WHEN STAFF IS UNDERPAID: DEALING WITH INDIVIDUAL COPING STRATEGIES OF HEALTH PERSONNEL

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Health sector workers respond to inadequate salaries and working conditions by developing various individual "coping strategies"—some, but not all, of which are of a predatory nature. The paper reviews what is known about these practices and their potential consequences (competition for time, brain drain and conflicts of interest). By and large, governments have rarely been proactive in dealing with such problems, mainly because of their reluctance to address the issue openly. The effectiveness of many of these piecemeal reactions, particularly attempts to prohibit personnel from developing individual coping strategies, has been disappointing. The paper argues that a more proactive approach is required. Governments will need to recognize the dimension of the phenomenon and systematically assess the consequences of policy initiatives on the situation and behaviour of the individuals that make up their workforce.

Keywords Health personnel/economics; Public sector; Salaries and fringe benefits; Ethics; Job satisfaction; Adaptation, Psychological; Emigration and immigration; Career mobility; Motivation; Employee incentive plans; Socioeconomic factors (source: MeSH, NLM).

Voir page 46 le résumé en français. En la página 48 figura un resumen en español.

The coping strategies of underpaid staff

The current fashion is to blame governments and civil servants for the public sector's poor performance as a health care provider. Doctors and nurses in government employment are labelled as "unproductive", "poorly motivated", "inefficient", "client-unfriendly", "absent" or even "corrupt". Widespread "demotivation" is said to be due to "unfair public salaries", which are presented as the de facto justification of "inevitable" predatory behaviour and public-to-private brain drain (1, 2). In many countries, developed and developing alike, this has eroded the implicit civil service values of well-functioning public organizations. Public sector responses fail to acknowledge the need for a new-style "psychological and social contract" that takes into account the individual perspective of the employment relationship (3). A stark contrast exists between the apparent ease of blaming victims and the reluctance of official discourse to face up to the problem.

It is common knowledge that predatory behaviour by public sector clinicians — such as under-the-counter fees, pressure on patients to attend private consultations and sale of drugs that are supposed to be free, etc.—is rampant in many countries:(4–14). On top of that, many underpaid public sector clinicians switch between public and private practice to top up their income — whether public service regulations formally allow this or not (15).

Health system managers have fewer opportunities for predatory behaviour than clinicians, but they also have to face a working environment that does not live up to their expectations — financially or professionally. Some may abuse their position for corruption or misappropriation, and to provide extra income many resort to teaching, consulting for development agencies, moonlighting in private practice or even dabbling in non-medical work. Others still manage to be seconded to nongovernmental projects or organizations or to concentrate on activities that benefit from donor-funded per diems or allowances (14, 16, 17).

Together, these practices constitute a set of individual "coping strategies": the health professionals' ways of dealing with unsatisfactory living and working conditions. In many countries, the prevalence of such practices has increased over

recent years. Not all of these strategies can be characterized as predatory behaviour, and their effects on the health care system can be positive as well as negative. They do, however, play an increasing role in how health services function and are perceived, and they cannot be ignored.

It has long been considered politically incorrect to raise these delicate issues explicitly. Recently, however, some (timid) attempts at bringing the debate out into the open — beyond public service rhetoric and ritual condemnations of "unethical behaviour" — have been made (18). These have provided a better understanding of how individuals create and use opportunities for pursuing their own interests — an understanding that is the key to developing adequate strategies to deal with the consequences.

Beyond predation: competition for time, brain drain and conflicts of interest

With current salary levels in many countries, it is quite surprising that so many people actually do remain in public service, when they could earn much more in private practice.

Money is clearly only one element; other "motivators" include social responsibility, self-realization, access to medical technology, professional satisfaction and prestige (19). Still, income does remain fundamental. Individual income topping-up strategies allow professionals to achieve a standard of living closer to what they expect. In one study, such strategies more than doubled the median income of managers, increasing it from 20% to 42% of that of an individual in full-time private practice (17). The upside is that income topping-up helps to retain valuable expertise in public service (7, 20), but there is also a downside.

