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Improving availability and retention of health workers in remote and underserved areas: The Lao PDR experience

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Abstract

The recently formulated Lao National Policy on Human Resource for Health puts great emphasis on providing and retaining health workers in remote and underserved areas. The Ministry of Health (MOH) is expected to base staff distribution primarily on consideration of public health needs of its population. To this end, the MOH endeavours to fill in gaps in the provision of qualified health workers, particularly female health workers in remote and underserved areas by initiating evidence-based practices. Measures have been taken to decentralise training of health workers to the provinces in-order to promote recruitment and retention of staff closer to their home and cultural settings. Further efforts are made to provide bridging courses, upgrade staff and provide various incentives to attract health workers in remote areas.

This presentation is intended to highlight the Lao PDR efforts to improve availability of staff in remote areas and to provide data that demonstrates current achievements and further challenges that need to be addressed.

Background:

The Lao PDR vision for health Development is based on the 8th Party Congress Resolution and the 6th National Socio-Economic Development Plan under the vision of the Party and the Steering Committee of the Ministry of Health, which asserts the need to “Free the country from the status of least developed country by the year 2020 and ensure that all Lao people have access to healthcare services.”. Further declaration concerning poverty alleviation and the importance of empowering the people to take responsibility for their own health is expressed in the Five Year Lao Health Master Plan (2006-2010) and the Primary care policy issued in 2000.

The delegates to the HRH Conference convened by the Ministry of Health in collaboration with the World Health Organisation in 2007 adopted the following Vision and major goals which form the foundation for the formulation of HRH policy.

“Achieve universal coverage in Lao PDR, by providing quality and equitable health services for all peoples through a financially sustainable health system with an adequate, competent and productive health workforce that is responsive to changing health needs, especially of remote and rural populations”

The key outcomes associated with this vision are;

- Strengthening the ability of the health care system to provide access to regularly available, appropriate, affordable, and good quality essential health services that are responsive to people’s needs and expectations, especially for those who are currently underserved or underserved
- Empowering communities, families and individuals to make their own health-related decisions and become self-reliant

Conceptual framework:

Under the *PHC Policy*, issued by the MOH in January 2000, expanding access to better quality services at the grassroots level, especially to remote areas inhabited by ethnic groups is a priority. The Policy foresees two strategies to achieve full coverage of remote areas. The first strategy is to develop the health center network and the second strategy is provision of basic care by village health workers, where establishment of a health center is neither appropriate nor feasible. To achieve more effective health service coverage, health zones will be defined under strategic considerations, rather than administrative boundaries.

This presentation is intended to highlight the Lao PDR efforts to improve availability of staff in remote areas and to provide data that demonstrates current achievements and further challenges that need to be addressed.

Case Study Findings

The recently formulated Lao PDR HRH National Policy puts great emphasis on providing and retaining health workers in remote and underserved areas. The MOH is expected to base staff distribution primarily on consideration of public health needs of its population. To this end, the MOH endeavours to fill in gaps in the provision of qualified health workers, particularly female health workers in remote and underserved areas by initiating evidence-based practices including:

- a) Improving rural working environment and conditions by strengthening health infrastructure, including health facilities, access to supplies and equipment, transport, communication, and referral mechanisms.
- b) Requiring newly qualified health workers to serve in district or health centres, based on public health needs, for at least a two year period within the five years after qualification (in line with Decree 82/ PM dated 19 May 2003).
- c) Offering financial and non financial incentives to staff working in rural areas.
- d) Offering efficient and timely transfers for staff who have completed two years service at district or rural areas, and ensuring the same opportunities for career progression to these staff.
- e) Revising training curricula to ensure that graduates are fully prepared to work in district or rural locations.
- f) Identifying priorities for staffing in different facilities and services to address priorities emerging from the HRH Plan and priority public health areas such as maternal and infant mortality.
- g) Allocating MOH recruitment quota for appointment of staff needed for specific posts, with priority given to rural and remote areas.
- h) Identifying redundant posts at central level in order to reallocate positions for priority areas.

