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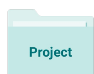

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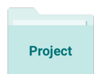

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Retaining and Motivating Health Worker in Very Remote Area of Indonesia, Do They Respond To The Incentives?

Ferry Efendi[1], Retno Indarwati[1], Anna Kurniati[2], Rizki Fitryasari PK[1], Ah. Yusuf[1], Susan Nancarrow[3]
[1]*Faculty of Nursing Airlangga University Surabaya Indonesia,* [2]*Center of Planning and Management of Human Resources for Health-Ministry of Health Indonesia,* [3]*School of Health and Human Sciences Southern Cross University Australia*

***Abstract*— Adequate Human Resources for Health (HRH) are crucial to the delivery of health care services in very remote areas of Indonesia. However, very remote areas suffer shortages in terms the number, type and quality of staff. This situation must be addressed through innovative policy, planning and implementation, such as incentives for retaining and motivating health workers. This paper aims to assess the application of an incentive scheme based on working location. The role of decentralized local government on incentives given to health workers also will be discussed. A desk study was performed from a relevant published materials, MoH database and online literature. The document highlights the importance of financial and non financial incentives. However, financial incentives alone are insufficient to retain and motivate the health workforce. Incentive systems must be integrated within the health system, in line with the goal and objective of Indonesia's health development. The role of local leadership under decentralization is also crucial to motivate and maintain staff in the workplace. Different incentives between contracted and permanent staff in very remote areas must be established to ensure sustainability of the program.**

***Index Terms*—health worker, very remote area, incentives, Indonesia, human resources for health**

I. INTRODUCTION

Providing health care to very remote communities in Indonesia has long been a major concern. Lack of health workers particularly in rural, remote and very remote areas has hampered community access to good quality of health services, which in turn impacts on the health status of the population[1]. One of the main problems is retaining and motivating providers to deliver health care services to those living in remote and very remote areas. Indonesia, as with other asian countries, has critical shortages of health workers, particularly physicians, nurses and midwives [2]. Thus, it became a priority for the Government of Indonesia to increase access to underserved communities as stated in the public health reform roadmap [4] . Regarding access to basic health care services, of Indonesia's 497 district/cities, 83 districts located within 27 provinces lag behind; and 92 districts in the outermost small islands and 34 small outlying islands do not have even basic services [3].

Data from Ministry of Health of the Republic of Indonesia (MoH, 2006) found that approximately 30 % out of 7,500 health centers in remote areas were without medical doctors. Further findings were reported during the *Identification of the Need of Health Workers* conducted by Center for Planning and Management of Human Resources for Health - MoHRI (CPMHRH) in May 2006 [4]. The study involved 78 districts in 17 provinces of Indonesia. The report found that of 1165 health centers, 364 health centers (31%) are located in remote/underdeveloped/borderland/conflict and disaster areas and other undesirable areas. About half of the 364 health centers reported having no medical doctors, 18% were without nurses, 12% were without midwives, 42% were without sanitarians, and 64% without nutritionists. Compare to the health centers in ordinary areas, the absence of those types of health workers are much lower, for example, only 5% health centers were without medical doctors [4].

The reasons health workers choose not to go to these areas include; transportation and communication problems, lack of basic and social facilities, low salary, low or no compensation, high living cost, lack of security and unclear career options [1].

This paper aims to provide a brief description of the application of an incentive scheme for staff working in very remote areas. Implementation of a decentralized system and its impact on incentives will also be described.

Manuscript received October 19, 2012. This work was supported in part by Faculty of Nursing Airlangga University Surabaya Indonesia.
F. E., R.I, R.F., A.Y., Author is with Faculty of Nursing Airlangga University Surabaya, Jl Mulyorejo Kampus C, Indonesia (e-mail: fefendi@ indonesiannursing.com).
A. K., Author is Head of Sub Division Migrant Health Workers, Ministry of Health Indonesia and member of Country Coordination and Facilitation (CCF) of National Health Workforce Indonesia (e-mail: annakurniati@gmail.com).
S.N, Author is a Professor of Health Sciences, School of Health and Human Sciences Southern Cross University Australia (e-mail: susan.nancarrow@scu.edu.au).

DOI: 10.5176/2251-3140_2.1.24

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II. CURRENT SITUATION OF HUMAN RESOURCES FOR HEALTH

The Public Health Reform Roadmap by the Ministry of Health prioritised reforms in the areas of health care financing; drugs and health equipment availability; health management in the remote, country borderline areas and outer islands including human resources for health (HRH); and healthcare services. In the Ministry of Health Strategic Plan 2010-2014 [20], HRH development is one of the top eight priorities. It includes several strategic activities such as HRH planning and management, pre-service and in service training, HRH quality including registration and certification and other management and technical support for HRH development program [5].

