The State of Human Resources for Health in Zambia:
Findings from the Public Expenditure Tracking and Quality of Service Delivery Survey (PET/QSDS), 2005/06[1]

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DISCLAIMER:

This paper is part of the larger work on the Public Expenditure Review in the health sector in Zambia. The report findings do not reflect the views of the Government of the Republic of Zambia (GRZ), the Ministry of Health (MOH), the University of Zambia, the World Bank, or the Swedish International Development Agency (SIDA), which conducted, sponsored, or funded the PET/QSDS.

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I. INTRODUCTION

1. *This paper reports the findings of the PET/QSDS pertaining to human resources for health in Zambia*. The Public Expenditure Tracking and Quality of Service Delivery survey (PET/QSDS) was undertaken in mid-2006 to provide quantitative assessment of the state of health service delivery in the country. One component of the survey focused on the management of health personnel, including staff availability, vacancy, absenteeism, and tardiness; staff turnover; staff workload, use of time, and morale; and staff salary and benefits.

2. *The PETS survey adopted a multistage sampling frame involving provinces, districts, and health facilities, and within them, health workers and patients*. Table 1 provides the sampling framework for health facilities. In addition, the survey also interviewed patients and health workers. For patients, the sampling procedure involved picking every 4th to 7th patient on the queue, depending on the utilization level at each facility. Five patients were chosen per facility. For health workers, at least two staff from each health facility were interviewed.

Table 1. Sampling Framework for Health Facilities

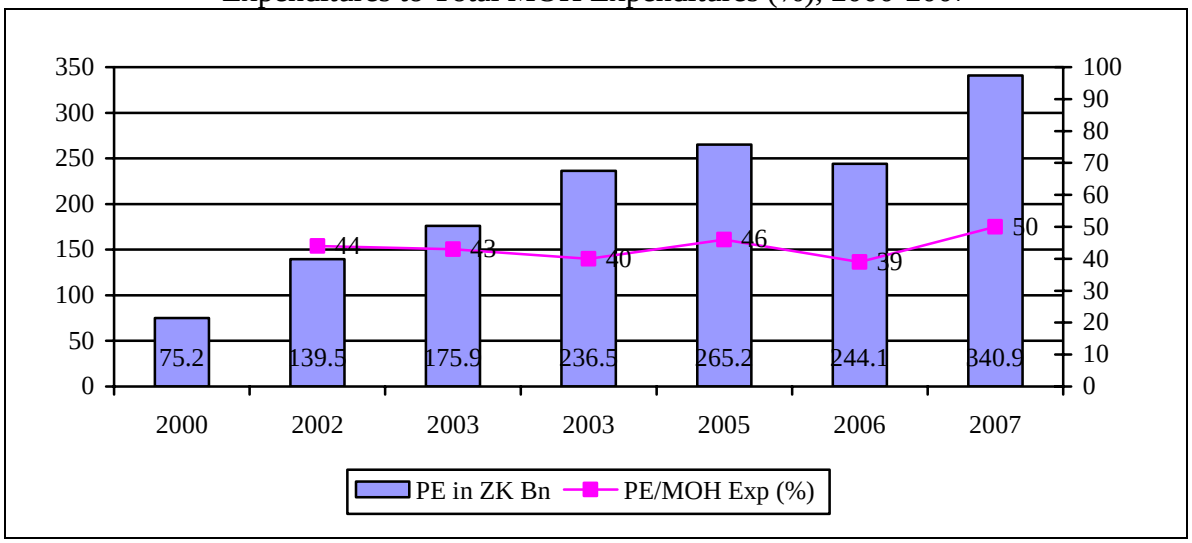
Province (No. of Districts)	DHMTs	Hospitals	UHC and RHC	Total Facilities
Lusaka Province (3)	3	3	17	23
Copperbelt Province (4)	4	4	30	38
Southern Province (5)	5	5	25	35
Western Province (4)	4	3	28	35
Northern Province (5)	5	3	32	40
Total	21	18	132	171

3. *The following survey instruments were used:* (a) a health facility questionnaire, (b) a patient questionnaire, and (c) a District Health Management Team (DHMT) questionnaire. Other sources of information were tapped, including the MOH Headquarters, the Ministry of Finance, Provincial Health Offices, and District Health Offices, and Medical Stores, Ltd.

II. KEY FINDINGS OF THE ZAMBIA PET/QSDS ON HEALTH PERSONNEL IN ZAMBIA

4. *MOH personnel expenditures steadily increased in nominal levels until 2005; it dipped in 2006 but is expected to rise dramatically to ZK340.9 billion in 2007*. Reflecting these trends in absolute levels, personal emoluments (PE) as a share of MOH expenditures peaked at 46 percent in 2005, and fell to 39 percent the following year (Figure 1), although it is estimated to garner 50 percent of the MOH's budget in 2007, the highest-ever share. MOH PE/GDP is about 1 percent of GDP.

Figure 1. Personnel Expenditures in MOH Budget (ZK Billion) and Share of Personnel Expenditures to Total MOH Expenditures (%), 2000-2007



5. *Human resource issues have become central in recent years and will continue to be topical in the near future*. On the one hand, the MOH is wracked by a human resource crisis. Expanding services to meet the Millennium Development Goals (MDGs) would require filling the large vacancies that exist today. Indeed, the new Human Resources for Health (HRH) Strategic Plan, 2006-2010 calls for an eventual increase in staffing levels from about 23,000 at present to 51,000. On the other hand, sustaining the increasing amount of resources devoted to PE would be a daunting challenge, given GRZ's patchy record of managing its overall wage bill (IMF Country Case Study, 2006). In between these "expansionist" and "sustainability" concerns are a range of factors that need to be addressed:

- The facts, as shown in the National Health Accounts analysis, that (a) an increasing proportion of MOH resources (and also donor resources, for that matter) are going to administration rather than service provision; and (b) that MOH facilities at all levels are far more labor-intensive than their mission and for-profit facility counterparts.

- The facts, to be discussed in this paper, that (a) staffing patterns continue to be perverse, as reflected in the composition of established posts; (b) absenteeism, tardiness, and morale reduce the actual availability of staff already at post, and these problems do not necessarily disappear with increases in salaries; and (c) multiple cash allowances and in-kind benefits are highly fragmented and only cover a minor percentage of MOH staff.

