	Monitors of his/her individual practice results
Is able to motivate others	Has an empathic relationship with his/her patients
Effectively ensures quality	Has an empathic relationship with his/her colleagues
Achieves results efficiently	
Is a good communicator	
Knows when to delegate	
Improves his own management skills	
Is a good example to others	

Table 14. Manager's perceptions of what is good management

Good management of a RHA/SRHA	*Good management of a Health Centre*
Fulfils pre-defined goals and objectives	Fulfils goals and objectives
Establishes relevant policies, goals and strategies	Adapts goals and strategies to the local reality and implements them
Adequate incentive policies	Ensures participation of all professionals in the previous point
Competently handles interpersonal conflicts	Handles interpersonal conflicts well
Provides leadership	Handles inter-institutional relationships well
Monitors progress towards specified goals and objectives	Ensures effectiveness, efficiency and quality
Defies norms, rules and regulations for the other levels of health care administration	Monitors progress towards goals and objectives
Ensures inter-sectoral co-ordination	Defines norms, rules and regulations for the internal functioning of the HC
Respects the hierarchy of decision-making	Ensures inter-sectoral co-ordination
	Provides leadership
	Motivates health personnel
	Knows the operational routines of a HC
	Communicates relevant information from more central levels and results to all relevant services in the HC

The second part of the interview tried to identify formal and informal tools,

and criteria used for performance management (Table 15). The final part of the interview tried to identify possible means of improving on the current situation (Table 16).

The respondent's understanding of what makes a good manager and good management overlapped and reflected a tension between a traditional public sector administrative culture and the more recent, more entrepreneurial "*new public administration*" approach

What became apparent is that although there are formal mechanisms of monitoring progress towards institutional objectives according to pre-established plans, formal performance management of individual managers and family physicians is not done "*because no norms and guidelines exist*". Even so, it was acknowledged that if managers wanted to formalise systems of individual performance management they could do so on their own initiative and they could actually implement local incentive policies to reward the best performers. It was acknowledged that one of the major obstacles to doing so is the local professional medical culture.

Table 15. Formal and informal tools and criteria used for performance management

Tools for performance management	*Criteria for performance evaluation*
Formal monitoring at all levels (quarterly at RHA level and yearly at HC level)	*Formal:*
Waiting list	Strategic plans & associated objectives
Complaints books	Budgets & associated action-programmes
Users' office	Terms of reference for project teams
Use of incentives: educational opportunities, promotion, extra resources for best performing HC, support for innovative projects, new remuneration policies	Indicators, namely:
	Professional satisfaction
	Patient satisfaction
	N of consultations per clinician
	Profile of prescriptions
	Absenteeism rates
Expenditure statements for each cost-centre	N of complaints
	Accessibility to health care
	Informal:
	Degree of participation of professionals in objective-setting & decision-making
	Absence of dysfunctioning associated with defective or lack of information

Table 16. Suggestions for improving on the current situation

Introduce a code of good practice/performance codes

Develop and formalise existing evaluation mechanisms in order to be able to apply them in a systematic and standardised fashion
Increase the focus on individual as well as team performance while ensuring the continuing management of institutional performance
Link future development to explicit rules, criteria and consequences (incentives)
Put greater emphasis on team work
Manage in a more participatory way

Conclusion

The literature review and the interview with regional managers reinforce our perception of a health care sector where performance management is not explicitly acknowledged. The literature reports on some experiences in team work with the explicit purpose of improving professional and user satisfaction. Managers point out several processes that are used to plan performance, monitor it and encourage good performance. These processes are not standardised and do not constitute official policy. But the fact that they are acknowledged and used is a starting point from which explicit performance management systems could evolve.

Measuring and monitoring staff performance in Ghana

Delanyo Dovlo

Introduction

HEALTH SECTOR REFORMS IN GHANA

Ghana has been undergoing restructuring and reform of the health services over the past five years. This resulted in the recent publication of a five year programme of work to realise the reform goals.

The goals of the reform include: first, improvements in Quality of Care, with the development of new standards of service delivery and provision of appropriate skills to health workers; second, efficient utilisation of resources available for health with through increased decentralised control over resources, incentives to managers to manage resources efficiently and performance targets and agreements with managers; third, client empowerment and new partnerships for health (involvement of communities in health services management, expansion of intersectional collaboration and involvement of the private sector in appropriate service delivery); fourth, improved access and equity with a shift of the control of resources from central to peripheral management units, expansion of the infrastructure for basic clinical and preventive services, and improved access to skills and well trained staff.

To operationalise these reforms Health Service Delivery had to be delinked from the Civil Service into a new Ghana Health Service with a new emphasis on work ethic, attitudes and behaviour. The new service would

have to improve client satisfaction and enhance health staff esteem and motivation. There was to be a new emphasis on basic essential clinical services. All this would require decentralisation of authority and resources to the Ghana Health Service and in some cases to contracted private institutions and autonomous hospitals. New Criteria have been developed for resources allocation to ensure equity and a fairer share of the cake to rural and poor communities.

The proposals required a new staff management system within the public sector with new personnel benefits, rules and regulations, managed within a decentralised framework and with vital emphasis on performance. Managers of Health services are required to enter into Performance agreements to reach certain service targets with the resources provided. Thus a new focus on performance of staff and various services and how to measure these have become very important.

This case study on staff performance management in Ghana reviews staff performance management systems in public/state owned hospitals(clinical services). It looks at the perceptions and practices of Clinical Health Workers (hospital managers, supervisors of clinical units, nurses, technicians, pharmacy assistants), using structured questionnaires served to service providers and supervisors, focus group discussions with service providers and in-depth interviews with hospital management.

THE STUDY SITES

Four hospitals were surveyed. Two were Ministry of Health owned public Institutions whilst two were Hospitals serving State owned organisations (Quasi-Government). The Quasi-Government organisations consisted of the Volta River Authority Hospital (main business electricity generation), and the Trust Hospital (main business - social security and national insurance trust). The total staff strength in the four hospitals was 884 (Table 17). 229 questionnaires were served (to 26% of the total staff), 28 of these were to unit supervisors. 190 filled questionnaires were returned, an 86.4% response rate or 19% of all staff.

The following issues were examined: (i) how well the staff knew the mission and objectives of the institutions; (ii) the staff performance appraisal mechanisms, methods and processes in use; (iii) the performance management tools and documents (e.g.; job descriptions, task schedules, guidelines, performance appraisal forms, interviews, processes).

Table 17. Staff and level of activity of the two quasi-governmental (QG) and the two General Public Hospital owned by the Government of Ghana

Hospital	*Total Staff*	*Doctors*	*Nurses*	*Others*	*OPD*	*IPD*
GG 1 urban	352	27	172	152	48361	5750
GG 2 rural	388	11	178	199	48188	9226
QG 1 urban	63	17	25	21	104,000	1200
QG 2 rural	81	5	64	12	62,244	1884
Totals	*884*	*60*	*439*	*384*	*262793*	*18060*

Findings

FACTORS THAT POSITIVELY INFLUENCE PERFORMANCE

Table 18 ranks a series of factors that positively influence performance, according to the respondents in the GG and QG hospitals. Other issues influencing performance were related by service providers in focus group discussions. GG staff needed to purchase own performance appraisal forms before they could be assessed. Whilst appraisals were expected to be on annual basis 56% of GG staff were not appraised in the past year compared to 48% QG hospitals' Staff. Appraisals involved one-on-one interviews with supervisors but then no further feedback was provided to the staff. Other fora such as Staff Durbars (Especially QG) provided some opportunity for discussing performance with staff.

A number of common benefits were reviewed during focus group discussions with service providers: free medical care, transport, accommodation, uniforms and protective clothing, loans, bereavement, weddings, salary advance, sponsorship for further training.

The Quasi-Government group was well aware of all these possibilities. Whilst these were actually available to MOH staff, few knew they existed and few had ever benefited from them. Support at occasions such as bereavement and weddings were strongly felt major sources of satisfaction. This stems from the financial support (which in the MOH is small), but also from the fact that their colleagues and management attended and participated in the proceeding if a co-worker was well liked – or a good performer?

Table 18. Ranking of a series of factors that influence performance positively

	GG	QG
Formal elements		
Regular unit meetings	1	4
Supervision and support from colleagues	2	1
Supervision and support from supervisors	3	5
Leadership style of supervisor/manager	4	6
Congenial work atmosphere	5	2
Equipment and tools availability	6	3
More informal factors		
Prizes(from management)	1	3
Equipment/tools	2	4
Cash incentives	2	1
Attitude/behaviour of clients and relatives	4	2
"Gifts" from patients	5	4

WHAT IS GOOD PERFORMANCE?

Most service providers and indeed supervisors defined good performance in terms of punctuality, lateness, respect for authority (seniors and supervisors). Some called this "bootlicking". Other factors mentioned (though less frequently) included *not complaining* when assigned tasks, and good interpersonal relationships with other staff. Good performance was rarely related to skills, specific health outputs or outcomes. However the QG group mentioned working beyond expected hours, and performing tasks satisfactorily. This possibly indicates a greater focus on output in those hospitals.

TOOLS TO APPRAISE AND ENHANCE PERFORMANCE

The top 3 tools mentioned as used by GG Hospital Supervisors were the Code of Conduct, the Performance Appraisal Meetings (with individual staff), and the Daily Task Schedules. The Quasi Government hospitals emphasised the Daily Task Schedules as the main tool in addition to Standard Operating Guidelines and Set Service Targets. Job Descriptions did not feature significantly in both settings; in GG existed only for nurses).

Eighty percent of QG supervisors and 57% of GG supervisors considered their assessments methods effective. Obviously the QG respondents felt more confident in their methods and the relevance and effectiveness of their systems than the MOH supervisors.

Table 19. Ranking of tools used- from the supervisor's viewpoint

	GG	QG
Code of Conduct	1	4
PA Meetings	2	5
Daily tasks schedules	3	1
Roles & Responsibility of Hospital	4	2
Job Description	4	6
Clinical Standards	4	6
Standard operating guidelines	6	1
Set targets	6	1
Hospitals targets	6	6
Treatment Protocols	10	7
Guidelines for operating Equipment	11	7

Table 20. The appraisal process

Government of Ghana Hospitals	*Quasi-governmental hospitals*
a. Supervisor & Appraised ↓ b. Head of Unit (same hospital) and Countersigning Officer) ↓ c. Hospital Manager ↓ d. M.O.H. Headquarters (Accra) (Handled by 3 units) ↓ e. Public Service Commission (Accra) and f. Office of the Head of Civil Service.(Approves & Processes Promotion)	a. Supervisor & Appraised ↓ b. Head of Unit or Department ↓ c. Management Committee: Approves & processes promotions)

The chain in the appraisal process in the GG hospitals was very long (Table 20). Final evaluation of appraisals occurred at centralised levels far removed from the management of the unit and in the event promotions were not perceived to be related performance. Little or no feedback is given to appraise on performance

In comparison, quasi government appraisal decisions ended within the unit. Decision making authority on performance is quite close to both appraised and supervisor. There is often feedback within a shorter period. Performance assessment is directly linked to promotion and salary increase.

"[The supervisors] are on you... they go round and round "

This quote from a quasi government hospital indicates the importance of active supervision in ensuring good performance. Benefits/Welfare available to staff were very clearly spelled out, communicated to staff and accessible when they are due. Decisions resulting from appraisals were taken by the appraiser and the results were more immediately seen by staff than in the MOH. Weak formal appraisal systems/forms etc.,. existed even in the quasi-government sector but this was stilled better organised. Job Descriptions, guidelines, etc., were not readily available but daily tasks schedules that clearly spelled out what staff were expected to do were emphasised. Pay and extra duty pay were clearly part of incentive systems, unlike in the MOH.

In government hospitals, supervision was weak. The appraisal system was not trusted by the staff. There were long delays in appraisals, and these were used only for promotion exercises. There was little staff information on, and awareness of benefits due to them as employees. Performance review and its links with reward determination (i.e., promotion) were far removed from the Hospital's Management and supervisors. However, there was a stronger sense of peer interaction and trust. This may mean a less competitive work environment compared to the quasi-government hospitals. Job Descriptions and other tools were not readily available. A lot of emphasis seemed to be placed on less tangible behaviour factors, such as "punctuality", "respect", "friendliness" rather than competence. There was hardly any mention of pay or incentives in the discussions, unless prompted.

Perceived performance enhancement factors in both types of institutions include rewards and incentives(which were rarely mentioned by both sides without prompting). Working equipment and tools were mainly a concern of GG staff. Staff were well aware of sanctions and disciplinary measures in QG but this was not so marked with GG staff. Both QG and GG expressed mentioned interpersonal communication and relations as an important factor. Training: was not mentioned much. QG Staff were much better informed of statutory benefits than GG staff.

New proposals received a mixed response. The idea of examinations and tests was slightly more popular with GG Staff – possibly because they did not trust the existing process, and may have felt this will be a more objective assessment system. QG Staff were clearly against tests of any sort. GG staff showed a higher preference for peer evaluation as part of appraisal process than QG staff. The latter seemed to fear peer influence on appraisals, possibly because of the greater competition for promotions.

Transforming the Ministry of Public Health in Lebanon

May Awar and Walid Amar

Lebanon has essentially a private health care delivery system. Since the early sixties the role of the Ministry of Public Health had been limited to disease prevention and purchasing hospital care from private hospitals for the uninsured population. During and after the civil war the private sector flourished, but the public service was destroyed, and the Ministry of Health had lost most of its authority. Without office space or equipment, little career perspectives and inadequate salaries less than one third of positions were filled. The lack of transparency in administrative procedures encouraged corruption. The rigid administrative rules and regulations continued to be practised within an outdated organisational structure, while epidemiological transition and emergence of new diseases, and rising health care costs were rapidly leading to a major crisis for MOPH.

By 1994, pressure for reforming the health sector was building up[63]. The MOPH started to prepare its reorganisation and found allies in both agencies WHO and the World Bank. It used the opportunity of a World Bank assisted Health Sector Rehabilitation Project, launched in February 1996, to get the budgetary flexibility to reorganise the Ministry. This led MOPH to reject a classical project management option with an independent coordination unit. Rather, the project was to provide direct inputs into creat-

[63] Van Lerberge, W; Ammar, W; El Rashidi, R; Sales, A; Mechbal, A.H. (1997). "Reform follows failure: unregulated private care in Lebanon". Health Policy and Planning. 12 (4).

ing a sustainable and effective MOPH.

This project was thus divided into two components: a classical rehabilitation component aimed at 6 public hospitals and 31 health centres, and a component of institutional strengthening of MOPH. The rehabilitation component was by far the most important in money terms, but for all involved it was the institutional component that was strategically important: it had to restore essential administrative and managerial functions of MOPH; re-establishing planning and normative functions in the sector; and prepare a plan to reform health care financing in the country.

The leadership of MOPH wanted the organisation to change in various dimensions. It wanted to change management culture and style moving from an administration concerned with process, to managerial concerns of efficiency. It also wanted to introduce new technology and re-examine work methods consequently. The focus was to come on results, emphasising output targets and accepting accountability through performance appraisal, with limited-term contracts and monetary incentives. And it wanted transparent management.

For its implementation, seven task forces were created: one for central administration strengthening; one for the health information system; one for health centres' management; one for public hospitals' management; one for cost containment; one for health services development planning; and one health sector financing reform. These addressed issues that were felt to be strategic, but could not fit in the organisation chart of the Ministry. Each task force consisted of existing MOH staff, local and international consultants, specially recruited staff, that was to be gradually incorporated in MOPH's regular staffing structure, and an advisory group consisting of institutions outside MOPH.

The task forces required new staff. Recruited mainly from the NGO sector, on short contracts but at competitive salaries, this new type of personnel had too deliver clearly defined outputs – developing and implementing new management systems –within their contract period. They were accountable for the results, but also for obtaining those results in close collaboration with the civil servants that were already in post. The nature of these tasks was such that it cut across the various administrative units of MOPH, and that none could be accomplished by a single individual. If they were to get results, they had to collaborate as teams, with each other and with the tenured officials. Initially this required direct supervision of the Director General; subsequently the team building support was delegated. The concern was with creating an inter group relationship between the task forces, in order to avoid conflict and to ensure better understanding and

improved relationships between them. Groups were brought together, on a regular basis to share progress and solicit alternative solutions for problems encountered.

To set up teams, members were chosen both for technical expertise and ability to work with others, with an emphasis on the latter. The team leader was seen as the team motivator, trouble-shooter, representative to outside customers, goal setter, and facilitator. As a motivator, the team leader encouraged members to improve their processes continuously and maintained the team focused. As trouble-shooter, the leader worked with team members to solve any problems beyond member's control that might degrade team performance. Team members held themselves responsible for all aspects of their job. They were responsible for bringing process and product innovations to management attention. Team members took the initiative to set the schedules, plans of actions, meet goals set. It was seen that to encourage open communication, the team should emphasise the role of the individual.

Both management and team members believed they could be part of more than one team if each member's primary team schedule was not impacted. Consultants acted as independent evaluators of team progress and as team trainers. Stakeholders were in contact with each task force on one-to –one basis and were fully aware of the team's responsibilities. Some members reported more planning was required because they were responsible for more aspects of their job. Team members received their technical training on-the job. To expand their proficiency, members were cross-trained whenever possible. To gain insight and encourage innovation, members worked on the field and visited customers. To ensure communication, two-weekly meetings were held. Teams would learn about each other's jobs and fill in where needed.

Some members were highly motivated about empowerment and the opportunity to express themselves, while others were sceptical of the new approach. As implementation progressed and positive results were realised, team members gained more confidence in the new structure. Team members soon overcame their hesitation as the new concept proved itself.

Intergroup team building implies friction, and as expected conflict intensity increased during the build-up. First, team members were not certain that they were fully empowered to make decisions that impacted the Project, and only through encouragement from the management, that they were finally convinced of that.

Another major barrier reported by team members was the lack of communication within the team. Team members were initially hesitant to voice

their opinions for fear of retaliation. Some team members tended to dominate the early team meetings, while others were withdrawn. The Project management overcame this problem by encouraging individuals' inputs during the general meetings, in an atmosphere of non-attribution.

A third barrier involved willingness to change the process. Civil servants were accustomed to follow specific procedures from hierarchy, and were not motivated to improve the process. The task forces were instilling ownership of the process within team members, who concentrated on improving, rather than simply repeating established procedures. As productivity and process improved, management gained confidence in the abilities of team members and their respective facilitators, to manage themselves.

Ultimately, the collaborations were formalised in a matrix structure, the structure usually recommended when an organisation operates in a project environment[64]. Since this matrix included new recruits as well as traditional ministry administrators; this made it possible to integrate the project – usually a foreign body in a ministry – in the organisational structure of MOPH, without sacrificing the commitment to performance.

This approach allowed for a better use of resources in avoiding the redundancy that occurs when adopting an independent project structure. It also acted as a catalyst in the "heavy" structure of the Ministry by injecting new concepts and recruiting qualified motivated personnel to work with the regular Ministry's staff.

This de facto structure prefigures a new, more functional organisational structure – which can only be changed by law – allowing for time to experiment, and to change the organisational culture even before formal hierarchical relations have been adapted. The new organisational chart will, for example, create a Directorate for Planning and Budgeting, to avoid the present mix of budgeting with finance and accounting, separated from planning. The flexible working arrangements make it possible already to work in a more rational way.

The concern is basically to do differently with what exists**,** focusing on the need to achieve strategic objectives and performance targets, with managerial autonomy and receptiveness to competition, open-mindedness, and initiative-taking of staff.

In summary, the "building blocks for change" were the following. First, MOPH wanted to make the most of staff, by setting up task forces with defined organisational missions; by clarifying the roles and responsibilities of

[64] Worley C.G. and Teplitz, C.J. (1993). The use of "expert" power as an emerging influence style within successful U.S. matrix organizations. Project Management Journal. 24, 31-36.

each staff; by developing and enhancing staff skills and motivation through training workshops; finally, by setting up a performance appraisal system and working towards career management of employees.

Second, there was an attempt to make MOPH more efficient by matching the organisational structure to the task and by identifying obstacles to efficiency, and removing them as time went by.

Third, financial management was made more responsive to the requirements of the policy makers by improving the management of inputs (e.g. by streamlining procurement procedures within MOH), and by focusing on outputs (e.g. by restructuring the department budget estimates and financial reports).

Fourth, quality of services of MOPH to the public was improved by providing information to the public on services provided, improving public reporting, and initiating quality systems.

The central administration was strengthened based on thorough systems' analysis. Procedures were simplified enhancing transparency. Office technologies were updated and skills of employees upgraded in the central administration to adapt with the attempted change. A National Health Information System was established.

The fact that in this way the machinery of MOPH became functional made it possible to improve its action in the field. The MOH financed and conducted studies on health services organisation, health care financing and stakeholders' analysis necessary for developing scenarios for reform. It managed to improve partnerships with organisations and agencies outside of central Ministry and other Ministries, such as establishing contractual arrangements with non-governmental health centres, to obtain specified performances in returns for support by MOPH. It also became possible to devolve more authority to the periphery – for example in authorising purchase of hospital care, or through the law of autonomy of public hospitals.

Bringing in new blood in the Ministry, recruited to achieve specific objectives rather than to fit in within the organisational chart, has created some insecurity and tension. On the whole, however, the experience is positive: the new recruits and the introduction of matrix-type working arrangements have introduced a new management culture in MOPH, in only a few years time. This has made it possible for MOPH to regain a position of leadership in the sector, and to regain control of a system that had got out of hand. Bringing change in the public sector is possible, and does not necessarily need lots of money.

Performance management in the Vila Olimpica primary care centre in Barcelona

Carmen Mompó i Avilés and Joan Rovira Forns

Introduction

In Spain the National Health Service is composed of 7 Regional Health Services with full health care responsibilities and an institution (INSALUD) that manages health care in the ten remaining regions. The National Health Service is essentially financed by general taxes. The Regional Health Service of has full health care responsibilities. It funds and buys public and private health care services within the National Health Service. So there is public financing but mixed provision, public and private.

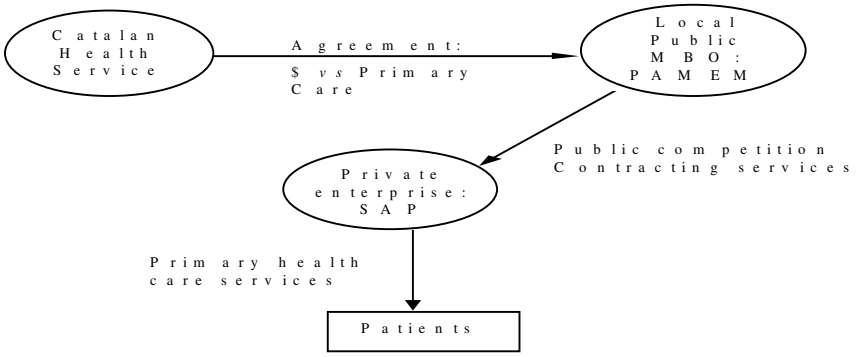
Figure 7 shows the organisational structure of the centre that we have analysed, a Primary Health Care Centre called "CAP Vila Olímpica" in Barcelona (Spain).

The Catalan Health Service has an agreement with a Local Public Mutual Benefit Organisation in the city of Barcelona. The Mutual Benefit Organisation provides health care services to civil servants of the municipal administration. By agreement it is responsible for providing Primary Health Care to the population of the Vila Olimpica area. After a public competition between private enterprise it has contract-out the provision of primary health care services to SAP (Primary Health Care Services, S.L.).

The covered population is around 27.000 inhabitants; the population

reflects a range of income levels (from middle-upper level income to middle-lower income) and different age. The staff of the centre is grouped in five Primary Care teams. The centre has also specialist physicians. Every team has two general practitioners, one nurse, one clinical assistant and one administrative assistant. There are 33 staff contracted by the centre. The centre provides preventive services, with several programmes like vaccination program, hypertension, diabetes, pregnancy, etc. and curative services. There is an emergency care programme and programmed home care for 12 hours from Monday to Friday and 7 hours on Saturday. These services are provided by the 5 Primary Care Teams (one every day of the week, and once a month on Sunday). The staff works with computerised clinical records making it easier to communicate with each other and to manage and control the activities of the centre. The managers of the centre try to apply business management tools like budget control, human resource management and Management by Objectives.

Figure 7. The organisational structure of CAP Vila Olimpica



Performance management system

FACTORS THAT MAY AFFECT PERFORMANCE

The factors assumed to influence staff performance include the Welcome Programme for supervision of new personnel, income, economic and promotion incentives.

The Welcome Programme is addressed to the staff joining the CAPVO. Through this programme a newly contracted person comes to CAPVO a

few days before the official starting date to meet the future supervisor and other staff members. Additionally, staff becomes familiar with the centre and receives the material necessary for effective performance of the job.

Income is seen as being partly related to the attainment of centre objectives, which are related to external objectives agreed with the Catalan Health Service and the Local Public MBO. The wages are not higher than in the public sector, but there are economic incentives that reward performance on a team and on an individual basis. Promotion incentives are used when a new job is created or it is necessary that one of the existing jobs assume more responsibilities.

TOOLS FOR EVALUATING PERFORMANCE

Several tools are used to monitor personnel performance.

The attainment of external and internal objectives is monitored during four yearly sessions of four hours each. In these sessions staff and managers control the degree of attainment of the objectives of the centre. This is related to the Management by Objectives.

Individual periodic evaluations are more frequent at the beginning of a contract. The evaluation is based on the appraisal of three criteria: aptitude (knowledge, experience, ability); attitude (dedication, discipline, punctuality); and values (tolerance and respect). This evaluation is carried out separately by the team leader and by the human resources director, who jointly write a report with recommendations to improve on weak performance (specific training, change in attitude, etc.). If the evaluation is positive the individual may be promoted. The employees do not participate in their own evaluation.

TOOLS TO ENHANCE PERFORMANCE

Financial incentives according to the objectives attained

Objectives are set by the managers without the participation of the employees. Fulfilment of these objectives is rewarded with a monetary incentive equivalent to two additional wages. These incentives may be individual or team based. The percentages in the table show the relative importance of each type of incentive.

