id21 health highlights #20

health systems

communicating international development research

Matching health service provision with patient choice in India

Orissa is one of India's poorest and least developed states. The state's strategy to improve health services is based on providing local and low cost primary health care, with referral elsewhere for more specialist treatment. Findings of this study showed that users were not accessing the available health services as anticipated, signalling the need to strengthen the quality of services.

Information is needed on the patterns of and barriers to rural populations accessing primary health care to guide the organisation of staff within the health care system. This UK Department for International Development funded study examined the health care seeking behaviour of rural people in Orissa, with particular attention to their views on the availability and quality of state health services at the primary care level.

The study was conducted as part of an evaluation of the Orissa Health and Family Welfare Project (OHFWP). The results show significant differences in the choice of service providers across the four districts surveyed. Nevertheless, hospitals were overall the most frequently used health care provider. Relatively little use was made of primary health clinics, staffed by a single doctor, and sub-centres, staffed by an assistant nurse midwife (ANM) or multipurpose health worker (MHW). The state strategy prioritises primary health care, but there was no evidence that the 'tiers' of the state health care service were being accessed in the way anticipated by the strategy.

- Reputation of the health provider was the most common factor influencing choice: villagers relied on the opinions and experiences of others - delaying treatment, travelling further or paying more in order to be treated by someone with a good reputation.
- Concern over the cost of medicines often discouraged people from seeking treatment.
- Physical access to health care providers was often restricted by poor transport and lack of roads. Even when roads were passable, the length of a journey discouraged some people from seeking health care.
- ANMs were seen as being concerned mainly with immunisations, family planning and child care, lacking commitment, having little expertise to deal with emergencies and not providing effective medicines.
- The role of the MHW was not clearly understood: users perceived them as being concerned with malaria control and acting as an assistant to the ANM.

Early OHFWP interventions to increase the number of and improve the facilities in local sub-centres were ineffective, with no greater use being made of them even when they were situated in a respondent's village.

The research has informed subsequent development of health services in the state, encouraging:

- sub-centres to be converted into 'new' primary care centres, providing a more comprehensive range of services
- setting-up pilot schemes to identify ways to include greater community participation in health service delivery, and to strengthen the link between the different tiers of the health system
- review of the role and practice of the ANM and improve the effectiveness and responsiveness of services at local level.

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Going around in circles?

Nigeria's drug revolving fund

The Nigerian government set up a drug revolving fund in 1988 to guarantee a reliable supply of low cost generic drugs for primary health care centres. The scheme was to be self-funded whilst improving prescribing practices and increasing equitable access to services. How have these reforms affected the practice and performance of health workers?

In its first five years the scheme was successful. Many health centres covered their costs with patients' fees and more people used their services. However, more recently, drugs have been prescribed irrationally and poor people use the clinics less. The University of Nigeria looked at the behaviour of health workers since 1988 and how patients feel about the service.

The study was carried out in four areas in southeast Nigeria. Data was collected using in-depth interviews with randomly selected health workers and exit interviews with patients who attended the health centres. The study found that:

- Salaries were low and were paid late while cash for staff incentives was not paid at all.
- Instead of selling DRF drugs, staff began to sell drugs bought on the open market to make money.
- Doctors prescribed drugs irrationally. Some, conscious of the cost of drugs, did not prescribe them even when they were needed, while others, keen to make a profit, over-prescribed.
- Staff did not receive training in the basic accounting skills needed to run the DRF.
- Government supervision of the clinics and staff was erratic and focused on income generation.
- There was more emphasis on curing sick patients, because it brought in revenue, than on promoting good health.

Despite these findings more than half of the patients considered the health workers to be polite and were satisfied with the drugs available. However, patients were generally dissatisfied with waiting times, the advice given and the fees charged.

In order to improve health workers' attitudes, the government should focus not only on providing drugs and generating revenue but also:

- staff supervision and training to avoid over-prescription and the buying and selling of drugs on the open market
- improving working conditions, including equipment in the clinics
- providing financial incentives to motivate health workers, for example, opportunities for earning commission on DRF drug sales.

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Improving health systems

TB control in the Russian Federation

The Russian Federation has an extensive tuberculosis (TB) control system which focuses on inpatient treatment and often allows long hospital stays. A large network of facilities exists to detect and treat cases, with 80,000 hospital beds reserved for TB treatment. How can the TB control system become more efficient?