Recent data on the HRH profile of Indonesia shows that the ratio of health workers has increased from 1.42 per 1000 population in year 2009 to 2.11 per 1000 population in year 2010. The largest category is nurses with 160,074 and the smallest is physiotherapists with 2,587 [5].

TABLE I Health worker/population ratios at national level [6]

Category	**2009**		**2010**	
	Number	***HW/1000 population***	***Number***	***HW/1000 population***
Medical Practitioners	34,544	0.15	41,322	0.17
Dental Practitioners	12,673	0.05	21,197	0.09
Pharmacy practitioners	10,778	0.05	18,022	0.08
Nursing and Midwifery practitioners	205,220	0.89	268,385	1.13
Non-Medical Public Health Practitioners	176,632	0.76	207,692	0.87
Other Health Workers	1,774	0.01	2,749	0.01
Health management and support staff	60,116	0.26	110,466	0.46

The general migration of people from rural to urban areas is reflected in the health workforce. Many health workers prefer to work in big cities for economic reasons. Therefore, there is an unequal distribution of health workers across the provinces. The largest health workforce is in Java-Bali, but outside these areas, the workforce varies. The most recent World Bank health workforce review found that in Java-Bali there is 1 doctor per 3000 people in urban areas, while in rural areas it is only 1 doctor for every 22,000 people. Outside Java-Bali, the doctor - population ratio is higher, but still only 1 doctor for every 12,000 people in rural areas, and 1 for every 15,000 people in remote areas, while urban areas have 1 doctor for every 2,430 people [2].

III. HRH IN A DECENTRALIZED SYSTEM

Enactment of the law on local autonomy in 1999 marked the beginning of the decentralized system in Indonesia, but implementation of this system was interpreted differently by each level of government. Districts perceived that transferring autonomy gave them more independence in regulating and managing their own affairs, including health. As a result, districts with abundant resources and good leadership have strong fiscal capacity and have been able to provide additional incetives and some privilleges to the health sector.

Decentralization resulted in devolved authority for the management of human resources, including the provision of incentives for personnel. It was expected that by providing financial incentives out of salary, the motivation of personnel would improve. The incentive levels vary depending on the financial ability of the local government. For example, the incentives for specialist doctors range from Rp. 3,5 million IDR to Rp. 12 million IDR (1 USD=±9000 IDR[1]) per month. Some local governments provide a meal allowance, housing and vehicles or means of transportation. But not all local governments are able to provide those incentives. Many districts, especially newly developed areas, are still financially dependent on the central government. As a result, there is some variability in the preferences for different remote and very remote areas for health personnel. Since May 2006 the MoH introduced new policies to attract more health workers to remote and very remote areas. These include shortening the service period and increasing the financial incentives for the contracted staff (PTT) medical specialists, doctors, dentists and midwives. The minimum service for PTT doctors and dentists in very remote areas is 6 months while in remote areas it is 1 year. Financial incentives are only given to those working in very remote areas and arranged as follow:

- Medical Specialist : Rp 8. 300.000,00/month
- Doctor/dentist : Rp 5. 800.000,00/month
- Midwife : Rp 2. 700.000,00/month

These policies are applied evenly to all PTT workers in very remote areas regardless of geographic barriers, availability of supporting facilities and other factors. The MoH RI provides a general definition that a remote/very remote area is difficult/very difficult to reach due to geographical conditions (islands, mountainous, land, forest and swamp), transportation and social culture.

The policy also created a further location category: "favorable" and "non favorable" areas. The favorable areas were marked by the higher number of applicants, the waiting list of PTT, length of the working contract, and the low turnover of staff in one place. Although most of favorable areas were in urban locations, there were also some remote areas included in this category. Favorable rural areas appeared to be those that were economically attractive to PTT, such as having logging or oil plantation companies, providing more opportunities to generate income from dual practice i.e. as a public employee and a private practitioner. There are currently 32,978 health workers actively working as contracted staff (Table 2).

Remoteness is determined by the local government, not the MoH, resulting in different interpretations of the characteristics of each area. Consequently, areas with similar characteristics may be considered remote or very remote by different local governments. For this reason, the regulation

[1] IDR=Indonesian Rupiah

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around the shortened service period in very remote areas varied slightly. The service period for favourable locations remains at one year while the service period for non-favourable locations remained at 6 months.

Table II. Contracted staff year 2010 [12]

No	Profession	Criteria			Total
		Common	*Remote*	*Very remote*	
1	Doctor	364	676	1,980	3,020
2	Dentist	126	119	659	904
3	Specialist (doctor/dentist)	6	60	20	86
4	Midwife	17,332	11,636	-	28,968
	Total	17,828	12,491	2,659	32,978

Table 2 shows that a substantial number of doctors and dentists serve in very remote areas compared to remote areas. This may be due to the different incentives, different policies from district to district and economic motives [13].

