Emerging opportunities for recruiting and retaining a rural health workforce through decentralized health financing systems

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Introduction

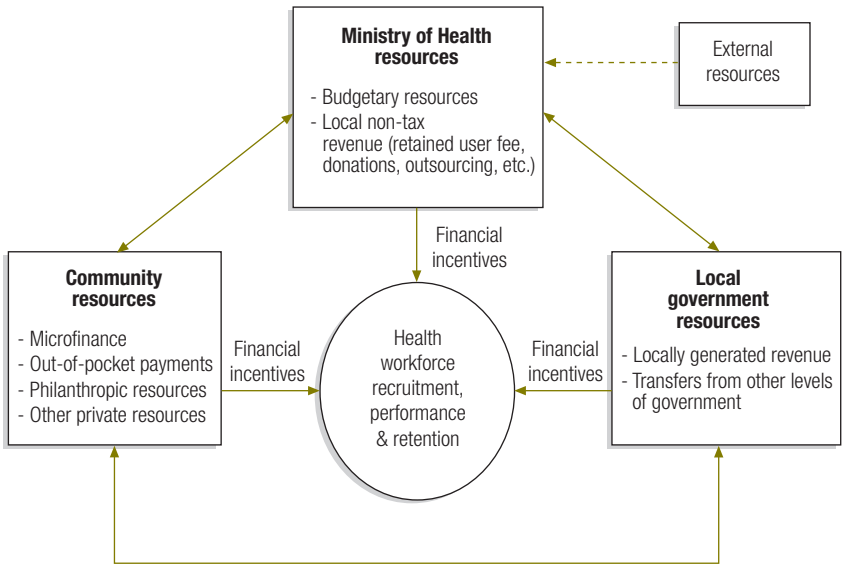
Decentralization involves the dispersion of power, functions and finances from a central authority to regional and local authorities. Decentralization reforms have become widespread in low- and middle-income countries, mainly due to movements towards democratization, the spread of multi-party electoral systems and transitions towards market economies. In particular, decentralization of financing systems, particularly for health, is now a common aspect of reform in these countries. The main advantage is the dynamism it can bring into the resource allocation mechanism; it also can facilitate re-allocation of funds through a visible, vibrant and bottom-up approach.[1] Besides bringing in additional financial and human resources, it can also improve utilization of existing health-care resources such as staff.

This paper looks at the potential for decentralization to lead to better health workforce recruitment, performance and retention in rural areas through the creation of additional revenue for the health sector; better use of existing financial resources; and creation of financial incentives for health workers. This paper also considers the conditions under which decentralized health financing systems can lead to improved health workforce retention, using examples from several countries, including Brazil, China, Costa Rica, Guyana, India, Kenya, Pakistan, the Philippines, Romania, Rwanda, Thailand, Uganda, the United Republic of Tanzania and Zambia.

Decentralization of health financing

According to the rationale of decentralization, smaller local entities that have more autonomy and funds can better respond to local needs and may also better manage human resources. As explained in Fig. 1, decentralized health financing systems are built around one or more of the three main sources of health-care finance: ministry of health, local government and the community. Where the decentralized health financing system relies on more than one source, the sources are seen to be interdependent (as indicated by two-headed arrows in Fig. 1). In some countries with decentralized health systems, such as China, India, the Philippines, Uganda and the United Republic of Tanzania, all three sources of funding for health exist but under different types of decentralization. In that context, financial incentives that aim to improve health workforce recruitment, performance and retention can stem from each source of funding. According to the mandate and aims of the different sources of funding, the nature of these financial incentives may vary.

Fig. 1. **Decentralized health financing and its links with the health workforce**



Decentralization, where it involves the dispersion of human resource functions to the local (government, health-care delivery or community) level, is an especially challenging process as it is influenced by various institutional and contextual factors.[2] Although financial resources are finite (but well accounted for under decentralization), decentralized health financing systems present opportunities to maximize resource availability and utilization. In particular, as shown in Fig. 1, three prominent sources facilitate this purpose: (i) autonomy within the ministry of health or decentralization of health-care delivery, (ii) local or decentralized government resources, and (iii) community resources. This paper mainly focuses on financial incentives from decentralized ministry of health and local government systems.

