Medicus Mundi Schweiz
Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All

MMS Bulletin #104
Gesundheitspersonal: die Krise überwinden

Human Resources for Health in the non-profit health sector in Uganda

Grappling with inextricable complexities

Von Daniele Giusti

A chronically underfinanced health sector can become efficient for a short while, but only at the very great risk of losing its most precious asset: its human capital. This is happening now in an acute way for the non-profit health providers sector in Uganda.

The Catholic Network in Uganda, together with other major non-profit health providers linked to the major religious denomination, has been progressively aligning itself to the national health policy for the last 8-9 years. The non-profit health providers' networks employ roughly 1/3 of the "public" (1) health system workforce. (2) In addition, a sizeable proportion of the key outputs of the national health system is produced by the non-profit health providers sector, at a cost for the budget that does not exceed 8% (3).

At the outset of the alignment process in 1998, the major declared constraint for the non-profit networks was financial; it is now increasingly clear that human resources constraints, albeit in some ways still related to finances, represent the major obstacle to scaling up, and perhaps even maintaining the current levels of service provision.

In 2003, the Uganda Catholic Medical Bureau (UCMB) stated its commitment to "do something" for human resources for health. Measures were introduced to improve retention of human resources, to increase their capacity (promotion of in-service and formal training – scholarship fund) and to help increasing their number (trying to unbundle the complexity of issues surrounding the critical training of nurses and midwives).

In the meantime, the government has increased remuneration for its employees and has frozen its subsidies to the non-profit health sector, thus plunging this latter in an even worse crisis than that already detected four years ago.

Three years down the line, and in the middle of an "acute on chronic crisis" of human resources, UCMB has a better perception of the variety of problems that it faces while "doing something" for human resources for health. This short report intends to be a summary of

issues, illustrating, whenever possible, the overarching questions encountered.

Quite obviously, issues, questions and problems are viewed from a declared perspective: that of an actor in the system, different from government (and from the private market oriented sector), yet determined to work in partnership with the government to step up efforts towards improving the population's health. The conclusion is somewhat foregone: without a major financial investment in the health system, all attempts at addressing the multifaceted human resource crisis are, to some extent, idle. The experiences of the non-profit health sector in Uganda offer proof of this.

Human Resources' Planning

Uganda is in the process of planning for its human resources. Projections are made for a 15 years' period (2005 to 2020). Although the data reported here are by far not finalised yet, some of the key indicators already hint at the direction the country is taking. The most striking indicator is the projected growth of the health worker/population ratio. This is projected to increase from 1:452 in 2005 to 1:440 in 2006 (4). In the literature (5), the ratio indicated as the minimum acceptable for the achievement of the MDGs is 1:400. If this were the case, Uganda would no longer be far off from the minimum required.

Slightly less encouraging is the fact that Uganda is projected to stay more or less at the same level in 15 years time. In reality, things might be much worse if one considers that the ratios presented in the planning document are based on the assumption that all 59,187 health workers identified in the latest population census do actually work in the health sector (public, non-profit and private health providers). Unfortunately, this seems not to be so. Head counts in the public, private and non-profit health providers sector invariably give lower figures, with a shortfall in the range of over 30% (19,000 health workers are "lost" to health). This is indirectly confirmed by the fact that all recruitment attempts in the public sector invariably cause a major shift of human resources within the sector (from poor districts to richer districts in public employment, from non-profit health providers to public employment, etc.). Very little if any evidence exists that actual numbers of health workers in service have substantially increased. This being the likely case, the ratio health worker to population is, at the moment, more probably in the range close to 1:669; hence well below the minimum desirable ratio indicated by the HLF and WHO in view of the attainment of the MDGs. Avenues for improvement of this ratio seem to be scarce if one further considers that the projected annual increase in health expenditure is 6%, hence not sufficient to grant attractive increases of remuneration.

On the whole, the entire planning scenario seems to be based on the projected availability of financial resources rather than the demands posed by the health needs of the population. This corresponds to the repeatedly declared stand and consistently pursued policy of the Ministry of Finance, i.e. to restrict public expenditure within the limits allowed by the prevailing macroeconomic constraints of the country.

Scaling up, stabilising, scaling down or … changing job? The overarching question hence emerges: what should be the driver of human resources planning? Population needs or financial resource availability? If the latter prevails (and without questioning its legitimacy) should pressures to scale up service delivery be maintained? Would they have any ethical legitimacy or justification? Will the two-speed pressure (resources not increasing, demands skyrocketing) further motivate health workers, or much rather convince them that it's better to change job?!? The religious leaders of the country have already raised their voice to denounce this problematic state of affairs (6).

