Public service reforms and their impact on health sector personnel in Jordan

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Preface

Over the past decade many countries have undergone public service reforms of some kind, however the consequences for employment and working conditions in the health sector have hardly been documented. This gap in information needs to be addressed, as any public service reform should be judged in terms of its influence on various sectors. The health sector is in most countries predominantly a public sector and therefore influenced by public service reforms. Achievement and improvement in the health sector are crucially dependent on the performance of staff at all levels which, in turn, is intimately related to their general employment and working conditions.

In 1998 the International Labour Office (ILO) and the World Health Organization (WHO) therefore launched a joint research programme to document selected reform processes and detail their impact on health care personnel. The lessons drawn from the individual cases are designed to assist international advisers, governments and organizations of civil society to implement more effective health sector reforms. Six countries from different regions of the world were selected as the focus for this international research (Cameroon, Colombia, Jordan, the Philippines, Poland, Uganda) and studies on public service reforms and their impact on health sector personnel in these countries were carried out in 1998 and 1999. Colombia and Uganda served as pilot country studies in 1998 and the other country studies followed in 1999. They all were discussed at an international round table. The Public Administration Promotion Centre of the German Foundation for International Development (DSE), Public Services International (PSI) and the International Council of Nurses (ICN) together with their affiliates assisted this joint effort of WHO and ILO throughout the whole process by providing technical advice and information at national, regional and interregional levels. The reasons for ILO and WHO launching this programme had different origins, but led to the same interest in the theme for the joint programme.

The 1998 sectoral meeting on health services requested the ILO to facilitate the exchange of experiences among countries through regional meetings and network arrangements of representatives of employers, workers and governments and to facilitate research activities on the impact of reform processes on the workforce. The joint programme with the WHO and the round table were a first response to these requests. For the ILO, this programme contributes to the follow-up of a series of sectoral meetings on reforms in both the health services and the public service sectors which concluded that "reforms are most likely to achieve their objectives of delivering efficient, effective and high-quality services when planned and implemented with the full participation of the public sector workers and their unions and consumers of public services at all stages of the decision-making process. Continuing dialogue between governments and the citizenry as a whole, including public sector workers, should be ensured" (1995) and that successful "health care reforms cannot be imposed from above and from outside" (1998).

For the WHO, the study of the impact of public sector reforms on health human resources is part of a programme to better understand the environment, factors and conditions that have an impact on health workers. With these data and information, discussion papers have been developed and disseminated to enable and increase debate on the key issues. These issues include: education and training, motivation of health care providers, policy development, planning, recruitment, retention and deployment. The

research is intended to provide the basis from which policy options can be developed for use by decision-makers in different countries. The WHO's workplan in the area of health workforce, education, performance and policy includes:

- a review of the changing roles of health professionals in many countries, through a reprofiling of different methods of health provider mix under different institutional arrangements;
- strengthening national capacity to use existing computer-based tools for health workforce planning and management;
- development of a set of standards for quality in the education of health workers;
- development of a set of policy options for improving provider performance;
- direct country support in overall human resource policy development and more specifically in nursing educational issues.

The WHO is working with countries as well as bilateral and multilateral partners in forwarding this agenda.

At an international round table of experts hosted by the DSE in October 1999 in Berlin, the experiences documented in the country studies were analysed and complemented. This round table was attended by the authors of the country studies, representatives of governments, private employers' and workers' organizations from the countries, as well as by officials from the organizations cooperating in this programme. The result of the discussions was the formulation of critical questions which were meant to facilitate the design, implementation and evaluation of human resource policies in public service and in particular health sector reform. This set of "Critical questions for initiating and reviewing public service reforms" is published in the report of the round table in Berlin in October 1999 and can be obtained from the organizers. With the present working paper the ILO and the WHO make also available the full text of the country studies which were revised by the authors in the light of discussion at the round table in Berlin. The opinions expressed in the studies are those of the authors and not necessarily those of the ILO and the WHO. Working papers are preliminary documents circulated to stimulate discussion and obtain comments.

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Executive summary

Jordan is a developing country with a population of 4.4 million, a growth rate of 4.7 per cent per year, and a fertility rate of five children per woman. The age distribution is typical of many developing nations with most (42 per cent) under the age of 15 and very few persons over age 65. Jordan experienced a major economic crisis in 1988 and 1989 when foreign exchange reserves fell precipitately, the stability of the Jordanian dinar (JD) exchange rate was shaken, and the external debt burden and the inability to service it became apparent. The country has small, limited natural resources, chronic water shortages, limited arable land (5 per cent), and must import virtually all energy resources. The recent worldwide recession coupled with repeated migrations into the country have adversely affected the economy resulting in a major decline in income, high inflation, and an increase in unemployment and poverty. In addition the country has a high debt level.