The HRH National Policy further stipulates that the MOH in consultation with local authorities should identify gaps in staffing according to agreed staff norms, and set priorities for resolving imbalances in staff distribution and skill mix with reference to:

- a) The provision of essential services in compliance with the PHC framework and MOH Decrees concerning roles and responsibilities of health facilities and the Law on Health Care;
- b) The promotion of equitable access to and utilization of services based on factors such as: the size of population served, burden of disease, cultural and demographic considerations, road access to health facilities and potential access to alternative facilities.

- c) Targeting increases in the recruitment of the health workforce to address specific gaps, particularly in District Hospitals and Health Centres.
- d) Linking any increase in the size and quality of the health workforce with strategies to increase demand for and utilisation of public health services.

Table 1 presents the distribution of staff to different levels in the health system and the differences between 2005 and 2008 in staff distribution. It is noted that of the total increase of 976 staff employed during this period , 63% were female and 56% were employed at district level (75 staff) and health centres (472 Staff) These increases are in line with the MOH HRH policy directions for recruitment of female and allocation of resources to the grass root level.

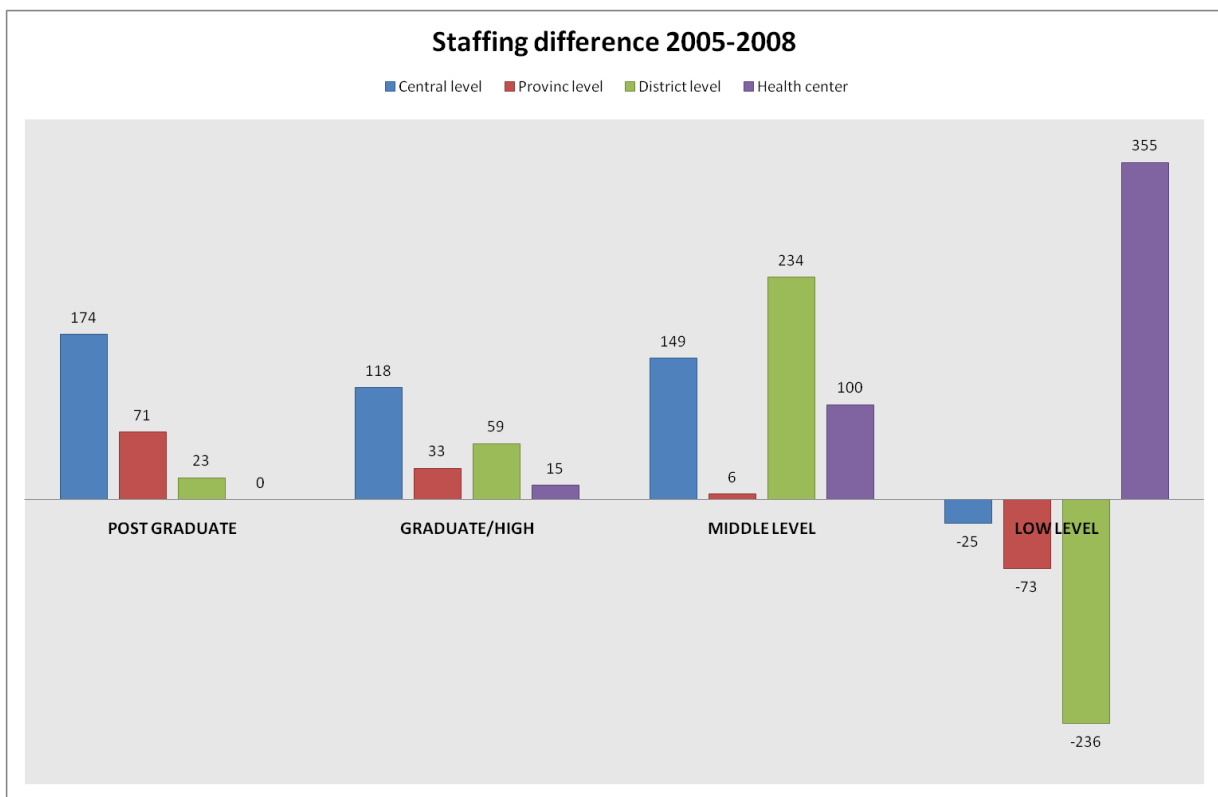


Table 1: Staffing at different levels with differences between 2005-2008

	2005						2008						Difference 2005 to 2008					
	Total	Post graduate	Graduate/high	Middle level	Low level	No qualification	Total	Post graduate	Graduate/high	Middle level	Low level	No qualification	Total	Post graduate	Graduate/high	Middle level	Low level	No qualification
Total country	11037	373	1818	3765	4916	165	12,013	641	2,043	4,254	4,937	138	976	268	225	489	21	-27
Female	6342	122	773	2123	3208	116	6,959	214	939	2,498	3,213	93	617	92	166	375	5	-23
Central level	2052	228	701	770	305	48	2,460	402	819	919	280	40	408	174	118	149	-25	-8
Female	1235	76	359	552	212	36	1,481	146	432	668	203	32	246	70	73	116	-9	-4
Provinc level	3598	128	698	1372	1343	57	3,619	199	731	1,378	1,270	41	21	71	33	6	-73	-16
