TECHNICAL BRIEF 3

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Holding Health Workers Accountable: Governance Approaches to Reducing Absenteeism

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Somewhere in the world...

A nurse rushes to leave the health center with the sun still high in the sky. She does not want to travel in the dark. Despite promises of secure housing next to the facility, the building has yet to be constructed. She has been renting a spare room in a larger town some distance away. The road is unpaved and poorly maintained, making travel difficult, especially in the rainy season, and the nurse often arrives to her shift late. Recently the doctor has been making inappropriate comments at work; the nurse has felt increasingly uncomfortable. At least in the afternoons, she does not have to deal with the doctor's comments because he is seeing patients at his private clinic. However, the nurse then has no one to defer to when an emergency arises. When the nurse manages to visit her family and young children in the city, she will stay a day more than was authorized, which seems to be common practice. She will also likely miss another day from work this week as rumors are circulating that the health worker paycheck deposits, delayed six months, have finally reached the bank, a two-hour ride away.

Earlier in the day, a mother carries a feverish child on her back and walks 15 kilometers to the health center, only to find it empty. She returns the next day to find the waiting room overwhelmed with patients. The mother waits all day, but when the time comes for the child to be seen, the doctor has already left. An overworked nurse rushes through the appointment, speaking harshly. Unsatisfied, the mother returns home and tells her neighbors about the negative experience. The next time one of her children falls ill, instead of visiting the clinic, she buys medicine from the drug peddler in town.

The cost of absenteeism

From a health systems perspective, absenteeism[1]—defined as chronic, unexcused absence from work—adversely affects health worker productivity and undermines health service quality. Since the 2006 World Health Report, some studies have been undertaken to systematically measure absenteeism's effects; however, more needs to be done to adequately address underlying motivation and accountability issues, inform country policies, and reduce health worker absenteeism (World Health Organization 2006).

Absenteeism has high costs on many levels: individual, organizational, and economic. To compensate for absent colleagues, health workers are burdened with additional work and sometimes forced to perform tasks for which they are unqualified. As more workers are absent without consequences, those who tended to respect their work hours become increasingly demotivated and may also adopt these negative practices. This can result in a culture in which absenteeism is accepted. The financial costs of reduced productivity due to absenteeism can be high. A study in Machakos District, Kenya estimated that the absenteeism rate, averaging 25%, cost each health facility $51,000 per month (IPAR 2008). While absenteeism has adverse consequences at the facility level, its impact on a country's health system can be substantial. For example, an average absenteeism rate of 40%, such as has been observed in India, translates to a national health workforce that is effectively 40% smaller than it appears on paper.

[1] The authors recognize the distinction between absenteeism and excused absences. While the absenteeism rates as shown in Figures 1 and 2 include health workers that may not be present at their posts due to job vacancies, planned travel for trainings, excused sickness, vacation, or scheduled leave for social obligations such as marriages or funerals, these issues are not specifically addressed in this brief.

As illustrated in the example of the nurse and mother above, absenteeism also has consequences for health service demand. If health workers are not at the facility during their scheduled hours, whether for part of the day or the whole day, their unreliability prevents communities from accessing needed care. Patients pay increased transport costs and lose daily wages when they make multiple attempts to be seen; additional costs may be incurred to manage a condition worsened by delays in accessing care. In China and India, clients are forced to pay a higher price for services in the private sector (Hsiao and Heller 2007; NCMH 2005). These factors ultimately limit improvements to health.

Underlying governance issues affecting health worker absenteeism

Unexcused absences within the health workforce perpetuate in part because there are insufficient governance mechanisms to address the underlying issues (Lewis and Pettersson 2009; Vujicic et al. 2009). Building on Lewis and Pettersson's (2009) definition of

Quantifying Public-Sector Absenteeism

In countries facing a health worker shortage, quantitative research shows high rates of absenteeism. Absence rates are calculated as the number of person days lost in a given time period over the total number of workable person days in that period. For the purposes of observation, it is the fraction of health workers contracted for service but not on site during the period of observation.

To the extent possible, it is helpful to examine the heterogeneity of absence rates (**see Figure 1**). Chaudhury et al.'s (2006) multicountry study revealed that smaller health facilities, higher-level cadres of health workers, and facilities serving poorer communities were all positively correlated with greater rates of absenteeism. In addition, men were more likely than women to be absent, and cadres more able to make money in private practice were more likely to be absent.