Retaining health workers has become a priority for the Indonesian government. As a result, the MoH has implemented several policies:

1. Scholarships to upgrade education level (training in medical specialists, community health midwives, and nurse specialist/medical specialist assistants).
2. Encouraging district governments to use the Special Allocation Funds (Dana Alokasi Khusus/DAK) from the central level to improve health facilities (including equipment and vehicles) and housing for health personnel in very remote areas.
3. Career opportunities:
   After completion of the PTT service, staff had 3 choices: (i) continue with their education to become a specialist; (ii) become a civil servant (PNS) by taking the PNS examination [7]; or (iii) or go into the private sector. General Practitioners in very remote areas have a 90 % chance of getting into the PNS after completion of their service; General Practitioners in remote areas have a 50 % chance while those serving in ordinary areas have only 10% [2].

The MoH provided scholarships for 134 nurses, 80 midwives and 700 medical doctors in 2008. Scholarships were made available for health workers who were willing to return to their rural post for maximum 2n (n=length of study) years or those willing to be posted to rural and remote areas. Preference for selection of applicants was given to health personnel with PNS or post PTT status, having at least 2 years' experience, and those working at health facilities outside Java-Bali. The selection process took place in two stages; at the provincial level and then at the central level. Candidates who passed the administrative selection may be required to undertake academic selection in education institutions.

In addition, some local governments offer scholarships for local people to attend medical and midwifery training (Diploma 3 level or 3 years schooling after high school). This policy has been seen to be an effective way to retain health workers. A tracer study on fellowship participants conducting by Fifth Health Project, MoH in year 2004, found that 99.4% of 1578 alumni in MoH, Central Java, Central Kalimantan and South Sulawesi returned to their original provinces after completion of their studies. About 74% returned to their original working place (Figure I). The minimum length of this service was twice of the length of study or minimum of 3 years [8].

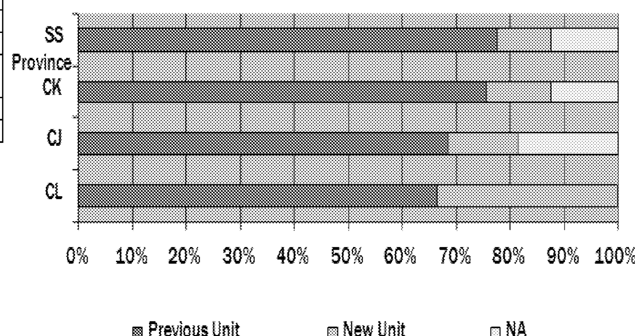

Figure 1 % Unit Redeployment of PA graduates by Province

According to various studies monitoring health personnel retention, becoming a civil servant was one of the main reasons that many contract health workers stay working [9], [10]. State Ministry for State Apparatus (MENPAN) identified that the number of contract personnel awaiting transfer to PNS was 78,576 persons, mostly contracted at the local level [11]. Employment as PNS was still attractive to many. In 2006, 26,490 applicants competed for 1,745 posts as health personnel at various health services managed by MoH. During monitoring visit by an MoH team to two districts in 2009, most contract health workers (nurses and sanitarians) said that their career aspiration was to be employed by the PNS [12]. There was no reliable documentation on how many PTT doctors converted to PNS status during that period and whether in fact this attracted graduates [2].

Internationally, financial and nonfinancial incentives are widely used to recruit, retain and motivate employees, including health staff [14-17]. The rural retention program introduced by the Australian Goverment, for example, has succeeded in retaining 65% of the health workforce through incentive programs [17]. Other studies have shown the positive effects of financial incentives on increasing the attractiveness of rural areas. A survey in Thailand found that salary increases, better housing provision, extended medical coverage and accelerated promotion have a significant success [18]. In line with other findings, a study conducted in the Indonesian province of Papua also highlighted the importance of financial incentives on staff retention [19].

CONCLUSION

In conclusion, various incentives, financial and non financial have been implemented. However, the impact on the performance and reduction on unavailability certain health workers needs further study. Fair incentive systems should be developed, as there is no difference in payment between medical workers who continuously serve in the location and

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those who leave the working location for long time. As this policy is only applied to selected types of health personnel, it may caused demotivation among other types of health workers in the same location. Strengthening the capacity of local government might contribute to improving the HRH situation with a clearly defined role between central and local government in the provision of incentives.

ACKNOWLEDGMENT

We would like to express our gratitude to Faculty of Nursing Airlangga University for partial funding.