Female	2213	43	288	815	1025	42	2,270	62	330	863	985	29	57	19	42	48	-40	-13
District level	4273	17	410	1403	2383	60	4,348	40	469	1,637	2,147	55	75	23	59	234	-236	-5
Female	2346	3	125	653	1527	38	2,406	6	169	810	1,389	32	60	3	44	157	-138	-6
Health center	1114	0	9	220	885	0	1,586	0	24	320	1,240	2	472	0	15	100	355	2
Female	548	0	1	103	444	0	802	0	8	157	636	0	254	0	7	54	192	0

In preparing a strategic plan for HRH, the MOH consulted widely about the staffing requirements at different levels and prepared workforce projections for the period 2010- 2020. This projections based on assumptions concerning staffing levels enable estimation of the number of staff that need to be trained to bridge the staffing gaps with priority to the District and health centre facilities and programs. The plan will be used for advocacy with central agencies to increase funding and allocation of positions to enable adequate skill mix in the remote areas.

Table2:

Staffing Norms Assumptions for Health Facilities																						
Health facilities	Type	Master level	specialist level 2	specialist level 1	MD	MA Nurse practitioner	Bachelor nurse/ higher	Regis/Tech Nurse	Comm Mid/Midwife	Lab	Asst LAB	Pharmacist	Pharmacist ass	Dentist	Dentist Assit	Hygienist	Physiotherapist	X-Ray	AUX/N	PHC	Support and logistic staff	Total
Health Centre	A				1	1			1		1									2		6
	B					1			1											1		3
District Hospital Including admin and Preventive unit	A	1		1	5		1	14	6	1	1	1	3	1	1	3	2	1	4	0	5	51
	B	1		0	5			11	6	1	1	1	3	1	1	3	1	1	4	0	4	44
Provincial hospital		2	1	2	2		1	12	10	3	8	3	6	3	4	4	10	6	0		5%	

Planning scenarios

If number of HC increase by: **10** %

If number of staff in MOH central office increase by: **2** %

If number of staff in education institutions increase by: **20** %

Remarks

The staffing norm for specialist , MD and Nurses for Provincial hospitals is estimated by section rather than total number

MA or Nurse with extra clinical skill for treatment of common diseases and emergency/life saving skills

PHC and AUX/N with health promotion/disease prevention/life saving skills/

Community Midwife following upgrade from AUX/N or PHC

In HC B ensure female provider with life saving skills for MCH. (nurse practitioner rather then MA for the future?)