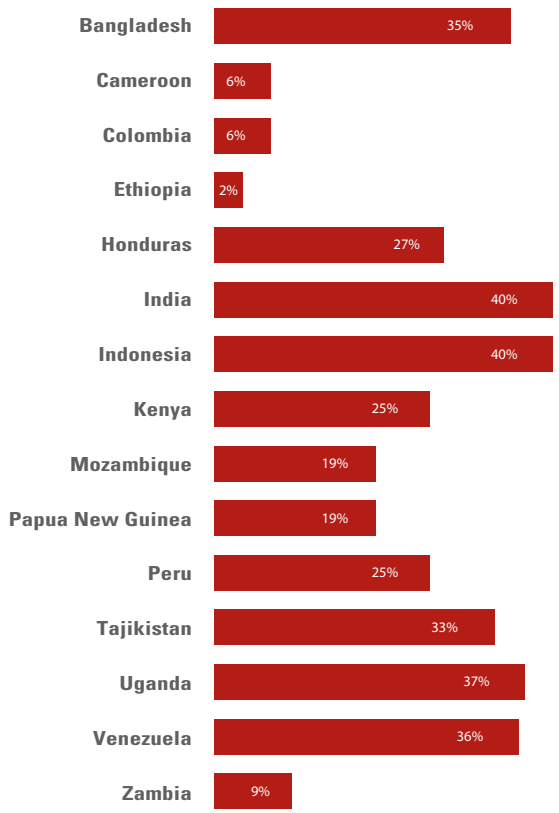
In Kenya, an absenteeism study disaggregated by cadre demonstrated that pharmacists and lab technicians were twice as likely to be absent than nurses; pharmacists gain substantial financial rewards through private-sector opportunities (IPAR 2008) (**see Figure 2**). In Bangladesh, doctors recorded disproportionately higher rates of absenteeism (42%) compared to their colleagues from other cadres (<27%) (Chaudhury and Hammer 2003).

The most common characteristics for absenteeism are when the health worker:

- Is a higher-level cadre/has higher authority (e.g., doctors and managers)
- Is male
- Has greater opportunity to earn money in private practice (e.g., doctors, pharmacists, lab technicians)
- Is posted in a poor, remote or rural community
- Is posted at a lower-level health facility
- Was recruited to a post without being informed of the post's geographical location.

Figure 1.

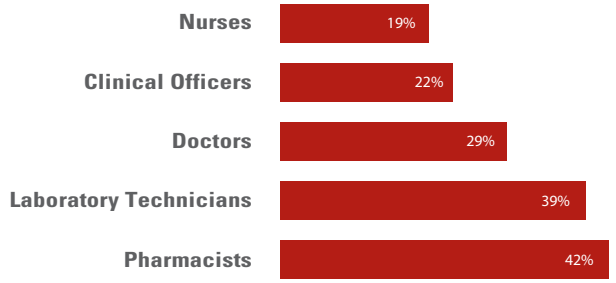
Absenteeism in Primary Health Care Centers in Selected Countries



Sources: Chaudhury et al. 2006; Vujicic 2010.

Figure 2.

Absenteeism by Cadre in Machakos, Kenya



Source: IPAR 2008.

governance, the reasons for absenteeism can be attributed to a breakdown in one or more of these fundamental elements: standards, incentives, information, and accountability.

Failure to meet health worker and facility standards

- *Standards that are not transparent or well known:* Staffing norms may not be known or adhered to. Workers may have unclear job descriptions and inappropriately structured assignments. Many health systems do not adhere to a fixed number of allowable days or hours for employees to take off, or schedule workers' shifts equitably. Further, standards of service quality are compromised when staff with inadequate skills are required to perform the jobs of absent workers.

- *Insufficient supervision:* Inefficient organization, prohibitive costs, inadequate skills, and insufficient time prevent supervisors from providing supportive supervision to staff, especially in rural and remote areas. Supervisors are often not located at the same facility so they are unaware of or unable to adequately document their supervisees' absenteeism. Health workers do not receive sufficient professional support for needed skills trainings and mentoring. Further, centralized supervision limits their participation in problem-solving and decision-making at health facilities.

- *Poor working conditions:* Inadequate supplies, outdated or missing equipment, and lack of potable water and/or electricity demotivate workers. Unsafe work environments as well as workplace violence and insecurity—including isolated overnight shifts, harassment, and gender inequities—may result in absenteeism.

