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# An Overview of Performance of Health Workers in Uganda

Tom Mulegi

Department of Public administration and Management Faculty of business and management Kampala International University Uganda

ABSTRACT

Poor performance of service providers lead to both inaccessibility of, and inappropriate care. This contributes to reduced health outcomes since; people are neither using nor accessing appropriate services. Uganda has significantly improved access to maternal and child health care as well as response to HIV/AIDS. Performance of health workers depends not only on their competence (knowledge, skills) but also on their availability (retention and presence), as well as the available systems in place. The public health system in Uganda has a mechanism for regular performance appraisals and development plans for all staff. However, evidence shows that the appraisals are inconsistent. Moreover, staff development activities are organized not in response to staff skills needs, but rather in an adhoc manner. Health service delivery is the backbone of any health system.
**Keywords:** Performance, Health Workers, patients and Uganda

## INTRODUCTION

In Uganda, downward changes in government health care already began with the onset of a period of dictatorial government and civil war in 1971 that, would last well into the 1980s. Before it began to deteriorate, public healthcare in Uganda was among the best in Africa, whence its breakdown showed sharply [1; 2]. Descriptions of the deterioration process include shortage of drugs, shortage of highly qualified staff members, doctors and nurses leaving their services and migrating to other countries, delays in payment of salaries [2]. Results of two studies show how the remaining health workers dealt with the above strains. There are four health professional councils in Uganda: Nurses and Midwives Council; Medical Practitioners Council, Allied Health Medical Professional Council, and the Pharmacy Council. These are all autonomous bodies created by an Act of Parliament and, independent of the MoH, but governed by the health sector policy. Ratification of the pharmacy Council Act is still pending, but it is fully functional as a registering body. There is evidence that the Uganda Nurse and Midwives Council is under-resourced and unable to provide effective regulation. One study showed that licensure to practice was only provided to 28 percent of the 25,482 nurses and midwives that graduated before 2006 [3]. The most recent data available indicate that while a total of 42,166 nurses and midwives has been registered, only 17,582 (41 percent) are licensed. Much as fees for licenses may play a part in low licensure percentages, the ability to practice without a license raises the question of why a nurse would seek a license. Regulation and oversight of health sector performance is the responsibility of the Ministry of Health (MoH) while professional Councils oversee professional conduct and adherence to ethics. The code of ethics applies to all public servants and stipulates a number of standards among which are requirements pertaining to attendance to duty and time management. However, reports show widespread absenteeism and tardiness in the public sector, threatening service delivery and

quality of MoH services [4; 5]. Periodic annual performance reports of MoH (2001 to 2010) indicate that, the councils lack adequate resources to perform their duties, especially given the rapidly growing private sector and the mitosis of districts. For example, the required funds for the activities of the councils dropped from UGX 95.8 million in 2000/01 to UGX 20.0 million in 2006/07 [6]. Most of their revenues are from the licensing fees, which are grossly insufficient to ensure an effective oversight and performance of their mandate [7; 8]

Poor performance of service providers leads to both inaccessibility of, and inappropriate care. This contributes to reduced health outcomes since; people are neither using nor accessing appropriate services. The final report of the Joint Learning Initiative clearly outlines the importance of a workforce in performing services. This report states that, the number of health workers, and the quality and type of professionalism, determine output and productivity [9]. Several articles and documents have reported problems relating to service provision due to poor performance of health workers [9; 10; 11]. Accordingly, Poor performance results from too few staff, failure of staff to provide care according to required standards, and not being responsive to community and patients' needs. "Most performance problems can be attributed to unclear expectations, skills deficit, resources or equipment shortages or a lack of motivation" [12].Additionally, these causes are rooted in a failing health system, low salaries, difficult working and living conditions and inappropriate training. The literature considered performance to be a combination of staff availability, competency, productivity and responsiveness [10]. Although, this simplification undervalues the complexity of interrelations between factors that exist in reality, the authors appear to have designed a framework to simplify the concept of performance and foster further analysis.

