
Title: An incentive package for deployment and retention of
Public-sector health workers in hard to reach areas of
Bangladesh

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Abstract

Retaining health workers in remote and hard to reach areas has become a challenge not only in developing countries but also in the developed ones. Different mechanisms have been tried over the years for making it more sustainable. A strategy found to be quite successful in one country can bring about unwelcome results in another regional setting. This paper is an attempt to look into the various factors that affect migration/non-retention and to suggest some specific recommendations as gathered through the respondents' perspective.

The data collection tools included Key Informant Interview, Focus Group Discussion and Rapid employee satisfaction assessment, in addition to relevant literature reviews. The studies reveal that there are several reasons for the health care professionals to concentrate in the urban areas. The large urban areas are the hub of latest technology and new advancements in medicine. All the tertiary care centers are located in the large urban areas. The health professionals prefer to work in these metropolitan areas that provide greater opportunity of professional development and better career prospects. They also have easier access to private practice in these settings. It is also perceived to be more prestigious to work in large urban based hospitals. Studying to become a doctor is often seen as an investment as it requires a great deal of time, efforts and finances. Hence it is expected to have a substantial pay off in terms of a good job, better salary and private practice. The rural areas lack the lifestyle related services and access to education opportunities for their children is limited. It is seen that even medical professionals belonging to the rural areas do not want to go back to serve in their villages. Lack of appropriate facilities such as equipment and supplies in the rural health facilities also acts as a deterrent to accepting jobs in these areas.

Looking into these various factors, the authors elicited recommendations from the key respondents. The results of this study have been summarized by grouping them in three parts, (1) Conditions affecting retention in rural/remote areas; (2) Conditions affecting performance; and (3) Manager's opinion. A better accommodation with adequate electricity/water supply, more preference in case of promotions/advancement/higher education/training/scholarships for those working in remote areas, good schooling facilities for their children, better medical coverage for their families are some of the strong recommendations that came out. The respondents also suggested for mandatory rural posting of fresh graduates for a minimum of 2-3 years. In addition, they expected the government to ensure adequate equipments/supplies and fill in vacant positions so that they could deliver quality services.

Although there is no single answer or solution to address the needs of doctors and nurses in hard to reach areas, yet a large number of study respondents suggested to take short and long term approaches in resolving this problem. It is clear from the study results that administrative directives and guidelines are helpful but not sufficient to ensure availability of service providers in hard to reach areas. The short term answer to the challenge is to provide more financial benefits through contractual appointments with higher salary and benefits or special financial and non-financial incentive package for those who are willing to work in those areas. The long term solution lies with the use and development of local service providers with higher salary and benefit package. Local youths should be encouraged to commit to study for five to ten years in their own community after completion of their study in exchange of getting scholarships and seats in medical and nursing schools and colleges. Once placed in their own community, they should be provided with a special package of benefits. However, the real long-term solution lies with overall economic development of hard to reach areas through special development programs and integrated multi-sectoral effort for overall socio-economic development of these areas.

Background

The acute shortage of doctors and nurses prevailing in Bangladesh poses a great impediment in the provision of adequate and quality health services. This shortage is more acute and chronic especially in the remote and hard to reach regions. The people living in the urban and peri-urban areas can access better health services as most facilities have adequate number of doctors with fewer or no vacancies. The rate of absenteeism of doctors and nurses is also minimal. On the other hand the remote and hard to reach areas continue to have very high rates of vacancies and absenteeism. People posted in those areas are usually reluctant to continue and as such tend to be irregular in workplace or seek a posting in a geographically more convenient area. All these have led to serious mal-distribution of health care workers, especially doctors and nurses, in the health service delivery system causing concern about performance and quality of service.

As in many developing countries, the shortage of health care providers in Bangladesh is limiting access and quality of healthcare provision and outcomes. Rather, Bangladesh experience is unique, specially because the doctor nurse ratio is very high. While the absolute number of healthcare providers is low, the mal-distribution of providers is acute. Rural and hard-to-reach areas especially lack an adequate number of skilled providers. The providers available in the system are inequitably distributed between urban and rural areas, with rural facilities experiencing 23% vacancies. Studies reveal that there is huge national shortage of nurses and this has become advantage of the providers (nurses) opting for better employment in urban areas. The following table gives a clear picture of this shortage:

Table: Estimation of demand for nurses in the public sector for the period of 2006-2020

