



WORLD BANK GROUP



Oxford Policy Management

Understanding Bottlenecks and Future HRH Challenges: Will Health Workers Remain Motivated in Timor-Leste?

June 2015

This briefing note presents the key findings and policy implications of the health worker survey implemented in all 13 districts of Timor-Leste in 2014. The survey was administered to 443 health workers.

The key findings are:

- Most of the health workers were intrinsically motivated
- The majority of respondents would like to continue working in the government/public sector, however, most of them would eventually prefer to be posted in higher tier facilities
- Wage differentials within each cadre were relatively small, and income did not vary much based on years of experience, particularly for doctors
- Workload was not too high, especially in rural health facilities
- In-service trainings were inadequate especially in rural health facilities
- Supervision were frequent

The following recommendations are based on the evidence gathered through this survey:

- Develop a long term Human Resource for Health plan to manage the career development expectation of health workers, particularly for doctors
- Ensure salary progression for doctors to provide an incentive to stay in public service as staff gain experience
- Provide necessary training for health workers, especially in rural areas
- Ensure more active and effective supervision of health workers

Background

At the time of independence in 2002, Timor-Leste had a seriously weak health system with only a handful of doctors in the country. At that time the governments of Timor-Leste signed an agreement and the Cuban Medical Brigade started to train medical students and deploy them in the country, particularly in rural areas. While the initial massive shortage has been minimised, there are concerns over more complex issues including facility functionality, rural retention and the motivation, preferences and competence of health workers.

The objectives of this study, conducted in 2014, were to understand (1) facility functionality; (2) health labour market dynamics among health workers, including the preferences, concerns and motivation of health workers; and (3) the skills and

competence of doctors. This briefing note presents the findings of the health worker survey, which investigated health labour market dynamics.

Methods

Doctors, midwives and nurses were sampled from all 13 districts of Timor-Leste. The sampling was conducted using systematic random sampling with probability proportional to size. The health worker survey questionnaire included modules on demographic characteristics, job history, preferences, views on the profession, current job, training, supervision and absenteeism. Three field teams collected the survey data during July and August 2014. The team also reviewed the existing government policies and guidelines to understand the benchmarks and compared the findings to them. Results were analysed using STATA, SPSS and

SAS. Weights were used to correctly represent the survey population.



Key Findings

Health worker characteristics

The survey was administered to 443 health workers (175 doctors, 150 nurses and 118 midwives). Among the sampled health workers, the majority (56%) were women, including 58% of the doctors, 36% of the nurses and all of the midwives. The distribution of the sample broadly coincides with the 2014 health worker census data obtained by the World Bank from the Civil Service Commission, which indicates that 53% of the health workers were female including 48% of the doctors, 37% of the nurses and 97% of the midwives. Since there were only a few doctors in Timor-Leste at the time of independence, almost the entire cohort of doctors was newly trained. Most of the doctors (96%) interviewed in the survey had less than five years of experience in the sector. Data also showed that the experienced health workers were working in higher tier health facilities.

Motivation and preference

The vast majority of staff selected medicine in order to help people and health workers indicated high levels of satisfaction: only 4% of respondents indicated they were “unsatisfied” or “very unsatisfied” with their work. Intrinsic motivation is also shown by the fact that eight in ten medical staff say they would stay in the facility until the last patient is treated – even if they do not receive additional money. However, this level of

motivation might change if private opportunities develop and increase in the future.

Table 1: Long-term Preference of Sectors

	Doctors	Nurses	Mid-wives
Public	99%	93%	96%
Private	1%	6%	2%
NGO	0%	0%	1%
Others	0%	1%	0%

In the long run, the majority of respondents would prefer to continue working in the government/public sector, including 99% of the doctors. This is also the case for the majority of nurses and midwives, although 6% of nurses would prefer to move to the private sector. HPs were the least attractive stations for medical staff, with only 6% of doctors choosing HPs as their long-term preferred facility type, although 32% were content to work in community health centres (CHCs). Only 22% see themselves working in rural *sucos* in the long term. The majority of respondents (97%) were not looking for another job in the short term.

Salary and financial benefits

The average monthly income of health workers was US\$ 505. The average salary was higher for rural health workers (US\$ 514) than for urban health workers (US\$ 500). The wage differentials within each cadre were relatively small, and income did not vary much by years of experience, particularly for doctors. On average, a doctor with more than 10 years of experience earned only US\$ 50 more per month than a newly joined doctor.

More than half of the health staff interviewed believed their salary to be too low. However, they did not see other preferable labour market opportunities. All medical staff receive their money through a direct deposit to their bank account and only very few (2%) have experienced any delays in receiving their money.

Very few reported working in private practice (but this may be under-reported). More non-financial benefits (such as housing and

motorbikes) are reported by doctors and at lower-level facilities. However, only half of respondents reported that they receive either sufficient fuel, or funds to buy fuel for the motorbike, and more than half of all respondents mentioned that these benefits are often delayed.