REFERENCES

[1] Kurniati A & Efendi F. (2009) Viewing Decentralization as an Opportunity: In Improving Availability of Health Workers in Underserved Areas. Joint WHO/Asia-Pacific Action Alliance of Human Resources for Health Conference, November 2009, Hanoi, Vietnam

[2] Bank W. In Indonesia's Doctors, Midwives and Nurses; Current Stock, Increasing Needs, Future Challenges and Options Jakarta: World Bank; 2009.

[3] AAAH: Annual Review of HRH Situation in Asia Pacific Region 2006-2007. Thailand: AAAH; 2007

[4] Kurniati A, Efendi F: Kajian Sumber Daya Manusia Kesehatan. Jakarta: Salemba Medika; 2012.

[5] Kurniati A, Efendi F. Human Resources for Health Country Profile of Indonesia. WHO SEARO

[6] BDEHRH. 2010. HRH Registration 2010. Jakarta: MoH

[7] Heywood PF & Harahap NP. 2009. Human Resources for Health at The District Level in Indonesia: The Smoke and Mirror of Decentralization.

[8] The Fifth Health Project – MoH. The Final Evaluation Report on Fellowship Program. 2004

[9] Chomitz K.M.et al. What do Doctors Want? Developing Incentives for Doctors to Serve in Indonesia's Rural and Remote Areas. 1998.

[10] Ministry of Health of Indonesia. Draft of Policy Paper on Distribution of Human Resources for Health. 2002

[11] State Ministry for State Apparatus (MENPAN). Provision of Formasi PNS to Improve the Health Personnel Need. Workshop Proceeding on Health Workforce Planning. 2008

[12] *Sedyaningsih ER.* Strategi dan Kebijakan Kementerian Kesehatan Menuju Universal Coverage dan Pemenuhan Serta Pemerataan Fasilitas Tenaga Kesehatan. (Online) 2011. Available: http://www.kebijakankesehatanindonesia.net/sites/default/files/images/Paper-Bu-Menkes.pdf (Accessed 20 March 2011)

[13] Efendi F. 2012. Health Worker Recruitment and Deployment in Remote Area of Indonesia. http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=2008

[14] Hanson K, Jack W. Incentives Could Induce Ethiopian Doctors and Nurses To Work in Rural Setting. Health Aff August 2010 29:81452-1460

[15] Dieleman M et al. Identifying factors for job motivation of rural health workers in North Viet Nam. Journal of Human Resources for Health, 2003, 1(10): 1–10.

[16] Iipinge SN et al. Perceptions of health workers about conditions of service: A Namibian case study. Harare, Regional Network for Equity in Health in Southern Af -rica (EQUINET), 2006 (Discussion Paper No. 35) (http://www.equinetafrica.org/bibl/docs/DIS35HRiipinge.pdf, accessed 15 August 2012).

[17] Gibbon P & Hales J. Review of the Rural Retention Pro-gram – Final report. Australian Government, Depart -ment of Health and Ageing, 2006. (http://www.health.gov.au/internet/main/publishing.nsf/Content/751B9B296D05A4C8CA25741E0079E487/$File/review.pdf, 15 August 2012).

[18] Pagaiya N et al. Discrete Choice Experiment To Elicit Job Prefence of Newly Graduated Nurses. Third AAAH Conference: Globalization and its Implications for Health Care and Human Resources for Health, October 2008

[19] Remco Van De Pas. Human Resources for Health, Opportunities and Challenges in The Indonesian Province of Papua. Royal Tropical Institute-The netherland. Thesis. 2010

[20] Kemenkes. 2010. Rencana Strategis Kementerian Kesehatan 2010-2014, Keputusan Menteri Kesehatan RI No. HK.03.01/60.I/2010. (http://www.perpustakaan.depkes.go.id:8180/handle/123456789/703 accessed 13 October 2012)

Fery Efendi. Author is a lecturer at Faculty of Nursing Airlangga University Surabaya Indonesia. He was born in Lumajang, East Java province of Indonesia on February 18 1982. His highest degree is Master of Science in healthcare administration. He was a co-author of the Country profile of Indonesia's book and Human Resources for Health in Indonesia (HRH) book.

Retno Indarwati, RiZki Fitryasari PK, Ah. Yusuf is a lecturer at Faculty of Nursing Airlangga University Surabaya Indonesia. They are the department of Community Health and Mental Health Nursing. Ah Yusuf is the head of the Indonesian National Nurses Association East Java Province.

Anna Kurniati is the Head of Sub-division of Migrant Health Worker, Center of Planning and Management of Human Resources for Health, Ministry of Health, Indonesia. She has extensive experience dealing with the distribution of the health workforce within the country and working with alliance of Human Resources for Health.

Susan Nancarrow is a Professor of Health Sciences, School of Health and Human Sciences Southern Cross University Australia. She is Director of Research and Editor in Chief of the 2012 Global Healthcare Conference.

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