Year	Projected Hospital Beds		Demand for Nurse (Time Series)		Demand for Nurse (Model)		Mean Demand for nurses	
	Time Series	Estimation Model	Existing Country Ratio	Standard Ratio	Existing Country Ratio	Standard Ratio	Existing Country Ratio	Standard Ratio
2006	17115	17331	12167	12836	12321	12998	12244	12917
2007	18188	17376	12930	13641	12353	13032	12638	13333
2008	19328	17422	13740	14496	12385	13067	13045	13763
2009	20540	17468	14602	15405	12418	13101	13466	14207
2010	21828	17515	15518	16371	12452	13136	13900	14665
2011	23197	17563	16490	17397	12485	13172	14349	15138
2012	24651	17611	17524	18488	12520	13208	14812	15627
2013	26197	17660	18623	19648	12554	13245	15291	16132
2014	27839	17709	19791	20879	12589	13282	15785	16653
2015	29585	17759	21032	22189	12625	13319	16295	17191
2016	31440	17810	22350	23580	12661	13357	16822	17747
2017	33411	17861	23752	25058	12698	13396	17366	18322
2018	35506	17914	25241	26629	12735	13435	17929	18915
2019	37732	17967	26824	28299	12772	13475	18510	19528
2020	40098	18020	28506	30073	12811	13515	19110	20161

Source :Need Assessment Study on nurses in private and public sectors

Further, high absenteeism of service providers in remote areas affects the performance and quality of care. Designing of financial/non financial incentives for the health service providers is

crucial in Bangladesh. It has become an important issue that needs to be addressed through policy formulation, planning, and implementation of incentives

About 75% of the population of Bangladesh live in rural areas but the human resources available for health is less than 20%. All the key health providers are mainly concentrated in the urban areas; doctors, dental surgeons, nurses and public health personnel where doctor to population ratio is 1:1500 as against 1: 15,000 in rural areas (Mabud, 2005) . The metropolitan areas especially the cities of Dhaka, Chittagong, Rajshahi and Khulna comprising only 14.5% of the population receive a major chunk of the qualified health workforce i.e. 35% of the doctors working in the public sector. The concentration of doctors is 4 times more in Dhaka district compared to the national average. The number of dentists produced every year is far below the desired number. Around 56.2% of the dentists working in the public sector are concentrated in the metropolitan and the rural districts of Dhaka. This leaves only 97 dentists to attend to a population of more than 66 million. In the rural districts the population to dentist ratio ranges from 1 to 500,000 to more than one million indicating that the access is virtually non-existent (Hossain and Begum, 1998).

In the last 5-10 years, the issue of attraction and retention of healthcare workers has received much attention. Accessibility and mal-distribution of health workers have been exacerbated by these reasons. Incentives for retention have been tried in many developing countries, albeit with mixed results. Various kinds of financial incentives were worked out but those were found to be ineffective since those had least effect on rural-urban migration trends. With much analysis done in the field, the time has now come to assess whether introduction of incentives, either financial or non-financial, can improve the situation of retention in workplace, work performance and productivity. In the light of this, the authors tried to understand the crucial factors that function as 'influential' for migration.

Purpose of the Paper

Bangladesh has made remarkable achievements in certain areas of health sector because of targeted interventions e.g. immunization, family planning, nutrition supplementation, the national oral dehydration solution etc. However, accessibility of the disadvantaged people to quality health care services still remains a major challenge. The major basic challenges include acute shortage of doctors and nurses, mal-distribution of healthcare workers, high absenteeism and concerns about performance and quality of care

The purpose of this paper is to look into the factors affecting retention and recommend ways to develop an incentive package for human resource in health. The main purpose of the paper is to come up with suggestions/recommendations (a) for retention and distribution of doctors and nurses over different geographical regions especially addressing the problems of remote, inaccessible and hard to reach areas, and (b) for improved performance and productivity in hard to reach areas.

Methodological Approach

The study collected data from both primary and secondary sources. The main source of the secondary data was the review of literature from international, regional, national experiences mainly focusing on the developing countries. Research, Training and Management (RTM) International has conducted several studies on human health workforce, its shortages, strategies/recommendation for more production, equal distribution and also on incentive required for retaining doctors/nurses and Primary Health care (PHC) providers in remote rural

areas of the country. All these studies have been conducted in collaboration with the Government of Bangladesh and with funding support from international organizations/donor agencies such as Abt Associate (USA)/ GTZ, Health Watch Bangladesh, Swisscontact etc. Almost all studies probed into various factors of motivation, job satisfaction, performance, advancement, training that are crucial for positioning health workers in remote areas. All these studies came up with recommendation for solid incentive packages that are attractive and lead to retention of health workers in remote areas. A recent assessment of RTM International is expected to recommend a few major policy steps and introduction of a sustainable incentive package for the national health program. In this paper, the authors have tried to summarize the findings of all relevant studies of RTM with main focus on the recent study currently being conducted for the Ministry of Health and Family Welfare, Bangladesh.