Individual financial incentives are untended to have no more than 4 days of absenteeism in the year. It represented 15% of the total value of incentives paid out in 1997.They related to objectives negotiated with the Catalan Health Service and the Local Public MBO, as reflected in the action plan of the centre itself.

Table 21. Distribution of proposed financial incentives in 1997

Objective	*Incentives to individuals*	*Incentives to teams*	*Additional incentive to all staff if all teams reach objective*
Individual incentives related to absenteeism	15% of total	NA	NA
Team incentives for 100% reporting of team meetings	NA	10% of total	5% of total
Team incentives for 75% codification of chronic illness visits	NA	25% of total	10% of total
Team incentives for including the therapeutic plan for chronic patients in the clinical record	NA	25% of total	10% of total

The evaluation is done by an external company through a computerised program. When a team reaches an objective, every member of that team is rewarded with the team incentive, in proportion to his/her wages. But if all the teams reach this objective, every team is rewarded with an additional incentive. This system promotes collaboration between teams. During 1997 two individuals out of 36 were not rewarded with the individual incentives.

Continuous training programmes

Every member of the staff is entitled to 32 hours of training every year. These hours are distributed in 4 blocks. Training is compulsory for all the full time employees. These training hours count as working time. The content of the training varies different for different staff categories: clinical and administrative assistants receive training in office computing and customer attention; physicians and nurses focus on clinical themes and statistics. Current training does not address weakness identified during individual performance appraisal, but this will be considered for the development of future training programmes.

Finally, we emphasise that these are preliminary results, and that we plan to continue studying performance management contrasting the views of the management with those from the staff, and assessing how different organisations relate to one another.

Part II. How individual professionals cope: from moonlighting to brain-drain

Good Samaritan or exploiter of illness? Coping strategies of Mozambican health care providers

João Schwalbach, Mariamo Abdula, Yussuf Adam and Zuraida Khan[65]

Background

The increasing number of health professionals, the economic crisis and structural adjustment programmes and the trends to privatisation in developing countries where modern health care has been organised mainly by the public sector, have implications for the professional attitudes and coping strategies of individual health professionals. Overcoming contradictions between professional requirements and social aspirations of health personnel in a changing society is crucial for the implementation of effective health services. There is, however, little systematic knowledge on the ways health professionals have to ensure economic survival, professional satisfaction and social status in such conditions.

International studies in health personnel have identified problems of

[65] This paper summarises the work produced during the first phase of a research project on the coping strategies of health care providers in Mozambique, executed between October 1996 and October 1998, as a part of the ongoing INCO-DC project "Health Sector Reform: Coping strategies and professional identity of primary health care clinicians in Mozambique and South Africa", funded by the European Commission under grant IC 18 CT 960 108. The project was started and initially co-ordinated by Dr. Manuel Julien. After he became critically ill in 1997, the project was continued by Dr. Aurélio Gomes and Dr. Yussuf Adam (co-ordinator).

morale, career perspectives, stress, isolation and remuneration. There is a dearth of research about policy strategies to deal with these problems. Issues related to health personnel attitudes and behaviours tend to be addressed in moralistic terms ("lack of motivation", "corruption") rather than in their relations with structural conditions or the social and cultural environment.

The present research aims at a deeper understanding of the coping strategies of health professionals, their consequences and determinants. Based on this understanding it further aims to influence the strategies of development and implementation of norms and policies in the health sector. The purpose is to develop a framework of analysis allowing to address these questions not only in Mozambique and South Africa, but in other societies as well.

The process of transformation in Mozambique and South Africa is taking place amongst growing expectations of the population and the health personnel. Transformations are happening under duress: changes usually precede enabling legislation and are done in response to labour conflict or consumer dissatisfaction; medical practitioners confront the dilemma of how to adhere to the basic principles of medical ethics in an atmosphere of hunger, poverty, war and ever-shrinking resources.

The project addresses central but highly sensitive issues that are of direct relevance to policy makers and the donor community in the region. Precisely because it is so sensitive, the topic can in a first phase better be dealt with in a research setting than in a straightforward policy debate.

Mozambique and its health care system

The Republic of Mozambique is situated in Southern Africa and has a coastline of 2,515 km on the Indian Ocean, and a total surface area of 799,380 km^2.

The estimated population is 16,7 million. Close to 80% of the population live in rural areas, with an average density of only 20 inhabitants per square kilometre. The population structure is very young, with 45,6% less than 15 years old. By 1997 women accounted for 53% of the population and 60% of farming activities. Only 20% of women and 57.7% of men are literate.[66] Health services are weak. By 1987 there were 327 physicians in the country, of which 110 were Mozambican. The coverage in 1990 was of 1 doctor to 45,000 people in the countryside, and 1:5,500 in Maputo.

[66] UNDP - Mozambique 1998. National Human Development Report 1998. Maputo, UNDP

Mozambique gained independence from Portugal in 1975. Opposition to the new socialist inspired FRELIMO government took the form of guerrilla warfare with support from the South African Apartheid regime and resulted in a devastating civil war that lasted more than a decade. Since peace was re-established in 1992, Mozambique has embarked onto a major economic restructuring process, transiting from central planning to market economy. A new Constitution was introduced in 1990, opening way for the peace process and for multi-party elections in 1994. A cascade of new laws and regulations have been issued since then, legalising or liberalising economic activities that previously were under State control, including health services. Local government (autarquias) in the form of elected, autonomous municipalities that are administratively separated from the central government structure and manage their own budgets, has been introduced in larger cities and towns and will be gradually extended countrywide.

The first systematic health care programs in Mozambique were established in the second half of the 19th century to attend to the needs of the Portuguese settlers and troops. A few hospitals and other infrastructures had been built already in the 16th century.[67]

During the first half of the 20th century, primary health services were extended to the growing indigenous workforce. From 1946 and onwards emphasis was on preventive measures to control the main endemic infectious diseases, including compulsory inoculation campaigns.

In the same period a number of religious organisations established mission hospitals and health centres in different parts of the country. These became important sources of health care for the indigenous population at large.

By the end of the colonial period the health network was still fragile and discriminatory, and was not getting sufficient funds to improve services.

The principles for a new health policy were established during the pre-independence transition period 1974/75, based on FRELIMO's experiences in the "liberated zones". Emphasis was on the education and mobilisation of the people to improve sanitation in the local environment and other preventive measures taken in co-ordination with other state bodies.

A massive exodus of Portuguese and other foreign settlers occurred around independence time and resulted in severe brain-drain in the health sector as in all other areas of the economy. It is reported that only 73 physicians stayed on in Mozambique after independence in 1975.

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[67] This chapter is based on: Y.Adam and L.Golube, 1997 - História da Saúde em Moçambique Post-Independência: Políticas e estratégias do Sistema Nacional de Saúde. Maputo, CEP

The new government banned private medicine, with the argument that nobody should be allowed to make profit on the pain of the people. Mission hospitals were nationalised. The staff of the confiscated health care units were integrated in the National Health System and for many this resulted in a decrease in salaries and other benefits as well as a worsening of working conditions, as the State in reality did not have the means to run the system effectively. Traditional medicine, on the other hand, was for a long time seen as obscurantism and was ignored by the health system.

Primary health services were seriously affected by the civil war, that resulted in the destruction of almost one half of the rural health centres.

In the towns, on the other hand, increased stratification of income created a pressure for "special clinics" within existing hospitals, for patients who were willing to pay more for better service. The special clinics were initially established in the 'eighties to cater for civil servants of any level whose working time the Government considered too valuable to be spent in the line waiting for the doctors. In the early 'nineties these special services were opened up for paying patients.

The fees collected in the special clinics, it was reasoned at that time, would be used to buy urgently needed inputs for the general hospital and for topping-up the salaries of the health personnel. In practice, though, this arrangement is controversial and has led to friction between beneficiaries/non-beneficiaries.

In 1992 the provision of health services was liberalised, and several private clinics have been established since then.

The research process

The objective of the research on Coping Strategies of Health Care Providers in Mozambique and South Africa was to survey existing practices, determine their causes and effects and find solutions recommending new policies for the health sector.

The study was envisaged as *multidisciplinary* (involving medical doctors, sociologists, historians, geographers); *qualitative*; *participative* (involving individuals with different social status and hierarchical position in the health system and institutions relevant or interested in the subject); and *action oriented* (which is to say that one of the project results should be a contribution for change of the status quo). Undertaking this endeavour was also organised as a *multinational* exercise involving research teams from Portugal, Belgium, South Africa and Mozambique.

The research process involved the following phases: definition of the research team, elaboration of the project and search for funding; creation of communication mechanisms between different partners, discussion of methodologies and development of a common approach; establishment of a national research team, establishment of contacts with partners and institutions and selection of areas for field research; data collection about the health sector in Mozambique, its history, current problems and solutions as envisaged by different actors; field data collection in health care units, which represent the different components of the health system; elaboration of reports; presentation of data gathered to the institutions that participated in the research and to local institutions interested on the subject; discussions with health care providers and institutions about changes needed and strategy to create the changes. These steps did not occurred in a linear fashion and the last step on the list is not the final one. Research on a subject such as this ends up rather as a research program than as a project, because it is very difficult to confine it to the time limits imposed by the standard project model.

Research methods

The research strategy used in this study can best be described as one of simultaneous use of various methods. We identify it by the acronym *YOM,* which means *"Your Own Method"*. This is to say, an approach dictated by the subject matter itself and by the researchers and other participants involved.

Documentary research, case studies, bibliographical study, interviews, focus group discussions, interviews with key informants, observation and group discussions are some of the techniques used to gather information and knowledge. The methods had to be frequently adapted to the changing situation in the project.

For each person who agreed to reply to our questions, four declined. The justification given was simply that they did not want to speak on the subject. Medical Doctors especially did not want to give details about religious, or other type of social practices used as coping strategies. In three cases, the informant expected be paid a fee before replying.

The methods used allowed us to collect useful information but did not permit a deep comprehension of the non-economic coping strategies used by health care providers.

At the end we applied the triangulation method, using information on

the same topic collected through different methods and from different sources. This, eventually enabled us to draw a quite clear profile of the coping strategies used.

Population and area of study

This study was conducted in two different areas, one urban (Maputo city) and one rural (Maputo province). Both are located in southern Mozambique and were chosen for the convenience in terms of access for the researchers. The study in Maputo City included the Central Hospital of Maputo, the General Hospital of Mavalane, the Health Post of Boquisso (Matola) and the neighbourhoods of Chamanculo, Xipamanine, Polana Caniço, Maxaquene, Hulene and Mavalane .The rural area of Maputo province included the Moamba District (Ressano Garcia, Tenga, Sabie and Corrumana) and the Health Centre of Matutuine (Table 22).

Table 22. Number of interviews and areas of study

	MDs	*Nurses*	*Orderlies*	*Traditional Healers*	*Users*
Urban Areas:					
Maputo Central Hospital	2	11	1		21
Mavalane General Hospital	9	19	9		
Chamanculo and Xipamanine		10	4		22
Polana Caniço, Maxaquene, Hulene and Mavalane				6	2
Boquisso Health Post		1	2		7
Rural areas:					
Moamba district		15	5		35
Matutuine Health Centre		1	1		3
Total	*11*	*57*	*22*	*6*	*90*

Results

The material collected through interviews showed the tendency of different groups to blame each other. Nurses working in the special clinics were considered by colleagues not working there as being responsible for the crisis in the health system. Doctors criticised nurses, nurses criticised the orderlies and everyone blamed the government. The opinions of service users were

generally dismissed by health personnel as lies or personal attacks.

The coping strategies used by health care personnel vary according to the concrete situation in which they are working and their position in the health system. The goal of the health care provider is to provide him/herself with the maximum of profit – economic, political or social – in any given situation, i.e. a nurse in a border town will give special attention and treatment to police officers and border guards because they allow his goods to pass without paying duties.

DIFFERENT CATEGORIES OF HEALTH PERSONNEL ADOPT DIFFERENT COPING STRATEGIES

MEDICAL DOCTORS and other health professionals with university degrees or equivalent, have small families, 2 to 4 members on average. They live in apartment buildings or houses, situated in well-developed neighbourhoods. They own a car or another means of transport. This group includes a high number of members of social minorities – "whites", "mestiços", "Indians", etc (as considered by the others and by themselves). Some are declared atheists.

Providers in this echelon maintain health provision as their main activity. Increased income comes from working in different sectors or health systems and from taking advantage and maximising the opportunities and benefits found in each sector. They pursue health related activities considered legitimate under existing laws and provisions. They take advantage of any opportunity offered by the system - bank loans, tax advantages, international and national business partnerships, etc. When they intervene in areas other than health it will generally be through formal business activities.

NURSES. This group comprises technical personnel with medium level education. The households of this type of health care providers have on average between 4-5 members, inhabit neighbourhoods with some infra-structures, do not have own transport, practice religion (majority catholic) and includes, as a majority, individuals who belong to educated black elite from the southern part of Mozambique.

Nurses and other medium-level health care providers do work in different health sectors and systems at the same time, but also invest in income generating activities outside the health care system, for example agriculture, commerce and transport. They tend to use their connections and relative social importance to engage in cross border trade or other informal activities. The nurse's economic activities tread the ever-changing line between

the formal and the informal, legal and illegal activities, taking advantage of the market and their own knowledge and family networks.

ORDERLIES and other health care personnel with basic level education live in extended family households with, on average, more than 7 persons and more than one income earner. They live in the part of the cities considered suburbs without infrastructure. They practice religion and have a large number of dependants.

Orderlies work mainly in the institutions of the public health system where they take advantage of any market opportunity that arises - sale of drugs that should be distributed free of charge, queue jumping and other facilitation of access to doctors and specialised care. Working from home they become the principal health care providers for low income population in the suburbs. This group also displays the most heterogeneous mix of income generating activities investing in commerce and services of any kind. Due to their characteristics - often not licensed, not respecting any regulations and norms - their activities are mainly informal or illegal.

Problems expressed by health care providers and users

The twenty-two major problems mentioned are listed in Table 23. They can be grouped in two categories: a) the problems faced by health care providers and b) the problems faced by the users-patients. Results from urban and rural areas are presented together, as the opinions generally coincide.

Health care providers mentioned 14 problems, all related to the general economic condition of the country. Only two problems out of the 14 mentioned are common to the three categories of health care providers: lack of transport and low salaries. Users/patients interviewed all over the study areas mentioned nine major problems about the health system. These are related to the lack of conditions that the health units can offer.

Table 23. Problems expressed by Health Care Providers and Users

	MDs	*Nurses*	*Orderlies*	*Users*
Social pressure to get special treatment or other favours		X	X	
Barriers for professional upward mobility		X		
Lack of career promotion		X		
Lack of training and recycling		X		
Selective recruitment for special clinics		X		
Delays in payments in special clinics		X		
Lack of transparency in special clinics' economic results		X		
Lack of respect by orderlies		X		
Lack of contact between the personnel	X	X		
Lack of basic supplies (syringes, gloves)		X		
Bad hospital food for providers and patients		X		X
Lack of transport	X	X	X	
Low salaries	X	X	X	
Illegal fees charged				X
High prices of health care				X
Lack of motivation of personnel				X
Lack of health transport				X
Prices of Medicine				X
Lack of kerosene lamps for night treatment				X
Distances between health Posts and residences				X
Use traditional healers to advantages in prices, payments				X
NGO strategies				X

Coping strategies

MD's and nurses use straddling - working simultaneously in two different sectors (public and private) - as a coping strategy. Straddling provoked resentment from those who could not participate in the private sector, especially among the nurses.[68] A large number of nurses and orderlies rely on farm plots worked by family members for their subsistence. Most of the money earned is invested in small informal business.

Lack of time for patient care, specially in the public health system; low quality of diagnosis and prescription, tiredness, discrimination of patients

[68] There are few vacancies in the private sector, and the doctors chose their teams individually.

according to their capacity to pay, are some of the negative results of the current coping strategies of health care personnel. The additional resources created in the special clinics generate internal struggles between different categories of health care providers. Discriminatory practices occur in the two types of consultations available in a public hospital – normal and special consultations.

The health care providers consider as positive results of their present coping strategies an increase in the supply of medicine and materials, topping up of salaries, formation of teams of doctors and nurses, opportunities for extra-employment. The special clinics inside the public hospitals provide funds to complement the limited budget supplied by the state.

Table 24. Coping Strategies employed by Health Care Providers

Coping Strategy	*MD*	*Nurses*	*Orderlies*
Working in private clinics	X	X	
Working in special clinics	X	X	
Charging extra fees		X	X
Sale of medicines at market prices		X	X
Commission from food suppliers	X	X	
Teaching	X		
Consultancy work	X		
Working with NGOs	X	X	
Working with donors	X	X	
Working with enterprises	X		
Investment in commerce		X	X
Investment in agriculture		X	X
Investment in industry		X	X

Most of the health care providers recognised that some of their own coping strategies had negative impacts. The solutions proposed by all types of health care providers were economical: better working conditions and higher salaries(Table 25). These proposals of solutions are in harmony with the diagnostic of the situation made by health care providers.

The three categories of health care providers mentioned the following three measures as a solution: salary increases and transport for health personnel, and charging higher fees. These are the basis for satisfaction of the health providers demands. Another solution proposed by health care providers is the access to credit for housing because *"if you are happy at home you are happy anywhere"*.

Table 25. Solutions proposed by Health Care Providers

Solutions	*MDs*	*Nurses*	*Orderlies*

Salary increase	X	X	X
Fees increase	X	X	X
Transport for health personnel	X	X	X
Promotions in careers		X	
Credit for housing	X	X	
Abolition of special clinics		X	
Distribution of economic benefits of special clinics		X	X

The role of the traditional healers in the health system

Traditional healers use a blend of herbal remedies and suggestion rituals to address a wide variety of problems, from bad luck to incurable diseases. As an activity embraced by a large number of women, this group also includes traditional midwives The belief in spirits and witchcraft is widespread in Mozambique, in urban as well as rural settings, and the population in general firmly believes that certain ailments should be treated at the hospital while other are best treated by traditional methods, because they have been caused by spirits.[69]

There are some points of contact between this group and the state health system. Traditional healers express their desire to work more closely with the medical profession, not to become part of the national health service but rather to act as a parallel service interfacing with the hospitals, where people can go when modern medicine has proven useless, or where they can refer patients for diseases which can be better treated in the hospital. From the government side, courses have been given for traditional healers, with the aim to improve hygiene during childbirth and to avoid HIV infection in practices which include tattooing, for example. Traditional healers are consulted about herbs and plants that might have therapeutic potential also in the modern health practice.

The proportion of traditional healers to the population is estimated to be 1:200. Compared with the figure of 1:50.000 for medical doctors, it is quite understandable that the traditional healer is the closest and most accessible source of assistance in emergency cases. Users appreciate these services, and are willing to pay relatively high fees for traditional consulta-

[69] This section is based on M.D.Mazive Medicina tradicional em Moçambique. Projecto: Estratégias para fazer frente à sobrevivência e identidade dos profissionais de cuidados de saúde. Maputo, SEP, May 1997.

tions and cures. But they complain about the scarcity and quality of modern health services, because there is a clear perception that not all maladies can be treated just as effectively by either system. Users would like to have more choice, channelling each ailment to the most adequate cure.

Discussion

Conventional wisdom argues that the present coping strategies of health care providers result in deformations of the social and public character of health services. This, in turn, results in inequality among staff, discrimination of users and degradation of quality of the care rendered. The data which we have collected shows that, while it is true that various ethical problems emerge from the behaviour of health care providers, their coping strategies do extend the existing heath care system. The orderlies represent the health system in neighbourhoods and areas where the public state network is not present.

Health care providers tend to present their behaviour as a response to the existing situation and to the problems they have to face. This kind of argumentation is a blame lying schemata, where the actors – the health care providers – are presented as victims. The responsibility of the situation is not theirs. Orderlies and nurses said regularly that they did not accept bribes and that they did not elicit the payment of extra money: The service users gave them money simply because they wanted to show their gratitude.

The problems faced by the national health care system were presented by the care providers as the causes explaining their own behaviour. The problems mentioned include working conditions in the health institutions – food, medicine - working relations between doctors and nurses, management practices and transport. Only low level health care providers mentioned as problems questions linked to culture and family traditions, that can be a difficulty for their profession.

It is important to note that no health care provider discussed as coping problems the difficulties related to treating terminally ill patients, AID-HIV cases or other medical difficulties. Hunger and the general social and political environment was considered a given factor influencing health, not as a problem to be addressed by them.

The coping strategies adopted by health care providers end up maintaining the existing system because the providers supplement their incomes and create their own working conditions closing the gaps left open by the state. The coping strategies – even if there are negative – are also a fruit of

the relationship that develops between provider and user in a given context. Nurses and orderlies are used as entry points by users to get a better position in the queues.

Health care providers capitalise the resources they have – in the public and private systems – in order to get the maximum of economic returns from the knowledge, abilities and means they have at their hands. The underdevelopment of the public and private services also suits very well the local health care practitioners. Newly established private clinics do not have to invest in expensive equipment, as the patients can be referred to the public hospital for tests or treatments demanding the use of such equipment.

The argument made by all the health care providers, namely that the most important coping strategy is to improve their economical situation by all means, due to the low incomes and the high cost of living and expenditures, does not seem to hold water.

Health care providers due tend to make as much money as they can in a particular situation, but many times health care professionals defend a socialisation of the health services or a separation of the public care from the private, at the same time as they often enter into alliances with the state in order to consolidate their own positions.

Certain coping strategies that are used but are not expressed as significant, such as the use of religious support, family and friends and other cultural factors, are in reality very important. Observation shows that they are used, but there was a deliberate attempt to cover these facts during the field work. The reason can be that health care providers consider those of a private nature, but it should also be taken into consideration that the study can have been used as a way to convey their message to the government and the aid agencies: pay us better.

The general tendency is to link the emergence of the coping strategies identified in this study, to the economic reforms of the last decade. But before 1986, the year the International Monetary Found inspired the structural adjustment program, health care providers used coping strategies that were not different from the ones presented here. However, private practice was delivered in a covert way. Special clinics were created before 1986 to cater for the needs of people whom the government could not afford to have absent from their jobs spending time in queues, and for special groups like expatriate workers and resident diplomats. But the special clinics ended up as a health care system for the "estruturas", the Mozambican nomenklatura.

Arguments about the present day coping strategies of health care pro-

viders are contradictory. Conventional wisdom explain them as robbery, as exploitation. The health care providers explain it as a fact of life derived from the socio-economic development policies adopted in Mozambique and by Health Care Policies.

The two arguments are in a way valid, but the data gathered shows that they are generalisations that do not correspond to the situation in the health system. An evaluation of coping strategies depends very much on the values of the analyst . In the case of Mozambique, the coping strategies used show the limitations of the Health Care System and of the Health Care Policies. Any future policy will have to tackle the profound problems and limitations signalled by the present day coping strategies.

Conclusions

The coping strategies used by health care providers are not different from the ones used by other civil servants and by the public in general, according to the social status of each individual.

The special nature of the health system creates an environment where criticising the health care providers becomes one of the ways people use to criticise the government. People's arguments could be used by the government to wash its hands from the responsibility of improving health services, laying the blame on the health personnel. The medical association of Mozambique recently published a communiqué alerting about this tendency, and showing that the health system was working due to the engagement of the health care providers.

The question of what constitutes positive or negative coping strategies is very difficult to answer. Health personnel are obliged by the nature of their profession to be Good Samaritans. The Hippocratic wow is taken seriously by every doctor and health care provider. But their attempts to cope with the difficulties of everyday life – in the same way as other professionals and the rest of society do – is seen as a betrayal, something negative. The coping strategies of health care providers cannot be judged as individual behaviour and decisions but as the individuals' reply to a system failure.

Coping strategies of health workers in Uganda

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Introduction

Uganda's years of civil strife are well known to the outside world. Clearly, such disruption would not leave health services unscathed. Since Uganda's health service was the envy of Africa in the 1960s, the effects were all the more extreme. Between 1973 and 1982, the crude mortality rate, infant mortality rate, and child mortality rate all increased whereas in other African countries they declined significantly[70]. In 1986, the value of the public health budget was only 6.4% of its 1970 level. While the political and economic situations have recovered fast over the past decade, it is far from clear that health service recovery has been commensurate. Donor efforts have been substantial. By the period 1986-8, donor aid flows to the health sector had reached US$ 40 million compared to only US$ 5 million in 1982-3[71] and have continued to grow. However, the effects of such efforts are mixed. Uganda's is now one of the most donor dependent health sectors in the world with the effect that Ugandans have lost some control over health sector development, and have little stake in accountability for some key health sector resources. The hyper-inflation of the war years caused

[70] Macrae J, Zwi A, and Birungi H (1994) A healthy peace? Rehabilitation and development of the health sector in a post-conflict situation - the case of Uganda. PHP Departmental Publication No. 14, London School of Hygiene and Tropical Medicine.
[71] ibid

civil service salaries to plummet in real terms but the economic strategies pursued over the last decade have accorded this issue low priority, and it has been one of the last to be tackled. Substantial pay increases were awarded to some other sectors of the civil service, but health workers were not included and have received relatively moderate increases to date.

The legacy of these developments in the form of poorly motivated health workers, poor accountability for health sector resources, informal charging of users of public health facilities and health worker absenteeism, caused by parallel working, is well known to Ugandans and has been documented in a descriptive way in two districts by Jitta and van der Heijden[72] (1994). Similar situations have been described in other countries[73] (for example, Liu et al. 1994, Witter and Sheiman, 1997, Roenen et al., 1997) but comprehensive research faces particular difficulties given the secrecy implicit in the nature of the activities. Nevertheless, if they are as widespread as popularly reported, they are of crucial importance for the health services. The situation described by Jitta and van der Heijden implies that much of what seems to have been achieved (specifically a free or nominally charging health service; relatively good geographical accessibility; and a quality of care commensurate with the well trained health workforce and the extensive essential drug programme) is chimerical. Further implied is that any health sector policy must take realistic account of how it will be mediated through such an environment if it is to achieve its objectives.