Table 3: Training Requirement 2009-2020

Categories	Total training required	Annual training required	Estimated Attrition	Total Gap
PhD	25	3	12	13
Master Degree	97	9	12	85
Medical Specialist (1&2)	913	77	36	877
MD	1,171	98	384	787
Medical Assistant/Associate	118	10	400	-282
Nurse (Bachelor)	244	21	12	232
Nurse (Technical & Registered)	4,815	402	112	4,703
Midwife (Community & Registered)	1,663	139	24	1,639
Lab Technician	218	19	12	206
LAB Assistant	169	15	72	97
Pharmacist	188	16	84	104
Pharmacist Assistant	267	23	108	159
Dentist	165	14	48	117
Dentist Assistant	209	18	48	161
Hygienist	404	34	96	308
Physiotherapist	269	23	72	197
X-Ray	306	26	12	294
AUX/Nurse	0	0	1,092	-3,094
PHC	777	65	12	765
Support and logistic staff	886	74	192	694
Total	12,903	1,083	2,828	8,061

Improving distribution of staff through training

Decentralisation of training institutions to the Provinces was intensified in-order to increase participation and retention of health workers closer to their home settings and culture. The six provincial Schools of Public Health are currently preparing comprehensive development plans for the next five years. These plans will be used to mobilize and coordinate the very significant investment required to improve the quality of programs, teaching staff, learning resources, equipment and facilities. The provincial schools have been mandated to commence new courses for Community midwife and Medical assistant and to increase substantially the intake of students.

With the support of development partners efforts are currently being made to upgrade low level staff to higher level positions. Auxiliary nurses are being upgraded to mid level positions as Community midwives, Medical assistants and Primary Care Workers. These staff trained at the Provincial Schools of Public health will be posted to Health Centres and help to bridge the big staffing gaps in these facilities. Furthermore, to facilitate entry to training programs, scholarships and bridging courses are being provided to enable disadvantaged young people to achieve the pre-requisite educational standards needed to gain entry to health workers training programs.

Primary Health Care Workers trained in six public health schools and recruited at health centre and district level

<u>Year</u>	<u>Graduation</u>	<u>Recruited at DH and HC</u>	<u>percentage</u>
2005	109	87	80%
2006	132	113	86%
2007	95	25	26%
2008	179	101	56%
2009	90	72	86%
<u>Total</u>	<u>605</u>	<u>398</u>	<u>66%</u>

As shown in table 1 the number of low level health workers at the district level has decreased in the period 2005-08 by 236 staff members though it has increased by 355 health workers at the Health Centre level. The MOH plans to decrease the overall number of low level health workers by upgrading existing staff and discontinuing training programs for low level staff in-order to improve quality of staff performance and improve health workers opportunities for career progression. (an important non financial incentive for recruitment and retention of staff)

Table 3 shows the MOH targets for upgrading of staff from low to mid level categories of staff in the next five years.

Table 3: Targets for upgrading of staff from low to mid level

Upgrade low to middle level	Average annual number for upgrading 2010 to 2015
Bridging courses in basic science	50
Upgrade pharmacist low to middle level	5
Upgrade aux nurse to hygienist middle	5
Upgrade aux nurse to physiotherapist middle	5
Upgrade aux lab to lab middle	5
Upgrade aux nurse to technical nurse	200
Upgrade aux nurse/ to community midwife	60
Upgrade PHC to Middle level PHC	120
Upgrade to Middle level of Imaging	26
Total	476

Remuneration and incentives

All countries in the Region report difficulties in retaining and motivating health workers, particularly for posts in rural areas due to inadequate remuneration. In many countries the salaries of health workers are less than the cost of living, in some cases by a significant amount. Low salaries are a major influence on retention and performance. In Lao PDR, public sector doctors earn around USD\$90 per month, and nurses earn around USD\$40 per month. These amounts, even when augmented with other allowances staff may be eligible to receive, are insufficient to ensure full participation of the health worker in their public sector job. Dual public / private practice is common for doctors, midwives and nurses, particularly in urban areas, while rural health workers often supplement their salaries by farming, which leads to a reduction in the number of hours they spend working at Health Centres or Hospitals. It is estimated that a salary of around USD\$400 per month for doctors and USD\$200 per month for nurses, would be necessary before most doctors and nurses would relinquish their private sector work and only work in the public sector.