A. Staffing Patterns and Availability

6. *Skewed staffing patterns persist as reflected in the composition of established posts.* Urban health centers (UHCs) have the heaviest staffing for administrative posts: 14.0 percent of all available UHC posts are administrative, compared to only 10.2 percent for hospitals (Table 2). Rural health centers (RHCs) have the heaviest staffing for low-

skill, non-clinical, non-administrative posts at 31.4 percent, compared to about 24-28 percent for UHCs and hospitals. RHCs also have the highest proportion of established clinical posts (63.4 percent), compared to 61.5 percent of hospitals, which should have a higher proportion of them. The table also shows the average number of staff per health facility. Note that UHCs have a higher preponderance of administrative staff, compared to hospitals.

Table 2. Established Posts and Average Number of Actual Staff by Major Occupational Groups, 2006

Staff	RHC		UHC		Hospitals		All	
	No.	%	No.	%	No.	%	No.	%
Established Posts								
Prof'l/clinical staff	590	63.4	1,240	61.8	1,291	61.5	3,124	62.0
Administrative staff	48	5.2	280	14.0	215	10.2	543	10.8
Non-clinical, non-administrative staff	292	31.4	485	24.2	594	28.3	1,371	27.2
Total	930	100.0	2,005	100.0	2,100	100.0	5,038	100.0
Average Number of Staff								
Prof'l/clinical staff	5	57	25	60	52	58	16	57
Administrative staff	0	0	6	14	8	9	3	11
Other staff	4	44	11	26	30	33	9	32
Total	9	100	42	100	90	100	28	100

7. *Health facilities have very high rates of staff vacancy.* The percentage of vacant posts is 42 percent in RHCs, 22 percent in UHCs, and 41 percent in hospitals (or 33.6 percent overall). Key posts left vacant all involve professional staff (Table 3). Districts with high rates of vacancy (>50 percent) among professional staff: Chilubi, 79 percent; Chinsali, 58 percent; Kalomo, 59 percent; Kasama, 66 percent; Mpika, 57 percent; Mpongwe, 53 percent; Mufulira, 66 percent; Nakonde, 60 percent; Namwala, 54 percent; Sesheka, 74 percent; Shangombo, 56 percent (Figure 2).

8. *The rate of staff turnover is worrisome, especially in rural health clinics.* In RHCs, out of 688 staff, 69 were "incoming" (10.0 percent) while 148 were "outgoing" (21.5 percent) (see Table 4). It would seem that the stock of RHC workers is not being replenished quickly enough. In UHCs, out of 1,756 staff, 166 were "incoming" (9.4 percent) while 172 were "outgoing" (9.8 percent). In hospitals, out of 1,442 staff, 133 were "incoming" (9.2 percent) while 60 were "outgoing" (4.2 percent), i.e., hospitals are retaining their staff better than RHCs. These rates of staff movement in and out of health facilities raise concerns not only about staff availability, but also about new staff's ability to adjust to the new workplace, and the old staff's "institutional memory" that s/he takes with her/him, and is lost from the facility.

9. *Health facilities are increasingly relying on expatriate and volunteer staff.* Hospitals have become highly dependent on expatriate staff: as much as 50 percent of them have an expatriate doctor, 25 percent have an expatriate nurse, and 14 percent have other expatriate staff. Some 3 percent of RHCs and 10 percent of of UHCs also report having expatriate personnel. Volunteer staff are less common in hospitals, but they

predominate in health centers: 32 percent of RHCs and 48 percent of UHCs rely on volunteers, half of whom work full-time and half, part-time.

Table 3. Vacancy Rates (%) in Health Facilities, by Cadre, 2006

Cadre	RHC			UHC			Hospital		
	No. of estab posts	No. of vacant posts	% of posts vacant	No. of estab posts	No. of vacant posts	% of posts vacant	No. of estab posts	No. of vacant posts	% of posts vacant
Doctors	11	10	91	58	22	38	85	50	59
Clin officers	110	64	58	136	59	43	111	59	53
Medical licentiates	15	13	87	12	5	42	24	18	75
Midwives	109	55	50	282	90	32	179	63	35
Nurses	215	92	43	577	131	23	695	344	49
Env health officers	76	30	39	37	9	24	14	6	43
Pharma, etc.	18	12	67	34	7	21	37	17	46
Dentists, etc.	13	13	100	44	9	20	23	9	39
Lab, x-ray tech, etc.	15	12	80	48	13	27	76	37	49
Physio, etc.	8	8	100	15	3	20	47	34	72
Administrative staff	48	24	50	280	24	9	215	79	37
Other staff	292	55	19	485	62	13	594	152	26
Total	930	388	42	2,008	434	22	2,100	868	41

B. "UNACCOUNTED" WORKERS, STAFF ABSENTEEISM, AND TARDINESS

10. *The survey revealed inconsistency in the number of posts actually filled.* The total established posts for the health facilities included in the survey is 5,038 (See Table 5). Of this number, the vacant posts are 1,690, as reported in the discussion on vacancy rates above. Hence, the filled posts must be 3,348 (5,038 less 1,690). However, in the staff count made to assess staff absenteeism (see below), health facilities reckoned a total of 3,885 filled posts. The difference between the two figures (i.e., 3,385 and 3,438) is 537 posts, representing about 11 percent of the established posts (column "a"), or 10 percent of "vacant + filled posts" (column "b+c"). Possible reasons for this discrepancy include casual staff, or un-updated roster of established posts.

11. *A significant number of staff are posted in one facility but working elsewhere*: 13 in RHCs, 20 in UHCs, and 4 in hospitals (or 1.0 percent of all posted staff). Because these could not be physically accounted for in the facility where the survey was conducted, there is uncertainty about their actual existence.

Figure 2. Vacancy Rates (%) in Health Facilities by District and Type of Cadre, 2006