This paper reports a study which was undertaken between 1994 and 1997 with the overall aim of describing and accounting for the 'socio-economic survival strategies' of health workers and their effects. It took place against a background of substantial health sector development in the country which has accompanied its economic recovery. Among other developments, decentralisation of administrative authority across all sectors in the country has had major implications for the health sector. The World Bank's series of Health Projects together with other aid programmes such as the EC's health service rehabilitation project in the South West of Uganda

[72] Jitta J and van der Heijden T (1993) Economic survival strategies of health workers in Uganda, study report, December. Child Health and Development Centre, Makerere University, Kampala.

[73] Liu G, Liu X, and Meng Q. (1994) Privatisation of the medical market in socialist China: A historical approach. Health Policy 27, 157-174. Roenen, C., Ferrinho, P., van Dormael, M., Conceicao, M.C., and van Lerberghe, W. (1997) How African doctors make ends meet. Tropical Medicine and International Health, 2 (2): 127-35. Witter, S., and Sheiman, I. (1997) The private sector and 'privatisation' in health. Chapter 9 in Witter, S., and Ensor, T. An introduction to health economics for Eastern Europe and the former Soviet Union. London: Wiley.

have had a substantial impact on the quality of the physical infrastructure for health service delivery. Supply of drugs and other essential supplies has been improved through Danish aid and within the decentralisation framework. The study was first discussed in 1990 alongside proposals which were put to the Ugandan parliament to introduce user charges on a national basis. The acceptance by parliament of the user charge proposals and their subsequent introduction was widely believed imminent at that time but in the event, they were suspended and a national programme never approved. Nevertheless, decentralisation policy and the development of health unit management committees (HUMCs), intended as preparation for the policy, prompted widespread local adoption of user charges using different levels and structures from district to district and even from health unit to health unit.

Methods

The study was divided into two phases, the first of which focused on health workers' activities within public health units and the second, outside.

The study used qualitative and quantitative methods of research to establish the range and magnitude of health workers' socio-economic survival strategies, the implications of different strategies for quality and accessibility of care and the influences on health workers' choice of strategy, and on policy. The study undertook a participative approach involving district health management team members. It was based on voluntary co-operation of health workers, health unit management committee members and members of the public in collection of data.

Two districts were selected after five possible ones had been visited. Those in which the district teams expressed strong interest and willingness to participate in the study were chosen.

In Phase 1, the units were selected on the basis of a structured sample aiming to reflect the four levels of the health system with the district; hospital, health centre, dispensary and maternity unit, and dispensary. In each of the two districts, six health units were selected. In selecting facilities at the different levels of the system, the study incorporated the different local environmental settings in which these various health units were located. The varied environmental factors, health workers' characteristics and policy levels which form the core of our conceptual framework were therefore represented by the sampling frame. In Phase 2, individual health workers were selected from among those met in Phase 1 according to their willingness to

be followed up in the manner required by the protocol. 36 health workers were selected.

All the research instruments can be found in the two protocols for Phases 1 and 2 respectively (available on request). In general, the approach used is one known as 'triangulation': the collation of evidence from different sources[74]. Since the information sought by this research was sensitive, a single tool might produce misleading information. By approaching our research questions from different angles, it was possible to assess the balance of evidence regarding each, taking into consideration which sources and informants have incentives to mislead.

DATA COLLECTION PHASE 1. A short questionnaire designed to solicit background information was administered to all health workers at each unit. A total of 196 health workers were interviewed using the questionnaire and information collected regarding socio-demographic status, career in the health sector, income and expenditure.

This was followed by structured and key informant interviews, intended to be of increasing depth, whose respondents were selected according to the co-operation indicated by the responses of health workers at the previous stage. On average, three structured interviews were carried out with health workers at each unit and the same number of interviews were also conducted among community members known to utilise the unit or at least be familiar with it. In addition a separate structured interview with at least one member of the Health Unit Management Committee was conducted for each unit. A total of 87 structured interviews were carried out, of which 38 were from health workers, 35 from community members and 14 from HUMC members.

Focus Group Discussions (FGDs) were carried out for both health workers and community members. For health workers, this was planned to be a homogenous group of 5 to 10 members in a given unit. Where feasible a researcher formed a group of respondents of the same rank and sex. However because most units were small, breakdown by sex was mostly not possible. A total of 41 FGDs were conducted (27 with community members and 14 with health workers).

For each unit a facility record was completed. The facility record checklist required details of the daily patient attendance recorded at the unit for the previous year; drug stocks and stock outs for the same period (for six commonly used drugs, numbers of prescriptions were counted); user

[74] Mechanic, D. (1989) Medical sociology: some tensions among theory, method and substance. Journal of Health and Social Behaviour 30 (2): 147-60.

charge levels income and expenditure by department; and information on in-patient drug use. This last component compared record with patients accounts of what they had received.

Observation was carried out at each unit. The purpose of this observation instrument was to collect information to supplement and cross check the facility records. The observations lasted one week at every unit and included observation and enumeration of the utilisation rate, the accessibility of services in terms of presence of equipment and personnel; and the drug situation checked using exit polls.

DATA COLLECTION PHASE 2. Two researchers spent one week each with health workers who had already been identified as carrying out specific economic activities in Phase 1. Three data collection instruments were applied in each case, modified according to the nature of the activity explored: First, a questionnaire explored the living conditions and businesses of the health workers in more detail than the original questionnaire of Phase 1. Second, an observation checklist collected observable data related to the health workers' standards of living such as the size and condition of the health workers' home and direct evidence of development activity; and related to the health workers' place of private business including a count of utilisation. Third, where relevant, an exit poll was applied to users of services offered by the health workers. Users were asked about aspects of the quality of care they had received; the price they had paid and the types of drugs they received. 99 clinic exit polls (from 10 clinics including 1 waged worker); 90 drug shop exit polls (from 9 drugs shops including 2 waged workers); 35 home treatment exit polls and 50 ordinary shop exit polls were completed.

Results

Analysis of qualitative information was in all cases based on a preliminary categorisation and grouping of statements made and the construction of tables indicating on how many occasions each type of statement was made. Each category of quantitative information was analysed according to the question addressed as explained in the following sections.

HEALTH RELATED STRATEGIES

In all facilities lists were compiled of strategies identified as being carried out by specific health workers, using information collected through ques-

tionnaire and qualitative instruments where the strategies were either admitted by the health worker interviewed or described as carried out by an identifiable health worker, by other health workers or community members. These lists undoubtedly omit strategies pursued by a number of workers since not all were interviewed, other than by questionnaire, and not all health workers' activities are known to others or happen to be described. Even where interviewed through structured or key informant instruments, health workers have patently been selective in the strategies they have admitted. For example, in some cases a particular health worker is described as owning a drug shop by many of his or her colleagues and community members but does not say so when interviewed. In all relevant cases, evidence of others is included in the strategy list despite not having been admitted by the health worker concerned. The lists were inclusive rather than exclusive, using all information given even if only by one source.

Table 26 shows which health-related strategies are concluded to predominate in each of the facilities. In addition, health workers claim that agriculture is a major activity in all units. The facility numbers used in Table 26 are used consistently throughout the paper. Facilities 1 to 6 are in district 1; Facility 6 is the hospital. Facilities 7 to 12 are in district 2; Facility 12 is the hospital.

Health workers in all but two facilities routinely charged users beyond the formally agreed levels. The amounts charged vary (Table 32), and the numbers who avoided such charges range from almost none to sometimes apparently quite large numbers including prisoners to whom it seems health workers could not avoid offering treatment, and those with authority over health workers such as LC and HUMC members.

Drug leakage occurred in all facilities but one. In this one, accountability was much more stringent and although there was qualitative evidence that drugs did leak, the procedures used were too sophisticated to be detectable by our simple methods. In most facilities, leakage rates were very high (Table 27) and account for the greatest part of the incomes earned by health workers as a whole (Table 29).

Table 26. Main health related survival strategies

	District 1					*District 2*						
Facility	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*
Informal charges		X	X		X	X	X	X	X	X	X	X
Leakage of user charge revenues	X		X	?		X	X	X	X	X		
Leakage of drug supply	X	X	X	X	X	X	X	X	X	X	X	
Home treatment	X	X	X			X	X				X	
Ownership of clinics etc.[1]				X	X	X	X	X	X	X		X
Waged work in clinics etc.			X	X		X	X				X	X
Training nursing aides		X										

NOTE: 1. Clinics etc. means private clinics, drug shops, and maternity homes.

The main health related strategy outside the unit varied between units. In some, more than one health worker owned a drug shop or clinic where the facility drugs were likely to be used. In others (mostly the smaller units) health workers mainly treated patients at home, probably indicating that their capital base had not reached the level where they could establish separate premises. Waged work in the clinics and drug shops of others was available in towns and around units large enough to sustain separate private premises.

Training nursing aides was an activity of only one facility but made a substantial contribution to the income earned there (Table 30).

DRUG LEAKAGE

A number of health workers' survival strategies listed above depended on use of drugs supplied to the facility. Health workers always claimed to purchase drugs for their drug shops and clinics from nearby towns but other sources of information frequently contradicted this. Drugs with essential drugs labels were said to be purchased from health workers' shops; health workers seemed to know where 'out of stock' drugs could be found in nearby shops and clinics; and community members, management committee members and health workers themselves frequently accused other health workers and committee members of supplying or receiving consignments of drugs originally supplied to the facility. In one facility, a health worker immediately opened a drug shop on assuming the in-charge position.

Treatment at home, and sale of drugs from home were also facilitated by use of the unit's drug supply, as one of the researchers witnessed in two cases.

The design of the protocol took account of the difficulties of measuring drug leakage, and developed a several pronged strategy Theoretically, drug leakage might be identifiable through any of the following audits:

a) Comparison of stock depleted with number of prescriptions. A standard volume of drug per prescription was identified for each of five tracer drugs (cotrimoxazole, metronizadole, chloroquine indictable, PPF indictable and ampicillin). Actual rates of use per prescription were then compared.

b) Comparison of observed and recorded utilisation rates. Since prescriptions were listed against every patient with very few exceptions, one method of recording more prescriptions than were actually made would be to fabricate attendance figures. The number of patients attending the health facility was counted for a period of one week during 1995. This was then compared to the number of patients recorded for the whole of 1994. The comparison enabled an estimate of whether or not the order of magnitude of attendance was similar to that recorded.

c) Comparison of the recorded issuing of drugs to attending patients with drugs actually received. Drugs may be recorded as issued while patients received either a smaller quantity than recorded or were told the drug was out of stock altogether.

Drug leakage was therefore estimated to be $1-(a*b*c)$, where a is the proportion of drugs accounted for by the number of prescriptions at the reasonable prescription rate, b is the proportion of the recorded utilisation judged to be real attendances, and c is the proportion of drugs prescribed which were issued (taking the mean of inpatient and outpatient evidence where both applied).

The table shows that a very small proportion of the drugs supplied to health units were prescribed and issued there. In the median facility, drug leakage was estimated at 78%. Only in facility 2, for which we believe we have a reasonable estimate, did more than half the drugs supplied reach patients who attended there. Overall, considering the uncertainties surrounding the estimates discussed above, there is reason to believe that they under rather than over-estimate the size of the problem. Those drugs which were issued through the facility were in some cases supplied free and in others paid for there.

Drug leakage was not said to reflect the activities of facility health workers alone but was frequently alleged also to involve members of the District Health Teams and the Health Unit Management Committees.

INCOME AND EXPENDITURE LEVELS, AND LIVING STANDARDS OF HEALTH WORKERS

OVERALL ESTIMATES. Structured and key informant interviews and diaries asked health workers to estimate their income levels directly.

Table 27. Drug leakage estimate

Facility	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*
% recorded patients □ghost□[1]	13	0	22	80	57	-	0	29	64	0	0	0
% prescribed OPD drugs received (exit poll)	95	73	73	90	54	-	68	67	54	72	38	69
% prescribed IP drugs received (in-patient audit)	-	84	-	-	-	-	62	71	75	-	26	80
% drugs issued from stocks accounted for by no. of prescriptions (median)[2]	40	76	53	36	29	16	40	35	40	40	68	100
Working leakage estimate	67	40	70	94	93	84	74	83	91	72	78	?[3]

NOTES: 1. Comparison of recorded with observed utilisation is either calculated on the basis of OPD alone (where OPD alone observed), or making an adjustment for immunisation numbers on immunisation day in the facility, and recorded immunisation numbers. This is because recorded immunisation numbers include attendance numbers recorded at outreach clinics. 2. The median rate of over-use per prescription of tracer drugs is used because a few drugs are prescribed so rarely (and yet still are used up) that an average rate would be excessively biased by a few results whose representativeness of other drugs is not known. Four (33%) of facilities were not able to produce, or had not completed stock cards, even although these are meant to be a pre-condition for receipt of essential drug kits. It is unlikely that these facilities have a better than average record of leakage at this point. The median of the medians for the other facilities has been used to produce a working estimate of drug leakage for these facilities (shown in italics). 3. In facility 12, the relationship between drug supply and expected patient needs is not known. Drug audit is much more rigorous than in other units meaning that drug leakage, if any (which is suggested by qualitative evidence), must use more sophisticated means which were not detectable by our methods. It is not clear that where patients did not receive drugs, it is not due to drug supply inadequacy, as is clear in all other facilities.

In comparison, other qualitative and quantitative sources provided indirect information relevant to income levels to the extent that a number of strategies identified and described could be analysed with respect to the income likely to be generated. In particular:

a) information concerning informal charge levels and frequencies was used to estimate the total informal charge revenue generated by the facility;

b) the estimate already made of the extent of drug leakage was com-

bined with estimates of local drug prices to calculate the resale value of the leaked drugs;

c) the expected income from user charge revenues calculated by multiplying the official charges with the utilisation rate imputed from the observed attendance numbers was compared with the recorded income from user charges, and the recorded expenditure of user charges; and

d) the utilisation and charge levels at health workers' private businesses enabled an estimate of the gross income earned there. It was not feasible to collect cost information from which to calculate net incomes.

Similarly, health workers made direct estimates of their expenditures in structured and key informant interviews. This was compared to an estimate of what health workers required in order to provide adequately for their households, given their household characteristics. Household characteristic information provided by the questionnaires enabled estimate of the total expenditure requirement of the health workers' household based on its size, age and sex characteristics, and the number of members in full time education, under the assumption that the expenditure requirements per person in each category would be the average for the area as reported by the Uganda National Household Budget Survey (1990-1) and were adjusted for inflation using the Uganda consumer price index. Since the researchers themselves had experience of financing school education in the two regions, their own estimates of requirements were used for this component of the calculation. Expenditure requirements for households in which the health worker was the sole bread winner were made separately, but did not differ greatly or consistently. This suggests that second bread winners did not explain the difference between estimated expenditure requirements and health workers' formal incomes.

Direct estimates of income and expenditure suggested moderate incomes. The average facility directly reported income was 118,162/- per health worker household per month, and expenditure 136,635/-, but these were strongly influenced by one outlying facility and the medians were 81,010/- and 103,360/- respectively. These estimates would suggest that health workers were poor compared to the average resident of their region, and that incomes are insufficient to meet the expenditure requirements associated with their household characteristics (average facility level 167,298/-).

However, other evidence suggests this is unlikely. There were 1.11 children at school for every one school age child in health workers households (many outside school age are also at school). For their regions as a whole, there was a range of 0.64 (Western rural) to 0.84 (Western urban) children

at school for every school age child in 1989-90 (extrapolated from the Uganda National Household Budget Survey, February 1991). 35% of health workers were undertaking development expenditures (usually building or establishing a business), indicating a surplus of income over basic requirements, and 15% of health workers employed house servants or casual labour at their homes. However, there is likely to have been a wide range of incomes and expenditure around the experience of the average health worker. 22% of health workers had school age children who were not in school which would usually indicate an inability to raise income for basic requirements. A majority did not undertake development activities or employ servants indicating an income not much greater than that needed for basic expenditures.

These considerations suggest more credence should be placed on the indirect estimates of income (average facility level, 172,446/-, see below) as measures of the average. Nevertheless, the qualitative evidence suggested incomes were highly skewed with a few health workers monopolising most income earning activities in each unit. The incomes of these few can be estimated in multiples of the average indirect income estimate. About 65% of health workers who did not undertake development expenditures can be estimated to have had incomes in the range of, or below, the indirect expenditure estimates. About 22% of health workers whose children were out of school could be estimated to have had incomes below these levels.

INDIRECT ESTIMATES OF INCOME. Table 29 allows further analysis of the sources of income, and insight into the explanations of the variation in income by facility. It shows that the greatest source of income for health workers in most units was resale of drugs. Since the number of drug kits supplied per unit was higher in District 1 than in District 2, drug related incomes dominated to a greater extent in this district.

Incomes from unaccounted user charge revenues are bracketed and not added to the total where informal charge incomes are calculated, since it was assumed that informal charge amounts quoted by the community included formal charges. The maximum of either amounts was usually smaller than the income from drug sales.

In some cases the amounts estimated were likely to be over-estimates since they assumed that everyone paid, which was only the case in some units. In others, they were underestimated since the lowest estimates reported by the community were always used, and some types of charge had usually been excluded because the frequency of use was not known.

Salaries and allowances were insignificant relative to other sources in most units.

Table 28. Income and expenditure estimates (Uganda shillings, monthly)

District 1:	*1*	*2*	*3*	*4*	*5*	6
Average income (directly reported)	69297	88,740	69457	520240	89500	89000
Average income (indirectly estimated)	186497	142567	270922	164729	292039	-[1]
Average expenditure (directly reported)	47398	101319	111450	407300	105400	168100
Average minimum household expenditure (indirectly estimated)	164747	164468	186604	244097	181336	219934

District 2:	*7*	*8*	*9*	*10*	*11*	*12*
Average income (directly reported)	107423	82290	67824	79729	28586	153663
Average income (indirectly estimated)	142309	161479	76461	156658	173765	129479
Average expenditure (directly reported)	98533	153075	88165	74248	61408	223229
Average minimum household expenditure (indirectly estimated)	137633	121069	108781	107184	97084	274,648

NOTES: 1: Could not be calculated because utilisation levels could not be reliably estimated during the strike.

Table 29. Indirect income estimate by source (Uganda shillings, monthly)

District 1:	*1*	*2*	*3*	*4*	*5*	6
Informal charge income	0	362000	445000	0	345000	(1)
Drug leakage value	680873	541371	711360	1233145	708825	(1)
Unaccounted user charge revenue[3]	104613	-	(344025)	261500	-	651652
Training NAs	-	250000	-	-	-	-
Salaries and allowances	147000	272300	198249	482100	114330	5217252
TOTAL	932486	1425671	1354609	1976745	1168155	(1)
Average income per worker (total)	186497	142567	270922	164729	292039	

District 2:	*7*	*8*	*9*	*10*	*11*	*122*
Informal charge income	372400	938600	304800	647500	545,400	3442000
Drug leakage value	650892	701610	777689	406767	428755	-
Unaccounted user charge revenue[3]	(210562)	(320108)	(155633)	(311616)	-	-
Training NAs	-	-	-	-	-	-
Salaries and allowances	115176	459017	370268	199000	242200	2902466
TOTAL	1138468	2099227	1452757	1253267	1216355	6344466
Average income per worker	142309	161479	76461	156658	173765	129,479

NOTES: 1. Data missing because utilisation unknown: facility visited during strike period. 2. Facility 12 data relates to outpatient department only. 3. User charge income in parentheses where it is less than informal charge income. It is assumed that informal charge income estimates include these amounts. Totals exclude these amounts in order to avoid double counting.

PRICES, UTILISATION LEVELS AND INCOMES EARNED IN EXTERNAL ACTIVITIES. Those questioned in exit polls in Phase 2 were asked how much they had paid; whether or not they had previously visited this or the public facility; and if they had visited the public facility, how much they had paid there. Weekly utilisation was observed for one week at each care setting. Income was imputed based on the observed utilisation level and the reported total charges. These data are presented in Table 30.

Table 30. Prices, utilisation patterns and imputed incomes from external activities (Uganda shillings)

	Private clinics	*Drug shops*	*Home treatment*	*Mean*
Own price	2946	1376	1660	2116
Weekly utilisation	95	77	17	79
Imputed monthly income	1,212,770	459,125	122,287	724,377

Private clinics had the highest charges at nearly U.Sh.s 3,000 whereas drug shops and home treatment were likely to cost patients similarly at around half that amount. Private clinics were most heavily used, and home treatment least so. The imputed income estimates calculated by multiplying the observed utilisation by the average prices paid confirmed the vastly superior earning power of private clinics over drug shops (2.6 times more profitable) and especially over home treatment (9.9 times more profitable). Of course, these income estimates are gross rather than net: they did not allow for business expenses which were likely to be much higher for private clinics than for home treatment.

LIVING STANDARDS ASSOCIATED WITH EXTERNAL ACTIVITIES. Information on living standards derived from the questionnaire and observation schedule of individual health workers in Phase 2. The sample sizes were small, but consistently suggested (with only a few minor exceptions) that clinic owners had highest standards of living. They were inconsistent in ranking other economic activities in their capacity to support living standards.

USER CHARGES

Nine of the 12 facilities had instituted formal user charges. These had generally not been successful according to both community members and health workers, although two facilities seemed to provide exceptions. Most commonly, health workers talked of initial enthusiasm for the scheme, encouraging them to work harder and please patients, in the expectation that a considerable cost sharing allowance would result. To some extent these expectations may have been unrealistic. It is also clear that leakage of revenues at different levels caused allowances to fall far short of the level they would otherwise have reached. Whatever the cause, such enthusiasm proved short lived and if anything, user charges had been added to health workers list of grievances and serve as an additional demotivating factor. Health Unit Management Committees were widely accused of participation in the leakage of revenues and drugs, and of awarding themselves overgenerous sitting allowances and other benefits. Even in the facility where

user charges were working better, community members did not recognise the HUMC as representing them.

In general, community members did not consider the levels at which formal user charges were set (usually, for example, between 300/= and 500/= for an outpatient attendance and between 2,000/= and 3,000/= for a delivery) to constitute a barrier to utilisation in isolation. However, in combination with unavailability of drugs and other perceived quality problems they might have done so.

Table 31 estimates the extent of leakage of user charge revenues. Combining the difference between recorded revenue and expenditure, and the difference between expected and recorded revenue, leakage ranged from 0 to 77%, most commonly around 70%.

Table 31. User charges (Uganda shillings)

District 1:	*1*	*2*	*3*	*4* [9]	*5*	*6*
Recorded user charge revenue (per month)[6]	60825	NA	193100	-	NA	1372583
Recorded user charge expenditure (/month)[6,8]	36387	NA	151475	-	NA	1202348
% shortfall (excess)	40	NA	22	-	NA	12
Expected user charge revenue (per month)[1,2,3,4,7]	141000	NA	495500	-	NA	1854000
% shortfall (excess) compared to expected[5]	57	NA	61	-	NA	28

District 2:	*7*	*8*	*9*	*10*	*11*	*12*
Recorded user charge revenue (per month)[6]	52317	259433	128400	133300	NA	3390761
Recorded user charge expenditure (/month)[6,8]	63583	150791	59967	124266	NA	3341478
% shortfall (excess)	-22	42	53	7	NA	-1
Expected user charge revenue (per month)[1,2,3,4,7]	274100	470900	215600	435882	NA	-
% shortfall (excess) compared to expected[5]	81	45	40	70	NA	-

NOTE: Expected user charge revenue is calculated using the following assumptions. 1. Observed numbers of attendances were used as the basis for calculation, adjusted as for table 3 12. 2. Where charge rates are divided according to first and repeat attendances, all OPD cases are assumed to be first attendances and all ANC cases are assumed to be repeats. Where adult and child rates are separated, OPD attendances are assumed to be half child, half adult. 3. No allowance has been made for exemptions. 4. In facility 6, recorded numbers have been used since observation occurred during the strike period and cannot be assumed to be representative. 5. Where separate charges for laboratory and theatre are made, these

are excluded from both the denominator and numerator of the comparison of recorded with expected income, since numbers of operations and laboratory tests are not known. This leads to some of the percentages in row 5 not reflecting the estimates in rows 1 and 4 exactly. This could not be done for facility 12 where revenue records were not broken down by department. Expected revenue has therefore not been calculated. 6. Where there is missing data, the monthly average of the data available is used, periods are not always exactly coterminous for all calculations. Where all data were available, the period compared is July to December 1994. 7. Inpatients are assumed all to be charged at the rate for one day, or the minimum. 8. Where records of banked amounts were available (only in one facility), they were included as expenditure. 9. There were no records available in facility 4 which had only just begun charging user charges.

INFORMAL CHARGES

There were considerable differences in the real cost of consulting each facility as indicated in Table 32.

Table 32. Real financial cost of consulting facility (Uganda shillings)

District 1:	*1*	*2*	*3*	*4*	*5*	*6*
Outpatient visit	(300)	(0)-3,000	(500)-2,500	(500)	500-1,000	(600)-2,000
Delivery	NA	2000	5000	(3000)	1,000-7,000	(5,100)-10,000
Inpatient stay of 3 days	NA	5000	NA	(2000)	-	(4,600)-6,600

District 2:	*7*	*8*	*9*	*10*	*11*	*12*
Outpatient visit	(200)-5,000	2000	(500)-5,000	(300)-5,000	1,400-4,500	(500)-20,000
Delivery	3000	3000	3,000-10,000	3,000-7,000	3,000-10,000	10,000-200,000
Inpatient stay of 3 days	NA	Not reported	4,000-5,000	NA	9,000-11,000	4,000-7,500

NOTES: 1. In each case the range of charges reported by community sources is quoted. 2. Amounts in brackets are equivalent to formal user charge levels indicating that informal charges are not always levied.

The amounts shown were sometimes equivalent to the formal charges (in facilities 1 and 4), and sometimes included the formal charge as the lower estimate, indicating that informal charges were not always levied. Qualitative evidence on the implications of these estimates for financial accessibility indicates that some of the amounts charged were absolutely outside the ability to pay of most people. This applied to almost all charges at facility 12 which was considered by the community to be a facility only

available to the relatively rich. In the facilities where charges were usually quite low, they are considered affordable by most. Some facilities were even said to be only for the poor, since anybody with more resources was expected to seek better quality services elsewhere.

