

# Will They Stay or Will They Go? Putting Theory into Practice to Guide Effective Workforce Retention Mechanisms

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## Abstract

Policy makers in healthcare in all countries are faced with challenges of designing and implementing strategies that will achieve three major and essential goals: produce enough health workers for a cost-effective skills mix to deliver high-quality care; attract trained health workers into the workforce; and deploy health workers where they are most needed and keep them there. Yet these apparently straightforward strategies are seldom wholly successful, and there is little clear evidence to guide the frustrated policy maker.

This paper explores the reasons why it may be so difficult to come up with strategies that guarantee success and looks at what we do know about attracting, retaining and motivating health workers to get them and keep them working productively where they are most needed.

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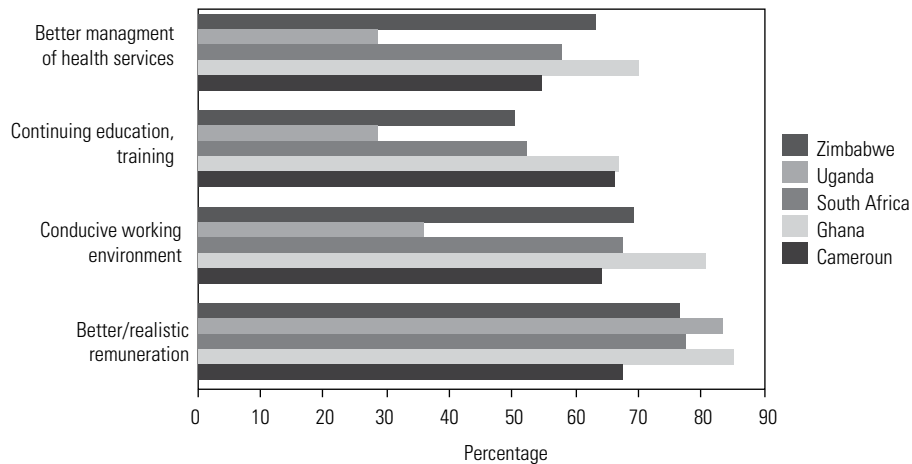
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**Work and Motivation**

The psychology of motivation as it relates to work is complex and has been studied since the beginning of the 20th century. Motivation (in the context of work) is defined as “the individual’s ability to exert and maintain an effort towards organizational goals” (Franco et al. 2002: 1255-6). What complicates the formulation of strategies to motivate workers is that motivation and job satisfaction are two different things. When someone is satisfied with their job, they are not necessarily motivated to perform well. In a seminal study in the 1960s, Herzberg demonstrated that different factors result in job dissatisfaction and motivation (originally published in 1968 and republished in Harvard Business Review Book [HBRB] 1990). Herzberg called this the “Two-Factor Theory.” The first set of factors do not necessarily lead to job satisfaction. However, the absence of these “hygiene factor[s]” (using Herzberg’s original terminology) may lead to job dissatisfaction. These include company administrative policies and behaviours, relationships with supervisors, working relationships and compensation. However – and this is the heart of the complexity of the issue – modifying these factors did not increase motivation but reduced job dissatisfaction. Factors that increased motivation, or motivators, included achievement, recognition, responsibility and the worthwhile nature of the work itself.

The implication of Herzberg’s theory, which has been tested by others in 12 countries in the intervening years (Vroom 1990), is that problems of workforce retention will have to be addressed by changing factors different from those that lead to poor performance, though the two sets of factors are linked. Herzberg’s Two-Factor Theory is supported by many studies of health worker motivation undertaken in the past decade. For example, Awases et al. (2002) questioned health workers in five countries about the reasons why they were considering leaving their jobs. The four most highly rated reasons are shown in Figure 1.

**Figure 1: Most highly rated reasons health workers were considering leaving their jobs (Awases et al. 2002)**



All of the factors listed are aligned with satisfiers, that is, their absence can lead to dissatisfaction. Changing them for the better – increasing pay, for example – can result in better retention of workers, though not necessarily better performance at work. However, there are likely to be overlaps with motivating factors that derive from professional development and a good working environment. In essence, decreasing the dissatisfiers will mean having a more satisfied workforce but not necessarily one that is satisfied enough to be motivated or feel valued.