Delinked wages

One of the main fiscal constraints on health-care financing is the fixed level of funds allocated to the ministry of health from the ministry of finance in accordance with the health wage bill. Decen-

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tralization offers more flexibility, notably by addressing budgetary constraints by delinking the health workforce from the civil service and the overall wage bill. This provides the ministry of health with autonomy to control the use and the size of the salary budget concerning health and, additionally, enables the health workforce to be employed directly by decentralized entities with some level of independence from the government. Moreover, in cases where governments have a budgetary ceiling on the overall wage bill, this option allows for an increase in health spending without affecting the overall salary budget, enabling local health facilities to expand their health workforce base.

This strategy was employed in the Philippines, Rwanda, Uganda and Zambia, and showed to be particularly successful in Rwanda, which partially separated the health sector from the overall wage bill. Basic health worker salaries in Rwanda were paid from the overall wage bill, while supplementary performance-based allowances were paid from block grants provided to district level authorities and facilities (and not counted as part of the overall wage bill). Evaluations of the programme indicated that the system allowed for greater control over the health wage bill at the district and facility level, and facilities were able to better fund incentives to improve health worker retention and performance.[2]

Devolved recruitment

Decentralization has been shown to improve administrative efficiency in some cases where responsibilities of hiring and firing of health workers have been devolved to the local level. In the United Republic of Tanzania, partial devolution of recruitment processes for junior-level health care staff to the district level led to a decreased administrative burden at the central level, which could then focus on senior-level recruiting functions. Similar gains in efficiency were observed in Thailand, where recruitment processes decreased from 68 to 31 days with the devolution of responsibility to local line ministries.[3]

In China, the devolution of recruitment procedures to the township level showed that health centres were better able to match demand with supply costs[4]; and in Uganda, one study indicates that approximately 75% of health workers interviewed said that salary disbursement procedures were more efficient after devolution to the district level.[2] Moreover, studies have also found that devolved recruitment functions by divisional-level authorities in Pakistan have reduced levels of physician absenteeism.[2]

Flexible contracts

Decentralized financing systems can facilitate the effective use of donor assistance by using these funds to finance health workforce salaries through flexible short-term contracts. This was illustrated by the Emergency Hiring Program in Kenya, where resources were provided by donors to hire health workers on three-year contracts tied to geographical areas. The programme allowed for a better match of candidates with the appropriate position, and led to significant improvements in staffing and health workforce retention in underserved areas where it was implemented.[2]

The use of flexible short-term contracts has also improved staffing in Guyana and the United Republic of Tanzania, where such contracts were implemented to allow retired and part-time workers to re-enter the health workforce, and therefore decrease the burden on existing health workers. Additionally, experiences from Cambodia have shown both increases in accountability and decreases in the level of absenteeism and informal payments with the implementation of such contracts.[2]

Strategic allowances

The need to address shortages in the health workforce has been the focus of recent global debate. However, evidence suggests that addressing factors of health worker performance (i.e. absenteeism, productivity, quality of care) is equally important, particularly where fiscal constraints inhibit the expansion of the health workforce.[5]

While available fiscal resources can be used directly for recruitment purposes, one approach to addressing factors of health workforce performance and retention involves the strategic use of allowances within the health sector. Salaries of health workers in the public sector are usually based on a national pay scale and are not typically contingent on measures of performance.[5] Alternative uses of allowances can provide direct incentives to improve health worker performance and retention, as well as improve health-care delivery outcomes, particularly in underserved areas.