UTILISATION LEVELS OF PUBLIC FACILITIES

The qualitative evidence indicates, therefore, that low utilisation was sometimes caused by financial inaccessibility, and sometimes by poor perceived quality. The result in all non-hospital units was extremely low utilisation. Table 33 shows selected utilisation levels in the 12 facilities.

In the average facility there were less than 20 outpatients per day. In some facilities there were also significant numbers of ante-natal care patients and there is usually a busier immunisation day. Nevertheless this level of utilisation was less than expected of the smallest rural unit and most units could and did manage the workload with only one qualified health worker despite the expected staffing levels being much higher. Seven of the ten non-hospital facilities had utilisation levels lower than the average for the small private clinics studied in Phase 2 (see Table 5 14above: the weekly utilisation of private clinics reported there of 95 is equivalent to a monthly utilisation of 411).

Table 33. Utilisation levels of public facilities

District 1	*1*	*2*	*3*	*4*	*5*	6
Monthly outpatient attendances[1]	327	845	701	359	117	1964
Monthly deliveries	0	25	19	20	0	64
Monthly inpatient admissions	0	4	4	5	0	223

District 2	*7*	8	9	*10*	*11*	*12*
Monthly outpatient attendances[1]	335	386	330	599	358	2284
Monthly deliveries	39	30	7	10	0	369
Monthly inpatient admissions	6	21	24	?	30	1103

NOTES: 1. In each case numbers given are based on the observed utilisation rate, adjusted as for table 3 12, except facility 6 where observed data could not be relied upon owing to the strike. In this case, recorded data was used. 2. Ministry's official catchment population, not whole district population for hospitals.

Deliveries and inpatient services were offered only in some units. The

numbers of deliveries were extremely low indicating that deliveries did not usually take place in public health units. Only the hospital in district 2 (facility 12) seemed to offer a popular maternity service.

Inpatient numbers were insignificant at less than one per day in all non-hospital units. One unit (unit 10) provided inpatient services despite officially not having this role. Numbers were not recorded, however.

TIME INPUTS OF HEALTH WORKERS

TIME INPUTS BY PUBLIC HEALTH FACILITY. The major source of information used to address this question was the direct observation of health worker attendance during one week. On each day, arrival and departure times in the morning and afternoon by member of staff were observed and recorded, and a table constructed of the average weekly hours on duty by grade of staff. This was compared with health workers' accounts of their attendance patterns, and community accounts of their experience of health worker presence at health facilities. Table 34 shows the weekly hours worked on average by health workers in the 12 facilities.

The hours worked were very low reflecting the fact that most units were open only for 2 to 3 hours in the morning and had informally arranged shift systems which required at most one qualified health worker to be on duty at any one time. Given the low utilisation levels described above, one qualified worker was usually sufficient to deal with the workload.

In most facilities, the largest proportion of the hours worked were contributed by nursing aides and the average number of hours contributed by qualified workers were even lower. In total 71% of total hours of available health worker time were contributed by the unqualified group. In Unit 8. no qualified health worker attended at all during the observation week.

HEALTH WORKERS TIME DISTRIBUTION OUTSIDE THE FACILITY. This question was explored further in Phase 2. Health workers were observed for six days (clinic, drug shop and ordinary shop operators) and three days (waged workers and those engaged in agriculture) and their activities throughout were recorded. Table 35 gives a summary of the results of this observation in terms of the percentage time spent in each activity. These data have not been standardised to ensure comparable time periods have been observed.

These data confirm that clinic owners and waged workers allocated least time to work at the public facility. For all but those engaged in home treatment and those operating ordinary shops, the public health facility consumed significantly less of the workers' time than their primary economic activity.

Table 34.: Average weekly hours worked in the facility per health worker1

District 1	*1*	*2*	*3*	*4*	*5*	*6* [4]
Total weekly hours	30	58	128	14	42	-
Hours per worker attending during week observed	15	14	26	2	14	-
Hours per worker (total[3])	8	7	26	1	8	-

District 2	*7*	*8*	*9*	*10*	*11*	*12* [2]
Total weekly hours	86	86	133	172	137	355
Hours per worker attending during week observed	12	29	12	22	27	27
Hours per worker (total)	11	7	7	21	20	7

Notes: 1. The table includes clinical and laboratory health workers only. 2. In facility 12, the number of health workers prevented identification of job titles with individuals and the total number of clinical staff on duty is estimated as the largest number attending on any one day (13). The calculated total is therefore a maximum. Facility 12 data relates to outpatient department only. 3. Health worker totals are counted as the number observed in the unit during the whole month since the establishment is often a poor guide to how many workers are actually employed there. In facility 12, the number observed was too high to count and the official establishment figure has been used, adjusted for the fact that only the outpatient department was observed. 4. No analysis of the hours worked observed in facility 6 has been carried out owing to the unrepresentative (strike) period in which observation took place.

Table 35. Time allocation (%)

Primary economic activity / Daily activity	*Private-Clinic*	*Drug shop*	*Home treatment*	*Ordinary shop*	*Waged work*	*Agriculture*
Primary economic activity (as column headings)	55	51	20	37	74	39
Gardening	2	2	11	0	2	
Public health facility	12	31	33	37	9	31
Other (housework, leisure etc.)	30	16	34	25	16	29

Conclusions

This research has attempted to access the "hidden" aspects of health care delivery in Uganda. Most research stops at what is officially acknowledged and accepts the accounts of those within the system at face value. As a result, the findings of this research may seem unusually bleak.

It should be remembered that Southern Uganda has returned to peace and stability for not much more than a decade and that while the surface of a society can respond quickly to a new situation, underlying characteristics must be expected to take longer. The types of activities explored here have been the basis of survival of health workers during a critical period in which survival could not be taken for granted and required both entrepreneurism and prioritisation of self interest. It is probable that they will not be given up lightly or without a substantial level of confidence in alternatives.

In this perspective, progress must be measured in small units. Much progress has been made in policy development and in the articulation of the issues affecting the health sector. That much of this is yet to bear fruit in effective delivery of services to those who need them, should not be interpreted as the failure of the efforts which have been made. This is a long process to which this study hopes to contribute. Nevertheless, recognition that the public health system largely fails to effectively deliver services to those who need them is an essential part of that development process and the evidence of this study makes clear that this is the case.

This research has not addressed the question of how amenable to change health workers are. Research to follow-up this study will most usefully address whether or not a change of culture within the health services, and a new generation of health workers is required, or whether the putting in place of key measures which attempt to change the incentive structure in the system could suffice.

At this time in Uganda, decentralisation policy and the growing culture of democracy offer substantial opportunity to enforce greater accountability for health service delivery on the part of district administrations and incentive for administrations to enforce greater accountability on those within the health sector. There seem to be a few important policy areas which offer scope to intervene in the situation - the area of policy around salaries, allowances and personnel; regulation of the private sector; public representation at the health unit level, including the communitys role in setting and regulating user charge policy; other aspects of user charge policy; and drug management. Much has already been done in each of these areas, and there is clearly an awareness of where problems lie among policy makers.

Coping through private practice: a cardiologist in Maputo, Mozambique

Albertino Damasceno, Wim Van Lerberghe and Paulo Ferrinho[75]

Introduction

Mozambique is one of the poorest countries in the world. At in dependence it inherited from its colonial power a health system singularly deprived of human resources, particularly doctors. Even today population/doctor ratios in Mozambique remain far below sub-Saharan African averages. Most doctors are hospital specialists who concentrate in the larger cities to work at the most differentiated hospitals. Work in large cities also has the attraction of a growing economy that supports a small but increasing private-for-profit-health-sector. This sector can provide an (additional) income to health professionals in public service.

This attraction for the private-for-profit-health-sector corresponds not only to emergent strategies of the health professionals to make ends meet, but also to policy options of the government and international organisations. This departure from previous public health policies (that prohibited private practice) was based on claims of greater efficiency, greater coverage, greater patient choice and professional satisfaction and better quality. These claims were voiced essentially through the highly- influential medical class in Maputo, but were not based on hard evidence.

Since then most Mozambican doctors in public employ also do private

[75] The authors wish to acknowledge the help of Drs Carolina Omar, Mariamo Abdulah and Jesus Fernandes.

practice. They may do so in the so-called "special private clinics", within the public hospitals, or in "private clinics", in a completely private sector setting.

This case study documents of the monthly practice of one cardiologist in Maputo city, who sees patients in three settings: the outpatient department of the public services of the Central Hospital of Maputo (PSCHM), the Special Private Clinics (SPC) within this same central hospital, where he saw private patients on a fee-for-service base, and in Private Clinics (PC)[76].

The aim of this study was to verify the claims that private care would constitute an efficient complement to the public service, by looking at differences between "public" patients, "private" patients within the public structures, and "private" patients at a private clinic) did not affect quality of care and that private care is more efficient.

Public – private differences

PATIENT PROFILES

Of the 141 patients seen during the one month period, only 23% were in the public consultation of the Central Hospital: 30 (21%) were seen as private patients in the "special clinics" within the Central Hospital and 79 (56%) in private clinics outside the hospital. In the private clinic 52% of patients were women. At the public consultation of the Central Hospital the proportion of women was the same, 53%, but at the "special clinic" of the Central Hospital 73% were males (p=0,045). There were no differences in age (PSCHM 51,0 years, SPC 50,0 years, PC 51,8 years) or in completed schooling (8,1 years ±4,7 in the PSCHM, 9,0±4.7 in the SPC and 7,7±4,3 in the PS, p= 0,386).

Half of the private clinic patients, one third of the public patients, and 17% of the private patients at the special clinic of the Central Hospital were first patients (p=0,026). Public patients seem to be followed up for a longer time (an average of 2,6 consultations against 1,5 and 1,6 in the special clinic of the hospital and the private clinics, p=0,001).

[76] During one month (January to February 1999)), one of the authors (AD), a Mozambican cardiologist, entered into information on the patients he personally consulted in a standard, piloted schedule. The data collected included personal data, waiting times, profile of the illnesses seen, investigations requested and direct-cost of the consultation to the patient. He did this at the different venues where he provides ambulatory care.

The majority of patients (84%) were Maputo residents, but the private patients were somewhat more recent arrivals: SPC and SP patients had been residing in Maputo on the average 28 years; the public patients 32,7 years (p=0,187).

At the public consultation almost all patients were Mozambicans (93,8%); over one third of the private clientele had another nationality: 34% at the private clinic and 40% at the "special clinic" within the Central Hospital (p=0,010).

CLINICAL PROIFILE

12.5% of public patients consulted for a new problem (12,5%) compared with 56,7% and 45,6% of private patients in the special clinics and in the private clinics (p=0,000).

The most frequent reason for consultation of public patients was hypertension and associated problems (47%). This was followed by ischaemic heart problems (12%), rheumatic heart disease (9%) and other problems (31%). The pattern is similar in the "special clinics" (40%, 23%, 3.3% and 33%). In the private clinic outside the central hospital chronic degenerative disorders (hypertension and ischaemic heart disease) were slightly more frequent than in the other sectors (58%, 14%, 2,5% and 25%). Twelve patients had more than one presenting clinical problem.

DIFFERENCES IN CONVENIENCE AND CONTINUITY

Advanced booking of the consultation was more frequent for the public sector consultation at the Central Hospital: 81,3% against only 23,3% in the "special private clinics" in the same hospital. In the private clinics outside the central hospital 55,7% of the patients had an advanced booking (p=0,000).

The waiting time from time of booking to the day of consultation was shorter in the Central Hospital (35% of patients had to wait one week or more, both for public and for private patients) than in the private clinics outside the hospital, where 83% had to wait one week or more (p=0,066). On the other hand, public patients had to wait longer times on the day of the consultation (110,3 minutes) than private patients in the "special clinics" of the central hospital (39,7minutes) or in the private clinics (12,4 minutes, p=0,000). The duration of the consultation showed the opposite pattern, shortest for public patients, 22.3 minutes, longer in the special clinics (30.2 minutes) and longest in the private clinics (31,7 minutes) (p=0,000). Patients in the hospital saw the same doctor less frequently in

the hospital (77% of public and 75% of private patients) than in the private clinics (96%) (p=0,026).

The interval between repeat consultations was shortest in the private clinics, an average of 20,7 weeks. In the Central Hospital it was 28.7 for the public and 48,6 for the private patients of the "special clinics" (P=0,000).

DIFFERENCES IN CARE

We have seen above that private patients get more doctor time. Table 36 compares X Ray, ECG, laboratory tests and other investigations for the three groups of patients.

Table 36. Investigations in different kinds of patients

	ECG	X rays	Laboratory	Other
Public patients at the Central Hospital	6,3%	9,4%	62,5%	21,9%
Private patients at the special clinic of the Central Hospital	76,7%	0,0%	75,9%	76,7%
Private Patients at the private clinic	44,3%	5,8%	45,6%	40,5%
p	0,000	0,000	0,013	0,000

Surprisingly, the number of different drugs prescribed was higher for public patients (3.1, with 2.0 national formulary drugs) than for private patients, either in the Central Hospital special clinics (1,1, 0.6) or the private clinics (1.6, 0.8) (p=0,000).

DIRECT COSTS TO THE PATIENT

Public patients pay relatively small sums for the consultation and investigations: the equivalent of $US0.029. A consultation as a private patient is much more expensive: $US15-30 at the special clinic of the central hospital and $US 15-60 USD in the private clinic (p=0,000).

Discussion

More that three out of every four patient seen by this (civil servant) cardiologist were private patients. Moreover, two out of 32 public patients and a staggering 72 out of 112 private patients were actually non-Mozambican nationals. This reflects demand as well as the importance private activities

have for the professional concerned.

Although there were differences in socio-economic extraction (nationality, willingness and ability to pay, shorter stay in Maputo and more females), there were no major clinical differences between patients, were it not for somewhat more rheumatic heart diseases among public patients.

The marginal benefit of a consultation as a private patient stood in no proportion to the marginal cost. The direct cost of the consultation to the patient in the public sector was symbolic; it was considerable as a private patient. Treatments were similar – maybe even more rational for private patients. Para-clinical investigations were more complete for public sector patients, probably reflecting less cost-consciousness, or the fact that public patients tend to be first consultations more often than private ones. A consultation as public patient seems to be used as a means to initiate patients to the private sector, at the earliest stages of their process of treatment, when the need for investigations seems most frequent.

There is no evidence for discrimination against public patients in terms of investigation or treatment. The most striking observation is the extent of the competition for the time of a civil servant doctor. Out of 66 hours seeing outpatients in one month, less than 12 were spent seeing public patients; a considerable amount of time – over 37 hours – was for seeing private patients who were not nationals. Private practice in Maputo may allows a doctor to earn enough income to be able to care for public patients without much discrimination – but there is not all that much time left to do just that.

At the other end of the brain-drain: African nurses living in Lisbon

Margaret Luck, Maria de Jesus Fernandes and Paulo Ferrinho

Introduction

"Brain-drain" of trained health professionals through emigration is a problem faced by Ministries of Health in many African countries. There is surprisingly little scientific evidence about its extent, determinants and consequences.

The opportunity for this exploratory study[77] arose during the development of an action research project in an immigrant squatter community in Greater Lisbon. Initial contacts with the community revealed that its inadequate housing conditions and lack of basic infrastructure belied a surprising wealth of human resources, including the presence of a number of trained health professionals. In most cases, these health professionals had abandoned relatively prestigious posts in public sector hospitals in Portuguese-speaking African countries to take up residence in this urban slum in Lisbon.

Having previously considered the issue of "brain-drain" from the perspective of African Ministries of Health, we were intrigued by the possibility of examining this phenomenon from the perspective of the emigrants them-

[77] This study was supported by the Associação para o Desenvolvimento e a Cooperação Garcia d'Orta and the Centro de Malária e Outras Doenças Tropicais. We acknowledge the assistance of Wim Van Lerberghe, Virgílio do Rosário and of Ermelinda dos Santos and the interview participants.

selves. We wondered why these professionals had chosen to emigrate, what their professional experiences in Portugal had been, whether they intended to stay in Portugal, and under what conditions they would consider returning to their country of origin.

Methods

In early 1999, a focus group discussion was held with eight health professionals who had emigrated from Portuguese-speaking African countries (PSACs) to a squatter community comprised largely of African immigrants. The focus group participants were sampled using a "snowball" technique. The primary contact, a nurse living in the community, contacted several individuals known to her. These individuals in turn suggested others known to them. The criteria for inclusion were that the individual be a health professional, a PSAC national, and a resident of the study community. A community resident who had received training on focus groups led the two-hour discussion, which was observed and tape-recorded by authors ML and MJF.

During the month following the focus group discussion, individual interviews were held with the participants in order to collect information on more sensitive issues, such as salaries and family problems, and to follow up on issues raised during the focus group discussion. The interviews were conducted and tape-recorded by author MJF.

The tape recordings of the focus group and individual interviews were transcribed using word processing software, and were coded and analysed using Nud.Ist software. The interviews were analysed using domain analysis.

Of the eight participants, four were nationals of São Tomé and Principe, two of Angola, and two of Guinea-Bissau. Seven were female, and one male.[78] The participants ranged in age from 31 to 56 years, with a median age of 39 years. Seven of the participants were nurses, and one was a pharmacy technician. All had worked in public sector hospitals in their country of origin, with a median length of service of 14 years (range 4-20).

The participants' year of arrival in Portugal ranged from 1989-1998, and the median duration of residence in Portugal was 6 years.

Circumstances in Country of Origin

In order to understand the participants' personal circumstances prior to

[78] To enhance confidentiality, information about and quotations by the male participant have been edited to use female pronouns.

their decision to emigrate, participants were asked about working conditions at the hospitals where they were employed, about their personal economic circumstances, and about the general political and economic conditions in their country of origin.

WORKING CONDITIONS. The majority of participants stated that the hospitals where they had been posted prior to emigration had inadequate working conditions, but at least one participant from each of the three countries represented had been on the staff of a hospital or ward with adequate working conditions. The hospitals and wards described as having reasonable conditions received support from foreign donors (n=2), or had deteriorated since the time of independence (n=1).

> *. . . Things were good. There were linens for the patients' beds. I worked in the paediatrics ward where we had everything. There was food for the mothers. [. . .] We had a room for nurses where we could change our clothes, leave our things in the cupboard.*
>
> *At the time, things weren't so bad. We didn't have a lot of [medical supplies], but it was enough to work.*
>
> *Until [independence], there was everything. Some years later we still had stocks, but then we began to go without. I was chosen to work in the surgical theatre. There, we began to have some difficulties in [obtaining] material, but we got by.*
>
> *Our hospitals didn't have [minimum] conditions. Many times a health professional would leave work and wouldn't have alcohol for disinfecting.*
>
> *There was a shortage of medical supplies, but that shortage was for some, because those with financial means didn't suffer.*
>
> *. . . We changed our clothes in the treatment room, and spent the night sitting on a chair. It was very difficult. The patients didn't have bed linens. [For] those who didn't bring them, we arranged a sheet somehow, and when they dirtied it they just laid there on the mattress. There were lots of mosquitoes there; conditions*

> *were very bad; there was garbage in the hospital. There practically weren't cleaning staff, because the salary wasn't enough to survive. The few there were came in at 8 a.m., and at 1 p.m. they went home.*

PERSONAL ECONOMIC CIRCUMSTANCES. All but one of the participants stated that the public sector salaries they received in their countries of origin were not sufficient to cover their basic living costs. Several participants said that their monthly pay funded less than one week's expenses. One noted that she often went months without receiving her pay.

> *A person working for the State in the area of nursing was not able to buy a decent outfit of clothing. If I did buy a decent outfit, then I wouldn't have money to buy milk for the whole month.*
>
> *What I earned [from the State] barely covered transport.*
>
> *If I had breakfast, I didn't have lunch; if I had lunch, I didn't have dinner.*
>
> *People eat once a day. A person leaves work, makes do with a donut, a cup of milk or baobab fruit juice and nothing more, and waits up to 13 or 15 hours for a meal--until the next day.*

Participants from Angola and São Tomé and Principe stated that their public sector salaries were adequate for basic living costs prior to 1989. Starting in 1989, inflation and currency devaluation eroded the purchasing power of their salaries to the point where they could no longer cover rent or other major living expenses.

> *In 1989 I earned 500,000 kwanzas, but at that time things got difficult, and that salary only bought fruit. Milk cost 70,000-100,000; a chicken was 25,000-50,000.*
>
> *[After inflation surged and the value of the national currency declined], no one was able to manage the situation. Poverty*

spread in such a way that a health professional working in the public sector could not survive.

Five participants described individual economic "coping strategies" they undertook to complement their public sector salaries. These strategies included working for a foreign-sponsored technical assistance project, selling food and drink, doing sewing, engaging in private practice, and working in a private clinic. For several participants, these "extras" provided more income than hospital jobs.

I sold beer at home, and food, because I had a big garden, with space where I could build another house. So I built a shack where I sold these things, and on the weekends I would go to sell at the fairground. Also, I did sewing. That is the money I spent during the month; it was quite a big struggle.

Even I, who worked in the hospital and worked part-time in another clinic, my salary didn't cover the whole month.

I did "extras" at home. [. . .] I set up a "mini health post" at home. I . . . attended to the [health problems of the residents] of the area [where I lived]. . . . Beyond nursing, I did other things; I made cakes to order for parties.

GENERAL POLITICAL AND ECONOMIC CONDITIONS. When asked about their lives prior to emigrating, participants from Angola and Guinea-Bissau described hardships, fear and uncertainty associated with unstable political and economic conditions.

They have returned to war again. I don't know, only God knows [what will happen]. It is the big leaders who are provoking the war, and there we are.

Now there is war, even today it has begun [again]. I am here, but I feel so bad. It is just that I am a person who doesn't like to show my difficulties on my face. Today I phoned Dakar. I have two children there since the month of August. I spoke with them

and then I went to the supermarket, and someone said, "Did you hear the radio today? There was something about Guinea [-Bissau]. As soon as I got home [. . .] I turned on the television. [On the television news], there were a girl and boy crying and screaming in distress; I could even hear the sound of the bombardment. I was so distraught because I have a son there. [. . .] He said that he didn't want to abandon the house.

My husband worked, and we would buy a case of chicken when we could, and we kept it in the freezer. Sometimes the electricity would go out, and everything would spoil. To buy things in the black market, the price was triple or more.

Because of the conditions that the country was experiencing at the moment, no one could afford the price of a chicken or of a can of milk at the time, with the situations that were just getting worse in the country.

Emigration

REASONS. Most participants named more than one reason for emigrating. The reason most often cited was to improve their personal economic circumstances (n=5). Four participants cited marital issues - either to join a spouse in Portugal (n=2) or get away from an unhappy marital situation (n=2). Three participants said they emigrated in order to provide a better education and social environment for their children (n=3).

I came here on an official mission, but noting the situation in my country getting worse, I came with the intention to stay, because everyone has the ambition to live a better life. I took this risk; I was already a widow with six children, poor, coming from a very poor family.

Sometimes a person leaves that sacrifice that is work, arrives at home, [and] doesn't have bread to feed the children. Seeing that, I came here on an official mission and resolved to stay.

> *In the schools [in the country of origin], there is separation. The children of Ministers, of big entrepreneurs, of businessmen, have a school called the Portuguese School where they study French, English. These children have a different education from my child. These schools are normally private schools. My child goes to the State school and has a teacher who is not well trained. This teacher doesn't even know how to speak Portuguese. [. . .] So I saw that my child, who is the same age as the others, has an education different from the other children. With what I earn, I cannot pay for my child to go to the Portuguese School.*

> *We are seeking a better social environment to offer to our children, a better education. In Africa, the teachers are always on strike. Because of the delay in receiving their pay, the teachers are on strike [. . .] So parents who are enlightened make the decision to emigrate, so that their children can have a better education than that in Africa. We have all come here seeking better conditions to offer to our children.*

VISA STATUS AT TIME OF EMIGRATION. None of the participants had requested official permission to reside and work in Portugal at the time of emigration. Instead, they travelled to Portugal for holiday (n=4), to study (n=3), or to accompany a family member receiving medical treatment (n=1), and then remained.

Employment in Portugal

ATTEMPTS TO WORK AS A HEALTH PROFESSIONAL. Several of the nurses had applied for the official "equivalency" required for nurses with foreign training to be professionally recognised in Portugal. They had learned that to obtain equivalency they would need to complete the "12th year" (the last year of secondary school) and three years of nursing school. None of the participants had chosen to return to school.

> *For those who left school ten years ago, it's not logical. A person feels psychologically affected [when told to repeat nursing school]. [. . .] Even in Germany, which is more developed than*

Portugal, they give you a chance. I have colleagues who went to France and Germany. They exercise their professions because they are given a chance. They ask you, "Did you do the nursing course?" A person responds yes, and they ask for the documents. Many don't even ask for the certificate. But they put you in an internship for 6 months to evaluate your capacity.

I never paid the 30,000 escudos [USD$160] [to request an equivalency] because they were talking about the 12th year. I, already 40 years old, with three children. Life here is so hard; how could I study?

All the participants expressed anger and disappointment that they were unable to work as nurses (or, in one case, as a pharmacy technician). Discussion of professional humiliation and rejection and of the indignities experienced when attempting to work in their field predominated in the focus group and interviews to such an extent that it was difficult for the moderator and interviewer to lead the discussions into other topics.

I don't know why many times the African can't get a job here to use his technical knowledge. I feel very defeated because of this. The African has capacity, has technical knowledge. I don't know why it is that the African is not considered to have level of a nurse trained here in Portugal. Really, they say that Africans do a technical course and they do a superior course, but there is no difference.

[The Portuguese] don't value our training. For example, last week there was an inspection [at the nursing home] and we had to take blood for analyses. The nurse herself was struggling to tap a vein. [. . .] The patient herself said, "When I go to the hospital, they don't do it like that." I said, "Let me do this exercise." In a short time, I tied the garrotte on the lady and got it right away. The patient said, "Sometimes people get mixed up. When I was admitted in Hospital E., there was a coloured lady there who was excellent at giving injections. Others would be sticking you on one side and the other, but the girl would arrive and you

would be set in an instant." I answered, "It's because here they don't value me, but in my country I worked for four years in Intensive Care, where it's life and death." Of course I know how to do it. I know how to defibrillate. But the whole time a person is here, she is stopped. Now I never do sutures, never defibrillate. What is the practice a person is going to have? Their training is going to die away. It's a shame; it's a shame.