Drastic declines in death rates and continued high birth rates coupled with the shifting composition of illness away from infectious diseases to non-communicable diseases shape Jordan's population and epidemiological circumstances. The population will continue to increase for decades even if fertility rates decline and the number of old-age dependants will steadily increase. The percentage of the population 65 years and older is projected to increase from 2.7 per cent to 3.9 per cent in 2015,while the population 15 years and under is projected to decline from 42.4 per cent to 33.6 per cent. These factors all place extra demands on the government health care services and have impacted and will continue to impact on national institutional capacities and capabilities (for health data, see appendix).

The current unemployment rate is 13.3 per cent and approximately 14 per cent of the population live under the poverty line. The dependency ratio is 1:4 according to the 1997 MOH statistical report. While per capita income rose from US$1,172 in 1990 to US$1,723 in 1997, the cost of living index increased by 20 per cent in 1997. The national Government controls most community services and a strong commitment is given to health, education and other social programmes. In 1997, health expenditure in Jordan was estimated at JD375 million which, compared to other countries of comparable income, is high.*(1, 2, 3)*

Different initiatives and efforts related to public service have been emphasized through the country five-year plans. For example policies relating to the civil service in the Five-Year-Plan of 1993-1997 were mainly presented under the public administration section. The Five-Year-Plan of 1993-1997 addressed the economic and social development issues for the country. The main and immediate goal of the previous plans was to achieve economic growth. Under the Five-Year-Plan of 1993-1997, growth was seen as a natural result of policies aimed at realizing fiscal and monetary stability, creating an appropriate investment environment and building confidence in the performance of the national economy.*(1)*

The Five-Year-Plan of 1993-1997 aimed at providing a greater role to the private sector in investment, direct production and employment. A new feature of the Plan was that it took into consideration the democratic atmosphere in the political life of Jordan. This dictates a new method of action and decision-making and new implementation mechanisms consistent with the degree of awareness, development and maturity achieved by the people of Jordan. It also allows for a healthy relationship among Jordan's civil institutions as well as between public organizations and the country's leadership. The plan

was based on a range of general principles, which determine the future course of the national economy. Important principles for the Five-Year-Plan of 1993-1997 regarding the public administration sector include:

- activating the role of the private sector in the areas of infrastructure and basic services, and increasing private sector participation in the management and ownership of public sector institutions on an equitable and well-considered basis;

- restructuring public sector institutions undergoing financial difficulties; improving their efficiency; and gradually implementing measures to eliminate subsidies, recover costs, free prices, production and wages, and adopt commercial performance criteria;

- increasing the efficiency of government departments, promoting decentralization and delegation of authority and preventing duplication and overlapping in the functions of the various departments.

Thus, the overall objectives of the plan were:

- realization of sustainable growth in excess of population growth rate;

- correcting structural imbalances and achieving fiscal and monetary;

- stability;

- realization of balanced social development.

The Government of Jordan has realized the need for more serious effort to promote development in the public administration and service sector. Thus, an ad hoc committee was established in 1994 to develop a strategy to organize the public administration sector in the country based on the belief that public administration has a major role in promoting and sustaining the success of the development plans of the country. The basic idea was to develop and strengthen the capacity-building and capabilities of the leaders as well as all employees through ensuring better living conditions and job security to improve performance and quality of services in the public sector. Committee members for the proposed strategy took the following concerns into consideration:

- size of the public administration (number of departments and employers, expenditure, etc.);

- relationship of the public administration sector with the private sector;

- promotion of the leadership role (criteria of selection of leaders for higher administrative positions, mechanism for recruitment and appointment,

professionalism in leadership, job and professional growth and development, incentives for excellence);

- institutionalization of the public administration system (rules and regulations, legislation);

- decentralization of services and decision-making;

- flexibility of civil service law (encourage excellence in performance, recruitment, selection, appointment, training, incentives, job description);

- individual and institutional performance.

The royal committee found that the public administration sector including the civil service suffered from insufficiency with poor coordination, organization and performance. Thus, the committee diagnosed different problems in the public sectors related to surplus in ministries, departments and institutions with lack of coordination among them; old and ineffective organizational structure; weakness in administration, monitoring and supervision; overlapping responsibilities among ministries, institutions and departments; rapid establishment of unnecessary institutions and departments in different sectors; bureaucracy of the public services; and lack of coordination between the private and public sector.

In addition, recommendations were made by the committee with regard to employees' affairs in relation to training, appointment, evaluation, promotion, incentives and disciplinary and ethical concerns; as well as decentralization. Based on the findings and recommendations of the royal committee, a new ministry was established (Ministry of Administrative Development – MoAD) in 1994 and started functioning in 1995 to monitor management, performance, quality and efficiency of the public sector including the civil services. The MoAD took the lead to plan for the administrative and public sector reforms. Interestingly, the word "development" has been used instead of "reform" for political reasons. Therefore, the MoAD with its mission and objectives represented the vehicle for public service reforms in Jordan.