Ineffective health worker incentives

- *Inadequate financial and nonfinancial incentives:* Many health workers conduct other income-generation activities, particularly private medical practices, which are performed during or after their public-sector shifts (Dobalen and Wane 2008). A study of health workers from developing countries found that 87% of respondents had at least one other job. Half of those respondents were not available more than 25% of the expected working time (Macq et al. 2001). In Uganda, absenteeism spiked on market days, when health workers would abscond from their duties in order to sell wares and compensate for inadequate salaries; in addition, 55% of health workers surveyed responded that inadequate housing or transport were reasons they missed work (Matsiko 2011). Lack of work-related benefits contributes to absenteeism. In Bangladesh and Uganda, health workers provided with housing were less likely to be absent (Chaudhury et al. 2006).

- *Delayed remuneration:* Ineffective payroll mechanisms force health workers to travel long distances to receive their paychecks. In some countries, a health worker's first paycheck may take up to six months to process, which could incentivize the health worker to take on other jobs to cover living expenses in the meantime.

- *Lack of performance incentives and limited opportunities for personal or career development* can erode workers' motivation, leading to absenteeism. Oftentimes there is insufficient reward for good performance at the individual or team level. For example, most facilities send their service statistics to a central authority but rarely receive feedback or recognition if targets were achieved. Too often, promotions are not based on merit but on favoritism or for political means.

Insufficient information

- *Limited quantity and quality of data:* Few developing countries have quantified absenteeism, which limits evidence-based decision-making. Paper records are slow to collect. Facility records and even electronic time-stamping to monitor attendance can be manipulated. Most facilities do not have a system for providing substitute health workers for either planned or unplanned leave.

- *Ineffective supervision:* Traditional top-down supervisory measures to get information about absenteeism—such as time and motion studies, quantitative service delivery surveys, surprise visits, focus groups with facility managers and patients, or direct observation—can be time-consuming and costly, and tend to perpetuate systemic hierarchies. They are often interpreted by workers as policing or punitive actions, resulting in workers' resentment of their supervisors. Finally, very few health workers are terminated or sanctioned for being absent (Vujicic et al. 2009).

Lack of accountability

- *Insufficient political will:* In large part, accountability measures are often not enforced due to limited political will at high levels of leadership to take a stand against absenteeism. Many leaders are aware of absenteeism as a perennial issue, but more must be done at their level to effectively address it. The significant political weight of professional councils to protect their cadres stymies efforts to enforce punitive measures against absenteeism.

- *Few consequences:* Colleagues tend to protect others on their team and are not likely to report those who are absent. Supervisors often do not report supervisee absenteeism because they do not want their own absenteeism revealed or because it is rare for corrective action to be taken against the chronically absent health worker. In addition, managers may avoid firing workers because the process for replacing them is difficult and slow (Vujicic 2010). There are also anecdotal reports of supervisors not reporting supervisees' absenteeism for fear of retaliation, especially from high-ranking relatives of the supervisee.

Stakeholders in governance

Reducing absenteeism requires a decentralized approach involving broad stakeholder groups to reinforce accountability mechanisms for addressing governance issues. These stakeholders include: 1) management, 2) health professional schools, 3) health professional councils and associations, 4) health facility teams, and 5) communities (**see Figure 3**).

- *Management* (e.g., Ministry of Health officials, regional directorates, district health management teams, facility managers) can more effectively address absenteeism by making it a political priority. Policies against absenteeism must be reasonable, widely communicated, and enforced through transparent processes and with methods for recourse. In turn, health workers should be able to hold their

Figure 3. Stakeholders in Governance

managers accountable for setting standards, providing promised incentives, and addressing their concerns about compensation, posting, working conditions, and incentives.

- *Health professional schools* can play a formative role in reducing absenteeism if they are selective and strategic in whom they recruit and train. Recruiting applicants from rural backgrounds, as well as integrating rural clinical practica and modules on rural health and professional ethics in training curricula, can instill in health workers the value of and need for rural service.

- *Health professional councils and associations* can organize members into communities of practice to help define sustainable standards as well as advocate for enabling working environments. Staying connected to a broader network of colleagues can motivate workers and increase job satisfaction. The councils and associations should be the primary advocates for ensuring professionalism of their cadres, instilling respect for their vocation. They are well placed to combat absenteeism, deeming it as "unprofessional" behavior, and thus to endorse and follow through on appropriate sanctions. For example, in Rwanda and Zambia, some sanctions have been successfully conducted by civil service associations (Vujicic et al. 2009).