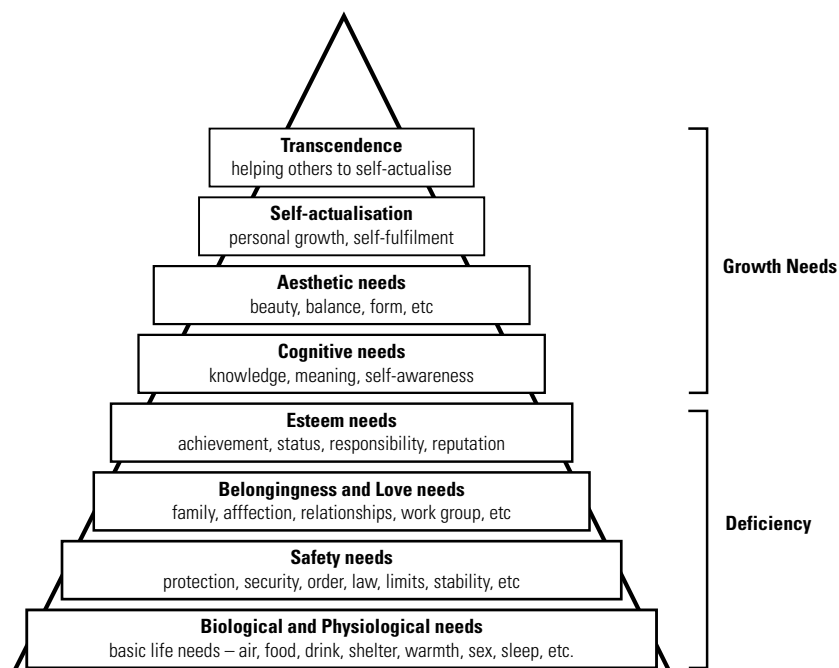
What Herzberg theorized – and what remains important in the health sector today – is that even if work-related satisfiers are addressed, so that working conditions are good and pay is adequate, the individual motivation of health workers is what will drive productive performance. Motivation is influenced, too, by perceptions of equity in the workplace. An individual will consider that he is treated fairly if he perceives the ratio of his inputs to his outcomes to be equivalent to those around him at the same level. So it is not only salary level that is important in motivation, but also how it relates to that of peers.

In many low-income settings, studies have shown that the time health workers spend on productive activities may be just over half of their working day (Adano et al. 2008; Kurowski et al. 2007; Ruwoldt et al. 2007). The reasons for poor productivity among health workers may be related to poor job design – for example, Kurowski et al. cite absence of patients in rural clinics, which means that for long periods health workers have nothing to do. Another reason may be having too few health workers, which results in burnout, stress and thence poor motivation among those who are having to work harder. Tackling the complexities of unproductive time could result in a potential productivity gain of 20%, or one day a week, from the existing health workforce. This is important where there are shortages of health workers; increasing the number of staff through better retention is an important strategy, but so is ensuring that existing staff are working productively to achieve the goals of the health system. Hence, for the health policy maker there will be greater efficiencies in tackling both the environmental factors that influence job dissatisfaction, such as poor conditions of work or bad job design, together with the individual motivators, such as equity, that influence health worker productivity.

### Where to Begin?

The key to unravelling all of these factors lies in understanding another theorist, Maslow, who proposed a hierarchy of human needs based on two groupings: deficiency needs and growth needs (see Figure 2).

Figure 2. Hierarchy of human needs (1990s eight-stage model based on Maslow)



Within the deficiency needs, each lower-level need must be met before moving to the next higher level, and an individual will only act on growth needs if deficiency needs are met. (See Huitt 2007 for a discussion of Maslow's hierarchy.) For a health worker, this means that when basic deficiency needs are met – needs such as food, water, housing and a sense of belonging – there will be an ability to learn and grow. Providing a health worker with no or poor housing, or posting someone to a remote area where they have no family close by, can result in a lack of motivation to perform well, be productive or learn anything new. In addition, it means that there will be problems with keeping health workers, as the deficiency needs align with Herzberg's satisfaction factors.