The predatory behaviour of individual clinicians constitutes, in many cases, a de facto financial barrier to access to health care (4, 21). More importantly, in the long run, such behaviour delegitimizes the public's expectations about public health service delivery and jeopardizes the necessary trust between user and provider.

Other (non-predatory) coping strategies also affect access, but through competition for time. In many countries, medical staf employed as civil servants are only nominally available to fulfil full-time tasks (14, 18). Moonlighting in private practice or training sessions attended for the per diem obviously eat into their availability, and thus limit access to care. This also results in a net flow of resources out of the public sector. In many countries, therefore, low salaries paradoxically lead to high costs per unit of output. Competition for time does not only affect access to clinical services. Managers who participate in other activities of development agencies, or provide expertise for them, are less available to run services and programmes (17). Many agencies are aware of this, and, in theory at least, try to emphasize task-specific and short-term reliance on national staff (22–25). In actual practice, however, concerns for short-term effectiveness often outweigh considerations of long-term sustainability (18).

More insidious than predation or competition for time is the problem of conflicts of interest. When health officials set up a business to improve their living conditions—or merely to make ends meet — this may not interfere with their work as civil servants (although it is likely to compete for time and to reinforce rural-to-urban migration). When officials take up an extra teaching job, this may actually be beneficial to the public agenda, because it reinforces the contact of trainees with the realities of the health services. When officials engage in private practice, however, the potential conflict of interest is obvious (26). Such conflict is also a real possibility when managers moonlight with development agencies: the institutional interests and policies of these organizations are not necessarily congruent with national health policies or the agenda of the public sector (15, 17, 27).

Looking for opportunities is part and parcel of developing individual coping strategies. This directly stimulates the brain drain. For health professionals, the brain drain is often thought of only in terms of intercountry migration (28). Failure to place and retain the right person in the right post, however, is not merely a question of a Congolese doctor deciding to move to South Africa or a Philippine nurse to the United States. It is also a question of internal — and at first rural-to-urban — migration.

Countries have attempted to retain and deploy professional staff in rural areas through a variety of methods. They have decentralized the location of training institutions (29), introduced recruitment quotas to ensure that the most peripheral areas are represented among medical students (29) and made rural field experience during medical training compulsory (30). Results are mixed. Indonesia, for example, used access to specialist training as an incentive to attract doctors to underserved areas. This appeared to work initially, but it proved expensive and attracted providers with the "wrong" skills and attitudes (31).

Ultimately, the main constraint is the inequitable socioeconomic development of rural compared to urban areas and the comparative social, cultural and professional advantages of cities. Cities also offer more opportunities to diversify income generation (26, 32). The need to make up for inadequate salaries in a setting where there are opportunities to do so thus fuels rural-to-urban migration and resistance to redeployment (2, 15, 16, 33, 34). Professionals who have successfully taken advantage of these urban opportunities increase their market value over time, until they are ready to leave public service. Rural-to-urban brain drain is then compounded by public-to-private brain drain.

Training, especially overseas training, is a highly prized opportunity to increase one's market value to complementary employers and to migrate to cities or even internationally. International development agencies have become more sensitive to the problem over recent years, even when they do not have formal, explicit policies on this matter. The World Bank, for example, has made recommendations to tie access to professional education to a commitment to practice a certain number of years in the country or reimburse the costs of training, to limit opportunities for training abroad, and to finance professional education through loans to students that need not be reimbursed when they accept work in an underserved area (35). To limit the brain drain due to their own activities, organizations such as the Norwegian

Agency for International Development (NORAD), the German Technical Cooperation Agency (GTZ) and the World Health Organization (WHO) in principle implement human resources recruitment policies that emphasize the employment of task-specific and short-term consultants, with a commitment of national institutions to retain such staff (21–24).