- *Health facility teams* can promote peer perception and collegial pride, cited as reasons motivating health workers to report to work (Chaudhury et al. 2006). Given their quotidian involvement, facility managers have the opportunity to understand and address the underlying causes of staff absenteeism. In Rwanda, health facility managers have been instrumental in implementing appropriate measures (Vujicic et al. 2009). Peer or team supervision can also be an effective first-line approach for holding colleagues accountable to fulfill their duties.

- *Communities* (e.g., municipal authorities, traditional leaders, civil society groups, community health associations, patients), as the beneficiaries of health services, should play a strong role in gathering information and providing feedback on health worker absenteeism. In Mali, where some communities may directly hire nurses for rural posts, members are more likely to demand a return on investment (Hilhorst et al. 2005).

Governance measures to reduce absenteeism

Following the structure of Lewis and Pettersson's four elements of governance, the authors recommend a diverse range of interventions and mechanisms to engage stakeholders to more effectively reduce health worker absenteeism. Some of the interventions proposed may not succeed if implemented in isolation; combining multiple efforts will be more likely to produce a positive outcome. In large part, the effectiveness of interventions for improving standards, incentives, and information will ultimately provide the foundation for stakeholders to justify the accountability measures they seek to make.

Standards

- *Encouraging participation to set and communicate standards.* Leaders and managers should take a participatory approach to set appropriate human resources (HR) standards related to attendance and other relevant performance management areas that will make workers' and managers' roles more explicit. Professional councils can play a specific role in reviewing and determining reasonable expectations for each cadre and then advocating for these standards. At the facility level, teams should work together to ensure more equitable shifts, so that workers are not unfairly scheduled or resentful of their hours. Once established, a facility's patient/provider bill of rights and hours of operation should be posted, communicating them to lower-literacy populations with visual illustrations and through traditional community channels (e.g., at community meetings, with traditional village chiefs) when possible. These lower-cost efforts will help inform communities about what they should expect and demand of the health workforce in their locale, which will encourage workers to be present.

- *Improving working conditions.* Work climate plays a critical role in health worker motivation and job satisfaction. There are many low-cost interventions that can be implemented at the local level to improve working conditions. In Kenya, facility-based teams assessed their own working conditions and implemented action plans to improve their environment and job satisfaction. These included making waste disposal safer, improving inventory management, creating staff lounges with free tea, painting and refurbishing facilities, posting facility signage, cleaning yards, and offering continuing education opportunities, all of which motivated health workers to come to work and perform well (Capacity Project 2009). Community involvement and contributions to improve the facility can increase health worker motivation and reduce the likelihood of health worker absenteeism, which in turn enhances the quality of the services they access. For example, community health associations in Mali have helped construct clinic staff housing; provide potable water, cleaning, or laundry services for a more hygienic environment; and offer transport for commuting health workers (Hilhorst et al. 2005).

Incentives

- *Implementing effective incentive packages* can greatly contribute to health worker motivation and productivity, including reducing absenteeism. This requires a solid comprehension of workers' preferences within specific contexts. Capacity*Plus*'s Rapid Retention Survey Toolkit

applies an evidence-based method to determine the optimal package of incentives based on health workers' motivational preferences. Providing housing near the workplace has been a helpful incentive in rural settings. In Bangladesh, lower rates of absenteeism were recorded among health workers residing close to the facility compared to health workers living farther away (Chaudhury and Hammer 2003). Evaluating working conditions and worker satisfaction may also reveal reasons for skipping work.

- *Recognizing dual employment* or authorizing certain hours for health workers to conduct private practice can accommodate for the limitations of public-sector remuneration. In the Dominican Republic, policy-makers incentivized doctors by reducing their official public-sector hours to 20 hours a week so that they could also practice privately (Vujicic 2010). In Indonesia, health workers are permitted to engage in dual employment after completing three years of exclusive public service (Berman 2004). Italy, Austria, Germany, England, and Ireland have introduced privileges for private practice to health workers that meet public-sector performance standards (Kiwanuka et al. 2010). These examples indicate that developing guidelines on dual practice can help reduce absenteeism as well as attract and retain more rural health workers (Macq et al. 2001).
- *Implementing performance-based financing (PBF)* can incentivize individuals, teams, or entire facilities. Because these schemes pay based on the results of performance, health workers need to be present and work effectively to receive the financial incentives directly, as a share of a team disbursement or to raise the chances for a facility to receive its eligible benefits. As such, PBF encourages peer-to-peer accountability and increases remuneration and health worker motivation. This approach, used in several low-income countries, can directly influence productivity and access to health services when compensation eligibility criteria are presented to facilities, coupled with strong leadership and technical support in a decentralized health system. The provision of financial incentives through PBF in Rwanda led to significant gains in facility productivity: in the Kabutare district the number of institutional deliveries increased by 233% and the number of referred deliveries by 459% while in another district the number of contacts per inhabitant increased from 0.39 to 0.66 per year (Meessen et al. 2006). Community evaluation of quality indicators in PBF can also motivate health workers to fulfill their contractual obligations.