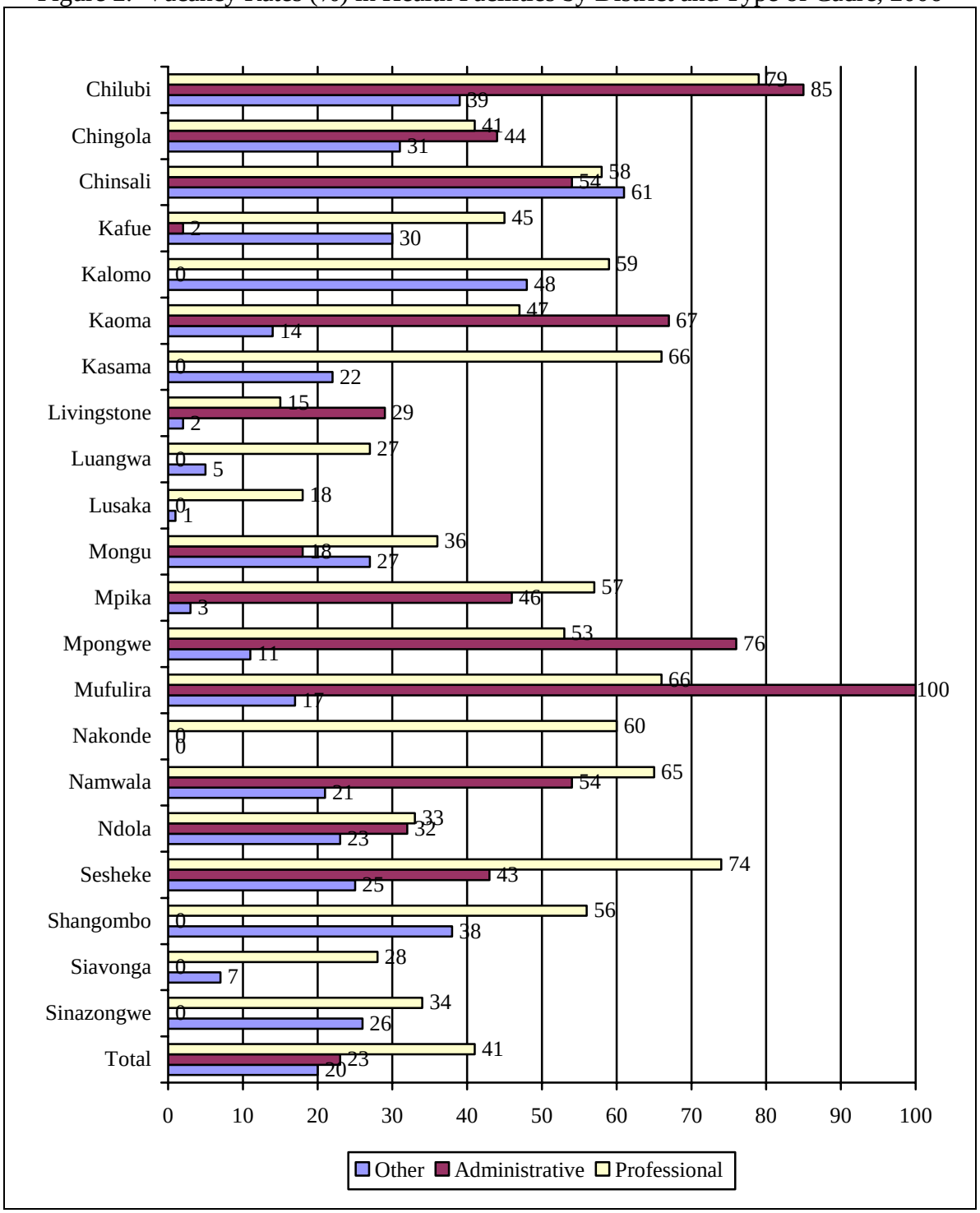


Table 4. Total Staff Who Joined or Who Left This Year, 2006

Staff Turnover	RHC	UHC	Hospitals	All
Total staff	688	1,756	1,442	3,886
No. of staff who joined the facility	69	166	133	368
No. of staff who left the facility	148	172	60	380
▪ Retired	15	20	7	42
▪ Transferred	116	120	24	260
▪ Resigned	10	22	14	46
▪ Dismissed or suspended	7	10	15	32

Table 5. Established, Vacant, Filled, and Absent Posts, 2006

Cadres	Estab'd Posts (a)	Vacant Posts (b)	% Vacancy Rate (b/a)*100	Filled Posts (c)	Vacant + Filled Posts (b+c)	Absent from Posts (d)	% Absent (d/c)*100
Doctors	154	82	53.2	84	166	26	31.0
Clin. officers & med. lic.	408	218	53.4	219	437	44	20.1
Midwives & nurses	2,057	775	37.7	1,604	2,379	222	13.8
Other clinical staff	505	219	43.4	341	560	48	14.1
Administrative staff	543	127	23.4	410	537	17	4.2
Other staff	1,371	269	19.6	1,227	1,496	16	1.4
Total staff	5,038	1,690	33.5	3,885	5,575	373	9.6

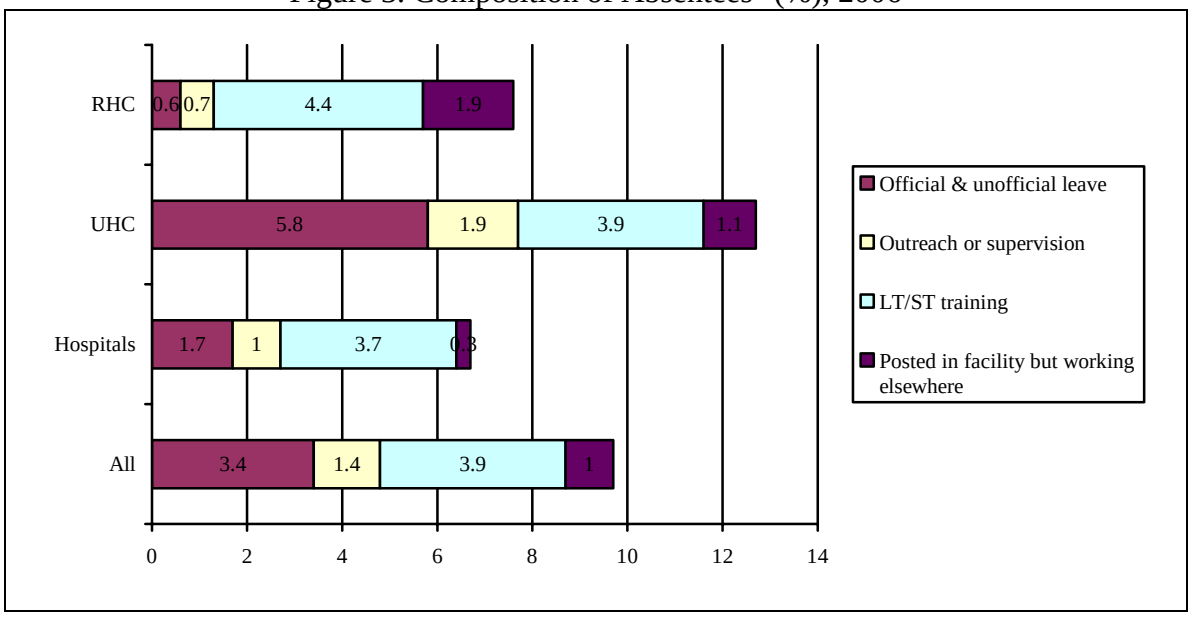
Note: "Absent" is defined broadly in this table to mean any staff not physically in the health facility during the survey.