They say that here in Portugal there is no racism, but if I were white I would already have a position [as a nurse].

The first day that I went to work [at a private clinic], an aide went to tell the boss that I was not be a nurse because I didn't know how to make a bed properly. Imagine; a person completes a nursing degree and is submitted to an exam in bed making. At the time, I had been a nurse for 20 years. I had been head nurse in the Intensive Care unit [of the capital city hospital] in my country.

[Not being able to work as a nurse] only brings psychological consequences for a person who thinks, and who has the power of reflection. Because everyone since childhood has been gaining knowledge, learning a profession in order to execute his profession correctly, to earn his bread each day, to help his family. Arriving here, we encounter certain obstacles, like not having documentation, asking for equivalency. With equivalency, they ask for [Portuguese] nationality, with nationality, they ask for other things.

PRESENT EMPLOYMENT. At the time of the interviews, none of the participants was working in her professional capacity.[79] Five participants were employed: two as aides in nursing homes, one as a cleaner, one as an aide in a community centre, and one as a manual labourer in civil construction. One of the unemployed participants had previously worked as a nurse in private

[79] Several months after the interviews, one of the unemployed participants, who had done her nursing training in Angola during the colonial era, received her nursing "equivalency" and began work as a nurse in a Portuguese health center.

clinics, but had been dismissed after a Work Inspection team found that she did not have an "equivalency." Another participant had worked as a nurse in a Portuguese health centre on a short-term contract, but had lost her job when the Government instituted a policy prohibiting the hiring of public sector nurses on a contract basis.

Four of the five employed participants provided information on their current salaries. The salaries ranged from USD$2,580 to USD$8,000 annually, with a median of USD$4,280. The participant who did not reveal her salary worked in civil construction. Personal communications with individuals familiar with this industry indicate that this participant's annual salary is likely to be around $8,400. If this were true, then the median annual salary of the five employed participants would be USD$4,580.

Several of the participants described the working conditions at their actual places of employment as exploitative, principally because they were often required to work extra hours for which they were not paid. One participant noted that she had an appointment to see a doctor but feared that she would have to miss it because her employer would not allow her to be absent from work.

> *My work schedule is from 8 a.m. to 4 p.m., but many times I leave at 6 p.m. The boss doesn't pay me extra hours. [. . .] I live in the midst of confusion, and many times I arrive at home and say that I will not go to work the next day. My mother, my children always say, "Go [to work], because if not you will have to return to the cleaning service [. . .]"*

> *My schedule is from 8 a.m. to 4 p.m. When 4 p.m. comes along, or 3:50 p.m., [they tell me] I have to [accompany a nursing home patient] to the hospital, and I know I am going to have to stay there a long time. [. . .] They know that the hospitals always take a long time. If I leave [the hospital] at 9 p.m. they don't pay me; they always say, "She stays at the hospital [a long time] because she wants to."*

Most of the participants raised the issue of instability in their employment due to the fact that they work on temporary contracts and lack of social security benefits—particularly short-term disability insurance.

If [my bosses] don't like me, when the contract ends they can throw me out on the street.

They can throw us out when they want to. They always have nurses willing to work for them. We don't have any other option [but to work in the nursing homes]. The hospitals don't want us. We have to put up with it, or go work in cleaning services, which is another kind of exploitation—leaving the house at 5 o'clock in the morning or 4 o'clock.

Return to country of origin

When asked about returning to their countries of origin, the participants acknowledged the difficulties of life in Portugal compared to that in their countries of origin, but also re-iterated the reasons they decided to emigrate. None expressed a firm intention to return.

The standard of living which I had back home and that which I have here are so different, in all aspects, principally at the family level. Because here I live only with my nieces. I have a child here who is in [a provincial city in Portugal] and only comes every two weeks. The older [child] is living in his house. [Back home], I had my work, I exercised my profession. But here, no. This situation worries me. I left for matrimonial reasons and because of that, I must deal with the situation I encounter here. Because I can't go back, no. One day I should return because it is my homeland. I wouldn't like to stay here as an old person; however I will not return because I want my husband to forget about me, to arrange another [wife] so that I can return. If I were to return now, he would begin to put pressure on me.

I tell my colleagues in [country of origin] that they are [surviving on their salaries] through a miracle.

Here life is more agitated. There, I liked [the work] I did. I had a more relaxed life. Whereas here, it's the opposite. I am not

satisfied with what I'm doing [professionally] and on top of that a more agitated life and the struggle to survive.

Participants were asked under what conditions they would consider returning to their countries of origin. Economic stability was the most often cited pre-requisite for return. One participant said that if a technical assistance project in his country of origin were recruiting personnel, she would return.

Discussion and conclusions

For the interview participants in this study, inadequate salaries, family reasons, and education of their children were the principal immediate factors, which caused them to emigrate from their countries of origin. In most cases, a combination of two or more of these reasons applied. This suggests that for these health professionals the decision to emigrate—like most major personal decisions--is multiply determined. One implication for policy-makers of the causal complexity among factors spurring emigration is that the marginal effect of policy reforms addressing one or more of the multiple determinants of emigration may be sufficient to retain some proportion of health professionals, even when other determinants of emigration are present. For example, improving educational opportunities for the children of health professionals may reduce brain drain even when salaries remain low and other family-related reasons for emigration remain unaltered.

All of the interview participants in this study had had to abandon their professions after immigration. The employment they were able to obtain in Portugal was generally unskilled (nursing home aide, cleaning service), and offered few social security benefits and no long-term security. Six of the eight participants were earning more than the national minimum wage of $3,850 annually.

When asked about their views regarding their decision to emigrate, the participants expressed vehement indignation at the Portuguese legislation and bureaucracy, which they felt, was unfairly preventing them from working in their professions. The participants' comments revealed the degradation they felt in going from high-status (albeit low-paid) professional roles in their countries of origin to low-status jobs in which they have little control over their environment and are treated with little respect by their bosses and colleagues. It is clear that the participants were struggling to cope with the discordance between their present realities and the professional ethic

and pride they had developed in as elite in their countries of origin (as expressed in statements such as "nursing is universal," and "the class of nursing is a class that we have to defend at every moment of our life").

The results of this study offer little encouragement for Ministries of Health seeking ways to encourage the return of health professionals who have emigrated. Given the difficult conditions in the study community and the inability of the participants to secure work in their professions, it is reasonable to view these participants as among the more likely to return than, for example, other emigrants who had succeeded in working in their professions. Yet none indicated any concrete intentions to return. Even direct questions about the conditions, which might motivate them to return, stimulated only a vague response about returning "some day."

Managing health services in developing countries: moonlighting to serve the public?

Jean Macq and Wim Van Lerberghe

Introduction

Since the late 1980s it has become commonplace to blame 'government failure' for the public sector's inability in poor countries to deliver efficient quality care and to regulate the health sector. 'Unproductive', 'poorly motivated', 'inefficient', 'client unfriendly', or 'corrupt' civil servants get a large share of the blame. The moralistic connotation of these adjectives contrasts with a *de facto* tolerance of authorities towards behaviour that, to say the least, is not always congruent with what is expected from a civil servant.

Predatory behaviour among poorly paid public sector clinicians is certainly a problem. Under-the-counter payments for access to 'free' services or goods are common.[80] The problems related to combining salaried public sector clinical work with a fee for service private clientele are also increasingly recognised.[81]

[80] Lambert, D. (1996) Unofficial health service charges in Angola in two health centers supported by MSF. MSF medical news 5, 24-26. Meesen, B. (1997) Corruption dans les services de santé: le cas de Cazenga. MSF-Repères, 5, 1-20.. Parker, D. and Newbrander, W. (1994) Tackling wastage and inefficiency in the health sector. World Health Forum,. 15, 107-13.

[81] Aljunid, S. (1995) the role of private medical practitioners and their interactions with public health services in Asian countries. Health Policy and Planning 10, 333-349. Alubo, S.O. (1990) doctoring as business : a study of entrepeneurial medicine in Nigeria. Medical Antropology 12, 305-324. Chiffoleau, S. (1995) Iti-

Like many clinicians, the managers of public health services also often practice in an inadequate economic and professional environment. Unlike clinicians, they cannot take advantage of the contact with patients to extract under-the-table fees. Some may abuse their position for corruption or misappropriation of public goods, but most resort to other individual coping strategies.[82] They dedicate part of their working time and energy to activities that are not, strictly speaking, what the State pays them to do. They may take up a second job: teaching, consultancies for non-governmental or development agencies, private practice, or non-medical activities that generate extra income. Others manage to get seconded to non-for-profit NGOs or health development projects, or concentrate on activities that benefit from donor-funded per diems or allowances.[83]

However, little is known about the extent of the phenomenon, about the consequences for the proper use of the scarce public resources dedicated to health in developing countries, or about the balance of economic and other motives for doing so.[84]

We have investigated work mix and income generation among public health civil servants in managerial positions in developing countries. The aim was to understand to what extent public sector health care managers engage in other income-generating activities, whether this really corrects 'unfair' salaries, and what possible consequences are for the health care system.

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néraires médicaux en Egypte. Revue Tiers Monde 36, 515-530. Frenk, J. (1993) The public/privatemix and human resources for health. Health Policy and Planning 8, 315-326. Roemer, M.I. (1984) private medical practice. World Health Forum 5, 195-210. van der Gaag, J., Stelcner, M. and Vijverberg, W. (1989) Wage differentials and moonlighting by civil servants: evidence from Côte d'Ivoire and Peru. The World Bank Economic Review, 3, 67-95. Kamat, V.R. (1995) Reconsidering the popularity of primary health centers in India: a case study from rural Maharashtra. Social Sciences & Medicine, 41, 87-98.

[82] Roenen, C., Ferrinho, P., Van Dormael, M., Conceição, M.C. and Van Lerberghe, W. (1997) How African doctors make ends meet : an exploration. Tropical Medicine and International Health 2, 127-135.

[83] Gloyd, S. (1996) NGOs and the "SAP"ing of health care in rural Mozambique. Hesperian Foundation News, 1, 1-8.

[84] Asiimwe, D., Mc Pake, B., Mwesigye, F., Ofoumbi, M., Ortenblad, L., Streefland, P. and Turinde, A. (1997) The private-sector activities of public-sector health workers in Uganda. The nature and characteristics of health-care markets. Berche, T. (1996) Per-diem et topping-up. quelques enjeux de pouvoirs et stratégies dans un projet de santé au Mali. Bullatin de l'APAD 11, 128-138. Roenen, C., Ferrinho, P., Van Dormael, M., Conceição, M.C. and Van Lerberghe, W. (1997) How African doctors make ends meet : an exploration. Tropical Medicine and International Health 2, 127-135.

The information comes from a mail survey of 437 African, Asian and Latin American physicians who had obtained an MPH degree in Europe between 1976 and 1996. 101 of 138 respondents were considered eligible, as they worked as civil servants in their own country, in a managerial or in a mixed managerial-clinical position. Their median age was 45 and they had obtained their MPH on the average 16 years before the survey. They can be considered as fairly well advanced and stable in their careers. Although primarily managers, about one in two also had clinical and teaching duties as part of the terms of reference of their public sector job.

A fair salary?

The median salary of these civil servants is US$ 5,000 per year. Corrected for purchasing power parity (PPP) they range between US$ 2,671 and US$ 89,111 per year (median 19,432) (Figure 8). On top of their salaries 54 respondents also have fringe benefits such as free housing (9), a car (28) or both (17).

In low-income countries this puts doctors-managers definitely among the privileged in their societies. All but two have net salaries that are higher than the average GDP(PPP) per capita of the richest quintile in their country. For one third this remains the case after adjusting for dependants. In purchasing parity terms respondents from middle-income countries earn twice as much as those from low-income countries.

More relevant to what the managers perceive as a 'fair' income is a comparison with what their peers earn in alternative occupations in the same context. Two attractive alternative occupations are private practice and expert-consultancy work for development agencies or NGOs.

A month's salary corresponds roughly to the fees for one week's consultancy work, at going rates, and is equivalent to less than one quarter (median 22%) of the monthly proceeds of a small private practice of 15 patients per day (Table 37). Their public sector salary may thus put these managers among the well-off compared to the distribution of GDP in their countries, but it definitely remains below what they can reasonably expect from alternative occupations in their own field and in their own country. The gap is particularly impressive in low-income countries.

Figure 8. Distribution of the public sector salaries of the respondents, in US$ at current exchange rates and corrected for purchasing power parity, compared to per capita GDP corrected for purchasing power parity

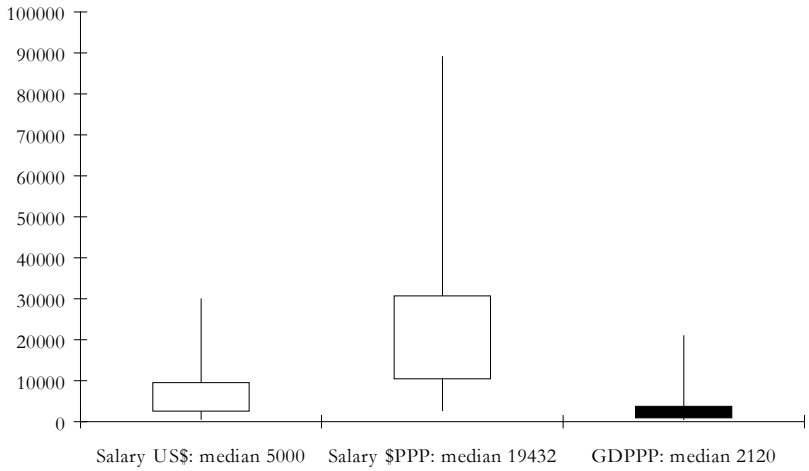


Table 37. Median and range of take-home salaries

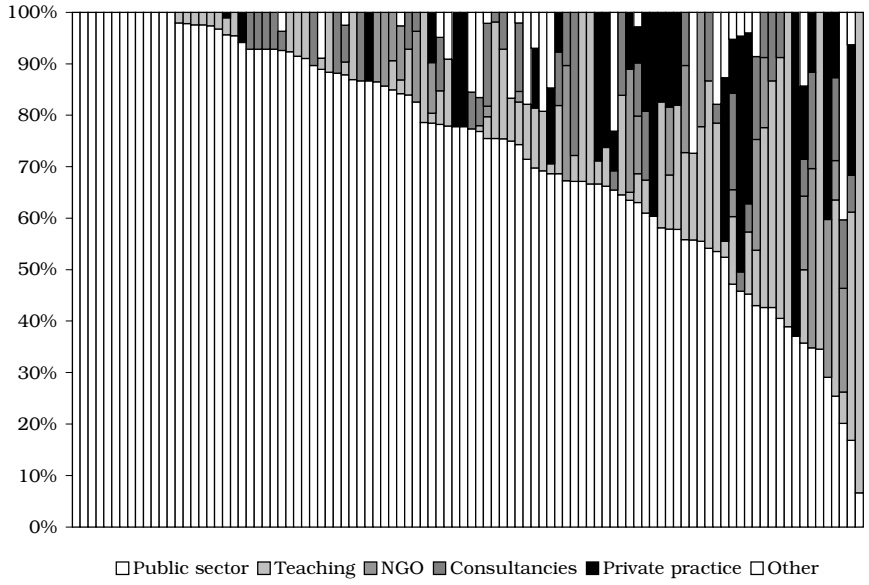
	Low-income[85] *countries (61 respondents)*	*Lower-middle-income countries (32 respondents)*	*Upper-middle-income countries: (7 respondents)*
In US$ at official exchange rate	3,802 (522-14,201)	10,177 (780- 24,960)	20,400 (9,600-30,000)
In US$ corrected for purchasing power parity	13,890 (2,671-51,692)	29,666 (3,024-89,101)	21,111 (9,935-31,046)
As % of the income of a private practice of 15 patients/d	14% (6-176)	30% (13-150)	28% (10-42)
As % of the income of 250d/y full-time consultancy work	31% (3-238)	76% (11-228)	107% (29-158)

[85] Low-income countries in the sample: Burkina-Faso; Burundi; Cameroon; Cape Verde, China; Congo; Ivory Coast; Erythrea; Ethiopia; Ghana; Guinea; Haiti; India; RDP Laos; RD of Congo; Togo; Viet Nam; Madagascar; Mauritania; Mali; Nicaragua, Niger; Uganda; Senegal; Tanzania. Lower middle-income countries include Bolivia; Ecuador; Indonesia; Morocco; Peru; Philippines; Salvador; Surinam; Thailand; Tunisia. Upper-middle-income countries are Brazil, Argentina and Mexico. Classification and PPP correction factors: World Bank (1997) World Development Report 1997, Washington D.C.: Oxford University Press.

Extra work. . .

Less than one third the respondents spend 90% or more of their time to their public sector assignment. Eighty-seven percent have at least one other job. Figure 9 shows how working time is distributed between civil servant tasks and other activities. Forty-nine respondents do work for NGOs or development agencies: 22 through stable secondments to projects and 40 through ad hoc consultancies or other occasional activities such as seminars. Almost two out of three (64%) teach. Twenty seven percent have an income from business or agriculture; this takes up between 2 and 40% of their working time (median 13%).

Figure 9: Proportion of working time of 100 public health services managers spent on public sector work, teaching, work with NGOs and consultancies, private practice, and other income generating activities (each vertical bar represents one respondent)



Private patients take between 2 and 63% (median 18%) of the time of 29 respondents. Four of these work in settings where there are no restrictions on this. Legislation is restrictive in all other settings, although many are either confused about what the regulation actually entails (17) or com-

ment that legislation is not controlled or enforced (37). Only four respondents stress that legislation is restrictive and strictly enforced.
Eventually, out of 100 person-years theoretically available for civil-servant work, they spend 10.3 person-years teaching, 7.3 person-years working with or for non-for-profit NGOs or donor agencies, 5.9 doing private practice, and 3.1 farming or operating small businesses. This leaves 73% of the theoretically available person-time for public service. Half of the respondents are available less than 75% of the expected working time. For 15% public sector employment corresponds, in practice, to less than a half-time job.

. . .. and extra income

Some of the additional work for NGOs (8/25) or teaching (19/37) is provided for free. As a rule, however, the extra work is paid. Private practice, ad hoc consultancy work and business or agriculture each generate an income that is 2.4 times the civil servant salary for the same amount of time (median 2.4, ranges 0.6-10, 0.3-54, and 0.6-9.1 respectively). Secondment to NGOs pays 1.3 times the salary (range 0-26), whereas teaching pays less, on an hourly basis, than the public sector: a ratio of 0.13 (range 0-26).

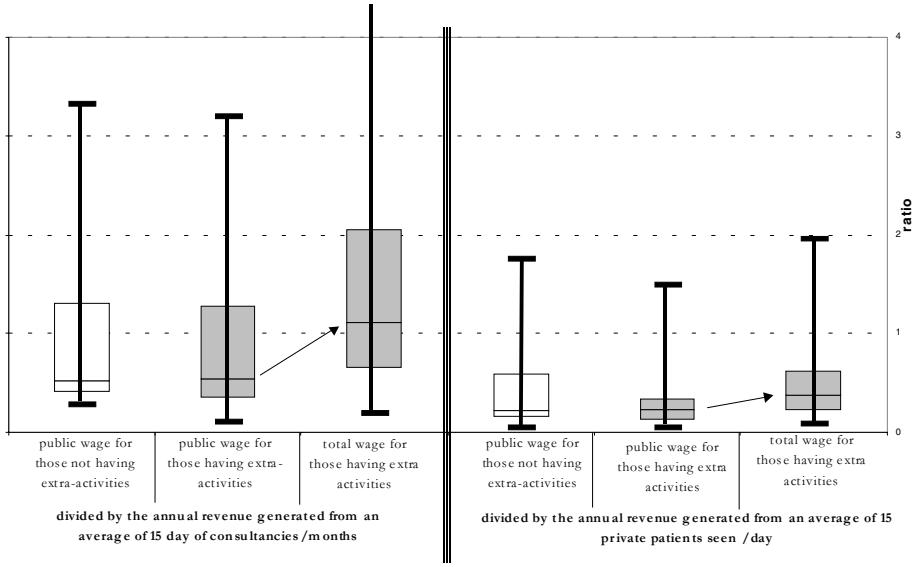
On the whole these side-activities generate a substantial extra income. They increase the income with between 50 and 80% of the public salary (Figure 10, Table 38).

The end result is a total monthly income equivalent to the fees these same doctors could earn by doing 15 working days of consultancy work, or one third of what they would have earned in a month from a small private practice of 15 patients per day. By combining various jobs the respondents from middle-income countries get a total income that approaches what they would earn by free-lancing 250 days per year (which would be pretty unrealistic). Compared to a private practice, however, their income remains pretty low, even if such practice is limited to 15 patients a day.

Table 38. Median and range of total income (salary plus income from extra activities) of civil servant health service managers

	Low-income countries (61 respondents)	*Lower-middle-income countries (32 respondents)*	*Upper-middle-income countries (7 respondents)*
Income in US$ at official exchange rate	5899 (522-21053)	15383 (1380-44000)	34880 (21600-91680)
In US$ corrected for purchasing power parity**	21438 (4081-84640)	47443 (5351-121080)	32453 (22353-45327)
Compared to GDP (PPP) per inhabitant	20 x higher (2.6-129)	9.7 x higher (1.4-38.7)	4.0 x higher (2.4-4.9)
As % of the income of a small private practice of 15 patients per day	27% (8-196)	40% (15-180)	37% (6-30)
As % of the income full-time consultancy work (250d/yr)	50% (4-560)	107% (14-780)	140% (35-231)

Figure 10: Increase in income through side-activities, expressed as the ratio of income form doing 15 working days consultancies per month, or form doing a daily private practice with 15 patients per' day



Competition for time and conflicts of interest

When the public authorities recruit civil servants to manage health services they expect them to be available on a full-time basis.

Clearly, this is often not the case, and the self-reported 73% of working time spent on official duties are probably overstated. Given the selection biases in the sample it is likely that in many situations a much greater proportion of working time is spent on activities that do not fit in with the public service job descriptions. This would result in a significant transfer of salary-resources out of the public sector – at least the equivalent of 27% of the salary mass in diminished availability – further compounded by the use of transport, office infrastructure and, at times, of diagnostic and therapeutic resources of the public service.

Apart from competition for time and transfer of resources out of the public sector, other effects on the system depend on the presence of conflicts of interest. Doing business or agriculture is neutral towards health services, but constitutes a *de facto* internal brain drain. In the case of teaching conflicts of interest are unlikely. Involvement in teaching actually probably benefits both the health system and the teaching institutions, as it reinforces the contact of trainees with the realities of the health services. Private practice presents, in the case of these managers, less of a problem of conflict of interest than it would for clinicians. Involvement in NGO projects or work for donors can foster better co-ordination in the provision of services, but may constitute a conflict of interest when NGO or project policies are at odds with national health policies.

Whatever the effect of moonlighting on the health care system, the implications for income are considerable and cannot be ignored. It allows a standard of living that is closer to what these doctors-managers expect, and thus helps retain valuable elements in public service. But money is obviously not the only reason for taking up a second job. The involvement in (relatively unrewarding) teaching, or in unpaid NGO work show that social responsibility, self-realisation, professional satisfaction, working conditions and prestige also play a role. Money is not, either, the only factor in retaining staff. Most could earn much more in private practice, at the locally going rates, but remain in office, and spend comparatively little or no time on private practice. It is unlikely that this is only for lack of opportunities – a saturated private health care market, or too much competition from the 'real' clinicians. There must be other sources of motivation to keep on managing public services.

What strategies can public authorities and development agencies propose?

In recent years the phenomenon of moonlighting has increased, fuelled, by a worsening professional situation of civil servants in many countries and by the *de facto* tolerance of public sector authorities. In this context it is unavoidable that managers look for additional work that is more rewarding, professionally and financially. As long as it does not get in the way of the performance of the public sector, this should not be too much of a problem. But in many, if not most poor countries the situation has got out of hand: even the collective memory of dedicated public doctors is fading.

There is a limit to the possibilities and attractiveness of moonlighting. In many parts of the world the number of doctors increases faster than the carrying capacity of development agencies to recruit managers, or of the population to support fee-for-service private practice. It would be an illusion, however, to hope to save public service merely by counting on market mechanisms to make an inadequate salary, poor career prospects and a depressing working environment competitive.

There are four ways out that seem easy only at first glance: prohibit moonlighting; increase salaries; downsize the public health sector; or introduce new public management type performance-linked incentives.

Prohibition of moonlighting without changing the salary scales is probably one of the least effective ways to tackle the problem. Enforcement is unlikely when the problems in retaining motivated staff become obvious, and the enforcers are in the same situation as those who have to be disciplined. As an isolated measure restrictive legislation only drives the practice underground and makes it difficult to correct or avoid negative system effects.

To close the salary gap by raising public sector salaries to 'fair' levels is not a realistic option in most poor countries. In the average low income country salaries would have to be multiplied by at least 5 to bring them to the level of the income from a small private practice. Doing this for all civil servants is not imaginable; doing it only for selected groups such as doctors-managers would be politically very difficult, if financially possible.

Downsizing would make it possible to divide the salary mass among a smaller workforce, thus increasing individual salaries. Experience with attempts at downsizing are disappointing: it usually provokes enough resistance among civil servants never to get to a stage of implementation, and where retrenchment becomes a reality this is not followed by substantial salary increases.

The rationale for the introduction of new public management techniques with performance linked incentives is that these would take care of a major drawback of the fact that managers engage in supplementary activities: the competition for working time. However, such approaches require performance measurement, which depends on a well functioning, transparent and honest bureaucratic system. The countries that would benefit most from new public management are the ones where it is *a priori* most difficult to implement on a large scale.

What is more likely to work is a piecemeal approach of trying to limit the negative effects for the system. A first pre-requisite is to deal with the problem openly. This is necessary if one wants to discourage those income generating activities that represent a conflict of interest, whilst leaving the door open for less harmful alternatives that can take the pressure off the system.

Second, it supposes a better understanding of and more attention for the other factors that help retain personnel. Good performance requires a proper working environment, but also investment in the career prospects, training perspectives, and freeing the professional from the clientelism and the arbitrary prevalent in the public sector of many countries.