The primary data were collected from the providers, especially doctors and nurses, working at the primary health care facilities known as the Upazilla Health Complex (UHC). A total of 19 UHCs were visited covering all the geographical regions of the country for selecting remote, rural and peri urban areas of Bangladesh. The major techniques of data collection included focus group discussions with doctors and nurses, in-depth interviews with them, and key informant interviews of Upazilla Health Family Planning Officers (UHFPOs) or Upazilla Health Complex Managers. A total of 6 FGDs with doctors and 12 FGDs with nurses were conducted. A total of 39 and 16 in-depth interviews were conducted respectively with doctors and nurses. Key informant interviews (KIIs) were conducted with 17 UHFPOs. As the target respondents were facility based no randomization was required. The doctors and nurses available in facility were selected for FGDs or interviews. The data collection at the field level was done by five teams each comprising two experienced qualitative data collectors. They were provided with two days of training on the objectives, methodology, data collection tools and other related issues. For data collection at the field level emphasis was given on rapid employee-satisfaction assessments as job satisfaction is a crucial factor towards retention in the place of posting especially in hard to reach areas.

At the central level key informant interviews were conducted with selected policy level respondents at different Ministries and Directorates such as Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP), Ministry of Finance and Ministry of Establishment, Directorate of Nursing Services, and Cabinet Division. They were asked about both financial and non-financial incentives. A clear mapping of the current employment practices including selection, placement, compensation, supervision, and performance evaluation was done. Pilot and in-process practices such as the Individual Performance Management (IPM) were included. In addition a day long stakeholder consultation/brain storming session was held where inputs for the incentive design and necessary recommendations were generated from the relevant participants by engaging them in small group work.

Perspective Analysis of Financial vs. Non-financial Incentives

In Bangladesh incentives are offered to health care providers along with other government officials who work in the Chittagong Hill Tract (CHT) area. They receive a 33% pay differential and a small transportation allowance. In an interview, an MOHFW official responsible for administering the program expressed her opinion that the program was ineffective in reducing high vacancy rates in the area. There have not been any changes in the financial incentives for the health workers in the other two notable hard-to-reach areas in Bangladesh, Char (shoals) and Haor (places encircled by water). On the other hand, salary differences between the public and private sectors indeed has lured health professionals from public sector to join private sector.

Especially in Bangladesh context, a doctor in a rural health facility typically has few opportunities to build a private practice- thus they perceive themselves to be in a doubly disadvantageous position. Large metropolitan centers offer more opportunities for career and educational advancement, better employment prospects for health professionals and their spouses, lifestyle-related services and amenities, and better access to education opportunities for their children. As such postings in urban areas are perceived as more lucrative than those in rural and remote areas. Studies also reveal that women are less prone to accept rural postings.

In Ghana, Mensah (2002) found that when asked why they would not take a rural posting, respondents often mentioned **non-financial considerations** such as lack of accommodations, lack of schools, lack of drinking water, electricity, roads, and transport. Remuneration was far down the list. **Compulsory rural service** is in use in several countries in the region. This strategy is being adopted by neighboring countries and the Government of Bangladesh (GoB) being inspired by the success rates has adopted a regulation to post newly graduated doctors at upazila and union level for two years after recruitment. But the implementation of this regulatory guideline is influenced by political and other types of favoritisms resulting in non compliance in most cases.

Designing Retention Incentive Systems: Some Considerations

Several factors contribute to the success or failure of incentive systems for retention. Care must be taken with how and from where providers are recruited for rural postings. In 2004, Pathfinder Bangladesh conducted a staff survey of six clinics (3 urban and 3 rural) run by NGOs under USAID funded NGO Service Delivery Program. The respondents were asked to rank 14 scale factors that are important for staff retention. A major recommendation of the study was to recruit providers from areas close to the place of posting. In this way, family and friends would form critical support groups for rural providers. Likewise, the Government of Thailand has had success in placing and keeping providers in rural posting through a combination of recruiting and training the providers near the place of their intended postings (Wibulpolprasert, 2003).

While incentives are an important consideration for performance, incentives for retention should be part of a **package of interventions** designed to meet the unique needs of the health workforce. For example, the same Pathfinder study from Bangladesh found that doctors rated as most important 1) autonomy of decision-making (scoring 4.4), 2) respect from fellow workers (scoring 4.6), and 3) good work/life balance (scoring 5.2). They rated salary level as least important. A similar survey in Ghana found that affiliation with their institution, sources of emotional support, and “job discretion” mattered more than pay (Masango et al, 2008).

Because of the complex interaction of factors impacting the attraction and retention, a proper mix of interventions such as attention to living environments, working conditions and environments, appreciation by managers and co-workers, management support, and development opportunities attached to financial incentives could be more effective.

Key Findings

The results of this study have been summarized by grouping them in three parts, (1) conditions affecting retention in rural/remote areas; (2) conditions affecting performance; and (3) Managers’ opinion.