Human Resources' Production

Train, retain, sustain (7) is the fifth core principle to address the health workforce crisis in Africa. Training of human resources, and in particular of the nursing professionals, the true backbone of the health system, has always been a priority for the non-profit health providers health sector. The first nursing schools in Uganda were established by this sector and, to date, 19 of the 27 nursing and midwifery schools in Uganda are non-profit health providers. In addition, most of these schools have been established in rural environment and train workers who, coming from the same environment, are known to be more likely to stay. This choice has one implication, given the poor quality of basic science training in a rural environment: candidates with good results in science subjects are few. Hence, non-profit health providers schools and, likewise, government schools had started accepting candidates without the required basic education standards. This notwithstanding, the outcome of training in non-profit health providers schools had always been very good. UCMB also demonstrated that there was little relationship, if any, between marks at entry and outcome of training (8).

Quality and surroundings. In 2002, the Nurses and Midwives Council issued a directive, strictly enforcing entry criteria for training in the nursing and midwifery profession. The reason was the declining quality standards registered in professional practice. Although perfectly legitimate, this directive came at a time when the schools were asked to scale up production. The net result was a drop in the admission of candidates from rural areas and a progressive increase of male entrants in the profession. Although partly corrected over time, this occurrence raises some issues around the determinants of quality of training and outcome of training. The Bureau had already demonstrated that it is possible to obtain good results in the training of candidates with less than prescribed marks at entry if the training and working practice environments are conducive. On the other hand, a couple of years later another issue became evident: foreign agencies started to actively recruiting nurses and midwives. It is reckoned that, in 2004, about 200 nurses left the country for employment in Europe. At the time, the event even made headlines in the newspapers. The conclusion of the debate was very pragmatic: "kyeyo" (the local definition of work-related migration) has positive returns for the economy, hence it should not be opposed. If nurses are exported, the important thing is to get funds from the rich countries that need them. How this will occur and if this can occur given the prevailing macroeconomic constraints was never discussed nor further mentioned.

Hence the overarching question: are purported quality agendas indigenous or exogenous? "Brain drain" being an important issue, wouldn't it be more reasonable to accept a "quality middle ground" rather than pursuing it for export?

Substitute health workers. Similar considerations can be made for substitute health workers. They are a reality. Without nursing aides the health system would grind to a halt. Many other tasks are carried out by substitute health workers (9). Although highly needed, and advocated for in many official documents they are often frowned upon by professional organisations (10). The diversification of training and the training of substitute health workers is one of the strategies open to the non-profit health providers health training in rural environment with smaller number of candidates for traditional nursing caused by the "gate" imposed by entry criteria. To a certain extent, the non-profit health providers sector has always been open to innovation. But this occurred at a time when the regulatory environment was less pervasive and space for innovation existed. At the moment, innovation in the field of human resources production is a risky business that few institutions/organisations can afford.

The overarching question emerging here is: who keeps the regulators open for innovation that is badly needed and advocated? Who protects the innovators?

Human Resources' Retention

Factors influencing the capacity of an organisation to retain staff are innumerable. Quite often they are so intertwined that every attempt at grouping them and classifying them is open to criticism. After all, capacity to retain human resources in an organisation boils down to what could be generally defined as "good management". Knowing the limitations of such an attempt, five factors are considered here: physical and material working environment, job security, professional development, social security and remuneration.

Here below follows a summary assessment of the situation of the non-profit health providers facilities with regards to the five factors and in comparison with the other major employer (public sector), followed by the developments "caused" by UCMB to address some of the critical problems detected. At the end, trends concerning attrition for some key cadres are presented along with the overarching question(s) the sector faces.

Physical and material working environment: The non-profit health providers facilities are known and often reported of "having good standards of infrastructure, equipment, supplies, housing". We could say that, in general terms, workers in these facilities cannot/do not lament because of poor infrastructure and equipment standard, poor or inexistent housing, nor they can/do complain because of lack of medicines, diagnostic facilities etc. In other terms: what is necessary to be able to do a fairly decent job in a conducive environment is in place. Strongly influenced by this perception, the Bureaux did not deem worth investing in addressing this factor.

Job security: One of the most common complaints heard from the employees of the non-profit health providers' network was the uncertainty about the terms and conditions of their employment, contracts, rights, etc., accompanied by the conclusion that, because of this, they felt always uncertain about their job. Times and again this complaint was raised at various meetings and fora and, although no hard data existed to corroborate their perception, it made sense to trust that this was a genuine problem and a point requiring action. The Bureaux prepared guidelines for the drafting of a Manual of Employment, including terms and conditions of service aligned with (and sometimes more advanced than) the labour legislation, etc. Eventually the existence of an updated (validated) Manual of Employment (and with time also the proof of consistent practices) became a pre-condition for accreditation to the network. By 2005, all hospitals had a valid(ated) manual of employment; in 2006, this practice has been extended to all the Dioceses (and Lower Level Units). By virtue of this manual's adoption each unit has clearly outlined procedures for employment, induction, discipline, appraisal, airing of complaints, termination, etc…. It could be argued that the existence of a manual does not imply implementing it, but this is also true for public and private employment. One could say that, with this move, a major step forward has been taken, and this problem has now been addressed at least to the extent to which public employment is concerned.