The Russian Federation has the 12th highest number of new TB cases per year in the world. Although the disease declined in the 1960s, the rate of cases almost tripled in the 1990s to reach 90.7 per 100,000 people in 2000. In 2001, 9.1 hospital beds were set aside per 1,000 people, compared with 2.4 in the United Kingdom and 4.1 in the European Union. Other countries with a high TB burden largely treat infected people as outpatients.

A detailed study led by the World Health Organization's (WHO) Stop TB Department, looked at the patterns of use of TB hospitals in four Russian Federation regions. They investigated what kind of patients were using the inpatient facilities in the hospitals, why they were being admitted and what scope there is for reducing the use of inpatient services.

The study made a number of findings, including:

- About 70 percent of the patients surveyed were male, the average age was 40 and high rates of alcohol abuse (32-49 percent), disability (17-39 percent) and unemployment (27-41 percent) were recorded.
- About a third of beds were occupied by patients who were smear-positive or culture-positive for TB, 20 percent by smear-negative and/or culture-negative patients, 20 percent by patients who no longer had TB, and about 20 percent of beds were not occupied.
- In all four regions, at least a third of beds were unoccupied or occupied by patients who did not have active TB. In two regions this figure was over 50 percent.
- If clinical and public health reasons were used as admission criteria for TB patients, less than 50 percent of patients would need to be admitted and less than 50 percent of beds would be needed.
- When including patients with social problems, up to 81 percent of patient admissions would be justified and up to 85 percent of beds would be needed.

The implications for policy are:

- To improve the efficiency of TB control delivery, health system standards and regulations will need to be reformed to improve resource allocation and clinical care. More cost effective alternatives to hospital inpatient care are needed for managing TB patients with social problems.
- The management of staff numbers will need to be improved when managing a transition from hospital to community-based TB care, as the large number of staff employed in TB control facilities accounts for a third of total costs.
- National and international agencies must focus on medium to long-term improvements in the health care system rather than on short-term change in TB treatment protocols.

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Motivating health workers in Mali

If accessibility to health care services and quality of care are to be improved, it is essential to have a workforce that is qualified and motivated. What motivates and demotivates health care workers in Mali? How are the motivators linked to the implementation of performance management?

Motivation at work can be defined as a worker's degree of willingness to make and maintain an effort towards achieving an organisation's goals. It is a challenge for managers to create this, as research shows that managers and workers tend to have different perceptions of motivation. Furthermore, little is known about what motivates health staff in poorly resourced work environments.

Motivation can be divided into two areas, according to theorists. The first is a person's motivation to stay in a job – or alternatively, their demotivation to stay in the job due to dissatisfiers (the main causes of job dissatisfaction). Examples of dissatisfiers are poor working conditions, low salary and poor relationship with colleagues. The second area of motivation is a person's incentive to perform well due to satisfiers (the main causes of job satisfaction), examples of which are responsibility, recognition and achievement. An organisation should ideally influence satisfiers through measuring, monitoring and enhancing the performance of its staff (performance management).

The Mali government's Ministry of Health, in seeking to improve the performance of its health workers, undertook research to identify what factors motivated health staff from eight professional categories – public health doctors and nurses, auxiliary nurses, registered nurses, midwives, laboratory technicians, sanitary technicians and community development workers. By matching the factors to existing performance management activities, it aimed to identify ways to improve the human resources (HR) activities of health services managers.

The study made a number of findings, including:

- The main motivating factors were recognition, responsibility and training, followed by salary.
- These motivating factors can be influenced by improving performance management and by better linking of these activities.
- Activities such as promotion, career development and performance appraisal were seen as administrative procedures rather than being used to boost work performance.
- Job descriptions were not specific enough to identify training needs or to allow staff to feel or be held responsible.
- Health workers viewed their managers' decisions as lacking in transparency, for example, on performance appraisals and training.

The research shows that it is important to adapt or improve performance management strategies to influence staff motivation. Policy recommendations include:

- Motivation could be improved by giving staff greater responsibility, holding them responsible and improving means of recognition.
- Matching improved performance management activities to the motivating factors identified could increase motivation and lead to improved quality of care and accessibility.
- The factors that motivate health workers in their specific contexts need to be identified before selecting the appropriate HR activities to address them.
- Performance management could be better focused on the provision of quality, accessible health care.

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