Abbreviations and glossary

BSN	Baccalaureate of Science in Nursing
CAD	Council on Administrative Development
CHC	Comprehensive health care centre
GDP	Gross domestic product
ILO	International Labour Office
IUD	Intra-uterine device
JD	Jordanian dinar
JU	Jordan University
JUH	Jordan University Hospital
JUST	Jordan University of Science and Technology
MCH	Maternal and child health
MoAD	Ministry of Administrative Development
MOH	Ministry of Health
MSN	Master of Sciences in Nursing
NGO	Non-governmental organization
PHC	Primary health care
RH/FP	Reproductive health/family planning
RMS	Royal Medical Services
RN	Registered nurse
UNFPA	United Nations Fund for Population Activities
UNRWA	United Nations Relief Work Agency
USAID	United States Agency for International Development
WHO	World Health Organization

1. Synthesis of public service reform In Jordan

1.1. Origin, context, socio-economic background and framework of reform efforts

Jordan is a developing country with a population of 4.4 million, a growth rate of 4.7 per cent per year, and a fertility rate of five children per woman. The age distribution is typical of many developing nations with most (42 per cent) under the age of 15 and very few persons over age 65. Jordan experienced a major economic crisis in 1988 and 1989 when foreign exchange reserves fell precipitately, the stability of the Jordanian dinar (JD) exchange rate was shaken, and the external debt burden and the inability to service it became apparent. The country has small, limited natural resources, chronic water shortages, limited arable land (5 per cent), and must import virtually all energy resources. The recent worldwide recession coupled with repeated migrations into the country have adversely affected the economy resulting in a major decline in income, high inflation, and an increase in unemployment and poverty. In addition the country has a high debt level.*(1, 2)*

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investment environment and building confidence in the performance of the national economy.*(1)*

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- activating the role of the private sector in the areas of infrastructure and basic services, and increasing private sector participation in the management and ownership of public sector institutions on an equitable and well-considered basis;
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The Government of Jordan has realized the need for more serious efforts to promote development in the public administration and service sector. Thus, a royal ad hoc committee was established in 1994 to develop a strategy to organize the public administration sector in the country based on the belief that public administration has a major role in promoting and sustaining the success of the development plans of the country. The basic idea was to develop and strengthen the capacity-building and capabilities of the leaders as well as all employees through ensuring better living conditions and job security to improve performance and quality of services in the public sector. Committee members for the proposed strategy took the following concerns into consideration:

- size of the public administration (number of departments and employers, expenditure, etc.);
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The committee found that the public administration sector including the civil service suffered from insufficiency with poor coordination, organization and performance. Thus, the committee diagnosed different problems in the public sectors related to surplus in ministries, department and institutions with lack of coordination among them; old and ineffective organizational structure; weakness in administration, monitoring and supervision; overlapping of specialties among ministries, institutions and departments; rapid establishment of unnecessary institutions and departments in different sectors; bureaucracy of the public services; and lack of coordination between the private and public sector.

In addition, the committee made recommendations with regard to employees affairs in relation to training, appointment, evaluation, promotion, incentives and disciplinary and ethical concerns; as well as decentralization. Based on the findings and recommendations of the royal committee, a new ministry was established (Ministry of Administrative Development-MoAD) in 1994 and start functioning in 1995 to monitor management, performance, quality and efficiency of the public sector including the civil services.*(2, 4, 5)* The MoAD has taken the lead to plan for the administrative and public sector reforms. Interestingly, the word 'development' has been used instead of 'reform' for political reasons. Therefore, the MoAD with its mission and objectives represents the vehicle for public service reforms in Jordan.

1.2. Reform objectives and strategies

The mission of the Ministry of Administrative Development*(6)* is:

> To improve the performance of the public sector; increase efficiency and proficiency; promote cooperation, collaboration and democracy principles in administration and management; deal with the administrative development as a continuous development process with concentration on benefiting from experiences and technical assistance of other countries; apply the scientific process to understand the internal and external environment and analyse factors affecting it through screening and research; and establish /or modify legislation to meet the objectives of the development and the needs of the country.