12. *Staff absenteeism is considerable.* Some 9.6 percent of staff were not in the health facility during the survey: 7.5 percent in RHCs, 12.8 percent in UHCs, and 6.7 percent in hospitals. The composition of absent staff include 1.0 percent who were posted in the facility but working elsewhere; 3.3 percent who were on long- or short-term training; 1.4 percent who were on outreach or supervision; 3.2 percent who were on sick, annual, or vacation leave; and 0.2 percent who were absent without leave or cannot be accounted for.

13. *Clinical staff have the highest rates of absenteeism.* On the day of the survey, 31.0 percent of the doctors were not on site, as were 20.1 percent of clinical officers and medical licentiates, 13.8 percent of midwives and nurses, and 14.1 percent of other clinical staff. Administrative and other staff have much lower rates of absenteeism.

14. *Staff self-reported rate of absenteeism is much higher than the rate found in the facility survey*. For the previous month of the survey, 30 percent among RHC staff, 16 percent among UHC staff, 16 percent among hospital staff (or 21 percent overall) reported being absent from work at least once . The average number of days absent the previous month was 6 for RHC staff, 8 for UHC staff, 3 for hospital staff (or 5 days overall). The main reasons for being absent were sick self (40 percent of al responses), sick relatives (18 percent), and another extra job to attend to (9 percent) (Figure 3).

Figure 3. Composition of Absentees[4] (%), 2006



15. *Tardiness is a much bigger problem than absenteeism.* Staff self-reported tardiness last month was 37 percent among RHC staff, 47 percent among UHC staff, and 47 percent among hospital staff (or 43 percent overall). The average number of days late the previous month was 3 days for RHC staff, 4 days for UHC staff, and 3 days for hospital staff (or 4 days overall). Workers reported that their tardiness was caused by long travel to work (35 percent of staff), sick relatives (17 percent), or they were "on-call" the previous day (17 percent).

16. *Absenteeism and tardiness erode in a major way the actual availability of staff who are already in post*. The self-reported absenteeism of 21 percent (pertaining to 704 staff), at an average of 5 days absent/month, translates to 3,250 working days/month. Similarly, the self-reported tardiness of 43 percent (pertaining to 1,176 staff), at an average of 4 days tardy/month, at 1 hour tardiness each time, translates into 588 working days/month. Together, these add up to 4,108 working days per month that are lost. Conversely, if absenteeism and tardiness were fully eliminated, these losses would translate to a gain of 187 full-time equivalent staff, a sizeable number in Zambia's health system. That number is enough to staff 2 hospitals (at 90 staff/hospital), 4 urban health centers (at 42 staff/UHC), or 21 rural health centers (at 9 staff/RHC).

[4] "Absentees" are defined broadly as total number of posted staff not in the health facility during the survey.

C. STAFF WORKLOAD AND MORALE

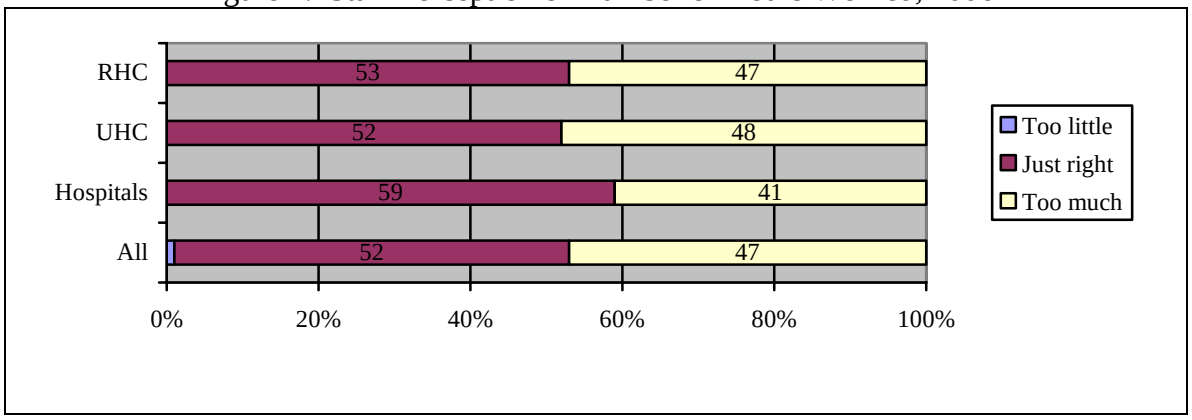
17. *Half of the staff surveyed complained of the long hours of work, because of the workload and their need to augment their meager incomes.* While most staff (91 percent) reported having a fixed work schedule, 47 percent reported long hours worked (Figure 4). The problem of long working hours afflicts workers in health centers more than hospitals. The long working hours, however, is an effect of both heavy workloads in the facility, as well as some staff's need to augment their incomes. Thus, on ordinary workdays:

- UHC staff reported working 12 hours per day. Further probing reveals that 32 percent of staff engage in income-augmenting activities. Of these staff, 7 percent engage in dual practice inside the health facility, devoting as much as 5 hours outside official hours (off-duty) each day. In addition, 25 percent of staff engage in non-health enterprises within the health facility, devoting 7 hours on average each day to such enterprise.

- RHC staff reported working an average of 18 hours per day. Further examination shows that 9 percent of staff engage in income-augmenting activities. For these staff, 3 percent engage in dual practice inside the health facility, spending 1 hour outside official hours (off-duty) each day. Moreover, 6 percent of staff have non-health enterprises within the health facility, spending 6 hours on average each day to such enterprise.

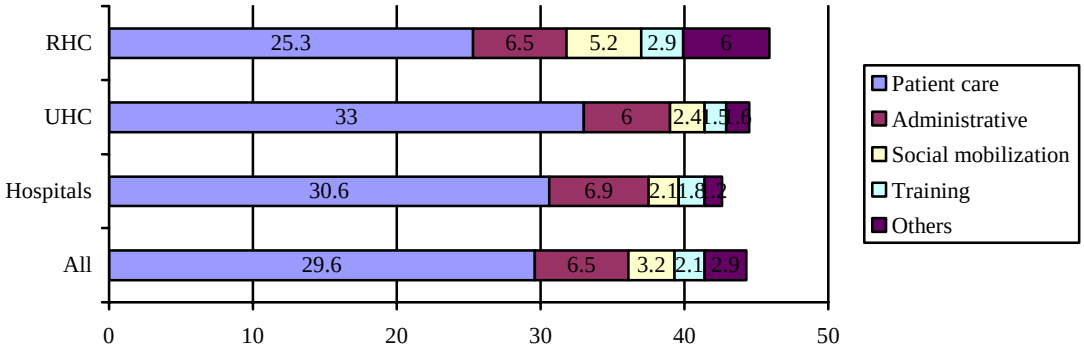
- A lower percentage of hospital staff complained of long working hours. A lower percentage of them (5 percent) also engage in any form of enterprise within the health facility, and among those who do, the amount of time devoted to these enterprises is lower (2 hours on average). However, there is a far greater percentage (24 percent) of hospital staff engaging in dual practice outside the health facility.

