Fostering development of sustainable incentive policies for a resilient health workforce: lessons from post crisis Zimbabwe

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Background

- Severe economic crisis between 1997 and 2008 affected health services in government, mission and municipal facilities.
- High vacancy rates for all health cadres meant that services were discontinued in most rural areas.
- The main factors causing vacancies were poor salaries, heavy workloads, and lack of equipment.
- Retention schemes formulated and implemented with support from development partners during emergence from crisis to improve attraction and retention.

Study objective and research questions

To examine how incentive environments evolved, their implementation and effects during and after the crisis.

The study sought to answer the following research questions:

- How did incentive environments evolve during and after the crisis?
- What influenced the trajectory?
- What were the intended and unintended effects?
- What lessons can be drawn for a resilient health workforce?

Methods and research tools

Method			Total interviews
Interviews			
Tool	**Gender distribution**		
	Male	**Female**	
Key informant interviews	15	13	28
Career histories	3	32	35
Health worker survey (doctors, nurses, midwives, environmental health staff)	50	177	227

Findings

A service-wide harmonised retention allowance was introduced as a post crisis incentive to revitalise health services.

Capacity to pay determined levels of retention allowance and other allowances.

Municipalities, due to extra cash from rate payers, paid more attractive rates for housing and retention compared to government and mission respectively.

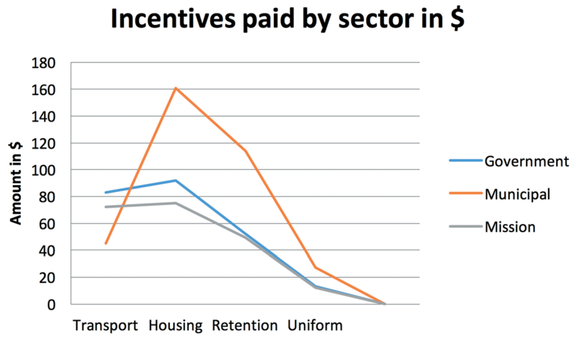


Figure 1 Comparison of monthly incentives by sector (2013)

Total remuneration was higher in municipalities for all cadres.

A breakdown of total income received by cadres in the municipality on average in 2013 was about 75% net salary and about 25% allowances, compared to about 60% and 40% in mission and about 40% and 60% in government respectively.

Health workers preferred working in the municipalities where salaries contributed more to total income than allowances as this had a positive effect on their pensions.

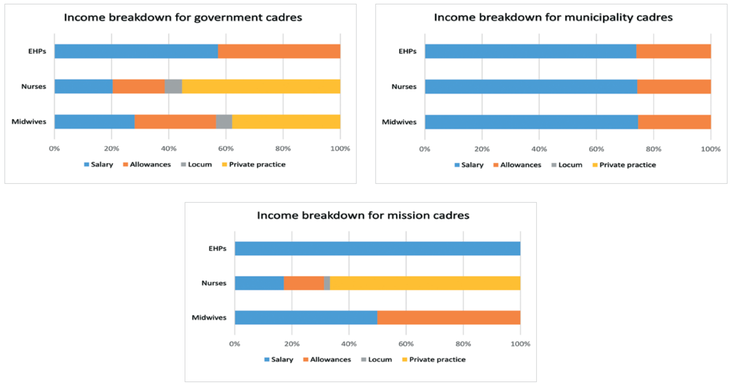
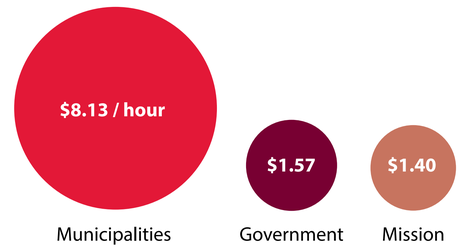


Figure 2 Breakdown of salary and allowances, by sub-sector (2013)

The asymmetries in allowances and salaries resulted in a huge gap in remuneration for the health workforce in the three provider organisations. The following were the hourly rates inclusive of salary and allowances in 2013:



Experienced and better qualified health workers were attracted from government and mission to municipalities.

"…as we entered the year 2000 the local municipality had become the most sought after employer by health workers across all cadres. You saw from the health worker profiles, we have highly qualified midwives here, better than at the provincial hospital and we recruited them from the government hospitals and you can also see that we have nurses, very old ones with SCN, these were recruited a long time ago." ***KII 002 Municipal Health department Manager).***

Conclusions and lessons learned

- Incentives attracted health workers in the immediate post crisis period but for government and mission facilities the effect waned due to a phased reduction in allowances.
- Incentive policies require an integrated approach to avoid remuneration asymmetries within the national health system, which cause distortion of the health workforce, with more experienced staff working at lower level clinics (if these offer better terms and conditions).
- A coherent mechanism for management of incentives is imperative to ensure good distribution of health workers to provide quality and appropriate services in all settings.

Resources

For a full list of ReBUILD's resources from its research on human resources for health in post-conflict and post-crisis settings, see:

http://bit.ly/2eJDBX2

ReBUILD Consortium

UKaid from the British people

Research for stronger health systems post conflict