In practice, many of the best clinicians end up in private practice and many of the best civil servants in development organizations. What starts as a job on the side to complement an inadequate salary quickly becomes a matter of professional and social prestige: leaving civil service turns into a sure sign of success.

Dealing with coping strategies

Most public responses to individual coping strategies fail to acknowledge the obvious — that individual employees are reacting individually to the failures of the organizations in which they work and that these de facto choices and decisions become part of what the organization is. Pretending that the problem does not exist — or that it is a mere question of individual ethics — does not make it go away.

At the centre of the reliance on individual coping strategies is a very strong motor — the gap between the professional's financial (but also social and professional) expectations and what public service can offer. Closing the salary gap by raising public sector salaries to "fair" levels is unlikely to be enough to break the vicious circle. The first reason for this is that it is not a realistic option in many of the poorest countries. In the average low-income country, salaries would have to be multiplied by at least a factor of five to bring them to the level of incomes from small private practices (17). Doing this for all civil servants is not imaginable; doing it only for selected groups is politically difficult. The second reason is that a mere increase in salary would not automatically restore the sense of purpose that is required to make public services function. As such it would not be enough to make moonlighting disappear spontaneously.

Downsizing central bureaucracies and de-linking health service delivery from civil service would make it possible to divide the salary mass among a smaller workforce, leaving a better individual income for those who remain. Experience shows, however, that such initiatives often generate so much resistance among civil servants that they never reach a stage of implementation (35). Where retrenchment becomes a reality, it is rarely followed by substantial salary increases, so the problem remains and the public sector is even less capable of assuming its mission.

Prohibiting civil servants from complementing their income is equally unlikely to meet with success, certainly if the salary scales remain blatantly insufficient. In situations where it is difficult to keep staff performing adequately for want of decent salaries and working conditions, those who are supposed to enforce such prohibition are usually in the same situation as those who have to be disciplined. As an isolated measure, restrictive legislation — when not blatantly ignored —only drives the practice underground and makes it difficult to avoid or correct negative effects (17).

Openly naming and attempting to solve the problem of moonlighting and brain drain, on the other hand, may contain and discourage those income-generating activities that represent a conflict of interest in favour of safety valves with less potential for negative impact on the functioning of the health services. Besides minimizing conflicts of interest, open discussion can diminish the feeling of unfairness among colleagues (37). It then becomes possible to organize things in a more transparent and predictable way. The indications are that professionals of the newer generation have more modest expectations and are realistic enough to see that the market for developing coping strategies is finite and, to a large extent, occupied by their elders.

This gives scope for the introduction of systems of incentives that are coherent with the organization's social goals (37). For example, where financial compensation for work in deprived areas is introduced in a context that provides a clear sense of purpose and the necessary recognition, it may help to reinstate lost civil service values (38).

It makes no sense to expect health workers to perform well in circumstances where the minimal working instruments and resources are blatantly deficient. Improvement of working conditions, however, is more than a combination of adequate salary and the decent equipment. It also means developing career prospects and providing perspectives for training (19). Perhaps most importantly, it requires a social environment that reinforces professional behaviour free from the clientelism and arbitrariness prevalent in the public sectors of many countries.

Piecemeal approaches may work to correct the situation, at least partially or temporarily. What is obvious, though, is that legislation and regulation are not enough. However ill-defined they may be, the value systems of the professionals are a major determinant in the difference between providing good or bad service to the public. It would be naive to think that this could be achieved merely through bureaucratic regulation by governments or donor agencies. Without building up pressure from peers as well as from users, disinvestment by civil servants is more likely to increase than to diminish. One way to increase pressure would be to include a formal "human resources impact assessment" as a condition for the approval of health projects or components of sectorwide approaches. This could force governments and their partners to tackle the problems caused by individual coping strategies and brain drain before they become part of the public organization's culture. It would not guarantee that these problems would be solved, but it would help limit the damage.

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