Figure 4. Staff Perception of Number of Hours Worked, 2006



18. *Despite the reported long hours worked, the amount of time being spent by staff on direct patient care is being squeezed by other tasks* (Figure 5).

Figure 5. Average Number of Hours Worked in a Week by Type of Task, 2006



19. *About half of the staff surveyed have low morale*. Staff are split in half, with 44 percent reporting satisfaction, 43 percent reporting dissatisfaction, and 12 percent indifferent (Figure 6). Rate of satisfaction appears highest among RHC staff (49 percent satisfied and 7 percent highly satisfied) while rate of dissatisfaction appears highest among hospital staff (45 percent dissatisfied and 9 percent highly dissatisfied) (Figure 7). Staff dissatisfaction arises mainly from stressful workloads (42 percent of staff) and low salaries (34 percent); only 7 percent reported bad facility management while 17 percent cited "other reasons".

Figure 6. Level of Staff Satisfaction, 2006

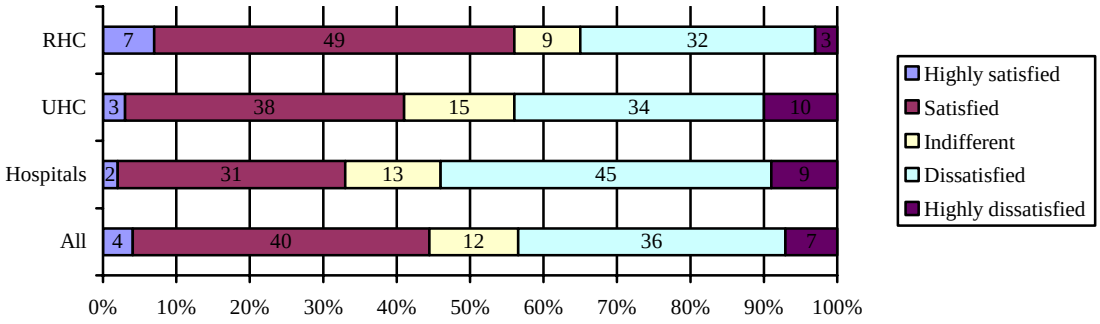
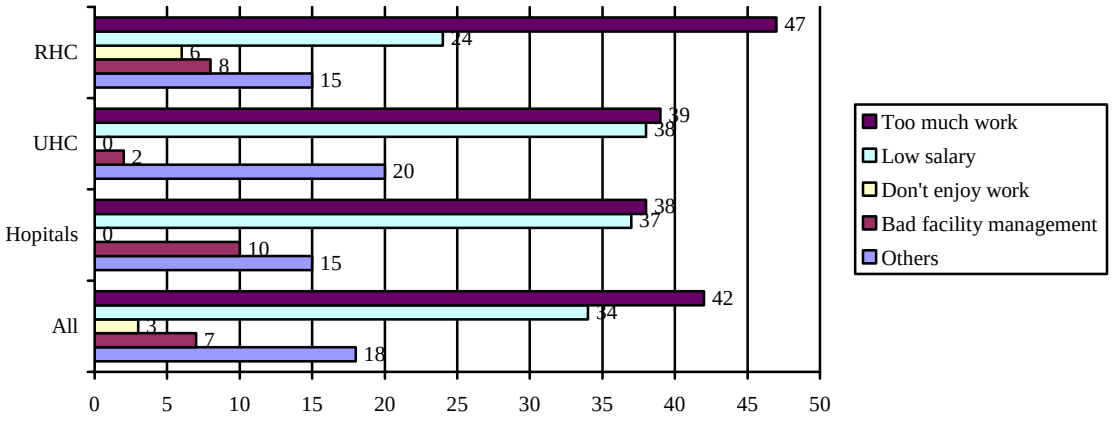


Figure 7. Health Staff Who are Dissatisfied (%), by Reasons for Dissatisfaction, 2006



20. *Health staff are engaged in various income-augmenting economic activities.*

- In-facility dual practice - About 5 percent of staff engage in medical or health practice inside the health facility (Table 6). While this percentage is certainly not disturbing, the amount of time devoted to these "unofficial" activities within the facility premises raises concerns about crowding out the remaining time to do official duties. This problem is particularly acute in urban health centers where health professionals devote as much as 5 hours on average for private practice, presumably outside official hours. The equivalent length of time for private medical/health practice within the facility is 1 hour in rural health centers and 2 hours in hospitals.

- Out-facility dual practice - Dual practice is also undertaken outside the facility by about 18 percent of health staff. This outside dual practice takes up a significant amount of time across the different facility types: on average, an RHC staff engaging in this practice devotes 7 hours; a UHC staff, 12 hours; and hospital staff, 7 hours.

- Non-medical/non-health enterprise inside the facility - Some 11 percent of staff engage in this type of activity, mostly in UHCs (where 25 percent of staff report doing it) and RHCs (6 percent). None of the hospital staff reported engaging in this type of activity. Staff resorting to these income-augmenting activities devote, on average, 6 hours to them.

- Other income-augmenting activities - The most popular income-augmenting activities are agricultural work (reported by 39 percent of staff) and trade (reported by 29 percent). Ten percent resort to teaching.

Table 6. Types of Income-Augmenting Activities Undertaken by Staff (%), 2006

Income-Augmenting Activities	RHC	UHC	Hospital	All
Medical or health practice inside the health facility but outside official hours	3 (1)	7 (5)	5 (2)	5 (3)
Medical or health practice outside the health facility	12 (7)	21 (12)	24 (7)	18 (9)
Non-medical, non-health activity inside the health facility	6 (6)	25 (7)	0 (0)	11 (6)
Agricultural work	41	32	45	39
Commercial or small-scale trade	18	37	35	29
Teaching	9	15	6	10
Other activities	7	4	19	9

Note: Numbers in parentheses refer to the average amount of time, in hours, devoted to the activity.