The Lao PDR HRH Policy assigns special urgency to the implementation of salary reform in the health sector. The MOH is expected to consult with central agencies and local authorities concerning appropriate adjustments to staff remuneration in line with health sector salary benchmarking criteria and in line with rises in the cost of living. The MOH will:

- a) Ensure basic subsistence wages and/or fair remuneration for tasks performed.
- b) Recognize and reward effective achievement of realistic activity targets or health care outcomes (e.g. proven immunization coverage; reduced

maternal or neonatal or paediatric death rates; referrals/transport of emergency cases)

- c) Develop and implement a clearly defined career path for all health professionals including:
- appropriate gradations within staff categories
 - options for upgrading to higher levels
 - predictable options for transfers
 - options for movement between categories
 - appropriate relativity between clinical/technical and administrative streams.

The MOH will provide financial and other incentives for rural practice, particularly in those locations most underserved, with consideration given to long-term sustainability [\(see table 4\)](#).

Table 4: Average targeted staff at district and health centre level who will receive incentive

Staff Categories	2009	2015	2020
Master level	10	46	50
Specialist level 1	6	6	8
MD	125	239	290
MA/Nurse practitioner	283	339	325
Bachelor nurse/ higher	3	6	8
Regis/Tech Nurse	157	360	579
Com mid/Midwife	124	405	628
Lab	0	31	50
Asst LAB	82	82	88
Pharmacist	27	45	50
Pharmacist ass	111	137	151
Dentist	25	41	50
Dentist Assit	21	37	50
Hygienist	69	119	151
Physiotherapist	25	48	59
X-Ray	0	28	50
AUX/N	975	782	202
PHC	110	243	363
Support and logistic staff	89	171	210
Total	2241	3165	3365

Note: The incentive will differ from remote area level 1 and remote area level 2 of around 60\$ a month and 40\$ a month respectively

Furthermore, the HRH Policy includes affirmative action strategies including measures to improve participation of females and ethnic minority groups in the health workforce. Preferential treatment will be given to female and ethnic minority applicants in higher-level medical education training quotas and in senior health management training, to address the under-representation of these groups at high-levels and in senior management.

Health equity funds have been used with some success in Lao PDR to increase access to and utilization of health services by the poor, and in protecting them from the impact of catastrophic health care costs. Community based health insurance schemes are also being piloted, aimed at developing pre-payment schemes for the near poor and others who could be otherwise impoverished by unexpected health care costs. These measures if successful are expected to increase the availability of funds that could be used to remunerate health workers in remote areas and thus improve their retention and motivation.

Lessons learnt

Policies developed to mitigate the perceived disadvantages of working in rural and remote health facilities, are not easily implemented. The cooperation and support of central agencies, provincial authorities, employers, communities and many other stakeholders are essential. Many of the difficulties arise due to the extremely low investment in the health sector and the solutions depend on socio economic development beyond the control of the health sector. Nevertheless, the development of policy that provides clear direction and puts emphasis on the priorities that need to be addressed is a critical step in securing commitment and mobilizing support.

Beyond financial incentives it is important to consider measures to improve the living and working conditions of staff in remote areas to mitigate the difficulties and lost opportunities they may face as a result of their posting

Training staff closer to their home settings and culture improves the participation and retention of staff from remote areas. Special provisions to compensate for educational deficiencies, such as bridging courses, and funding arrangements such as scholarships and living allowances are also very important in this regard.

With the support of development partners, Lao PDR is making major efforts to strengthen the training institutions in the provinces. These institutions are expected to play a major role in providing quality staff for the remote and underserved areas. At present the institutions are preparing development plans to identify priority needs and mobilize support.

The recruitment and retention of staff in the District and Health centres will depend to a large extent on effective 'People management 'skills and arrangements. Efforts are being made to improve the training of managers, the strengthening of supportive supervision and the provision for opportunities for professional development.

The Lao PDR experience is that with good leadership and targeted investments it is possible to improve the situation for health workers in rural areas and to achieve better balance in the distribution of health workers to the areas of greatest need.

Proposals for Region or Global Actions:

Lao PDR recognizes the need to learn from other countries experiences. There is a need to further explore strategies for improving the recruitment and retention of health workers for remote areas. We need to better understand the expectation of health workers in relation to appropriate incentives, supportive working environment and living conditions.

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