### **Putting Theory into Practice**

The lessons from these classical studies remain relevant to today's health policy maker. Firstly, health workers will neither be retained nor be maximally productive unless their basic needs are being met. Having a basic need met is not a motivational incentive: it is a factor that reduces job dissatisfaction.

Basic needs will include a salary sufficient to pay rent, utilities and food bills, and hence the salary has to be paid on time and for every pay period. In addition, using Maslow's hierarchy, basic needs will include safety at work and having relationships – family or otherwise – that are meaningful, along with higher-order needs such as being able to exercise responsibility and having a sense of achievement and some status in society. Though it may be tempting to think of the latter measures as motivators, they are not; they are satisfiers, and their absence will result in job dissatisfaction and probably attrition. Their presence will create work satisfaction and a foundation upon which motivators can be introduced.

Dambisya (2007) comments on the swift and dramatic effect that incremental salary increases can have on recruitment and retention. In Swaziland, a 60% salary increase resulted in many workers immediately opting to stay in the public sector, while in Malawi a 52% pay increase for health workers stopped them from leaving their posts within a few months. What characterizes these particular cases is that they come from the public sector in low-income countries, where public sector salaries may be too low to pay for a family to live in comfort. This is why Herzberg's theory remains important – increasing salary may only reduce dissatisfaction rather than increase motivation. A huge salary increase may keep people in the public sector but not motivate them to work any harder. In addition, raising salaries to this extent is not without problems for the policy maker. Clearly it is an expensive option to implement and maintain, but it is also a strategy that has to be reviewed constantly to ensure that it continues to meet basic needs with inflation and increases in living costs. At the same time, there is a danger that financial incentives can become dissatisfiers if not carefully handled; if, for example, I get a \$1,000 bonus this year and a \$500 bonus next year, I have received bonuses for two years. But because the second bonus is less, it can seem like a pay cut and therefore become demotivating.

The challenge for the thoughtful health-workforce-strategy developer is to understand what is causing dissatisfaction and demotivation in the health workforce and begin by meeting basic needs, then to review this strategy regularly to ensure that it is still working well. Enough of these basic needs have to be met for motivators to be effective (McCaffery et al. 2009).

### **Combinations of Satisfiers and Motivators**

Most studies of health workers' views on their work reveal a combination of factors that cause both dissatisfaction and loss of motivation. In a study in Mali, Dieleman et al (2010) surveyed and interviewed more than 400 health workers to elicit what motivated and demotivated them (and these were the terms the researchers used). Table 1 shows the top factors identified in both categories.

Table 1. Health worker motivators and demotivators (Dieleman et al. 2010)

Motivators	Demotivators
Feeling responsible	Lack of materials
Increase in salary	Lack of recognition
Receiving training	Difficult living conditions
Being held accountable	Lack of a job description
Being appreciated	Subjective performance appraisal
Promotion	Poor management
Getting incentives	Partner living far away
Team spirit	Poor functioning of [local administration]
Having a partner living near the workplace	Living far from an urban centre
Having good colleagues	Being far from the place where decisions are made

Developing successful combination strategies requires a reduction in the dissatisfiers as well as creating a motivating environment. Meeting basic needs is essential, as discussed in the previous section; pay increases, being with family, being appreciated for work and having tolerable living conditions would all fall into this category. Salary features in the factors identified by health workers as being motivating. Without being able to ask more questions, it is difficult to know whether this answer was because salary was insufficient to meet basic needs. But would an increase in salary have meant only that people stayed in their job, rather than increased the level of their performance? In low resource settings, more investigation is needed to clarify the role that money plays in motivation.