C. STAFF SALARY AND BENEFITS

21. *Salary levels of professional and clinical workers are highly compressed, and a variety of allowances are being used to decompress overall payroll*. The salary structure of professional and clinical health workers are highly compressed at the upper and middle levels. At the middle level, salaries are uniform across four different cadres (nurse to pharmacy technician). At the senior level, a nurse-tutor and a doctor's salary differs by a factor less than 1. To decompress the salary structure, a wide range of allowances has evolved, including housing, "on-call", recruitment and retention, commuted overtime, commuted night duty, and uniform upkeep. As shown in Figure 8, allowances already account for 39 percent of a doctor's and 35 percent of a senior nurse's monthly package. The number of these allowances tends to decline with the level of the health worker, although each type of allowance tends to be applied uniformly across levels, except for housing and recruitment and retention allowances.

22. *The cash allowances and in-kind benefits are varied but highly fragmented, and cater only to a small proportion of staff***.** While cash allowances are of wide variety, these are nowhere near universally provided. Indeed, only a selected few, i.e., senior-level staff, receive the plum benefits (Table 7). Thus, only 3 percent of all staff surveyed receive salary top-ups; only 3 percent are eligible for the retention scheme; only 2 percent have educational allowances for their children; only 4 percent are provided transport allowance; and only 7 percent obtain food allowance. In effect, 93-97 percent of staff do not get these cash benefits, and deem them to be discriminatory. Even the more liberally-provided cash benefits are not for everybody. Housing allowance is received by less than half (44 percent) of staff; clothing allowance, by only 27 percent; "on-call" allowance, by 33 percent; and rural hardship allowance, by only 16 percent. Non-cash benefits such as schooling of children, food, and transport benefit at most 1-3 percent of staff. Among the wide array of benefits, only health services at the facility can be accessed by 85 percent of staff surveyed. And up to this time, GRZ employees, including health workers, still do not have medical insurance cover.

Figure 8. Composite Monthly Salaries and Allowances (ZK Million) of Clinical/Professional Health Workers, 2005

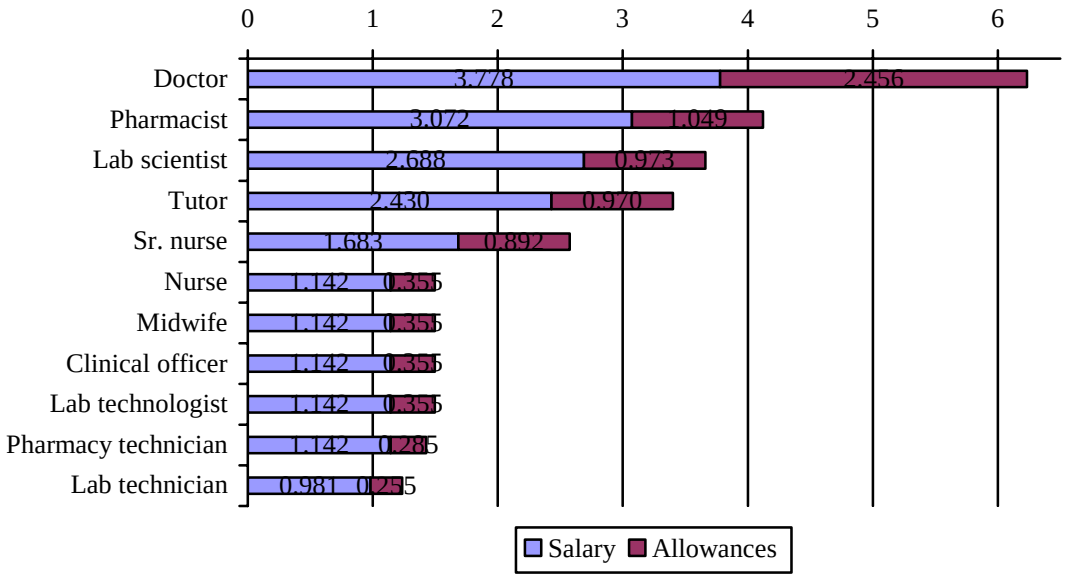


Table 7. Staff Cash Allowances and In-Kind Benefits Received, 2006

Staff Allowances	RHC		UHC		Hospital		All	
	% of staff who rec'd	Ave. amt. rec'd ZK1,000	% of staff who rec'd	Ave. amt. rec'd ZK1,000	% of staff who rec'd	Ave. amt. rec'd ZK1,000	% of staff who rec'd.	Ave. amt. rec'd ZK1,000
Cash Allowances								
Top-ups	1	256.7	2	159.6	1	424.0	4	255.9
Food	5	123.4	1	76.7	2	38.6	7	97.2
Clothing	11	38.9	9	59.6	7	79.5	27	56.9
Housing	9	142.6	20	162.1	15	199.9	44	171.2
Educational	0	-	1	307.6	1	125.0	2	246.8
Transport	2	152.6	1	148.7	1	358.7	4	212.5
Rural hard-ship	13	235.4	1	169.0	3	186.4	16	225.2
Retention scheme	1	25.0	1	20.0	1	155.0	3	89.0
MD on-call	11	48.4	9	49.9	13	229.1	33	120.8
Others	10	104.9	5	64.8	7	367.3	22	182.4
In-Kind Benefits								
Health service	31	-	30	-	24	-	85	-
Schooling	0	-	0	-	1	-	1	-
Housing & utilities	2	-	4	-	2	-	8	-
Food	1	-	0	-	0	-	1	-
Transport	1	-	1	-	1	-	3	-

23. *Managing the complicated cash and in-kind benefit system must be onerous.* The numerous benefits must be given individually to each eligible staff. Except for three allowances, namely housing, "on-call", and recruitment and retention, the other allowances and in-kind benefits are small in value. For instance, the commuted overtime is ZK40,000 (about US$9), the commuted night duty is ZK30,000 (about US$7), and the uniform upkeep is ZK35,000 (about US$8). The administrative costs of providing these benefits are unknown, though they must be significant. More importantly, forecasting the budgetary requirements of this complicated staff benefit system would be extremely difficult as it would require checking each eligibility criterion for each type of benefit. The effect of this system on staff morale and on team camaraderie is also not known, although it appears rather inequitable. Finally, it is doubtful whether this is the best method of "decompressing" the overall salary and benefit structure.

D. SALARY MANAGEMENT

24. *Some staff experience delays in salaries, nonpayment of salaries, or less-than-full salaries.* (See Table 8.)