Workload

Although most respondents work five days a week in HPs, CHCs and district/regional hospitals (63%, 66% and 54%, respectively), 22% to 36% work six and sometimes seven days a week. The number of patients seen by the sampled doctors who participated in the direct clinical observation was counted; the mean number of patients per day was 10.2 with the standard deviation (SD) being 7.5. In urban facilities the mean (SD) patient load was 11.5 (6.9) compared to 9.6 (7.8) in rural facilities.

The number of patients also varied by level of facility, with higher-tier facilities having more patients. Despite of relatively low patient load, nearly half of the respondents agreed with the statement that they have “too much work to do.”

Table 2: Patient Load per Doctor per Day, by Type of Health Facility

	Mean	SD	Min	Max
Hospital	13.2	9.2	4	26
CHC	10.9	7.2	2	37
HP	8.5	7.4	1	28

Training

Almost all respondents believe that their training well prepared them to diagnose and treat clinical cases in Timor-Leste. Roughly half of the nurses and midwives reported attending three or more short-term trainings of less than thirty days duration and one-quarter did not attend any such training in the timeframe.

At the same time, roughly one-third (35%) of doctors attended three or more training sessions and around the same percentage (37%) attended none. Despite all the training opportunities, roughly half (52%) of

respondents agreed that, “there is not enough opportunity to learn.”

Although a large number of doctors are posted in rural areas, only 19% underwent training on community health. Around 75% of doctors indicated that they require training on IMCI and 64% on EmONC. The doctors located in urban areas were found to benefit more: roughly half (51%) of them attended three or more training sessions in the year preceding the study, as opposed to 26% in rural areas.

Older doctors or highly satisfied doctors tend to be less interested in any kind of training, while females are keener than males to opt for visits from specialists. Workers in HPs and CHCs are more interested in specialisation.

Highly satisfied doctors have a lower level of interest in all kinds of training. Older nurses and midwives, as well as those with more medical experience, tend to be more interested in any kind of training. Rural facility health workers are significantly more willing to finish their bachelor’s degrees.

Supervision

Eighty-five percent of respondents indicated that they have a supervisor who is responsible for providing feedback on their performance.

The majority of staff has supervisory meetings at least every three months, with urban-based staff having more meetings. Supervisors’ activities are heavily biased toward activities that support technical staff development and quality control: supervisors observe consultations, provide health instructions and ask knowledge assessment questions.

The administrative task of checking records is at the top of the list. Seventy-five percent of all respondents mentioned that they felt the need to discuss difficulties with their supervisor within the last year. There are no important differences between rural and urban facilities.

Challenges

Challenges facing health workers include: low salaries (63% agreed or strongly agreed), inadequate opportunities to learn (52%), lack of transport to see patients (50%), inadequate housing (48%), too much work (47%), security problems (39%), lack of supervision (30%), lack of feedback on performance (23%), and lack of motivation (20%).

Absenteeism

Due to the scope of the study unannounced health facility visits to collect robust data on absenteeism were not conducted, rather the team collected self-reported absenteeism data, which should be interpreted with caution. The data indicates that 8% of respondents reported being absent from work due to sickness in the 30 days prior to the interview. Five percent were absent for personal reasons in the same timeframe. In the event of an absence, roughly 13% of respondents stated that their facility head had called them. In 2% of cases money was deducted from their salary due to their absence.

Policy Implications

The study highlights some encouraging findings, including the gender balance of health staff (overall, if not within specific cadres), the concentration of doctors in rural areas, the high level of staff satisfaction with

their work and high intrinsic motivation, the positive intention to stay in the public sector and the relatively frequent and satisfactory supervisions that are reported. However, some areas require more investigation and investment, including:

- Planning for future HRH needs so as to ensure continuity of service. It is important since most of the health workers (especially doctors) wish to move to higher tier facilities. In addition, this large cohort of doctors, who were deployed in a short span of time, will leave a vacuum when they retire.
- Ensuring a salary progression for doctors that provides an incentive to stay motivated and perform. Otherwise experienced health workers will be demotivated, may leave the public sector or engage in dual practice.
- Arranging more frequent in-service trainings and visits from specialists for doctors who are working in rural health facilities.
- Improving the supervision of health workers to be more active and effective. To this end, government needs to have clear guidance and training on the purpose, procedure and reporting of supervision. The supervisory visits should focus more on improving performance through clear feedback and motivation.



This project was carried out by World Bank and Oxford Policy Management (OPM) with funding from the Australian Department and European Commission. The Ministry of Health of the Government of Timor-Leste provided support at every stage of this project. Dili Institute of Technology (DIT) was the local partner. Detailed results and interpretations are available in the full report, which can be accessed at www.worldbank.org/en/country/timor-leste. If you have any queries please contact Xiaohui Hou, Senior Economist, World Bank (email: xhou@worldbank.org) or Rashid Zaman, Consultant, Health Portfolio, Oxford Policy Management (email: rashid.zaman@opml.co.uk).