Third, it means regulating and organising things in a transparent way, so as to minimise the feeling of unfairness among colleagues and the level of uncertainty in the availability of services.

All this is unlikely to be possible through bureaucratic regulation alone – from government or from donor agencies. Without building up pressure from peers as well as from users, disinvestment by civil servants is likely to increase rather than diminish.

Part III.
Dealing with the predicament of the health personnel: from denial to pragmatism

Coping with the consequences of reform: challenges for policy makers in Mozambique

Abdul Razak Noormohamed

Introduction

After independence Mozambique lost most of its skilled health personnel of Portuguese extraction. The immediate, acute shortage was partially relieved by the influx of skilled health workers mainly coming from socialist countries. Several western volunteers, moved by ideological or anti-apartheid motivations, complemented the foreign workforce. The Ministry of Health launched an intensive programme for the accelerated training of health personnel, with the creation of new, PHC-oriented categories.

The direction of this foreign assistance flow has not changed over time. Currently, about 300 foreign doctors work within the National Health Service while less than twenty Mozambican doctors work abroad.

The total number of national doctors now stands at about 400. Of these, about 50 work outside the public sector. The present situation compares favourably with that prevailing in the past. In 1980, the National Health Service employed only about 300 doctors. Expatriates made up more than half the total, including the vast majority of specialists. The ratio of physicians per 1000 population has doubled from 0.02 in 1980 to 0.04 in 1997, but it remains far from the average of 0.1 per 1000 in sub-Saharan Africa (World Bank, 1997). Thus, although the number of foreign doctors has increased since 1980, the ratio of national to foreign medical practitioners has improved significantly. In addition, deployment and staffing pat-

terns have significantly improved. In 1990, on average only half of the existing rural hospitals were staffed by a doctor. By 1997, the average number of doctors per rural hospital was about two.

Table 39. National and expatriate doctors in Mozambique

	Mozambican	*Expatriate*	*Total*
Specialists	156	231	387
Non-specialists	200	64	264
Total	356	295	651

SOURCE: Ministry of Health, 1998

There are many reasons behind the inflow/outflow imbalance. National doctors, particularly specialists, are absolutely inadequate in number to cover a relatively large hospital network, inherited from colonial times. The situation is made worse by their uneven distribution: around 79% of national doctors with post-graduate training are working in Maputo City, where lucrative opportunities exist in the private as well as in the public sector. Most doctors complement their earnings from the National Health Service with part-time activities in the private sector or with 'special' (i.e., paid) clinics in the public sector. The modalities of external aid compound the picture, as many posts for expatriates are tied as preconditions to projects. Additionally, expatriate professionals rarely face professional hurdles to practising inside the country as almost every medical qualification is accepted.

In relation to outflow, the migration of Mozambican doctors is hampered by the demanding requirements for obtaining a licence to practice medicine in many countries. Language constitutes a further barrier. English-speaking countries surround Mozambique and there are signs of saturation in other Portuguese-speaking countries further afield.

More than these however, there are strong incentives for doctors to remain in Mozambique. Whereas in many southern African countries, medical professionals feel isolated and under valued as well as under paid, in Mozambique doctors are granted considerable social status and professional respect. They find opportunities beyond the health sector and are able to pursue careers in government, management and politics with the promise of financial compensation in the future.

This situation may alter in the future through pressure from medical professionals eager to hold internationally recognised qualifications. Already, there is growing interest in improving medical training in Mozambique to levels comparable with those of neighbouring countries. The costs

of such a move would be significant, while the prime beneficiaries would be graduate doctors seeking employment opportunities outside the country. This would deplete the pool of national doctors in Mozambique and work directly against the national health policy. Furthermore, a more demanding curriculum at the medical school could reduce its already small output. For the present, this debate has not led to significant changes in the medical school, mainly because of a lack of resources.

Until now the public sector has maintained a policy of employing all health cadres. This choice was justified by limited training capacity and by the small size of health sector workforce, which in 1996 numbered only 10,000 health professionals. Training facilities, run by the Ministry of Health under centrally planned human resources programmes, are expected to graduate only the number of health professionals considered employable by the National Health Service.

The impact of donor agencies on recruitment and employment

Some co-operation agencies have recently started employing national professionals: they are promptly available, familiar with the country and, sometimes, cheaper than international staff. Whereas this policy has met with warm support from national cadres, its effect on the health sector is problematic. Immediate financial gains are putting pressure on qualified professionals to leave their posts within the National Health Service to take up management or consultant positions. The substantial investment in their training (often carried out abroad) is therefore producing dubious direct returns for the National Health Service. Furthermore, their new tasks are frequently unrelated to their core expertise.

More seriously perhaps, the presence of donor paid jobs outside the health sector (as programme co-ordinators, researchers etc.) is creating pressure on the Ministry of Health itself, exacerbating the skills shortages in the National Health Service and creating incentives for trained Mozambicans to leave the public sector. Ironically then, the donors, who are in this country to support the development of a sustainable health system, are one of the causes of persistent destabilisation of the higher trained ranks.

The immediate consequence of the imbalances caused by a shortage of national clinical and non-clinical professionals (epidemiologists, economists, health systems experts, managers, etc), is the huge cost of foreign technical assistance. The relatively high number of expatriate professionals

are almost totally covered by external financing which absorbs as much as 20 per cent of the total sector expenditure, excluding overhead costs such as taxation and administration costs often associated to expatriate posts.

Overcoming the problems associated with expatriate recruitment

In the past, the foreign workforce was recruited through an array of different schemes, depending on the financing agency and the co-operation agreement. This situation resulted in a disparate salary range linked to the hiring agency rather than to the job actually carried out, associated with erratic deployment, and supply-oriented staffing with dubious loyalty to the National Health Service.

In order to overcome these constraints, a unified approach has recently been introduced where donor funds are pooled to finance the recruitment of specialised doctors. The posts are tendered, and the range of salaries has been compressed into standard scales according to objective criteria. Many of the specialists applying for these posts are citizens of countries born out of the break-up of the USSR. Many came to Mozambique during the 1980s within the framework of bilateral agreements and have stayed on. National doctors may also qualify for a National Health Service post funded by the pooling agreement as long as they have been working in Mozambique for three years, but outside the National Health Service. Those returning to the National Health Service, after several years work on donor agencies contracts, could cost the health service much more than they otherwise would as nationally recruited personnel.

Thus, Mozambique represents an extreme case of donor dependence which, in the medium-term, cannot be reversed. On the contrary, the expansion and upgrading of the health network will require more trained health personnel and this need is likely to be met only through international contracts.

The position of national professionals

Gradually, more national qualified cadres are entering the work market. Whereas they're total number is still low (about 500 university-level health professionals), it is anticipated that within a few years, internal financial constraints will limit their employment in the public sector. The training of

health cadres has, until now, been the exclusive responsibility of the public sector. New university-level private institutions are being created and some of these are contemplating health-related training. This will further increase the supply side of the market but its net effects are not easily foreseeable. Besides this, the for-profit private sector is very limited in strength and coverage and will not create many jobs in the short term. Furthermore, the changes underway in external assistance will limit the number of jobs offered either to expatriates or national health workers. Many international agencies, which ran large operations during the emergency period, are now downsizing or closing down their interventions. The effects of all these changes may be that there are (temporarily) more qualified personnel than there are posts. Many of these individuals will be expatriate doctors who have lived here for years. Others will be national doctors previously employed by international organisations but out of a job as a result of down scaling of country programmes. Under this scenario, competition between local and expatriate doctors may increase.

Incentives and topping up: the policy of the Ministry of Health

There are several forms of incentives, topping up and US dollar contracting in the Ministry of Health in order to minimise the problems typically associated with donors paying incentives to selected individuals within the public sector. The most important are technical pooling agreements and incentives and topping up.

TECHNICAL POOLING AGREEMENT: In this arrangement, donors place funds in a pooled account which is then made available to the Ministry of Health to hire required clinical and non clinical staff on a dollar salary scale, at rates that are many times higher than national rates. The pool can fund any post in the normal line functions and can be filled by a national or locally available international candidate. To qualify, candidates must have been separated from the public sector for three years. The pool is managed by a multilateral agency in co-operation with the Ministry of Health. The advantages of the pool are that:

- It allows the Ministry to control who is hired for which positions;
- It enables the Ministry of Health to contract scarce professional at market salaries;
- It reduces dependence on individual donors;

- It creates opportunities for national staff on equal terms with international staff.

The principal disadvantage of this arrangement is the continuing dependence on donors for the US dollar funds with which to hire these professionals.

INCENTIVES AND TOPPING UP: This takes various forms although the Ministry of Health is trying to take greater control of the dispensing of incentives by creating a pool of funds from which to disburse incentives. The strongest advantage of Ministry of Health control over the disbursement of funds is that loyalty induced by additional payments remains with the Ministry of Health and not with a project or a specific donor. The principal objective of the incentive scheme is to try to establish some degree of stability in the leadership of the National Health System, improve the quality of work, reduce pressure on professionals to work outside the system in their spare time. The scheme has the additional benefits of:

- Creating an appropriately productive environment and thereby elevating the quality of work demanded from professionals;
- Reduce the drain of professionals from the public to the private sector because of higher salaries;
- Eliminate corruption and illegal collection of fees or other income.

The criteria used for the disbursement of an incentive are:

- The loyalty and commitment of the individual;
- Productivity related evaluation criteria for increases or continuation of incentives at regular intervals.
- The incentive scheme applies to all levels of management and professionals within central, provincial and district health facilities.

There were several preconditions associated with the development of the incentive scheme, which included the disbursement of one incentive per person (rather than the accumulation of several incentives based on the co-existence of several job titles). The scheme was also intended to be accompanied by the restructuring of the organisational functions in order to make particularly the Provincial teams more dynamic.

Given the context outlined in the first part of this paper, the main positive aspects of topping up and incentives are:

- That the National Health Service is able to retain staff that might otherwise be drawn away to the private sector;
- The National Health Service is able to attract highly qualified staff;
- The Ministry of Health retains the loyalty of its own staff which otherwise may be divided between the National Health Service and their

project or donor support;
- It is easier for the Ministry of Health to demand higher quality work and to conduct performance related evaluations independent of the general civil service reforms taking place in the country.

The principal dangers of the incentive and topping up scheme are:
- It reinforces donor dependence in an area that has traditionally been less affected by donor funds;
- It creates a double system within the National Health Service of 'haves' and 'have nots' and could be subject to favouritism;
- It does not address the over arching problem of low salaries throughout the civil service and ignores the needs of the frontline health workers who may continue to abuse the system for their own personal gain.

The future

It is difficult to see how else the system could be improved in the current climate in Mozambique. The real question at the present time is degree to which the system can be made more fair, less cumbersome and more comprehensive.

This will depend on the devolution of personnel matters to the provincial and district level, the broader reform of the civil service, which will include the cope for career development, the introduction of performance related salary increases and so on. The system as it stands now can only be terminated once the salaries of civil servants are improved to a substantial degree that is unlikely in the immediate future. The focus of the National Health Service should thus be on ensuring fairness in the manner by which incentives are disbursed and by addressing the continuing problem of illegal salary supplementation in health facilities.

World Bank policies in relation to human resources development in health

Gilles Dussault

In this presentation, I will try to reconstruct the recent policies of the World Bank (WB) with regard to incentives and to the brain-drain in the health sector. This is not an easy exercise since no formal policy has been formulated; an effort was made to reflect as accurately as possible the evolution of the thinking through the analysis of major policy statements relating to the health sector[86].

Incentives

Until its World Development Report of 1993[87], the WB did not have an explicit policy regarding incentives in the health sector, other than its traditional leaning towards market mechanisms regarded as the best way to optimise resource allocation. When it first became interested in the health sector, in the 1970s, the WB first concentrated its involvement in supporting infrastructure projects and showed little concern, if any, for human resources in health (HRH). Later in the 1980s, it became clearer that infrastructures alone added little value to the well being of populations, and that

[86] I am grateful to Eugene Boostrom from the Economic Development Institute of the World Bank for useful reactions to the paper.
[87] World Bank (1993). World Development Report 1993: Investing in Health. Washington.

reforming health care systems was a necessity. This idea was first understood as reforming the financing and the resource allocation mechanisms; this soon was perceived as yet another limited way of looking at "reform".

The WDR93 takes a broader view at health care systems, including at the role of HRH. First, it reviews more thoroughly the imbalances typically observed at the level of the workforce in poorer countries, but which are also often present in rich countries:

- imbalances between types of occupation (too many doctors, too few nurses and technicians);
- imbalances between specialities (too many specialists and not always of the kind which are needed, too few generalists);
- imbalances between urban and rural areas;
- imbalances between types of services (too much hospital services, underdeveloped primary services);
- imbalances between the contents and methods of training and the needs of services.

A number of recommendations were made to the countries to help them correct these problems:

- to implement policies which improve the systems of incentives, in the public sector to render it more competitive with the private sector, and thus more capable of retaining its workforce. This meant that the links between performance and income needed to be increased. It was also recommended to tie incentives to the performance of cost-effective services.
- to create better career development opportunities.
- to introduce or improve quality control of the training of providers.
- to tighten the control of the production of doctors and increase of the production of providers of primary care services, of public health specialists and of health services managers.

Generally speaking, the WDR93 emphasised the need for countries to prioritise cost-effective services and to adopt HRH policies consistent with that objective.

As the WB was making this major attempt to influence policy-making in the health sector, it was also increasing dramatically the volume of its loans and the number of countries in which it was supporting a health sector reform process. From its first loan in the Health, Nutrition and Population Sector in 1970, the WB went on to finance 225 projects in 89 countries between that year and 1996; at that date, it had 154 projects in 82

countries[88]. At first, the WB was not entirely ready for that increased involvement, as most of its staff and decisions-makers, trained as classical economists, were not always familiar with the specific characteristics of the health sector and with the limitations of market mechanisms in making the provision of health services efficient. In the late 1980s, staff with a greater familiarity with the health sector was hired and soon there was a production of studies and documents that called for better-adapted approaches to the health sector[89].

The publication of the WDR93 has had a significant impact on policy-makers, but it also showed the need of a "strategy" to guide the work of the Bank in health. This led to the publication of a Health, Nutrition and Population Strategy Paper, at the end of 1997[90]. This paper has received less attention than the WDR93, but it is as important, as it is much more specific about what the Bank intends to do.

The strategy is based on a diagnosis, which states that health care systems are not effective in many countries because these lack the capacity (institutional, technical, human, etc.) to implement affordable effective solutions to respond to the main problems of their population. The Paper recognises that the market cannot provide acceptable responses to health needs, particularly because there are no incentives to supply services with significant externalities, such as public goods, as is the case of many health related services. It offers the view that *"both economic principles and empirical evidence suggest that a mixture of public and private involvement leads to the best results in the HNP sector. Neither sector is effective by itself: each needs the other. Both too much and too little involvement by either sector is often associated with problems"* (p.5). It then proposes a series of prescriptions with a view to increasing the performance of the sector. These include:

- Reforms in the public delivery systems: improving equity in access, raising efficiency in the use of scarce resources, improving the effectiveness of interventions, raising the quality of care and maximising consumer satisfaction.
- Better balance in the public-private mix of services, particularly by fostering an increased involvement of Non Governmental Organisations, of local communities and of the private sector.

[88] Source: Health, Nutrition and Population Strategy Paper, 1997, p.14

[89] See Barr, N., ed., , 1994 "The role of government in a market economy" in Labor Markets and Social Policy in Central and Eastern Europe, New York, The Oxford University Press, pp. 29-50.

[90] World Bank, Health, Nutrition and Population Strategy Paper. Washington 1997, 97 p.

It is to be observed that the success of all of these proposals depends on effective HRH policies, a dimension of policy-making which has been notoriously absent of the policy-making process and similarly ignored by the WB itself (p. 15). The Strategy Paper does not address this issue explicitly, though it advocates the use of effective incentives and payment mechanisms, both for the public and the private sectors, to improve efficiency, effectiveness and quality through competition (p. 84). This is to say that the WB has yet to workout an explicit policy as regards HRH and specifically as regards incentives.

It is to be expected that the number of studies on the topic is likely to grow rapidly given the stimulus of the Strategy Paper. We can at least mention one recent study in Indonesia[91] which has looked at incentives to influence the choice of speciality and practice in undeserved areas . These authors have studied the use of access to specialist training as an incentive to attract doctors to rural and remote areas. It does seem to work but it is expensive and potentially inefficient, in that it attracts providers with skills and attitudes different from those which are required in a rural area. The study provides results consistent with the hypothesis that economic incentives alone might not be sufficient to attract providers to underserved areas, and that other incentives, professional and social, are just as necessary[92].

The brain-drain

As regards the brain-drain[93], the WDR93 made specific comments about it. It described it as predominantly not beneficial to the countries of origin, despite the existence of economic returns such as money transfers by providers working in richer countries. Recommendations to limit the emigration of health professionals include: to tie the access to professional education to a commitment to practice a certain number of years in the country or else to reimburse the real costs of training; to limit the training opportunities abroad; to finance professional education through loans to students,

[91] Chomitz, K.M., et al. (1998) What Do Doctors Want ? Developing Incentives for Doctors to Serve in Indonesia´s Rural and Remote Areas, The World Bank, Policy Research Working Paper no 1888. Washington, 43 p.

[92] For an analysis of the experience of the province of Quebec (Canada), which is one of utilization of sets of economic and professional incentives, see Bolduc, D., Fortin, B., Fournier, M.A. (1996), "The effect of incentive policies on the practice location of doctors: a Multinomial Probit Analysis", Journal of Labor Economics; 14 (4): 703-732.

[93] On that issue, see Adams, O., Kinnon, C. (1997) Measuring Trade Liberalization against Public Health Objectives: the Case of Health Services, Geneva, World Health Organisation, Task Force on Health Economics, Geneva, , 24 p.

which would not be reimbursable by those who accept to work in an underserved areas. This would also open the access to health professions to less well-off students.

Here we can also say a word about WB practices with regard to the brain-drain. Anecdotal experience which was gathered directly (Romania, Albania, Ecuador, Argentina), shows that in some countries the Bank itself or the projects it sponsors has hired some of the best professionals available in the country. In most, if not all, cases, people were hired after having worked for their Ministry of Health or an associated institution, and had been side-tracked on political grounds, usually after a change of Minister. It is thus difficult to conclude that the Bank has had practices, which have contributed to the brain-drain against the will of governments. Things might change if enough care is not taken. Since May 1998, the Bank has been implementing a new internal HR policy, whereby it would employ only 3 categories of staff and regularise the status of consultants, who had come to constitute almost half of its whole staff. The three categories are: permanent employees, consultant for a specific task and a pre-determined length of time up to three years and non-renewable, short-term consultants for a number of days which cannot exceed 180 days in one year. This will limit the capacity to use locally hired staff on a large basis, given that the institution would have to commit itself to keep them. It will still be possible to hire local staff as consultants but it will not be possible to keep them, thus forcing them to stay in the country. Another aspect of the new policy is that working conditions will be similar (not necessarily equal) in Washington and in the countries, which can make Bank positions even more attractive to locals. Given that the Bank practices a policy of hiring staff representative of its member countries, this is likely to contribute somewhat to the brain-drain.

Conclusion

The WB is more present than ever in the health sector, but is only awakening to the importance of sound HR policies. Given the weight of the "advice" it gives to client countries, this is important. At present, a number of new initiatives are being developed to raise the awareness of Bank professionals and that of countries as regards those issues: in-house seminars, module of the training program developed by the Bank for the country decision-makers (so called "Flagship program"). An initiative worth mentioning, is that of a World Bank – Pan American Health Organisation initiative

to prepare a joint policy paper on HRH, and to submit it in 1999 to a forum of decision-makers. These would come from the Health sector and from other related, and often more significant for HR policies, sectors, such as Education, Economy, Planning, Labour, Civil Service.

This initiative is welcome since it shows that it is now more clearly realised that HRH policies need to be comprehensive and touch on all dimensions of HRH Development. The improvement of performance and the reduction of imbalances can be facilitated by the introduction of adequate incentives; this is however only one, in a set of strategies. It is also important that the education of health providers be made more adapted to the new priorities of health services; that labour laws and civil service regulations be changed to allow more flexibility in the use of the workforce, particularly to facilitate delegation of tasks, team work and provider substitution; that the management structures and practices be professionalised and made less bureaucratic and more strategic and participative.

A good deal of research is still needed on the determinants of the behaviour of providers, on the impact of specific incentives and of various mixes of incentives. These are likely to be strongly determined by the cultural and socio-economic environment, so that they will vary form one health care system to another. This would lead us to conclude that incentive systems need to be designed to fit the specific characteristics, at a specific point in time, of each system, even sub-system. We can learn a lot from the various experiences, like those presented here, but at the end of the day, each country needs to find what suits its own reality.

Internal brain-drain and income topping-up: policies and practices of the World Health Organisation

Orvill Adams

Introduction

This paper addresses a set of questions on the policies and practices of international organisations with respect to the employment conditions of nationals. It is based on information provide by five of WHO's six Regional Offices with respect to the hiring of nationals. It draws extensively on a study of Contractual Arrangements for the Mobilisation of National Project Personnel prepared by the Department of Personnel of the Pan American Health Organisation Regional Office of the World Health Organisation.

Hiring of personnel by the WHO

The WHO traditionally hires its core and majority of personnel under rules and regulations for international civil servants. These international rules and regulations also apply to a large number of professionals hired as short-term Consultants, Temporary Advisors, National Professionals, and Temporary appointments of office support staff.

The growth of technical co-operation activities, the high cost of hiring all resources under international conditions, the growing availability of highly qualified individuals at the national level has resulted in an increase

of locally recruited personnel. In the WHO African Region for example there are currently 46 National Professional Officer positions, one for each office. The Regional Office for Africa is in the process of establishing another 112 positions. The will result in 4 National Professional Officers in each office. The appointment will be for a period of two years.

These appointments are governed by WHO Staff Manual Part 11: Personnel Section 19: Other Types of Contract with Individuals (March 1988). It states:

"A special services agreement may be entered into with nationals of a host country for the use of their services on either short-term or long term assignments, similar to those carried out by internationally recruited staff, on a specific national project or other activity. However such an agreement should only be concluded when the government is not able to second national civil servants or undertake the direct recruitment of national project personnel under a reimbursable loan agreement, or when it is considered essential to have a direct national as opposed to an international, input."

With respect to the remuneration the rule and the practice that is essentially followed is that the national program officer, hired under a special services agreement is as follows:

"The remuneration of WHO-financed contractors will be determined in consultation with the Government, and should, at all times, be at the best prevailing rates for comparable functions in the country. Total remuneration should not exceed that applicable within the United Nations."

While these Staff Rules provide the overall personnel policies to be observed in the administration of national personnel, in most countries where the system is in operation, WHO has developed, with the assistance of local legal counsel, specific contractual instruments detailing benefits, entitlements, and obligations particular to a given country.

The variations refer mainly to local legislation requirements such as participation in the national security system, special health and life insurance coverage, special leave entitlements, additional wages such as the thirteenth, fourteenth or fifteenth months of vacation, education, year-end bonuses or as applicable in compliance with the national labour laws.

The Pan American Health Organisation reports that it contacts staff through employment agencies and NGOs always endeavouring to meet the requirements of the local laws.

Apart from the national program officers being used to strengthen the WHO offices and projects in Africa, most contractual agreements with nationals are issued for periods not to exceed one year. Further individuals are normally required to provide his/or her services on a full time basis to avoid

conflict of interest, a government or another institution participating in the project or related activities may not employ them.

The national professional contracts offers familiarity with the national context, facility for continued participation through several short-term contracts, or for periods of one year or more in accordance with the project demands.

The main disadvantages are related to career expectations with the organisation that several contract renewals encourage in some, especially the younger National Professionals. The issue of equal pay for equal work is one that the Organisation is keenly aware of and is careful that the practices do not run contrary to it. Therefore, special attention is paid to the type of work assigned to locally recruited staff in relation to that assigned to staff in UN posts.

Office Support Personnel

With respect to office support personnel agreements have been made with host governments to include the specific employment of qualified secretarial and clerical personnel for special national projects and programs. Personnel services secured through government institutions, foundations, or NGOs do not create an employer employee relationship with the Organisation. PAHO reports that because the hiring is usually initiated on the basis of needs defined by their technical co-operation, its managers are able to actively participate in the design and adoption of personnel management practices that are closer or in line with those of other staff within PAHO.

The terms of reference, education and experience qualifications are also greatly influenced by PAHO. In general, funding of the post is borne by the host Government with regard to Government employees. As with the government staff "detailed" on a more permanent basis, PAHO establishes a "subsidy" for the purpose of raising the compensation to a more competitive national level.

Relationship to Coping Strategies

Health care personnel, service providers and managers, have always sought positions with WHO and other international agencies. WHO officers responsible for the recruitment of personnel suggest that the numbers of applications for advertised positions have increased and the numbers of general inquires and blind applications have also increased. The opportunities for long term employment are very limited. However, WHO provides pay-

ment to nationals recruited in a number of other ways. These include as consultants for specific pieces of work conducted within or outside of the country. For an employee of the public sector, special permission is required from the Government, the Ministry of Health to undertake the work. The contract for some research work, for example, is made with the Ministry of Health. In other cases the contract is with the individual but with the full knowledge of the respective institution.

Individuals are also recruited as Temporary Advisers for meetings for which they receive a per diem. The individual participation is sought through the Government. In situations where a few individuals benefit from these assignments other nationals can view them as inequitable. A broader participation of National Experts has to be balanced against the need for specific expertise. To address this we are seeking to take a more capacity building approach, identifying teams in particular content areas that will be able to participate and share the outcomes of consultations or undertake joint research.

WHO, other international agencies, bilateral and NGO undertake training activities which are often attended by the same select few. There is an incentive for self-selection by participants because of the per diems that are paid. The per diems for one week in some countries can be as much as two months' salary. To address this WHO is seeking ways to rationalise the number of training activities it undertakes by asking programs to examine the potential for combined training programs. WHO must also continue to build partnerships with other agencies as it does now with UNFPA for example in the deliver of interagency training. At the country level more comprehensive training plans, with clearly identified training needs and registers of participants can begin to address this issue.