- Some 85 percent of staff received all their salaries due for the past 12 months. However, about 15 percent did not get all their salaries, a higher percentage of them from hospitals. The unpaid salaries for these staff can be as high as 3-5 months.

Table 8. Salary Management, 2006

Percent of Staff	RHC	UHC	Hospital	All
% who received all salaries due the past 12 months	85.4	87.7	82.3	85.4
% who did not receive all salaries due the past 12 months	14.6	12.3	17.8	14.6
Ave. no. of months not paid	4	3	5	5
% who received all salaries on time	28.7	16.7	19.8	21.9
% who experienced delays in receipt of salaries	71.3	83.1	80.2	78.1
Ave. no. of months delay	1	1	1	1
% who received salaries in cash	11	10	10	10
% who had salaries automatically deposited in the bank	88	90	90	90
% who received salaries by other method	1	0	0	0
% who received all salaries net payable	90.9	86.0	75.0	84.5
% who received less than net payable salary, without consent or understanding	9.1	14.0	25.0	15.5
Ave. amt. of salary missing (ZK)	72,444	239,133	244,278	189,015
% who recovered missing portion of salary	18	0	25	21
% who paid "expediter's fee" to obtain salary	6	8	13	10

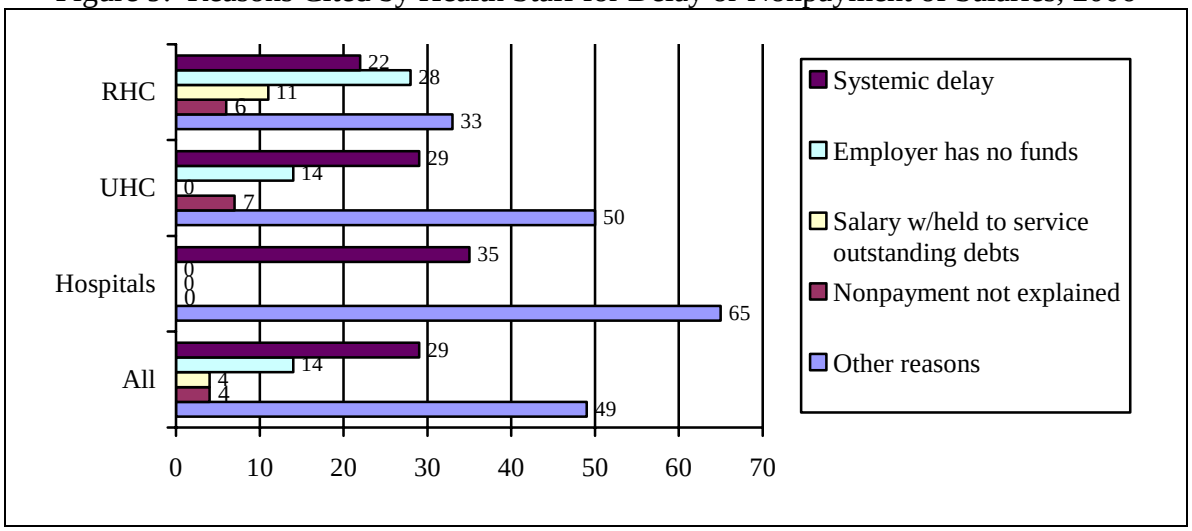
- A wider problem is delay in the receipt of salaries. Only a little more than a fifth (21.9 percent) of staff received their salaries on time; most staff (78.1 percent) experienced delay of about 1 month. Among the reasons staff cited for

nonpayment or delay of salaries are "systemic delays" (cited by 29 percent of staff who experienced delays) and "other reasons" (cited by 49 percent). (See Figure 9).

- Still other staff (15.5 percent) received an amount less than their net payable salary without their consent or understanding. This is highly prevalent in hospitals where 25 percent of staff who responded to the survey experienced this problem. The missing portion of salaries is not an insignificant amount: it averaged ZK189,015 among the staff in the different facilities, the missing amount rising with the level of the facility. Thus, although the missing salary amount is rather small in an RHC (average of ZK72,444), it reaches an average of ZK244,278 in hospitals. About 21 percent of staff who experienced this problem reported that they eventually recovered the missing portion of their salary.

25. *A tenth of the staff reported paying "expediter's fee" to obtain their salaries*. While paying a facilitation fee to get one's salary is not common, it was reported by about a tenth of staff. Surprisingly, a greater percentage of those staff experiencing this problem comes from hospitals. One can surmise that this problem occurs among those staff who continue to receive salaries in cash (10 percent of staff) or other method, since the salaries of most staff (90 percent) are automatically deposited into their bank accounts.

Figure 9. Reasons Cited by Health Staff for Delay or Nonpayment of Salaries, 2006



III. SUMMARY AND IMPLICATIONS

26. *The vacancy rates are undeniably high at 33.5 percent (it is even higher for professional staff at 41.4 percent), and the rapid staff turnover especially at RHCs has become untenable*. For this reason, the HRH Strategic Plan suggests a substantial increase in recruitment and in staffing establishments. As shown in this paper, however, skewed patterns continue to persist in existing established posts (e.g., the burden of having "in the books" so many low-skill posts in RHCs, and so many administrative posts in UHCs). The staffing pattern as reflected in these established posts need to be carefully

reviewed before any large-scale recruitment. This is all the more important because as shown in the NHA analysis, MOH facilities are far more labor-intensive than either mission or for-profit facilities, even with the large shortage of MOH workers. Alternatively, MOH should set explicit criteria on the types of posts/cadres that should be filled or created as urgent, i.e., professional staff and critical administrative staff in rural areas. Failing to do so would result in bloated administrative and low-skill cadres (because they are easier to fill) even as professional staff may continue to be in short supply. It would also seem reasonable that, given the increasing share of health expenditures going to administration (as shown in the NHA analysis), central MOH HQ should receive less priority in recruitment.

27. *Paradoxically, the HR shortage is worsening at a time when the health sector is being flooded with donor resources*. The causes are well-understood in Zambia.

- Firstly, vertical projects rarely, if ever, provide direct salary support. Belatedly, the Global Fund through Round IV has allowed the funding of health systems strengthening including human resource development. (Curiously, the Global Fund has funded NGO project staff from the very beginning, but not government staff.) Indeed, most of the other large vertical initiatives (e.g., PEPFAR) lie outside the purview of government, even though they involve the MOH service delivery system and rely on MOH health workers.