Professional development: Another common complaint heard times and again from employees in the network was (is) the scarcity of professional development opportunities offered. As an attempt to address this relevant complaint a scholarship fund was established five years ago. The fund awards grants to institutions to allow them to develop their own staff or, more rarely, to offer basic professional training to unskilled staff. In the last two years, this fund has awarded over 100 grants per year. This means that roughly 1.6% (1:60) of the network staff had a chance to develop professionally through formal training.

In 2005, the proportion of civil servants stood at roughly half this ratio. (11) In both cases, this excludes informal in-service training and scholarships awarded by the employing institutions themselves (the latter being more likely in the non-profit health providers sector than in public employment).

Hence, also in the case of professional development, the employees of the non-profit health providers sector do not fare too badly. One would venture to say that they are somewhat privileged if compared to their colleagues in public employment. No comparison can be made with health workers in private employment.

Social security: The social security provision for employees of the private (hence also non-profit health providers) sector are determined by law and differ from those applicable to the public sector. No pension scheme exists at the moment for private employees. The compulsory contribution to the National Social Security Fund (12) gives title to receiving a payment of a lump sum on retirement, death (13) or permanent withdrawal from employment. Discussions are being held to explore the transformation of this fund in a real pension fund. Public servants, however, accrue title to a real pension, but there has been no provision so far for the establishment of a fund: it can happen that the largest majority of retiring public employees has

to wait for years before being able to access their pension. The amount of money the government currently owes to its retired employees is staggering (14) and increasing. There is little chance for the situation to be adequately addressed in the near future. Hence, under the security point of view, private employees, although not entitled to a pension, fare better than public employees: when retiring, they have access to a lump sum that their colleagues in the public sector can only dream about. Unfortunately, reality and perception do not match in this case. In fact, one of the commonest complaints of non-profit health providers' employees is that their social security is not adequately catered for by their employers. Be as it may, also in this case, as in the previous three, if perception is excluded, non-profit health providers health workers are adequately catered for, to a degree that - all factors considered - compares well with public employment.

Remuneration: This is probably the aspect under which the employees of the non-profit health providers sector, with few exceptions and excluding medical doctors, fare poorly in comparison with their colleagues in public service and in private employment (15). The last two years' investment in staff remuneration by this sector should have decreased the difference created by a civil service selective increase of the health workers' salary in 2004. Although the gap is still reported to be important, it is reckoned to have sizeably decreased.

The dilemma for the non-profit health providers sector, in view of the stagnation of public subsidies for the last three years (and probably in the next financial year too), is how to finance the increased cost of labour. As funds from donors are accessible in an unpredictable way, the only other remaining avenue are the contributions of the patients (fees). This goes against the network policy to move progressively towards better access and equity in order to align with public sector (16). Once again, the sector is financing its crisis by underpaying its staff. But, perhaps, this in not the whole story.

Summary considerations on human resource retention: The final step is the assessment of attrition of selected cadres. Despite the obvious difficulty in obtaining data, a special effort has been made in this direction during the last year. There are categories of staff in high demand who constitute markers of the situation.

	2003/04	2004/05	2005/06
Clinical Officers	22%	21%	32%
Enrolled Nurses	16%	17%	25%
Enrolled Midwives	15%	10%	28%

Medical Officers	28%	21%	32%

Uganda: categories of staff in demand

It is clear that attrition is increasing, despite the efforts made in increasing salaries and despite the fact that other factors determining retention seem to be, at least objectively, of lesser importance. Hence the question: if not all of the reported factors, what remains to explain the increasing attrition?

One factor which was not considered earlier is work pressure. Very little is being said about it, although some of the exit interviews which have become practice start revealing one aspect of the story which had been underrated earlier. Increasingly, staff report that they leave and join public employment because "they can work less and are paid more". An indirect confirmation of this fact comes from the productivity index registered in the network over the year. Although one could go proud of the data registered – the constantly increasing productivity of the last five years, however, the down side is that, if given the chance, staff prefer to opt out from an unwelcome work pressure. As matter of fact, efficiency gains obtained by increased staff productivity have financed access and equity in the network, but are proving to be unsustainable and counterproductive.

Hence the overarching question: does the pursuance of efficiency (the much loved "value for money" of the health economists) pay?