In the past, perception on staff performance was that, it was a function of skills and knowledge. In recent years however, there has been a growing recognition that additional factors influence performance [10]. Performance of health workers depends not only on their competence (knowledge, skills) but also on their availability (retention and presence), as well as the available systems in place [13]. The public health system in Uganda has a mechanism for regular performance appraisals and development plans for all staff. However, evidence shows that the appraisals are inconsistent. Moreover, staff development activities are organized not in response to staff skills needs, but rather in an adhoc manner. Health service delivery is the backbone of any health system. Historically, African governments provided the majority of health services through a vast infrastructure. However, this public-only delivery system has changed dramatically in the last 20 years. Uganda is no exception to this trend and in fact, the health service delivery system includes a wide array of public and private health care providers working in many different clinical settings. The challenge when assessing health services, is to capture how inputs and services are organized and managed among all health actors to ensure access, quality, safety, and continuity of care across health conditions, locations and time [14].

Uganda has significantly improved access to maternal and child health care as well as response to HIV/AIDS. Further, the Global Fund to fight AIDS, Tuberculosis, and Malaria (Global Fund) USAID, and other donor programming have facilitated an increased availability of HIV prevention, outreach, and treatment services. Most Ugandans now live within five kilometers of a health center. Despite this progress in service availability, there are still significant challenges in improving quality of service delivery and

addressing continued health status issues like high infant and maternal mortality. Primary health care remains difficult for some to access, and quality of care is inconsistent. The referral system is not functional, and patients often ignore secondary or tertiary care due to the high costs involved. Neither has evidence- based medicine been consistently followed nor existing facility-based quality improvement initiatives been uniformly institutionalized. Additionally, the system does not invest sufficiently in public health services to minimize unhealthy behaviors that lead to increases in both non-communicable and infectious diseases [15].

In 2004, the Joint Learning Initiative published a report estimating that need for 1 million additional health workers in sub-Saharan Africa; nearly triple the number currently working in the region. The WHO has since updated these data, and the outlook is even grimmer. According to the WHO, 36 of the 57 countries suffering from a serious shortage of health workers are in Sub-Saharan Africa; there is need for more than 4 million additional doctors, nurses, midwives, managers, and public health workers to fill this gap. Countries with the highest relative need have the lowest number of health workers. The African region suffers from more than 24 percent of the global burden of health, but has access to only 3 percent of the world's health workers. In contrast to the WHO's recommendation of at least one doctor per 5,000 people, ten African countries have averagely one doctor per 30,000 or more people. These statistics mask the rural-urban divide, as doctors congregate in urban areas leaving the rural areas even more underserved.

**The Structure of the Health System in Uganda**

The National Health System (NHS) in Uganda constitutes of all institutions, structures and actors whose actions have the primary purpose of achieving and sustaining good health. It is composed of the public and the private sectors. The public sector includes all government health facilities under the MoH, health services of the Ministries of Defense (army), Internal Affairs (Police and Prisons) and Ministry of Local Government (MOLG). The private health delivery system consists of Private Health Providers (PHPs), Private Not for Profit (PNFPs) providers, and the Traditional and Complimentary Medicine Practitioners (TCMPs). The health services are structured into National Referral (NRHs) and Regional Referral Hospitals (RRHs), general hospitals, health centre IVs, Health Center Ills and Health Center one's. The Health Center I has no physical structure but a team of people (the Village Health Team (VHT)) which works as a link between health facilities and the community [16]. The National Hospital Policy adopted in 2005, spells out the role and functions of hospitals at different levels in the National Health System, and operationalized during the implementation of the Health Sector Strategic Plan II. Hospitals provide technical back-up for referral and support functions to district health services. The public, PHPs and PNFPs, provides hospital services. The public hospitals are divided into three groups namely;

(i) General Hospitals provide preventive, promotive, curative, maternity, in-patient health services, surgery, blood transfusion, laboratory and medical imaging services. They also provide in-service training, consultation and operational research in support of the community-based health care programmes

(ii) RRHs offer specialist clinical services such as psychiatry, Ear, Nose and Throat CENT), ophthalmology, higher-level surgical and medical services, and clinical support services (laboratory, medical imaging, and pathology). They are also involved in teaching and research. This is, in addition to services provided by general hospitals. The MoH headquarters still manages the RRHs, even though they granted a self-accounting status. The

NRHs, namely Mulago and Butabika, are fully autonomous [7].