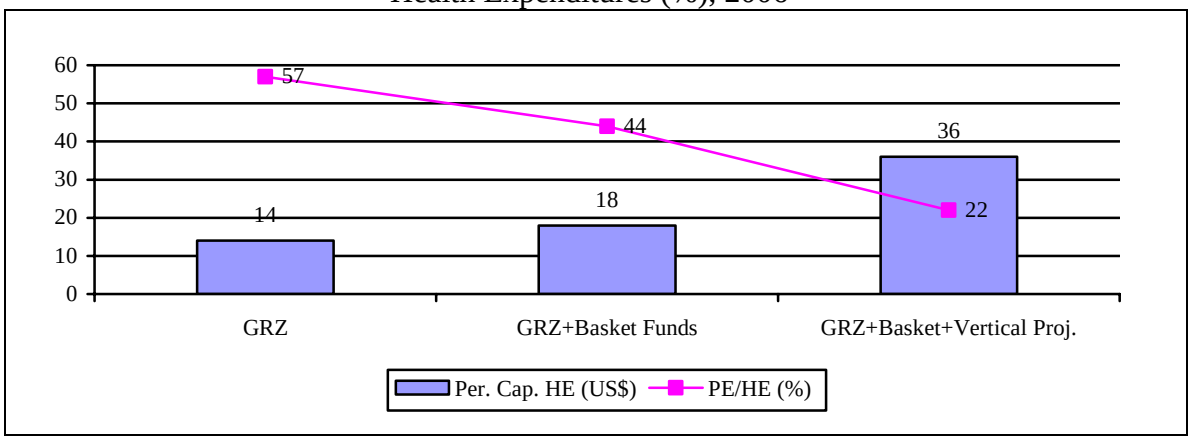
- Secondly, the basket-funding cooperating partners still haven't created a fund to support personal emoluments directly.

- Thirdly, MOH has been unable to adjust to the emerging era of budget support that could have increased the funding for human resources overall, preferring instead health-sector-specific support that it can control (IMF, 2006). Moreover, efforts in the 1990s to de-link health workers from the civil service so that they can be provided higher salaries failed.

- The combined result of these trends is depicted starkly for the year 2006 in Figure 10. As total per capita health expenditures increase with the addition of more funding into the health system, the proportion of PE to total health expenditures declines (even as the proportion of PE to MOH expenditures increases, as mentioned above). In short, it is the inability of the basket funds, health projects, and vertical financing to formally[5] finance PE that causes "so much money chasing so few workers". The imbalance in this factor ratio has not been properly analyzed.

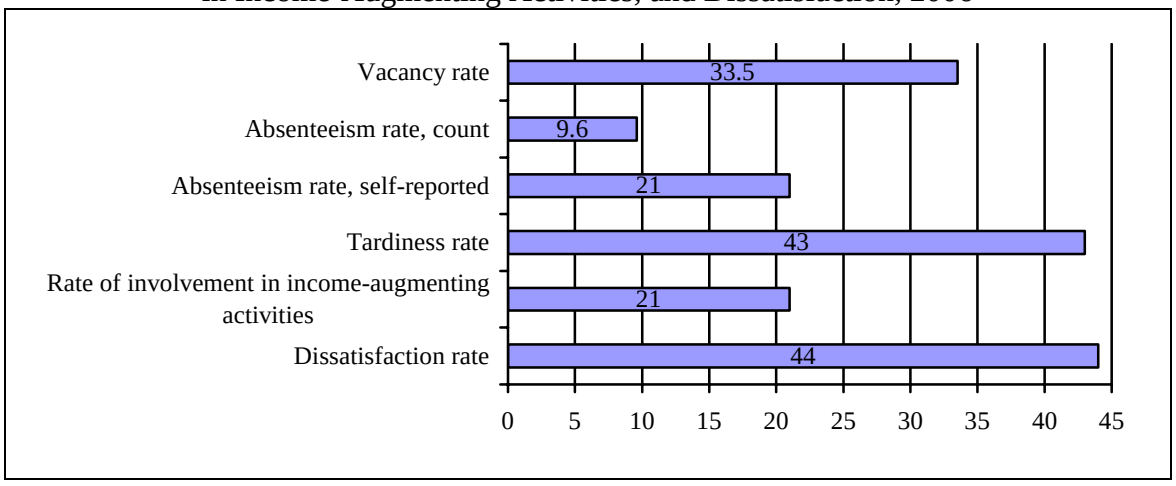
[5] The word "formally" is important, because as was shown in the the PER chapter on "Budget Allocation, Release and Spending," vertical funds are being used by health facilities to incentivize health workers through one form or another.

Figure 10. Per Capita Health Expenditures (US$) and Share of Personal Emoluments to Health Expenditures (%), 2006[6]



28. *Absenteeism and tardiness severely restrict the actual number of full-time equivalent ("real") workers, and these twin problems must be tackled head-on.* (See Figure 11). Human resource discussions in Zambia have overly focused on the need to fill vacancies, and have relegated the issue of staff absenteeism and tardiness to the background. The rates of absenteeism and tardiness derived from the PET/QSDS imply a total loss of 4,108 working days per month. Thus, if absenteeism and tardiness were fully eliminated, Zambia would gain virtually 187 full-time equivalent staff, enough to staff 2 hospitals, or 4 UHCs, or 21 RHCs. HR systems need to have a better handle on the problem, and how to deal with it.

Figure 11. Summary Rates (%) of Staff Vacancy, Absenteeism, Tardiness, Involvement in Income-Augmenting Activities, and Dissatisfaction, 2006



29. *An overall wage strategy is needed.* The salary structure is highly compressed and although the allowance system has given a reprieve in decompressing such structure, it is not the best way of dealing with the problem. While the retention scheme was a right

[6] The data and table are borrowed from Par Eriksson of SIDA who presented these data during the HR Roundtable in Zambia in 2006, held at the Swedish Embassy.

stop-gap measure at the beginning of the human resource crisis, it involved only a tiny minority of staff. The fragmented cash allowance and in-kind benefit system need to be consolidated. The wide variety of allowances and benefits only caters to a small segment of the health workforce, and it is difficult to forecast the budget implications of such a wide range of benefits.

30. *GRZ salary management needs to be strengthened.* The discrepancy in the number of filled posts, workers' payment of facilitation fees to receive salaries especially the 10 percent who continue to receive them in cash, delays in the receipt of salaries, and unexplained salary deductions in some workers call for a thorough review of the salary payment, and to plug the holes cited in this study.

31. *Due to time limitations, staff productivity was not assessed in this study.* However, it is critical that this be done - the raw data already exists from the PET/QSDS - to understand better the input-mix of service provision, and to provide better evidence on how health workers should be incentivized.