Devolution of human resource functions provides local authorities with greater flexibility and financial autonomy to manage funds and health workers. Indeed, experiences from the United Republic of Tanzania suggest that partial autonomy in the use of budgetary resources for health workers at the district level is positively associated with improved health workforce performance and better health-care delivery.[6] Similarly, in the Indian state of Kerala, effective financial intervention from local government authorities is shown to have improved staff performance.[1] Moreover, successful implementation of payment systems linked to performance for the public health workforce has been noted in Brazil, China, Costa Rica, Romania and Rwanda.[2]

Conditions for success

Numerous challenges exist with the proposals and incentives examined in the light of decentralized health financing systems. For instance, delinking the health workforce from the civil service requires strong regulatory frameworks as well as flexible labour laws. Moreover, as this policy implies high levels of autonomy for the ministry of health in setting the health wage bill and salaries, there needs to be a system of accountability in place. This proved to be a challenge in Zambia, where the separation of the health boards from the ministry of health led to more unequal terms of work, and the wage bill took up an increasing portion of the health budget, limiting other investment.[2]

Additionally, while the use of donor funds for health workforce purposes has been shown to be successful in countries such as Kenya, there are several challenges associated with this proposal. For instance, donor assistance is often earmarked for specific purposes and related to certain diseases, which limits the flexibility of its use. Moreover, while donor funding can effectively be used to increase fiscal space for the purpose of health workforce performance, recruitment and retention, the consistency of such funding cannot be guaranteed.

Challenges also exist with the appropriate use of financial resources locally. Studies suggest that salary increases are more effective when contingent on meeting performance objectives. While

policy-makers often cite that low salaries result in poor health workforce retention or performance, there is little evidence that simply increasing salaries leads to improved performance.[7] Experiences from Malawi have shown that when salaries for health workers were increased by approximately 50%, there was little effect on health workforce retention or performance.[8] On the other hand, in countries such as Rwanda where salaries are tied to performance indicators, improvements were noted in both health worker productivity and health-care delivery. However, successful implementation of strategic allowances, as with other incentives, also depends on institutional and contextual factors such as local-level capacity, legal infrastructure and government flexibility with labour regulation.[2]

Conclusion

It is evident that there are further ways that decentralized health financing systems can contribute towards health workforce recruitment, performance and retention. In particular, providing the ministry of health with autonomy, by delinking the health workforce from the civil workforce and providing strategic performance incentives, are means by which health workers can be successfully recruited and retained. However, such policies work only if health system objectives are aligned with appropriate institutional and incentive structures. ■

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References

1. Varatharajan D, Thankappan R, Jayapalan S. Assessing the performance of primary health centres under decentralized government in Kerala, India. *Health Policy Plan* 2004;19:41–51. doi:10.1093/heapol/czh005 PMID:14679284
2. Vujicic M, Ohiri K, Sparkes S. *Working in health: financing and managing the public sector health workforce*. Washington, DC: The World Bank; 2009.
3. Simananta S, Aramkul A. *Decentralization of recruitment in Thai civil service*. New York: United Nations Public Administration Network. Available from: http://unpan1.un.org/intradoc/groups/public/documents/UN/UNPAN021828.pdf [accessed 23 March 2010].
4. Liu X, Martineau T, Chen L, Zhan S, Tang S. Does decentralisation improve human resource management in the health sector? A case study from China. *Soc Sci Med* 2006;63:1836–45. doi:10.1016/j.socscimed.2006.05.011 PMID:16808993
5. Hongoro C, Normand C. Health workers: building and motivating the workforce. In: Jamison D, Bremen JG, Measham AR, Alleyne G, Claeson M, Evans DB, et al. (eds). *Disease control priorities in developing countries*. New York: Oxford University Press; 2006.
6. Mliga G. *Decentralization and the quality of health care in Tanzania* [Global, Area & International Archive]. Berkeley: University of California Press; 2003. Available from: http://escholarship.org/uc/item/7jd148mh [accessed 23 March 2010].
7. Mathauer I, Imhoff I. Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Hum Resour Health* 2006;4:24. doi:10.1186/1478-4491-4-24 PMID:16939644
8. Mtonya B, Chizimbi S. *System-wide effects of The Global Fund in Malawi: final report*. Bethesda: Abt Associates Inc; 2006.