Health worker remuneration and incentive policies in post crisis Zimbabwe: challenges and Implications for retention of human resources for health.

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Background

Zimbabwe experienced a severe economic, social and political crisis between 1997 and 2009. The health system was affected through loss of experienced health professionals, drug shortages, increased burden of disease and the attendant high demand for services, which led to a drastic decline in the quality of health services available for the population. A severe human resources for health crisis which affected all cadres ensued during the crisis. The key provider organisations, government, mission and municipalities responded differently to the crisis with varying effects. The study examines how incentive environments have evolved during and after the crisis in Zimbabwe, what influenced the trajectory, what have been the reform objectives and mechanisms, and what are their intended and unintended effects with regards to access and quality.

Objectives

To understand health worker incentive policies, their evolution, their implementation and effects in the post crisis period in Zimbabwe.

Methods

Mixed methods, including document review; key informant interviews; career histories of health workers and a health worker survey were used in the study.

Table 1: Summary of sample sizes

Method	Gender distribution		Total Interviewed
	Male	Female	
Key Informant	10	12	22
Career histories	8	22	30
Survey	50	177	227

Results

Remuneration, and incentives, both financial and non-financial impacted on health worker attraction, retention and distribution during and post the crisis in the key sectors studied. The municipality sector reviewed health worker salaries in line with inflation trends, reviewed salary grades, introduced retention allowances and ensured access to cash which was in short supply in banks. Non-financial incentives in the form of subsidised water and ensured easier access to land for developing residences during the crisis were formulated. The net effect was a fairly stable and motivated workforce. In the public and mission sector salaries were reviewed, new allowances were introduced like the remote area allowance and extant allowances increased. Policies to strengthen non-financial incentives were adopted, for example duty free importation of vehicles, and access to land for residential development. The policies were undermined by poor funding and very few health workers benefitted. The effect was a demotivated workforce.

In the post crisis period the disparity in incentives between the municipalities and public and mission sector got more accentuated. For the municipalities, policy decisions on salaries made during the crisis on salaries and grades were maintained in the aftermath of the adoption of a multi-currency regime dominated by the United States dollar in 2009 (Figure 1). In government and mission sector salaries remained depressed, some allowances were not paid because of the paucity of funds in the national treasury. The salary grade bands were distorted as government sought to reduce the public sector wage bill. The net effect was a very demotivated workforce. Excerpt from career histories, show high levels of demotivation:

"there is need to have a sustainable salary as the current level is so minimal - free maternity is not working and the post natal ward is now like an Indian market it accommodates everyone from everywhere making work unbearable (CH 011 Public sector facility manager)"

In the immediate post crisis period a retention allowance bankrolled by development partners helped in improving the salaries. However the retention allowance has become a source of renewed demotivation because it is now being phased. A manager in the public sector said: *Regarding retention allowance, the concept was noble but the way it was managed was very bad. Initially it was $250 and the next minute it was reduced. Firstly we were given in envelopes and then deposited into our accounts. It then became inconsistent and it was further reduced. We used to get it a week before or after pay day but at the moment you never know when it will come* (KII 04 Public sector health manager).

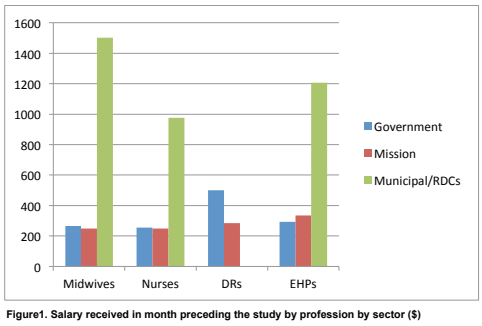

Figure1. Salary received in month preceding the study by profession by sector ($)

Additional incentives are offered and as can be seen from Figure 2, municipal health workers get superior rates for the traditional allowances paid to every health worker. These are supplemented by additional incentives peculiar to the municipality (Figure 3).

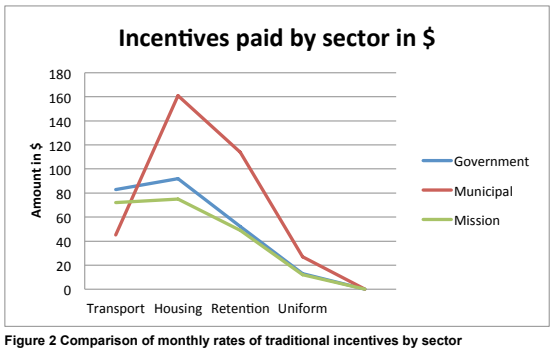

Figure 2 Comparison of monthly rates of traditional incentives by sector

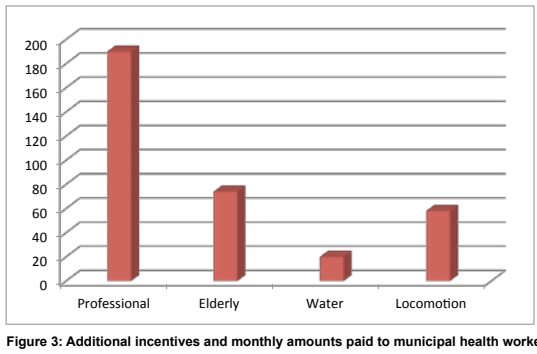

Figure 3: Additional incentives and monthly amounts paid to municipal health workers

Staff returns indicate that the municipality had all posts filled with highly skilled and experienced staff. Unfilled posts were those affected by a government freeze on recruitment. Vacancies were a result of retirement or death in the municipality, as opposed to resignation, abscondment or outbound migration, which were common in the public and mission sectors. Recruitment was not a problem for municipality, if the hiring freeze was removed, and retention was higher in the municipal sector than in government and mission sectors. Retention allowances effected after the crisis have helped stabilise the health workforce across all providers. The municipality had the most effective retention system, attracting cadres from the other providers. Out of the 227 health workers surveyed, 91 had moved from public to municipal employment and gave the reason for their move as the attractive remuneration.

Conclusion

Health worker incentive policies require an integrated approach to ensure that access to and quality of services is not affected. Migration of skilled and experienced health workers from sectors offering poor incentives to those that have superior incentives leads to poor overall distribution of available skills. Skilled and experienced health workers were concentrated in low level health facilities, usually municipal health facilities, meant to provide primary care. At the huge tertiary facilities (usually public sector, central and provincial hospitals) are found less experienced cadres who deal with complex health conditions for which they have little skill. Superior incentives as opposed to health needs define the distribution of the health workforces in post crisis Zimbabwe.

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