A closer working relationship between the respective agencies, NGO and bilateral agencies and adherence to a clear policy for the employment of nationals will begin to contribute to a reduction in the internal brain-drain.

Internal brain-drain and income topping-up: polices and practices of Norad

Rune Lea

It is difficult to address the particular topics of internal brain-drain and income topping up without considering the wider context of a human resources strategy. With in such a wider context, internal brain-drain and topping up are symptoms of a situation out of balance, a situation where in many countries there is a funding gap which leads to undesired negative effects in the workforce, and where the way donor funds are directed contributes to the imbalances. The challenge for countries is to map out and document the negative impact on the workforce, given the national characteristics, and look for ways of improving job satisfaction and performance with available interventions. From a NORAD perspective, it is only within the co-ordinates of this national map we will be able to contribute in a constructive way.

In health sector co-operation, NORAD has for quite some years had a sector wide perspective, with the aim to see individual health interventions/health co-operation programs or individual projects in the context of overall health sector development in partner countries. NORAD presently has a clear priority of entering into broad sector programs in close dialogue with partner countries and in co-ordination with other donors. Untied budget support and pooling arrangements with long-term commitments are natural consequences of this policy.

With the focus on Sector Wide Approaches to Programming in international health co-operation, it has become increasingly important for de-

velopment agencies to understand policy issues and overall development of the health sector, as a basis for a sound dialogue with partner countries. This approach represents new challenges for a development agency like NORAD. NORAD has now established a special Social Sector Initiative, headed by Dr. Sigrun Mogedal, in order to better be in a position to meet the demands and challenges which this sector wide approach puts on us a donor organisation.

It is within this context that NORAD now recognises that health manpower issues, a cornerstone for health sector development and reform, need to be put high on our agenda. It would be fair to say that even if NORAD has supported health manpower activities, the co-operation in this field has not been based on a well developed health manpower strategy. NORADs presence here in this meeting is part of a process of developing the strategy we so far has been lacking

Manpower developments, salary policies, incentive structures in the health sector have to be seen in connection with Civil Service Reform. In countries where the health sector is a key co-operation sector. NORAD seeks to be well informed about what is taking place with regard to Civil Service Reform. Even if reform measures may be piloted in one sector e.g. the health sector, sooner or later these measures have to be linked up to decisions made concerning Civil Service Reform.

Looking at NORADs support to Human Resource Development, attention has mostly been paid to training. Which in fact has been an important part of co-operation projects. Seminars and workshops, and funding of scholarships, as well as support to training institutions are examples of this support. Also, support has been given in many programs to construction of staff houses, with the understanding of the importance of housing as an incentive

What has been missing, is an overall Human Resource Development strategy which takes into account the context within which the activities takes place.

Linked to the topic of internal brain-drain is the use of national resources in the health sector.

NORADs policy on the use of national human resources has developed over time. The current policy is to encourage the development of the national resources, and to use national human resources whenever possible.

Going back to the late 1980ies, however, a total of 250 technical assistance posts, so called “experts”

Were recruited by NORAD and filled by Norwegians. This included all sectors. A Nordic evaluation in 1988 on Technical assistance concluded

that TA personnel were usually highly effective in operational positions, but much less so in transferring skills and in contributing to institutional development (Forss et al. 1988). Based on this assessment, the number of TA personnel have been reduced from 250 posts in 1985 to less than 20 currently.

However, during the early 90-ies based on a motivation to utilise Norwegian expertise and institutions, we have seen an increase in the number of institutions involved in institutional co-operation/ development projects. 35 Norwegian institutions (all sectors) are currently involved in more than 100 institutional development projects. National staff in the partner country is obviously involved in these co-operation agreements, and Norwegian staff participates in most cases on a short-term basis. This co-operation model, although not a blue print for success, is based on the involvement of national staff, but has the potential of complementing, without replacing, national staff, by a mix of short term and medium term foreign technical assistance.

There is a need to revisit the strategy for donor support to human resource development.

- Donors should be willing to give budget support. Improved staff performance and staff retention depends on, among other things, a revised salary and incentive structure for the public sector and available resources for daily activities in the health facilities. The existing financial gap in the public sector in many countries makes it difficult to address the staff performance and motivation issue adequately
- Untied budget support with long-term commitments from donors would improve this situation.
- Topping up as a separate approach should be avoided.
- Quick solutions using expatriate technical assistance or consultants should be avoided. Only in cases where national resources are not available and critical gaps exist, should expatriate staff be contracted. A pooling mechanism for technical assistance, under national guidelines, can be a useful alternative.

NORAD will pay a lot of attention to human resources issues in the time to come. This is not to say that NORAD has been unaware of issues such as the potential negative effect of too many seminars and workshops; the potential advantages of decentralised staff management; the complexity of creating fair and balanced incentives packages; the mechanisms health workers invent in order to survive. However, the approach to these issues has not been systematic. The challenge now is to approach the issues in a

much broader way than the narrow scope of staff training and providing funds for staff houses!

In the same frame of analysis, it is worth referring to a recent evaluation carried out by the Norwegian Ministry of Foreign affairs on institutional development in our development co-operation. The Synthesis report "Institutional Development in Norwegian Bilateral Assistance" summarises the experiences, including the co-operation schemes between Norwegian institutions and institutions in partner countries.

The Evaluation analyses the co-operation in at three main levels: the first being technical at the individual level (mainly education and training), the second being organisational (strengthening of individual organisations), and the third at a systems level, where institutional development is placed in the context of public sector restructuring and reform

The Evaluation concludes that *"Institutional development is too one dimensional and tends in all sectors to be equated with human resource development and provision of equipment and infrastructure. It does not sufficiently address the systemic aspects, which goes beyond the strengthening of individual organisations: formation of organisational linkages, reforms in the specific sector environment and the broader societal context" "... few cases of institutional development address the system level effectively*."

Turning now to the specific issue of topping up. The NORAD policy on this issue has been very clear, I would say categorical: Topping up is to be avoided. This policy has also been adhered to in practice. This has been the principle, but what has been missing, is a thorough discussion of alternatives. Without a better salary and/ or an alternative incentive package in place, and with the obvious temptation among qualified staff to take up positions in organisations with a higher salary/incentive pattern. The danger is that by not topping up, valuable national staff leaves the public sector, or take up part-time engagements that partly distract them from public service.

NORADs policy on topping up remains the same. However, if a balanced and transparent scheme for salary improvements and incentives/rewards for the public sector is in place in a partner country, the situation is different. Such an approach is quite different from ad hoc topping up. From a NORAD perspective, financial support in this situation would be considered positively, as a natural part of untied budget support.

Internal brain-drain and income topping-up: policies and practices of GTZ

Bergis Schmidt-Ehry and Doris Popp

GTZ's policy regarding incentives, topping-up, and recruitment of national staff in donor funded projects

GTZ is one of several implementing agencies of the Federal Ministry of Economic Co-operation and Development (BMZ)[94]. The experience presented in this paper is related to GTZ. The BMZ has no clear-cut policy on incentives, salary, topping up and recruitment of national staff in German funded projects. However, since 1995, the BMZ has encouraged the creation of a working group, which has led to the formulation of a concept for the supply of nationals and to development projects[95]. This concept will be implemented for an initial three-year period, with a possible reorientation of the concept in late 1998.

Major characteristics of the BMZ concepts and of GTZ implementation experience for the supply of nationals to development projects related to our discussion are as follows:

- The choice between hiring locally or recruiting technical assistance should follow the principle of "*Subsidiarity*" and the principle of the "*minimal intervention*".

[94] Other implementing agencies of the BMZ are DED, CDG, DSE, CIM, KFW.
[95] An. (1995). Sektorubergreifendes Konzept. Einsatz lokaler Fachkrafte in der Entwicklungszusammenarbeit. BMZ,

- The employment contract should be in accordance with local social laws
- Financial compensation should follow local labour market conditions

The BMZ concept has three models for the supply of local personnel. The German institution may sign a financial contract with a partner institution regarding the hiring of personnel by that institution; it may delegate the implementation of a project to a local consulting firm which hires local personnel; or it may hire local personnel that will be part of a project team. In some cases, locally hired personnel will be responsible for the project implementation.

The third model is by far the most frequently used by GTZ. However, the changing labour market and the search for increasing sustainability will allow more use of the two first models in the future, ensuring that capacity and institution building efforts will be even more directed toward our partners.

What is the actual practice?

It is the responsibility of each local Country GTZ office in developing countries to ensure compliance with the BMZ principles in matters of recruitment and financial compensation of locally hired personnel[96]. Over the past years, the number of locally hired personnel[97] has steadily increased in GTZ projects from, 5461 in 1994, to 8590 in 1997 (Table 40).

Table 40. Local and expatriate staff in GTZ projects

	1994	*1995*	*1996*	*1997*
Expatriates	1,539	1,537	1,586	1,601
Locally hired	5,461	6,319	6,502	8,590
Number of Projects	2,643	2,736	2,751	2,801

Actual practice in projects was collected through a survey of 15 GTZ health projects around the globe. The data collected are not representative but give an indication of the trends in the field. Most questionnaires were filled by expatriate staff.

[96] An. (1996). Leitfaden zum Einsatz lokaler Fachkrafte in der Entwicklungszusammenarbeit. GTZ.
[97] Includes locally hired with a written contract including part-time.

NATIONAL PROJECT STAFF. Over 90% of the locally hired personnel come from the public sector (Ministry of Health, Ministry of Planning, University). A few were hired after having retired from the civil service, a minority has been hired from the private sector (NGOs), and some where unemployed at the time they were recruited.

All nationals recruited by GTZ projects have a written contract. Contracts strictly follow social laws.

Salaries paid to project staff recruited through a contract ranges between 175% and 3000% (Cambodia) of the equivalent salary in the public sector, and 70% to 137% of the private sector. Cambodia is an extreme case due to the extremely low salaries in the public sector in that country: $US 10-30, barely enough to buy food for a single person for a week. In that country, salaries of $US 450 and 900 are dictated by market forces and are necessary to keep qualified staff within the GTZ projects.

TOPPING UP AND INCENTIVES. Topping up is usually considered as a sensitive subject within GTZ Locally recruited GTZ staff do not get topping-up. Topping up is paid to a few counterparts that work in close collaboration with the projects. In most cases, projects and executive staff at GTZ Headquarters leave it to the BMZ to decide if topping up can be granted. The BMZ does generally not allow topping up.

Other types of incentives directed towards non-project personnel include: limited honoraria paid to targeted staff at central (Cambodia), regional and district level (Madagascar); payment of medical expenses and health insurance (Burkina Faso, Madagascar); training abroad and in-country (Côte d'Ivoire, and others); personal use of project vehicles (Madagascar and other countries); end of year bonuses; good working conditions (air conditioners, computers, etc.).

Repercussions

POSITIVE EFFECTS ON THE PROJECTS

There are definitely a number of positive effects. The number of expatriates is reduced, with a consequent reduction of expenditures on personnel: these practices give access to low cost expertise. There is no doubt that hiring and relying on local personnel improves communication, through language skills and shared cultural background. These practices give staff the opportunity to work in a much less corrupt and open environment and

a fair monetary compensation for their work.

Positive effects on the health care system include increased staff motivation. Overtime work becomes acceptable, and there is a higher commitment to work. The incentive structure (financed through project funding) is sometimes the only way to keep trained postgraduates in place. The "incentive mentality" leads public institutions to sell their services and hence improve their performances. Incentives offered by projects keep competent staff in place who would otherwise leave the country, thus counteracting brain-drain. Cambodia is a good example of this. These practices also make it possible to introduce new competencies – anthropologists, sociologists, … – into the public sector through the secondment mechanisms made possible by the projects.

NEGATIVE EFFECTS ON THE PROJECTS

On the other hand the quest for incentives creates a spiral of demands for compensation – and, as side-product, rejection of project staff by underpaid MOH officials.

The negative effects on the health care system include an internal brain-drain from some critical positions in the public sector to projects. Project incentives may divert attention of public sector staff to project related activities at the cost of their regular (integrated) tasks. Incentives given to key people of the MOH have a demotivating effect on those who do not get these incentives. The sustainability of achieved results in the sector is put into question after project is closed.

How should these policies and practices be reoriented and how can this be achieved?

THE POINT OF VIEW OF GTZ PROJECTS

GTZ projects view local staff recruitment as much as a way to reduce personnel costs and attain objectives as an opportunity for capacity building and sustainable development. In the present situation, most projects see recruitment of local project staff and monetary incentives to counterparts in the public sector as mandatory to reach project objectives and to support health reform. What is lacking, according to projects, are relevant reforms in the area of Human Resources Management in the public sector in order to make the sector attractive, to pay staff a fair salary and to introduce the right incentives that would motivate civil servants. Thus, there is a respon-

sibility for the donors to support such reforms in developing countries.

THE POINT OF VIEW OF GTZ AS AN ORGANISATION

At the policy level the debate within GTZ on the effectiveness and sustainability of the supply of local experts to projects is controversial. Some think that the implementation of projects by local staff should not lead to the creation of a new high paid labour market for local expertise, which could erode the institutional development efforts. Others, more concerned with project objectives, think that it is fair enough to recruit local expertise from the private market if this helps contribute to the development of the partner organisations.

The increasing number of locally hired project staff has raised a number of questions at policy level such as whether the supply of local staff to projects leads to substitution of external assistance, or rather to complementary assistance, which could lead to increasing personnel expenditure.

Internal brain-drain and income topping-up: policies and practices of the Belgian international co-operation

Luc De Backer

Background

The Belgian Administration for Development and Co-operation, BADC programs, implements, executes and evaluates the Belgian activities in the field of international co-operation. This includes: (i) direct governmental co-operation (120ME): budget and human resources of institution and capacity building projects directly managed by BADC, including dept swaps and other bilateral financial operations; (ii) indirect governmental co-operation (240ME), which funds NGO projects and academic co-operation; and (iii) Multilateral co-operation (120ME), mostly core funding.

BADC is a public service department without performance management System of its own. The Belgian public services went through a very difficult period of global institutional crisis over the last three years. The BADC itself was confronted with a series of public accusations of inefficiency, ineffectiveness and even corruption. This led the restructuring of the department: the political and administrative part will integrate definitively as a Directorate-General in the Ministry of Foreign Affairs, while the executive and operational part will become an independent organisation, the BTC or Belgian Technical Co-operation.

The debate on Internal brain-drain and income topping-up particularly

interests the decision makers of direct co-operation, where the counterpart is often a Government Official and where solutions has to be in harmony with two official regulations. The ongoing reform process within BADC has created an atmosphere of instability, anxiety and even of demoralisation among the staff. It has hampered also the serene debate on some conceptual and development policy matters. This explains that despite the concern about how to compensate the local costs to our counterparts, the most recent official documents date back to 1996.

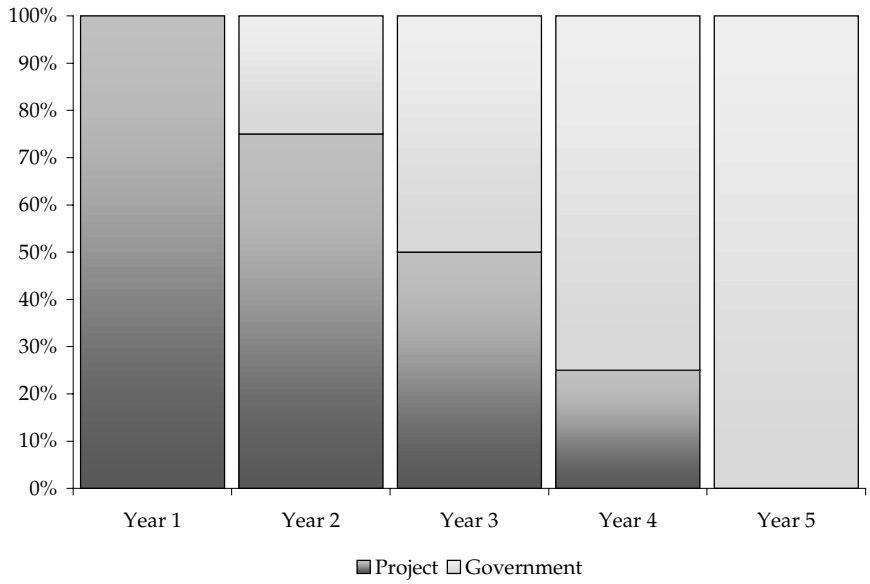
With that general background in mind, I will now present the formal standpoint and guidelines of BADC on the question, the problems and consequences their execution in the field generates and some conclusions and proposals.

Policy

The formal point of view on *"local cost compensation to government officials"* of the Bilateral co-operation within BADC encourages recipient governments to articulate a strategy to address Civil Service Reform. Topping-up salaries should be avoided.

The general guideline is the following. First , define if the concerned post is temporary an/or linked to the presence of a donor activity. If the answer is "yes" a compensation permitting to obtain, within the local market conditions, human resources of good quality has to be foreseen. If the answer is "no" (because the post overruns the project time or because it goes beyond the project context) the compensation has to be part of the local Government contribution to the project costs. In exceptional circumstances the compensation will be donor financed "IF" a realistic withdrawal plan is designed (Figure 11).

Figure 11. The withdrawal of co-operation funds from the payment of incentives: the expected phased take-over by government



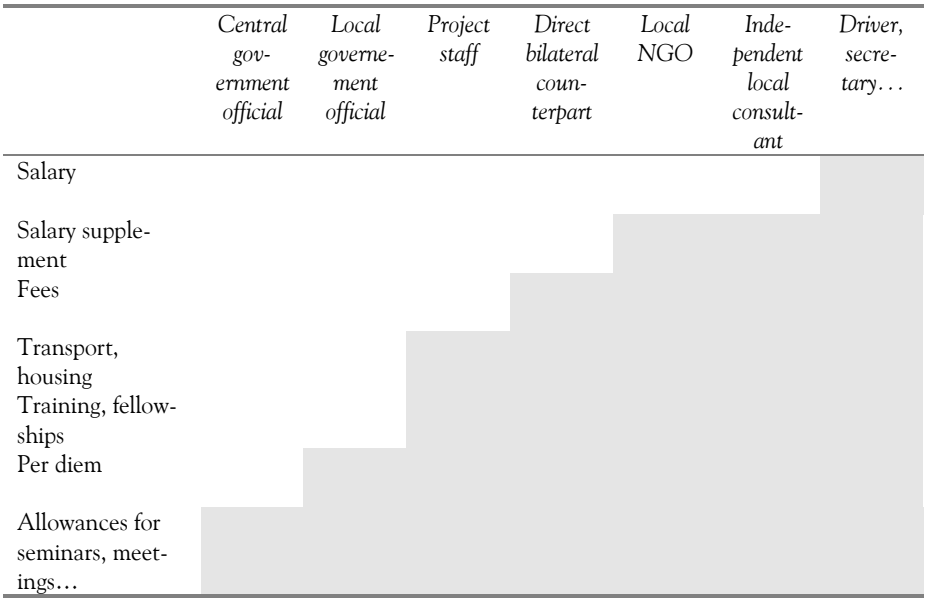
Practice

The willingness to pay a compensation (or "incentive") and its nature and volume are strongly and inversely related to the hierarchic level of the (official) counterpart. BADC is very reluctant to top-up salaries of government officials but it considers it acceptable for independent counterparts or collaborators as people from NGO'S, consultants or employees. Project staff and counterparts are generally "motivated" with travel per diems, fellowships and sometimes transport or housing facilities. Figure 12 summarises the different options.

It is interesting to compare this scheme with the list of priorities of the Mozambican health care providers as mentioned by Yussuf Adam. First come salary and fee increases, followed by credit for transport and housing, promotion in careers, special health clinics and distribution of economic benefits. Although the tendencies are opposite, there is an interface where the willingness of the donor and the priorities of the health providers meet each other: credits for transport, housing and for further study (promotion

in careers). This forms an excellent framework for negotiation.

Figure 12. The types of incentives BADC considers, in function of the category of personnel



On the practical level it is very rare to see a successful taking over by the so-called Exit Strategy. Financial foundation of the withdrawal planning is often absent or non-realistic and the end of the project means "The End". The ambivalent position against the topping-up policy is felt in the poor monitoring and managing of the incentive payments. This generates "creative" bookkeeping and a lack of transparency.

Problems and consequences

The policy of income topping up creates a conflict between the BADC supported logic of Health System Reform (based on capacity building, sustainability and national ownership of the development process) and the logic of obtaining project results in a reasonable time. The result is emphasis on project support and a poor support to broad-based sector programs. This policy can distort the existing salary structure and eventually obstructs ongoing pay and employment reforms. Civil services are further weakened by a

brain-drain from national public departments to these projects or by a competition between topped up and other civil servants. There is often a lack of common donor's approach and a competition between the different international organisations to contract the best quoted local human resources. All this diminishes the feeling of responsibility of governments for the donor supported projects.

The BMC policy tends to be consistent with its development mission statement and some policy tendencies are promising: the reduction of the emphasis on project support; the enhancement of the support to sector programs and integrated programs; the earlier and more important involvement of the National Governments; the strengthening of the civil services reform; the reinforcement of sustainable health services supporting the creation of financial backing systems. The BADC practice tends rather to be pragmatic in a competitive donor environment. This is expressed on the level of the individual counterpart by: the avoidance to pay allowances and incentives in cash and the preference for incentives in kind such as housing, transport, training, working conditions and career perspectives. BADC will try to insert income generating activities in the project design, earmark overheads of research projects for the researchers, arrange consultancies to other projects or services or teaching opportunities. In actual fact it somehow formalises informal coping strategies. There is clearly a need to move up these issues higher on the policy agenda.

Coping with Health Care Reform and the position of the International Labour Organisation

Valentin Klotz

I

The situation in the health sector is vital to the development of societies and for improved living conditions of people, as well as for increased productivity and employment. Moreover, universal access to health services is more and more viewed as a basic human right and a key to national economic prosperity and social well-being. Therefore, the ILO, beyond its general concern of health protection of workers attaches great importance to the adequate health protection of the entire population and to satisfactory employment and working conditions of health care staff, which are critical to the delivery of adequate quality health care services.

Over the past decades, the health professions have been growing rapidly in most countries and the health care workforce is today estimated at 35 millions persons world-wide. Due to demographic and epidemiological conditions, the demands for health services will further increase, and probably also employment opportunities in this field. Against today's background of increasing costs of health care services, structural adjustment and economic constraints, however, many countries are being obliged to rethink the financial implications and the scope of services of national health systems. The result has been growing debate on reform policies to improve the efficiency and quality of health services while lowering or constraining costs. This debate naturally touches on a wide range of medical, social and economic issues.

II

The response of health reforms to these issues vary and include an examination of policies on cost reduction, quality improvement, equality of access, systems management, levels of employment and conditions of work. An examination of these policy issues is often undertaken under the global issues of decentralisation, privatisation, costs reduction and the restructuring of benefit schemes and methods of finance. The ILO deals with some but not all of these issues directly but certainly is concerned on how all these issues impact on the working conditions in health services, on the health and social protection of the global workforce and on social security schemes. A natural partner in this respect is the World Health Organisation, whose "Health for All" strategy the ILO fully endorses.

As part of its standard setting activities and in addition to generally applicable international labour standards, such as on Freedom of Association and the Right to Collective Bargaining (Conventions Nos. 87 and 98), the ILO has adopted in 1977 particular labour standards for health workers: The Nursing Personnel Convention (No. 149) and Recommendation (No. 157). For health workers in the public sector, the more general Convention on Labour Relations in the Public Service (No. 151) and Recommendation (No. 159) of 1978 also apply. The specific standards for health workers refer to the general policy for this sector and the nursing personnel participation in this policy; education and training; practice of the nursing profession; career development; remuneration; working time and rest periods; occupational health protection and social security.

Within its Sectoral Activities Programme, the ILO has held a number of meetings dealing specifically with employment and working conditions, labour relations, equality of treatment and safety and health issues of the staff employed in health services. The last of these meetings took place in 1998 and had as theme "Terms of Employment and Working Conditions in Health Care Reforms". It included issues of finance and employment, labour relations, privatisation and restructuring, management and work organisation, contract arrangements, remuneration, training and ethical problems. It also discussed questions of assisting developing and transitional countries to deliver efficient health care services of improved quality.

III

The meeting adopted a number of conclusions on these issues, the main of which are listed below.

1. Medical and technological progress as well as demographic change are leading inevitably to higher costs of health care. Many reform initiatives

in health care have the objective of cost containment and may lead to rationalisation. However, rationalisation of health services leading to the exclusion of certain population groups from health care or from certain health care services because of cost-benefit analysis, is immoral. Health care reform efforts should foster primary care and preventive medicine for all, improve quality of care and create better work conditions in this area.

2. The provision for health care for all must be in the public interest. This does not necessarily mean that health care must be organised and implemented by public services but that it can be provided on a private basis. Health care is not a commodity and thus not a tradable good.

3. Health care reforms cannot be imposed from above or from outside. They are most likely to be successful if they are implemented in effective and efficient concertation with the representatives of workers. In the course of this concertation, all parties should endeavour to achieve the largest possible consensus. Where collective bargaining arrangements exist, these should be respected.

4. Access to health care is still often inadequate and inequalities persist between countries and between countries. It remains a challenge throughout the world, especially in the developing countries, to ensure universal access at least to primary health care and family planning. In industrialised countries there is a need for better distribution of health care services. This includes public responsibility to guarantee solidarity for all. In developing countries the main objective is the provision of health care services for all. There are large differences between industrialised and developing countries in the possibilities to finance health care. Self-reliant solutions in developing countries have not yet been found. Thus there is a need to develop partnerships in order to ensure the provision of quality health care. International organisations should assist developing countries in specific projects including training of health care staff, subject to peer evaluation and monitoring.

5. The health sector is highly feminised with women predominantly concentrated in low-paid jobs, which makes them more valuable. Major obstacles result from the fact that careers are often short and frequently interrupted. These facts influence the ability of women to compete for access to higher quality and better remunerated jobs.