Information

- *Customizing HR information systems (HRIS)* can assist HR managers with information on absenteeism. Capacity*Plus*'s iHRIS Suite of free open source software has been used in many countries to facilitate evidence-based decision-making in health workforce planning and management. Version 4.1 of iHRIS offers capabilities for district and facility managers to track leave balances and timesheets, and distinguish unexcused absences from approved leave. An integrated electronic payroll helps managers pay workers on time, which can maintain motivation and reduce absenteeism resulting from repeated efforts to obtain paychecks. In eastern Africa, mobile banking has expanded to the rural health worker payroll. Paying nurses and community workers with mobile money has shown to improve health worker retention and reduce tardiness (Doerr 2012).
- *Initiating mHealth innovations.* Health workers or communities can use mobile phones with SMS texting capabilities to encourage reporting the presence or absence of health workers, in addition to facility standards, patient waiting times, availability of medicines, and other quality or productivity indicators. Such crowdsourcing applications have the potential to provide managers and health workers with quantitative and qualitative information to develop action plans to address productivity (and/or quality) issues, such as absenteeism. Crowdsourcing can also empower communities to engage with the health system and hold it accountable to meet minimum quality and access standards for service delivery. Anonymous mobile-phone surveys, toll-free phone lines, or e-mail addresses provide outlets of communication for health workers to describe their work environment and housing conditions, make anonymous reports of absent colleagues or cases of harassment, or bring attention to other related components of their work climate. This can be effective, assuming that managers respond in a timely and confidential manner.

Accountability

- *Leveraging political will.* Taking a stand to increase health worker productivity through a reduction of absenteeism often requires a high level of commitment and authority as the decision and repercussions can be political in nature. In light of this, stakeholders should evaluate which leaders could be willing to take a stand against absenteeism. To the extent possible, the information they present to these leaders should include the specific factors leading to and consequences of absenteeism in their context, especially in regards to their economic impact and effect on health outcomes. Potential risks and risk mitigation measures should be thoughtfully considered. Advocates for improved accountability measures should consider how the timing of elections and political appointment cycles may affect a leader's willingness to support their cause. Advocacy efforts should also focus on professional councils and associations to engage them in fomenting high levels of professionalism among their cadres and supporting political decisions and appropriate mechanisms to address absenteeism of the health workforce.
- *Enforcing sanctions.* Managers and communities should be committed to hold health service providers accountable for their processes and outcomes. Transparency is essential in defining the indicators and processes for enforcing HR standards and applying appropriate disciplinary measures. If standards and rules are established but not enforced, health workers could actually be disincentivized to follow them, which can slowly unravel other efforts to reduce absenteeism. While it is never a pleasant undertaking, sanctions must be imposed if specified outputs and outcomes are not delivered (Lewis and Pettersson 2009). Professional councils, managers, and health facility teams can work together to decide what consequences are reasonable for occasional, chronic, and severely chronic absenteeism. Punitive measures should allow for adequate recourse, with step-wise warnings to avoid firing workers and leaving posts vacant for long periods (Vujicic 2010). It may be easier to take small disciplinary measures that respond to minor infractions to set the tone of "zero tolerance" than to impose serious sanctions after absenteeism has been taking place for a long time.

Conclusion

Health workforce absenteeism is a serious problem in health systems throughout the world and can greatly diminish the effectiveness of health service delivery. Reducing absenteeism requires a decentralized approach involving broad stakeholder groups to address underlying governance issues and reinforce complementary accountability mechanisms. This brief offers a number of recommendations for strengthening governance to reduce absenteeism, including: setting and adhering to standards; providing adequate incentives; improving information on absenteeism; harnessing political will; and committing to enforce disciplinary actions when deemed necessary. Although absenteeism is a complex and sensitive matter, addressing it is an important step toward enhancing productivity and performance of health services. Policy-makers and stakeholders should consider which approaches are best-suited to their contexts in order to improve their health system capacity and more efficiently utilize their limited health workforce.

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