The public health care system under the MOH exists in a tiered structure. Health Center IVs were a strategy to address poor access to health care services. The introduction of a Health Center IV to an area is a proxy for areas of poor access to hospital services. Therefore, in the absence of easy access to hospitals, Health Center IVs are supposed to provide at least some emergency services like emergency obstetric care, that hospitals would normally have to offer. Health Center IVs were established in 1999 under a national health policy. For every 100,000population, there must be a Health Center IV according to policy standards (Health Sub-district Concept of 1999-2000). There are 13 Regional Referral Hospitals (RRHs) in the country, but for the annual reporting, exercise 4 large PNFP hospitals (Nsambya, Rubaga, Mengo, and Lacor) with the scale and scope of RRHs are included, making 17 RRHs [15]. There are two National Referral Hospitals (Mulago and Butabika). Both the public and private sectors play an important role in supporting communities to improve their health. Uganda has a vibrant private sector, which contributes more than 50 percent of the services delivered in the country [17]. The country had a very effective public health care system in the 1960s, soon after independence; however, with the political turmoil of the 1970s and early 19805, the health system collapsed and this left a gap that was filled by the private sector, especially faith-based providers (also called private not-for-profits). The private sector benefited from the liberalization of the economy which began in the 1990s [18]. Spending within the private health sector now accounts for more than 70 percent of total expenditures on health [16].

The referral system is a formalized system that requires a patient from a lower level facility to obtain a referral note from the health workers in that facility in order to go to the relevant higher level facility. In practice however, the referral system in Uganda is not very effective. Lack of ambulances and fuel often prevents patients from quickly transferring from one facility to another in the case of referrals. Additionally, the referral mechanism also faces the challenges of poor road networks or terrain, and lack of referral forms, relevant emergency medicines, and supplies including blood for transfusion at the referral facility [19; 20]. In addition, people often have to pay for emergency care, and inability to pay for the services might delay access to or provision of referral services. A critical challenge for referral is the inadequate capacity of the health facilities, especially the Health Center IVs, to handle emergency cases such as caesarean sections or blood transfusion. A common practice is that patients, particularly those with more money than the average, by-pass the lower level facilities, and self-refer themselves to whatever higher-level facility they perceive as good for them. Consequently, patients with minor ailments, treatable at lower-level facilities congest high-level hospitals.