Other factors identified as motivating, such as being held accountable, being appreciated and feeling responsible resonate strongly with findings from Herzberg's studies (Vroom 1990). Herzberg cautioned managers against "loading jobs horizontally," by which he meant giving workers more of the same tasks to do but without increasing their autonomy or control over their work, thus "increasing the meaningless of the job" (Herzberg quoted in HBRB 1990: 60). Instead, Herzberg suggests vertical loading, enriching jobs by increasing responsibility and accountability. Among the examples he gives are allowing assistants who write letters to be responsible for creating, checking and signing them; giving a worker more difficult and complex tasks to do, supported by training; allowing workers to become experts in one area by allocating that to them; and giving feedback directly to the worker on performance improvements. Interestingly, this aligns well with recent work by Pink (2010). He asserts that the conditions necessary for highly motivated workers are related to three factors: autonomy, as discussed above; mastery, by which he means being able to be creative and to show real excellence in performance; and flow, which refers to having clear goals and a sense of being able to accomplish them. Pink cites an example from a study of hospital cleaners, nurses, and hairdressers. It was found that some members of the cleaning staff at hospitals, instead of doing the minimum the job required, took on new tasks – from chatting with patients to helping make nurses jobs go more smoothly. Adding these more absorbing challenges increased these cleaners' satisfaction and boosted their own views of their skills. "By reframing aspects of their duties they helped make work more playful and more fully their own" (Pink 2010: 117).

What is needed to improve most health systems is a strong management system and encouragement of creativity and leadership. Sadly, in many low-income countries, management systems remain weak and leadership is not developed (Adano et al. 2008). Enriching jobs requires performance support, training and supervision, and managers able to do this are rare in low-income settings (and not all that common anywhere).

### Moving Forward

So what can the policy maker, strategy developer and manager use from the theories and research? While there is a growing evidence base of what has been implemented to increase productivity and improve retention, the evidence is largely weak, as it has not been tested on a large scale, nor within different contexts and with varied populations. Certainty of success in designing retention strategies remains elusive, but, at the same time, the research that has been done for several decades does point to some conclusive findings. It is now clear that financial incentives cannot be a complete or a sustainable way of motivating health workers (Bennett and Franco 1999). A combination of incentives is needed that address basic needs, such as for housing, food, safety and affection, as well as the human need to be appreciated for work and to have interesting and meaningful work.

Progress has to be made incrementally (see Figure 3) and based on knowledge of what are the satisfiers and motivators in a particular context. There are now many methods available to survey health workers' motivation, including Discrete Choice Experiment (Jaskiewicz et al. 2010), which bundles and ranks preferences and may have predictive strength. But the real key is to ask health workers what influences their behaviour, no matter what tool is used. In itself, such a survey can be motivating, as it shows interest and concern for the health worker. But if nothing changes as a result of a survey, it can also be demotivating.

**Figure 3. A sequence for incremental improvement (McCaffery et al. 2009)**

- Low job satisfaction
  - Identify the main dissatisfiers (beyond salary)
  - Target specific incremental actions
- This gradually minimizes the dissatisfier, and over time turns it into a satisfier
  - Identify the main motivator(s) – soliciting health worker perceptions is helpful here
  - Target specific incremental actions to enable motivators to work
- Outcome: Improved retention and performance

Unfortunately, findings on successful implementation are missing from the research on health worker motivation. There are many assessments but few large-scale evaluated studies that have looked at the results of implementing changes based on the assessments. Stronger and more strategic human resources leadership capacity within ministries of health is needed to support better management to champion a strategic focus on satisfiers and motivators – to formulate the policies, shape the budgets and identify and help implement targeted improvements. As long as strong management is missing, there is little chance of large-scale implementation of changes.

The good news for policy makers, and those with the budgets to dispense, is that many strategies that will motivate health workers will not cost much financially. But these are perhaps the most important element of all for the health workers themselves: putting in place appraisal mechanisms to acknowledge excellence or delegating decision-making authority so physicians and nurses feel responsible, enriching their jobs and giving them importance and meaning.

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