6. Part-time work must always be protected and have proportional entitlements. Employees with fixed-term contracts should also enjoy social protection. Working conditions in health services have deteriorated in a number of countries in the course of reform processes. Health care workers in certain developing countries and countries in transition earn very low

wages and the delay of payment of wages can amount to several months. This entails negative social consequences and has in general serious effects on the economy and the quality of services. Wages should be paid regularly to all workers, including health workers, in accordance with the ILO Protection of Wages convention, 1949 (No.95).

7. Health care workers are particularly exposed to certain forms of stress and violence since they often have contact with people in distress and the large share of female workers intensifies the problem of sexual harassment at the workplace. Health care reforms may aggravate this situation. There is a responsibility of governments and employers to create safe workplaces. Workers, including health care workers, may also be subject to racism at the workplace. This is unacceptable. Employers and governments have the responsibility of fighting against racism at the workplace.

8. Basic training, lifelong learning and continuous training are essential for the maintaining of the quality of the services provided and for career development. Further training must be particularly provided for health care workers re-entering the service after a break. Workers' organisations should participate in the design and implementation of the training process. An evaluation of training, including by peer, and its contents id necessary.

9. International migration by health care service personnel such as doctors and nurses is sometimes referred to as the "brain-drain", particularly when it means migration from developing and transitional countries to developed countries. The term "brain-drain" implies a financial loss and an unwelcome brake on national development.

10. All parties, especially workers and employers, should be involved in human resource management development. Management training in the health sector is essential.

11. In the health care reform process, policies should be developed for social dialogue since the best reforms are developed through such a dialogue. In accordance with ILO Conventions Nos. 87, 98 and 151, health workers have the same right to organise and to bargain collectively as workers in other sectors. Pay determination and working conditions should be subject to bargaining procedures between health workers and employers. Especially in times when the contents of work, the financial environment and job security are subject to rapid changes, collective bargaining mechanisms are an appropriate way to improve the situation of the workers and their families.

12. Contracts of employment of health care personnel and/or collective agreements should contain safety provisions for the employee, such as conscience clause. While this clause protect the worker concerned from sanc-

tions on behalf of the employer, a code of professional ethics does not absolve an individual from the duty to comely with civil and criminal law. The ILO should assist governments and the social partners in the development of a patients' charter.

13. Under the terms of its mandate, the ILO engages in the promotion of basic human rights, the improvement of working and living and working conditions and the enhancement of employment opportunities. This is done through various means, including the formulation of development policies and programmes, the setting of international labour standards and the monitoring of their implementation as well as through technical co-operation and human resource development. The ILO's interest in health sector reforms relates to all these aspects and means. The ILO considers health care as a basic human right and an essential requirement for improving working and living conditions.

14. During reform processes in health care systems, the ILO can provide assistance with the aim of ensuring that changes which occur lead to positive outcomes both in the health services provided to all and employment conditions of health workers. Within this general objective, the ILO could undertake the following specific tasks: (i) develop internationally comparable statistics which are acknowledged and reliable source of information for trend analysis and policy formulation; (ii) facilitate the exchange of experiences among countries through regional meetings and network arrangements of representatives of employers' and workers' organisations and governments; (iii) facilitate research activities on trends and developments in areas identified by the Meeting as being important in reform processes in health sectors such as: the impact of reform processes on the workforce; gender issues; changes in qualification requirements for health care staff; workers' participation in reform processes. trends and developments in pay systems, labour conditions and workers' participation; increasing co-operation with other international organisations, its technical assistance and advisory services to governments, employers' and workers' organisations, particularly in developing countries, especially on the integration of relevant labour standards and planning and implementation of health sector reforms.

IV

These conclusions, together with one resolution (on future ILO activities and co-operation with other international institutions in the health sector)

and the final report of the meeting, are going to be submitted to the Governing Body of the ILO for final consideration and approval in March 1999. They represent an internationally agreed text by governments, as well as representatives of private employers in the health care sector on the one hand, and representatives of workers' organisations on the other hand, of al parts of the world in this sector.

Coping strategies of health personnel: experiences from South Africa

Sam Fehrsen, Gboyega Ogunbanjo and Vincent Shaw

Introduction

Our vision is to find a way to promote health reform for improved quality of care. We believe it is possible if we recognise primary care clinicians as persons, as key persons in the health system.

South Africa is in the midst of a major health reform. We are moving towards a decentralised district health system with an emphasis on primary health care. It is an exciting time for planners and academics. It is often a frightening time, full of despair, for practising clinicians. Our study[98] is about the perceptions and behaviour of these clinicians.

We made an early decision to attempt congruence between our vision for recognising clinicians as persons and our research process.

We thus formed two research teams consisting mainly of people work-

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ing at the functional level. Each member was both a researcher and part of the researched. Our premise was that asking about coping by asking the same questions of themselves. By participating as the researched we thought we would build a participatory process in which each person was valued.

We are finding that the participatory process has in itself become an effective agent of personal and system change. We want to present a sample of our findings from the two teams in the format of a dialogue representing the journey taken by the two groups.

The context of the project

One of the teams was based in KwaMhlanga health district, Mpumalanga Province, South Africa, which has a population of 250,000. The district is largely a rural and under-served area with 22 primary health clinics and 1 community hospital and in close proximity to the cities of Pretoria and Johannesburg. The research team comprised of primary health care clinicians working at both functional and managerial levels in the health district.

The other team was based in the Northern part of Eastern Cape province of South Africa. The research region is a very rural area, and could be described as a very harsh environment – there are huge distances between centres, and lots of villages dotted around the countryside. It doesn't rain often, and the scattered thorny acacias covering the rocky hillsides are sparse – Mountain goats plunder what little greenery is to be found, and the land is overgrazed. In places tracts of land are washed away by soil erosion. However, some will say that it is a very beautiful landscape , with stark outlines, hidden valleys boasting life-giving mountain springs, cicadas, and brightly coloured sunbirds. These islands of beauty are often in stark contrast to the surroundings. These views, in a sense, reflect the journey we have travelled in the Coping Strategies Research Project.

The Eastern Cape research team consists of six primary care clinicians, two doctors and four nurses, working in some of the areas of the province that, under the previous regimes, were grossly neglected. The team underwent a process of training in qualitative research techniques. We feel that through this process a great deal of capacity has been nurtured in qualitative research techniques amongst ourselves, an area which would previously have been regarded as a neglected wasteland of research skills. Through the training process we became reflective practitioners – far more aware of our surroundings, and our actions, particularly in the area of coping strategies. This awareness enabled us to understand, or at least to question some of

our actions, and resulted in us taking steps to make changes in our work environments. We found this an extremely exciting and satisfying process. We will take a number of key issues to illustrate some of our results.

In terms of research process, the first issue that the group wanted to deal with was to understand the concept of coping strategies in primary care clinicians and on how best to obtain reliable information. This was done through the distillation of a research strategy congruent with participatory action research, where we were involved as the researchers and the researched. We started focussing on the following research questions: What are the coping strategies (we and others like us) use? What are the positive or negative consequences of our coping strategies for health care delivery?

Through this process, knowledge has been gained on how primary care clinicians function and cope economically, socially, and at work; and how the public health system functions. This knowledge has influenced our practices on how we cope within and outside the health system. In the research team, we have experienced a member change his coping strategies positively to the point of having secured a higher position of responsibility in his job that has made him more productive and functional. Another member has developed leadership skills through the process of self-awareness so that she is now able to deal with supervisory issues of junior colleagues in a more participatory way, to her delight and that of her subordinates.

Results

THE DREAM TRAIN

While analysing some of the issues around coping strategies, we came up with the image of the "dream train". This metaphor shows the primary care clinician as having "internal and external tensions" due to expectations from the community, family, colleagues and self, to take on the roles of the "care giver", "provider", "saviour" and "elite in the community". Some examples of the dream train as seen from the study were primary care clinicians who lived in the typical comfort as expected by their communities and families, and who had to work in both public and private health sectors in order to cope with this lifestyle. There were other primary care clinicians that in the role of the provider gave whatever the community or family members asked them even when they could not afford the demands. In the process of satisfying these roles, the primary care clinician is caught up in this dream train that continues endlessly without any definite end point.

On the other hand, disembarking from the train was a difficult decision to make, as this would disappoint unfulfilled expectations of the community, family, colleagues and self.

DEALING WITH ISOLATION

Like our landscape, which is sparsely covered with vegetation, we have inherited health services with very poor infrastructure, equipment, and transport. Through the journey of this research project, we have experienced our primary care clinicians surviving out there despite adverse circumstances.

Doctors, especially those at the forefront of developing the primary care services, experienced the isolation of their environment in terms of lack of the nurturing effect of academic contact, and through the extreme scarcity of other like-minded doctors who could support them in their efforts to improve the services. However, this provided a challenge for us and we sought to break the isolation through establishing contacts with colleagues in other centres, and through participating in postgraduate training programmes. In Queenstown, we established a monthly meeting for medical officers where they could raise any problems they had experienced. This has developed into a really exciting programme where we are able to discuss difficulties in dealing with the flooding of outpatients and as a result in one of the hospitals they established a primary care clinic in a disused mobile home, just outside the main casualty building, to screen patients. This enabled the doctors to then run the casualty department, and left them with space enough to deal with any patients referred to them from the clinic outside.

We also decided to look at statistics of the work that we are doing and trying to interpret the data collected, in particular, what age groups of patients are we seeing and why, what are the main problems patients come to see us for and why, and why do we see the patients rather than the nurses who screen patients? Developing protocols for the management of certain conditions, for example eclampsia and TB – two areas identified as problem areas. The eclampsia management protocol is about to be distributed, and the different doctors are evaluating a flow chart of TB control in their hospitals and clinics.

This process has enabled us to look after our own needs, and we feel that as a group we are growing and developing in a way which allows us to deal with the issues we need to face. This process reflects the nature of this research project, which while it was participatory in nature in seeking to understand how clinicians cope, it also led to action being taken based on the knowledge that was generated through the research project.

COPING WITH A LACK OF PROFESSIONAL RECOGNITION

From this study, both nurses and doctors expressed the "lack of professional recognition" by health authorities and colleagues, after they acquired more qualifications, as a major issue that de-motivates them from putting in their best for the patients. Some nurses even had to incur debts with the banks and through the use of credit facilities to upgrade themselves professionally. The system does not allow nurses to be rewarded for additional qualifications. Also, trying to implement what they had learnt has been difficult as the opportunity to do so was often denied by their supervisors who had not bothered to upgrade themselves.

How do they cope with these disappointment? Some have resigned to join the private health sector where the salaries are higher, while others have stayed in the public health sector "frustrated and angry" with their employers, supervisors and the patients, and some have involved themselves in private businesses to augment their salaries.

COPING WITH INADEQUATE SUPERVISION

In the Eastern Cape environment, very little grows when exposed to the harsh elements – the sun and wind and dust. Nurses felt that, given the difficulties they faced, they were not being protected and nurtured by their supervisors. Nurses were able to identify their expectations of their supervisors very clearly. Chief amongst these were to be heard and listened to by the supervisor – to feel understood. To compensate for this apparent vacuum, many supervisory functions were taken over by junior nurses – one account being of a junior nurse who at his own expense and in his own time visited each and every clinic in a very remote area to inform his colleagues about a training programme that was being developed for nurses caring for psychiatric patients. In this way, the nurses were able to support one another's growth and development.

However, through this research project, and a growing realisation that unless we did something to assist our supervisors to perform better, our quality of care would not improve, we decided to arrange a monthly meeting where supervisors could come together and discuss their difficulties. We encouraged them to identify their problem areas, and not surprisingly they did not differ from ours as management. However, the first session was devoted to looking at the roles we play as supervisors, and management was very much part of this process, - we looked at how we respond when faced with a hopeless situation – e.g. a clinic not having immunisation vaccines – did we put on the hat of a judge, or that of the policeman, or a facilitator, or

that of the teacher? We also looked at the emotions we would experience by taking supervisors through role-plays. The outcome has been that we are again developing a set of norms and standards in a participatory manner, and enabling the supervisors to feel empowered to help their staff. We also decided to bring the supervisors into the training programme we have for primary care nurses – in the past this training was conducted for nurses alone, and supervisors were not involved. By bringing them in we were able to redefine the relationship and responsibilities of supervisors together with them and their staff. These examples show how, through the research project, we were able to identify an area requiring attention, and develop strategies to help us meet the need. Nurses and supervisors alike feel that there is now some hope, and are far more confident and motivated in their work.

BALANCING NEEDS

As said before, as we journeyed through this research project, we began to discover a great wealth of beautifully innovative activities amidst the stories of isolation and despair. We came to learn of the balancing act that the clinicians play between their work and their personal lives. This enacted itself in three areas, the family, financially, and in relation to time. Many of the nurses are single parents. Being stationed at clinics in remote areas brings its own challenges to the family unit. Most nurses will keep their children in the more urban environment where they go to school and live with other family members. They thus need to either run two households, or to commute daily to and from work. They are, after all, a powerful resource in the poor community.

In order to meet the additional financial demands placed on their lifestyles, nurses engage in additional work to augment their salaries. The Eastern Cape is a poor province, there is little industrial infrastructure, and farming is largely subsistence in nature, and generating additional income is difficult. They might engage in what they called – additional activities like selling vegetables or other food products, or handiwork like knitting or crocheting, or they might accept part-time job offers as a lecturer, or they might moonlight – this would require them to take leave and go to a larger centre to seek work. This was a very much frowned upon activity, and only became apparent some time into the research project as a trust relationship developed between ourselves and our colleagues or respondents.

With the proximity of the KwaMhlanga district to Pretoria and Johannesburg it is quite easy for primary care nurses to "moonlight" in the private health sector during their off-duty days and even during official hours of

service. On the positive side, the financial reward associated with this practice and their access to modern medical equipment (which is not available or has broken down in the public health sector) have helped them to remain within the public health sector. But with this coping strategy emerged negative consequences on patient care in the public health sector. Those involved are usually too tired to render optimal patient care, frequently absent themselves from work with sick leaves, and some even disregard their own health problems to continue moonlighting. They were boldly open about discussing this coping strategy when they knew that the health authority does not approve the practice.

The third area in the balancing act that emerged, is the pull and push that clinic nurses feel between opening a clinic over weekends, so that the community has access to their services, compared to being at home and in "*your community*" to be with the family and to participate in the community activities (like funerals and weddings). On the one hand the restructuring of health services pushes us to improve access to facilities, and so we need to keep our facilities open for extended hours, especially over weekends. On the other hand, by opening a clinic over weekends we have to resist the pull towards our communities, which requires us to: be with family ("*being at home over weekend is a compensation for being away during the week*"); attend funerals and other social gatherings ("*if your work makes you unavailable for this, then it places you in jeopardy of becoming ostracised because you are no longer an active community member*"), and, despite these tensions, working over a weekend in the clinic means facing security risks when patients often come in drunk and rowdy.

Nurses are having to make choices on these issues, and then to face the consequences of their actions.

COPING WITH STAFF SHORTAGES AND LACK OF MEDICATION

During the course of the project, we witnessed a dramatic breakdown in the services when the nurses unilaterally closed down some clinics and the maternity ward of the community hospital. There had been numerous complaints from primary care clinicians about the lack of medication and staff shortages. However the provincial health department responded through claims of budgetary constraints and inability to employ against frozen vacant posts. The nurses initially felt pressurised to continue providing suboptimal care hoping that the health authority would respond to the issues. When this did not happen, they unilaterally closed down some clinics and the maternity ward of the community hospital. They felt disillusioned and "disempowered" at being seen as incapable to address these issues and en-

tertained resignation. The district manager ignored the situation and displayed anger at the primary care clinicians for suspending services. Eventually, the provincial department had to concede under pressure from the nurses and the media, and more staff were appointed and the drug supply to the clinics was improved. The lesson for the nurses was that the only way the department listens to them is when they down tools.

Conclusion

The provincial health management is now aware of some of our findings and has shown a willingness to be more involved in a participatory way, so as to gain insight on how to help reform the health system in a way that will allow the primary care clinician to function better. As a result of the research, we have observed health care clinicians in the district become more aware of their coping strategies and making attempts to reform the health care system through the involvement of themselves and trade unions in the process of decision making and policy.

This research project has taken us on a journey of exploration. Though the journey we have learnt a great deal about ourselves, and how we cope. We have come to understand the choices behind the acts of coping. Some of these choices have adversely affected health service delivery, but others have enabled the services to function. In reality, amidst the harsh environment, which surrounds us, we have discovered great beauty that needs to be nurtured and allowed to grow and develop further.

Coping is a very complex, context-based matter. When we discovered this, it gave us a sense of awe and we felt that it should be approached with respect. We should be careful about meddling in such complex systems. Participation and greater self-awareness as research skills spontaneously became agents for change, for transformation. We found the participation process difficult and at times turbulent. It was easy to say the word participation and to discuss the concept but difficult to practice. However, even our imperfect efforts seemed to be effective change agents.

Coping strategies in Hua Thalay urban health centre, Korat, Thailand

Somyot Kittimunkong

Introduction

In Thailand most doctors work at hospital level. The Thai health care system favours high technology hospital care provided by specialists. Due to many factors, becoming a specialist is more interesting than being a general practitioner: more job satisfaction, higher income, higher prestige, etc. Most doctors actually practising general medicine are young Thai graduates who have to carry out a compulsory three-year service before being allowed to be trained as specialists. They work in community hospitals, Bangkok health centres, or provincial hospitals. Only a small number will remain generalist in the long run. Over the past decade, an average of 70% of doctors had started specialisation within 4 years after graduation and 90% within 6 years. The educational system is one factor that contributes to that condition because the Thai medical education system follows the western pattern, concentrating on the biomedical aspects of medicine.

Health Centres in Thailand, especially in rural areas, are staffed with nursing staff or with staff that has health related, non medical backgrounds. They have been working in the health centres for a long time and lack training in curative clinical work, which leads to little credibility in the perception of the public. The consequence of this is that rural health centres are not able to be really polyvalent or provide integrated care.

Coping strategies in Hua Thalay urban health centre

In Maung district (Korat province), an experiment has been launched to provide medical care by doctors in a health centre. However, young doctors are reluctant to be appointed at health centre level. This problem triggered our team to implement a system of incentives that would permit to attract young doctors for the job (on a rotation basis, at least), to respect some principles (Primary Health Care approach, equity among staff) and to improve working environment (air conditioners, equipment, computers, etc.).

AUTONOMY IN USING BUDGET AND INCOME. Autonomy at a level of organisation such as the district hospital and urban health centre in Thailand is necessary for the development and the management of that organisation. The official regulation allows us to retain our income at local level and we can decide locally to use that income in the frame of that regulation, which gives us autonomy to buy certain things like motorcycles, ambulance, PCs or even video projectors in some hospitals. The regulation allows the director of an urban health centre to spend up to 100,000 Baht at a time (approximately US$2,500) of the budget and the income on expenditures that we decide ourselves.

DECISION-MAKING. The utilisation of income for staff benefits could be expected to generate conflicts. Conflict management amongst the staff is a common problem for most organisations. We tried to solve this problem by reaching an agreement over certain issues at the table. Decision-making was processed through the democratic means of the team. Transparent management of issues such as the benefit of the staff was considered the first priority and discussed at the meeting table.

USING PART OF THE INCOME FOR INCENTIVES Level of income is an important factor that determines performance of the staff. It has an effect on the provision of care to the people. Thai doctors are allowed to perform private practice outside official hours. The doctors who do not perform private practice can get a compensation of 10,000 Baht (approximately 250 $US) as incentive from the government (Table 41).

Table 41. Sources and allocation for incentives

Allocation	*Source*	*Amount*
MD incentive for no private practice	Government	10,000 Baht/month
Incentive 1 (after hours)		
MD	Regular income	30 B./consultation
RN	Regular income	overtime+320 B. (4 hours)
	Social Security Fund	+ 10 B./patient (if >20)
TN	Regular income	overtime+240 B. (4 hours)
	Social Security Fund	+ 10 B./patient (if >20)
worker	Regular income	overtime+100 B. (4 hours)
	Social Security Fund	+ 10 B./patient (if >20)
Incentive 2		
MD	Social Security Fund	4 weighted units/MD
RN	Social Security Fund	3.2 weighted units/RN
TN	Social Security Fund	3.2 weighted units/TN
worker	Social Security Fund	not systematic

NOTE: the basic salaries are paid from government funds.

The regulation on one of the financing schemes - the income from Social Security Fund – allows us to use up to 60% of it to pay the staff according to the agreement decided by the committee of the health centre (Figure 13). In Hua Thalay urban health centre, we used this part of the income as incentives for all staff. The workers also got a benefit from this income. On average, some 100,000 Baht (2,500 $US) could be distributed per month.

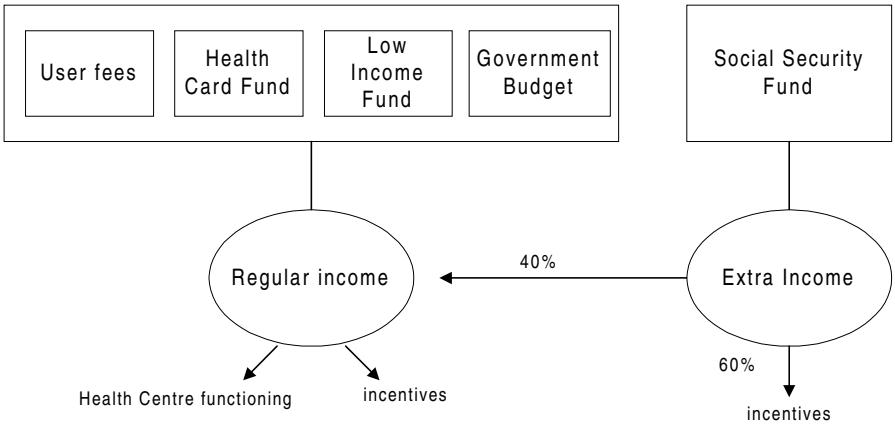
We further organised public service clinics at the health centre after official hours between 4 p.m. and 8 p.m., on each working day. During that period, the doctor got 30 Baht for each consultation. The nurse got the overtime allowance plus some extra money. If the number of patients in that period exceeded 20 cases, she got an extra 10 Baht for each case, paid by part of the 60% of income from the Social Security Fund. The remaining part of money was divided and distributed amongst the staff and workers of health centre, according to the agreement set by the committee.

The money or income that the health centre received this way was linked to the number of patients who used our service. Everyone knows that satisfaction of our patients or clients is important. The quality of care provided to the patients is therefore our concern.

ADDITIONAL RESOURCES AND WORKING ENVIRONMENT. Pooling additional resources money in a common pot was done because we wanted to make the team sharing the feeling of teamwork. Our members decided to use that

money for the staff. So, it increased the level of staff's income, which made the staff satisfied. Autonomy of the health centre, as allowed by the regulations, was a pre-condition for doing this. Furthermore, some of our patients made donations to our health centre such as money, air conditioners, etc. So, the physical working environment in this health centre improved.

Figure 13. Sources of financing



The effects

We can compare the total income of the government doctors who work at our health centre with that of government doctors who combine district hospital work and private practice – the least attractive alternative occupation for the doctors we recruit. Figure 14 shows that total income in our health centre remains below what our doctors could earn even in a district hospital. Table 42 shows, however, that their workload is less.

We found that the doctors who work at our health centre had a feeling of belonging to a team and they felt satisfied with their public mission for health services. They felt free to prescribe drugs because there was no income linked to the number of drugs prescribed (as it is usually the case).

Figure 14. The income of doctors in the health centre (salary plus pooled incentives) compared to the income of doctors in a district hospital (salary plus private practice)

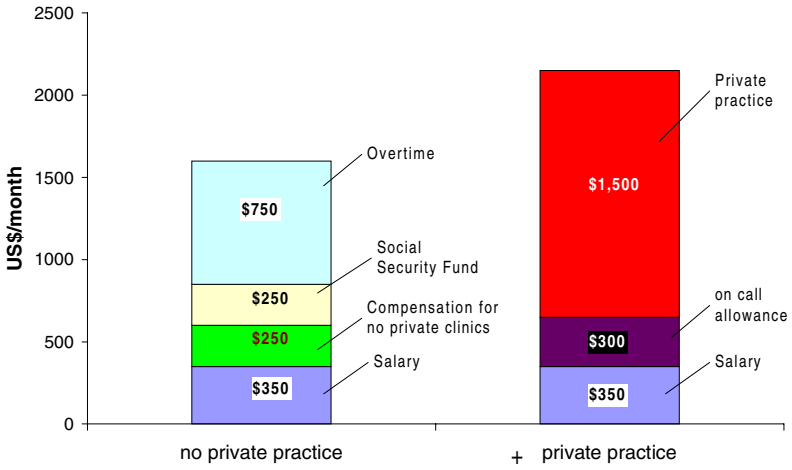


Table 42. The workload of doctors in the health centre (salary plus pooled incentives) compared to the income of doctors in a district hospital (salary plus private practice)

	In health centre (incentives but no private practice)	*In district hospital (no incentives, but combined with private practice)*
Working days per week	5	6-7
Working hours per day		
Regular	8	8
On call	-	0-10
After official hours	4	4-6
Number of patients per day		
Regular	60-70	80-100
On call	-	0-10
After official hours	40-60	50-60

The working environment, physical and non-physical, has been improved for the staff and the services users. We have a system of case conferences and team discussions that motivates the staff to provide holistic care to the patients. However, at present, the Health Centre is overcrowded

each day. The people who use Hua Thalay urban health centre are not only the people of the area of responsibility but also come from outside. Concerning the quality of care that is provided to the people in the area of responsibility, high workload hampers good quality services. The doctor has only 4-6 minutes for each patient, which is not enough for providing holistic, integrated and continuous care to the patient.

We found a possible solution to attract doctor to work at health centre level and they accepted to get lesser income, compensated by other factors. It was also possible to transform individual coping strategies into group coping strategies. Conditions were transparency and equity in the mechanism of collection and distribution of the money. Doing so, we kept responding to a willingness of the team members to maintain their vision of a public mission for health services.

Keeping our goal for public health service is challenging. We can conclude from our experience that our collective coping strategies bring some dangers. The staff tried to attract as many patients as possible to use their services, which threatened the quality of care provided to the people. The goal of public health service is "Good health" for the people; the "prosperity" of the staff should remain subordinate to this goal.

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