Independent variable (IV)
Skill Mix

Dependent variable (DV)
Employment performance

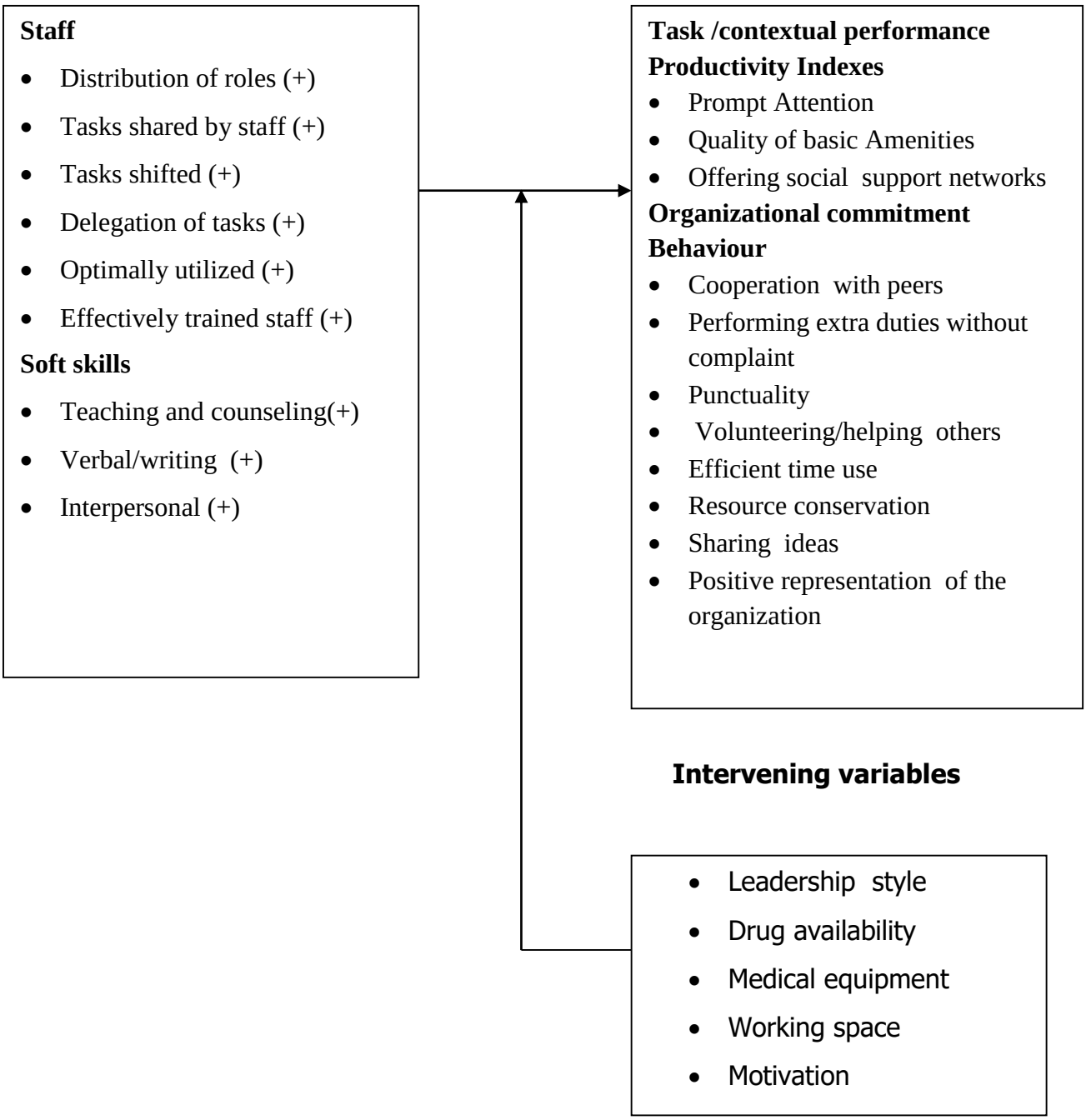


**Figure 1**: Conceptual model: Employee Performance Related to Skills via

Footnote: Sign against each concept implies the nature of relationship with the dependent variable. Developed by the researcher, using ideas by [25; 26; 27; 28;].

The conceptual model (Figure 1) depicts three soft skills, namely teaching and counseling, verbal and written, and interpersonal skills, all conceptualized to have a positive relationship with performance of

health professionals in government regional referral hospitals in Uganda. The conceptual framework further depicts that, the right skill mix, based on human and social capital theories, implies that, sharing of tasks, shifting tasks, delegation of tasks, and optimal utilization of health professionals will positively influence the performance of health professionals in hospitals in Uganda [26; 27]. [25] Found that soft skills were important in maximizing human capital in any facility. Similarly, [29] discovered that medical professionals need soft skills to effectively work with patients and colleagues. The right skill mix is an important way of solving problems like skill shortages, inappropriate use of skills, understaffing, and staff irregularities. Similarly, the right skill mix will develop care, maintain and ensure quality services [30].This will lead to responsiveness, altruism, courtesy and adequate attention to patients. Other factors like the leadership style, availability of drugs, working space, are also important in performance of health professionals. The ultimate aim of any health system is to have satisfied health workers.