To assess the conditions affecting retention in rural/remote areas the working and living conditions such as posting choice, patient load, staff shortages, supply of medication,

availability of equipment water and electricity supplies, accommodation, school for children, communication, transportation and team support were considered. The assessment surveys with doctors and nurses share common grounds of findings. Almost all the respondents did not have any choice regarding their posting as in case of doctors they were recruited as BCS (Bangladesh Civil Service) cadre and nurses were posted at the will of authority; but all respondents informed that if they were given a choice they would not have opted for that place. During the Focus Group Discussion, the respondents mentioned that (a) work load was usually high as the number of patients exceeded 150 on average for out-patient cases (b) there was a perennial storage of equipment and medicines (c) shortage of electricity and water supply had become routine problems and (d) there was good team spirit among colleagues. The respondents seemed to share good relationship with their supervisors who visited them in every 2-3 months. All of them considered the supervision as supportive where they discussed any problem with them. The living conditions were found to be poor with congested/old accommodation, insufficient electric/water supply, paucity of good schooling for children, inadequate communication networks and other social facilities. The respondents opined that housing allowances /good accommodation, quality education facilities for children, better transportation/communication allowances were those solutions for addressing the retention issue when it came to working and living conditions.

The parameters related to job satisfaction, performance support factors and employment practices were analyzed for ascertaining the conditions that affect staff performance. These included: career advancement options, compensation, training preference, scholarship facility, medical coverage, and recognition and appraisal systems in place. On the issue of 'career advancement' there were mixed feelings with 13% of respondents quite positive about the future training opportunities and scholarships, and the rest 87% saw no scope for them in this area as they stayed in remote areas. None of the respondents showed satisfaction with job. Even promotions and transfers were very limited in rural settings. They had yearly entitlement of leave but most of the time they could not avail this leave due to shortage of manpower. The study also revealed that there was no system of performance appraisal or recognition in place. None of the respondents found the salary compensation to be satisfactory. They also opened that the medical allowance coverage for their family was meager. Some of the nurses were not aware whether the medical included their family members or not. The study respondents strongly expressed preferential options in case of scholarship, higher studies, promotion, salary and systemic appraisals for remote posting.

Key Informant Interviews were carried out with Upazilla Health and Family Planning Officers (UHFPOs) and some key persons at central level to understand the Manager's views on staff performance, motivation, client perception of UHC and to check the current staff structure and related shortages. Data collected reveal that the numbers of approved/established posts (approx. doctors 9 and nurses 15) were inadequate in all locations. Despite this, the worst scenario was that almost 80% posts of doctors and nurses were found to be vacant or the incumbents were absent from the place of posting. Almost all the UHFPOs interviewed expressed satisfaction about staff attendance, productivity, performance, level of commitment and team spirit. But the UHFPOs felt that local people are not always satisfied with the services of the Upazilla Health Complex (UHC) as they were unable to provide them good services due to shortage of manpower. Some UHFPOs remarked "*We can not provide them good services due to shortage of manpower and power supply. We can not do many tests due to shortage of chemicals. We can not run the X-Ray machine due to lack of electricity. As a result, we fail to give proper treatment. The local people are not much satisfied about the services*"

Conclusions

Based on the above analysis of the study results it is evident that there is no single answer or solution to address the needs of doctors and nurses in hard to reach areas, but the majority of study respondents had suggested and recommended to take both short and long term approaches in resolving this problem. It is clear from the study results that administrative directives and guidelines are helpful but not sufficient to ensure availability of service providers in hard to reach areas.

The short term measure recommended by the respondents include more incremental benefits through contractual appointments with higher salary and benefits (which will have less bureaucratic problem in implementation) covering special financial packages (e.g. higher salary as allowance, scholarships, medical coverage etc and non-financial offers (e.g. accommodation, transport based on local situation, study tour, guarantee for higher education, etc.). Financial benefits include a sizeable salary difference between urban and rural postings, scholarship support, family medical coverage schemes and promotions. Non-financial benefits mentioned by the respondents include standard living conditions with separate quarters for UHFPOs, RMOs, consultants and separate dormitories for doctors, preference for higher studies, training, good performance appraisal mechanism, better transportation and communication.

However, it is clear from the study results that the long term solution lies with the use and development of local service providers of the hard to reach areas with higher level of benefit package (like the financial and non-financial benefit package mentioned above). As part of long term solution, local youths should be encouraged to commit to stay for five to ten years in their own community after completion of their study in exchange of getting scholarships and seats in medical and nursing schools and colleges. Once placed in their own community, they should be provided with a special package of benefits. However, the real long-term solution lies with the overall economic development of hard to reach areas through special development programs and integrated multi-sectoral effort for overall socio-economic development of these areas.

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