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## *When staff is underpaid. Dealing with the individual coping strategies of health personnel*<sup>‡</sup>

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### INTRODUCTION

It is fashionable 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 '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 organisations. 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). There is a stark contrast between the apparent easiness of victim blaming and the reluctance of official discourse to face up to the problem.

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

Health system managers have fewer opportunities for predatory behaviour than clinicians, but also have to face a working environment that does not live up to their expectations – financially and professionally. Some

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may abuse their position for corruption or misappropriation; many resort to teaching, consulting for development agencies, moonlighting in private practice, or even dabbling in non-medical work to provide extra income. Others still manage to get seconded to non-governmental projects or organisations, or 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 their prevalence has increased over recent years. Not all of them can be characterised as predatory behaviour, and their effects on the way the health care system can be positive as well as negative. But they do play an increasing role in how health services function and are perceived: they cannot be ignored.

It has long been considered politically incorrect to address these delicate issues explicitly. Recently, however, there have been some (timid) attempts at bringing the debate out in the open, beyond public service rhetoric and ritual condemnations of ‘unethical behaviour’ (18). This provides a better understanding of how individuals create and take advantage of opportunities for pursuing their own interests – an understanding that is the key for 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 actually surprising that so many people actually do remain in public service, even when they could earn much more in private practice. Money is clearly only one element: other ‘motivators’ include social responsibility, self-realisation, access to medical technology, professional satisfaction and prestige (19). Still, income remains fundamental. Individual income topping-up strategies allow professionals a standard of living that is closer to what they expect. In one study it more than doubled the median income of managers, and brought it up from 20 to 42% of that of a 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 a downside too.

The predatory behaviour of individual clinicians constitutes, in many cases, a de facto financial barrier to access to health care (4,21). More important, on the long run, is that it deligitimises the public's expectations about public health service delivery and jeopardises the necessary relation of trust between user and provider.

Other (non predatory) coping strategies also affect access, but through competition for time. In many countries civil servant medical staff is only nominally available to fulfil a full-time task (14,18). Moonlighting in private practice, or training sessions attended for the per diem evidently eat into their availability and hence limit access to care. This also results in a net flow of resources out of the public sector. In many countries low salaries thus paradoxically lead to high costs per unit of output. Competition for time does not only affect access to clinical services. Managers who provide expertise to or participate in other activities of development agencies are less available to run services and programmes (17). Many agencies are aware of this, and, in theory at least, try to emphasise task-specific and short term reliance on national staff (22-25). But in actual practice 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 they take up an extra job teaching that may actually be beneficial to the public agenda as it reinforces the contact of trainees with the realities of the health services. However, when they engage in private practice the potential conflict of interest is obvious (26); it is also a real possibility when managers moonlight with development agencies: the institutional interests and policies of these organisations 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 fuels the brain-drain. Brain drain of health professionals is often thought of only in terms of inter-country migration (28). However, failure to post and retain the right person at the right place 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 instruments. They have decentralised the location of training institutions (29); introduced recruitment quotas to ensure that the most peripheral areas are represented among medical students (29); 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 under-served areas. Initially this appeared to work, but it proved expensive and attracted providers with the “wrong” skills and attitudes (31).

Ultimately the main constraint is the inequitable socio-economic development of rural compared to urban areas, and the social, cultural and professional comparative advantages of cities. But cities also offer more opportunities to diversify income generation (26,32). The need to make up for inadequate salaries – and for being in a setting where there are opportunities to do so – thus fuels rural-to-urban migration and resistance against 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 for leaving public service. Rural-to-urban brain drain is then compounded by public-to-private brain drain.

Training, especially overseas, is a highly prized opportunity: to increase one’s market value to complementary employers, and to migrate to the cities or internationally. International development agencies, even when they do not have formal, explicit policies regarding this matter, have become more sensitised to the problem over recent years. The World Bank, for example, has made recommendations 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 that must not be reimbursed when one accepts to work in an under-served area (41). To limit the brain-drain consequent on their own activities, organisations such as NORAD, GTZ or the WHO in principle implement human resources recruitment policies that emphasise 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 then quickly becomes a matter of professional and social prestige: leaving civil service turns into a sure sign of professional 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 organisations in which they work, and that these de facto choices and decisions become part of what the organisation 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 core 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. First, because 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 five to bring them to the level of the income from a small private practice (17). Doing this for all civil servants is not imaginable; doing it only for selected groups politically difficult. Second, because a mere increase in salary would not automatically reinstate 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. However, experience shows 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 that 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 addressing the problem of moonlighting and brain drain, on the other hand, may create the possibility of containing and discouraging 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 minimising conflicts of interest, open discussion can diminish the feeling of unfairness among colleagues (36). It then becomes possible to organise things in a more transparent and predictable way. There are indications that the newer generations of professionals 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 organisation's social goals (36). Where, for example, financial compensation for work in deprived areas is introduced in a context that provides a clear sense of purpose and the necessary recognition, this may help to reinstate lost civil service values (37). The same goes for the introduction of performance linked financial incentives (36). These can, in principle, address the problem of competition for working time, one of the major drawbacks of moonlighting. However, such approaches require well functioning and transparent bureaucracies, making the countries most in need also those where they are a priori most difficult to implement on a large scale (38,39). A relatively untried area, at least in developing countries, is that of team-based incentives, with some successful experiences being reported from Spain (40).

It makes no sense to expect health workers to perform well in circumstances where the minimal working instruments and resources are blatantly deficient. Improving working conditions, however, is more than a mix of adequate salary and the right equipment. It also means developing career prospects and providing perspectives for training (19). Perhaps most important, it requires a social environment that reinforces a professional

behaviour free from the clientelism and the arbitrariness prevalent in the public sector of many countries.

Piece-meal approaches may work to redress the situation, at least partially or temporarily. But what is obvious 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 making the difference between a good service to the public and a bad one. It would be naïve to think that this could be achieved through mere 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 sector wide approaches. This could force governments and their partners to address the problems caused by individual coping strategies and brain drain before they are part of the public organisation’s culture. That would not guarantee that these problems would be effectively dealt with, but it would help limit the damage.

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