**Task Performance**

[31] Defined task performance as the organization's total expected value on task related proficiency of an employee. In other words, task performance is the behaviours referring to performing job-related matters. Task performance can be measured in terms of the absolute value or relative judgment [32]. According to [33], most human resource management studies adopted subjective measures of performance. They tend to measure performance basing on task-related and behavioural aspects. This measure of performance allows researchers to generalize the findings to a larger performance construct [33]. This is in accordance to [31] assertion that, task performance is best construed as a behavioural construct because it involves a psychological process related to selection, training, motivation and facilitating situational processes. According to [31], scholars have given limited attention to the most appropriate concept of task performance or in-role performance. This is so, despite the fact that an accurate definition of task performance or in-role behaviour is crucial before making any interventions to improve human performance in organizations. In human resource management studies, measurement of task performance applies a range of criterion indicators. They include supervisory ratings, productivity indexes, promotability ratings, sales total, and turnover rate. Although, the presumption is that these indicators might reflect performance at various degrees, [32] state that, there should be a distinction of task performance from quality and quantity of work performed; and interpersonal effectiveness. This study further, analyzes performance of health professionals from these dimensions as defined by [34]. This is because measuring performance from this dimension, gives chance for comprehensive analysis of the concept.

**Performance Indicators**

Indicators are significant in measuring performance of health systems [35]. The [36] emphasizes the importance of health systems as being more outcomes oriented. Consequently, [37] describe performance indicators as specific type of performance outcomes based on the dimension of reliable, quantitative process of outcome measure. These are related to one of the dimensions of performance such as efficiency, effectiveness, appropriateness, timeliness, availability, continuity, safety, and responsiveness [35]. Therefore, the performance of a health system depends on the knowledge, skills and motivation of the people responsible for delivering the services [38]. [39] Posits that health care performance indicators are; statistics or other units of information, which reflect, directly or indirectly, the performance of health care systems

in maintaining or increasing the well-being of the target population. [40] Describe performance indicators; as tools that monitor and enhance the performance of an organization in general, including at the clinical level. Specifically, indicators related to patient care are referred to as clinical indicators [37]. Human resource performance indicators, on the other hand, are concerned with the development and utilization of staff in an organization [35]. Such indicators are designated to monitor levels of organizational and workers' performance [35]. The relevance of performance indicator in modern health care management include: achieving business-oriented management techniques; building organizations that learn through measuring and supervising their performance; initiating management processes that support the core values of the organization; relating achievements, and outcomes to organizational resources; and empowering the workforce to improve their performance through performance management [41; 40; 42]. Indicators that promote professional values, learning, investigations, and trust have a desirable impact on performance [35]. While, approaches that involve judgment, obligatory performance improvement, table ratings, and mistrust impact negatively on performance [41; 43].

**Approaches to Performance Measurement**

Measurement and evaluation are often used to strengthen and improve performance practices [35]. [44] Describe performance measurement as; the periodic assessment of progress toward explicit short and long term objectives and the reporting of results to decision makers in an attempt to improve performance. Performance measurement provides quality information to decision makers so that they can determine whether their efforts are on course, and inform the political leadership and citizens who are entitled to regular reports on the performance [44]. According to [45], there are five approaches for measuring performance of workers: Comparative approach, attribute approach, behavioural approach, results approach, and quality approach. The results approach is based on the contention that results are the best indicators of the contribution of health workers' performance to organizational success [35; 45]. The results-based approach encompasses management by objectives (MBO). Here, goal setting is cascaded throughout the organization. Goals become the standards against which an employee's performance is measured [35]. The other technique is the productivity measurement and evaluation systems (ProMES). This involves a process of motivating employees to higher productivity [45]. The third technique under this category is the balanced score card (BSC). The concept of BSC is very relevant in the present era of emerging global competition; where organizations, including hospitals, are facing increasingly knowledgeable and demanding customers [35]. The BBC method gives insight into the organizational performance by integrating financial measures with other key indicators around client perspectives, internal business processes, organizational growth, learning and innovation [35].