Conclusion

Given the bleak scenario projected vis-à-vis human resource planning and considering the constrained capacity of human resource production, the realisation of efficiency gains seem to be the only possible avenue to finance the much desired "scaling up" of service provision advocated for by all and demanded by the MDGs in Uganda. The macroeconomic constraints and the cap posed to public health spending leave only this option open for Uganda at the moment. But there is a clear limit to what efficiency can achieve, especially when these are obtained at the expenses of the workforce. Right now it is the non-profit health providers sector that, with more determination than others, has pursued - and to some extent achieved objectives of access and equity through efficiency (17); however, this is the sector which is losing its overburdened staff. The experience of the non-profit health providers sector should leave no illusion: it takes a big effort to realise efficiency gains and returns may be good in the short term but are short lived. A chronically underfinanced health sector can become efficient for a short while, but only at the very great risk of losing its most precious asset: its human capital. This is happening now in an acute way for the non-profit health providers sector. And it is extremely likely that this will happen in the public sector. What will come next? This is the crux of the matter, but it is surprising how little priority it receives, at least in Uganda, and how

little it is known among the health activists of the country. Although clearly mentioned in various documents (18), nothing happens; if anything, ironically, things are even worsening in Uganda. If this issue is not addressed and solved, all advocacy for health will only result in more demand of service without comparable increase of resources. No surprise if health workers decide to leave the rural environment, non-profit health providers and public employment, the country and, why not, the profession!!!

*Daniele Giusti is Executive Secretary of the Uganda Catholic Medical Bureau (UCMB). Contact: dgiusti@ucmb.co.ug. *This paper first was presented at the International Alumni Meeting of the Institute of Tropical Medicine of Antwerp, which took place in Kampala from 18th to 22nd December 2006. The full text of the article including graphs can be ordered from the author.*

Notes

1. The term "public" here is used in a wide sense, to mean the providers in the sector operating in pursuance of the Health Sector Strategic Plan. In practice it includes governmental providers (national and district) as well as private non-profit (PNFP) providers.

2. 9,154 employees in the PNFP health sector against 18,333 in civil service (MoH, AHSPRH 2003/4, page 86).

3. The PNFP health sector finances its operations through public subsidies (about 25%), user fees (about 35%), aid from variable sources (about 40%). (MoH, AHSPR 2005/6, pages 73 and 74)

4. MoH, Uganda Human Resource for Health Strategic Plan 2005-2020 – Draft 22 October 2006. Availed at the XII Joint Review of the Health Sector. Page 37

5. High-Level Forum on the Health MDG, Addressing Africa's Health Workforce Crisis, Abuja 2004. Page 2

6. Open letter of the Religious Leaders to the Government of Uganda, par 3 and 4. The New Vision, 6th May 2005, page 27.

7. High-Level Forum on the Health MDG, Addressing Africa's Health Workforce Crisis, Abuja 2004, page 6

8. Issues emerging from the strict application of entry criteria in Nurses' Training. Note presented by the PNFP sector to the Health Policy Advisory Committee. December 2002

9. The PNFP health sector employs over 40 pharmacy assistants, trained between 1995 and 2003 by a joint venture of the Protestant and Catholic Medical Bureaux. The country has a dire need of pharmacy staff and no solution is in sight. Despite this fact, recognition of these cadres was refused: hence the decision of the Bureau to halt the training.

10. Delanyo Dovlo: Using mid-level cadres as substitutes for internationally mobile health professionals in Africa. A desk review. 2004, www.human-resources-health.com/content/2/1/7

11. MoH, AHSPR 2004/5, page 72. 150 scholarships awarded out of a workforce of about 19,000 staff, i.e. 0.78% or 1: 130 staff.

12. The contribution to the fund amounts to 15% of the gross salary, of which 10% are paid by the employer and 5% by the employee. The law holds the employer accountable for both.

13. In this case payment is effected to the indicated persons having title.

14. To date it amounts to over 300 billion UgSh., i.e. about 10% of the annual GoU budget.

15. UCMB, Facts and figures about the PNFP health sector, Ch IV Par 4. October 2004

16. Ten years ago, the PNFP sector, denounced an acute crisis (ironically precipitated by a similar occurrence: i.e. the increase of salary of public servants) over a chronic situation of under financing. At the time the sector declared that the coping mechanisms adopted for a few years had become progressively unsustainable; these coping mechanisms were the (1) underpayment of staff, (2) substitution of qualified staff with less qualified and junior staff, (3) delay in critical infrastructure characterised by a chronic underfinancing of service production. Recourse to increased user fees had resulted in a down spiralling trend, which was corrected only with great effort and thanks to public subsidies.

17. Giusti D, Lochoro P., Odaga J., Maniple E. Pro-Poor Health Services: The Catholic Health Network in Uganda. Development Outreach, World Bank Institute, March 2004

18. High-Level Forum on the Health MDG, Addressing Africa's Health Workforce Crisis, Abuja 2004. Action 2, Page 7

Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10

Suisse romande
Route de Ferney 150
CP 2100
CH-1211 Genève 2
Tél. +41 22 920 08 08

info@medicusmundi.ch contact@medicusmundi.ch