**The relevance of the Social Capital theory to performance**

Sociologists spearheaded the debate surrounding social capital and political scientists like [46] and [47], who stirred academic debates on the social context of education. However, it was works by [48] that launched social capital as a popular focus of research and policy discussion. The [49] also lent support to the popularity of the concept by pointing it out as a useful organizing idea. Accordingly, social cohesion is critical for the economic prosperity of societies and sustainable development. Social capital has also in recent times, captured the attention of organization and management scholars, who have shown an increased interest in the

concept, as a way of thinking about organizational development. In general, social capital is the glue that brings and holds communities together [50]. It refers to networked ties of goodwill, mutual support, shared language, shared norms, social trust and a sense of mutual obligation that can be of value to people. Subsequently, social capital is in relation to value gained from being constituent of a network. By being a member of a group, people gain access to resources that non-members do not have. These resources range from, for example access to potential career paths, and resources in entrepreneurial start-up processes to, access to cooperative services in developmental countries.

**The Human Capital Theory and Performance**

Human capital theory emerged in the 1960's primarily through the work of American economists like [51] and [52]. During this time, economists began making tangible connections between education and its impact on the ability of humans to earn higher wages. Shultz is credited for establishing the term "human capital" [53]. In his paper, "The emerging economic scene and its relation to high school education", Shultz was the first to write about the connections between education and productivity. Shultz identified people as the source of economic growth when other economists were attributing national growth to improvement in technology [54]. Shultz argued that traditional economists did not correctly calculate or consider the value of human knowledge. Jac Fitz-enz, in his book, "The R01 of human capital", considers all human abilities to be either innate or acquired. Every person is born with a peculiar set of genes, which determines her innate ability. Attributes of acquired population quality, which are valuable and can be augmented by appropriate investment, will be treated as "Human capital". The invaluable contribution of social capital to both individual and organization success has been acknowledged by several scholars. To find employment, one needs social capital in addition to human capital. Social capital explains who gets to the top of corporate America for instance [55]. It is also, what helps firms manage the cost of formal coordination mechanisms such as contracts, hierarchies, and bureaucratic rules [56]. For example, most contracts suppose a certain amount of good will that prevents the parties from taking advantage of unforeseen loopholes. In any case, it is often less efficient to incur the additional transaction costs involved in monitoring, negotiating litigating or enforcing formal agreements that try to specify all contingencies [56]. Generally, social capital often leads to greater efficiency than purely formal coordination techniques. Highly centralized, bureaucratized work places create much inefficiency due to delay in decision making and information distortions.

Contrary to human capital, which is a quality of individuals, social capital is a quality created between people [47; 55; 48; 57]. Social capital predicts that returns to intelligence, education and seniority depend partially on a person's location in the social structure [55]. While human capital refers to individual ability, social capital refers to opportunity. Some portion of the value a manager adds to a facility is his or her ability to coordinate other people. That is, identifying opportunities to add value within an organization and getting the right people together to develop the opportunities. Knowing whom, when and how to coordinate, is a function of a manager's network of contacts within and beyond the facility. Certain personnel relationships in and outside the facility can enhance the managers ability to identify and develop opportunities. Manager's with more social capital get returns to their human capital because they are in a better position to identify and develop rewarding opportunities than those with less [55].

## CONCLUSION

The public health system in Uganda has a mechanism for regular performance appraisals and development plans for all staff. However, evidence shows that the appraisals are inconsistent. Moreover, staff development activities are organized not in response to staff skills needs, but rather in an adhoc manner. Health service delivery is the backbone of any health system.

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