The development of Jordan's administrative and other governmental institutions constitutes the mainstay of efforts aimed at confronting the political, economic and social challenges that the Kingdom is facing. Hence, reforming the Government's administration has become inevitable, and has to be based upon certain assumptions, including the following:

- Human resources are at the core of development and have to be carefully planned, developed, and recycled: a successful administrator needs managerial knowledge and skills.
- Institutionalization, sound planning, and teamwork in the performance of governmental organs must be enhanced, and decentralization must be firmly established.
- The cost of administration must be lowered, public property must be protected, overstepping must be eradicated, and surpluses must be directed towards promoting effectiveness and raising efficiency.
- Decentralization of services delivery and decision-making must be bolstered, the role of local government must be invigorated, and the principle of follow-up must be firmly established.
- The degree of integration with, and outwardness towards the private sector must be uplifted; furthermore, this sector's role must be encouraged, and its particularities acknowledged.
- The quality of performance by governmental institutions must be improved and their distinction achieved by enhancing effectiveness efficiency.

These assumptions are actually representing the major reform components in Jordan.

To achieve its objectives of administrative development in the Kingdom, the MoAD undertakes the following tasks and responsibilities, which actually represent the strategies for implementing the reform components:

- participating in setting for comprehensive development;

- directing the efforts of organizing, developing, and following up civil servants to ensure high levels of performance and achievements;
- setting the standards for best utilization of human and other available resources in implementing administrative development plans, and development of these resources to meet the essential needs of the department;
- setting general plans for qualifying and training civil servants;
- studying the needs of the departments regarding consultations in the fields of administration;
- developing organizational structure for public administration, contributing to the process of designing administrative organization by-laws and organizational structures for the departments, unifying the nomenclatures/titles of the administrative units, and following up the implementation and development of these by-laws and organizational structures of the developments (reforms);
- setting basis for simplifying working procedures and following up on its implementation and development;
- supervising the application of civil service regulations and ensuring their proper application;
- documenting regulations and references pertaining to civil service and administration;
- preparing job descriptions and classifications on cooperation with the concerned departments;
- participating with the Public Budget Department and other departments, in studying the department's actual needs of jobs;
- preparing, updating, and developing a central register or more for the employees of the departments.

In summary, areas of concern for public service reform include:

- capacity-building through improving the capacity and capability of public services;
- supervision and monitoring of training activities through the establishment of administrative development units in each ministry that is connected to the secretary-general;

- restructuring the civil service, which was also stated in the Five-Year-Plan of 1993-1997. Commission and amending the 1988 Civil Service By-Law in such a way to ensure the following:

  - defining the criteria to be used for recruitment, promotion, incentives and disincentives;

  - monitoring the application of such criteria and taking measures to correct possible deviations;

  - follow-up of administrative development at ministries and public institutions;

  - drawing up job descriptions at ministries and government departments so that appointments to middle and upper management positions are made on the basis of such descriptions as well as qualifications and experience, rather than on the current basis of linking salaries to diplomas or degrees;

  - granting secretaries general or directors general, through committees established in ministries or departments, the authority to appoint, promote, grant incentives, and impose penalties in accordance with regulations to be enacted for this purpose and in agreement with the Civil Service Commission;

  - decentralization of services;

  - support for privatization and relationship with the private sector.

1.3. Reform processes and actors

To ensure administrative development and implementation in the public sector, the MoAD has identified its relationship with each governmental department through the establishment of an administrative development unit in each ministry as mentioned in the previous section. Major concerns for the reform included:

- the development of the organizational structure at different levels in the public sector;

- the establishment of the administrative development units in all ministries;

- the development of a central register for employees in the different departments in the public sector;

- the restructuring of the civil service;

- the development of human resources: through development of national plans to strengthen the capabilities of employees in relation to area of work and specialization;
- the supervision and monitoring of staff and institution performance;
- the support for privatization;
- the granting secretaries-general or directors-general more authority;
- capacity-building: through improving the capacity and capability of public services.

Moreover, to support and promote the MoAD initiatives and ensure implementation and follow up, a new Council on Administrative Development (CAD), has been established by the MoAD. The Council is to be chaired by the Minister of Administrative Development, and will consist of eight members, known for their efficiency and experience, that will be appointed by the Council of Ministers, at the recommendation of the Minister, for a renewable term of two years. The deputy of the CAD is the chairperson of the Civil Service Bureau. The duties of the Council include:

- setting the general policy for administrative development;
- approving national plans for qualifying and training employees;
- supervision and follow-up training centres and institutions in the different departments;
- study, develop and update legislation pertaining to the civil service and administrative development;
- propose salaries, wages allowances, and incentives and awards policies in accordance with the nature and the responsibility of the public job classification and description;
- deliberate on the Ministry's annual budget;
- approve regulations related to job classification and description;
- any other duties presented to the Council by the Minister.

The actors involved in implementing the reform process are:

- MoAD;

- CAD;
- Civil Service Bureau;
- Audit Bureau;
- Supervision and Inspection Bureau;
- senior administrators (line ministers);
- the secretary-general in all ministries;
- governors, mayors of municipalities;
- employers and employees.

1.4. Focus and scope of reform implementation

The scope of the development covers the whole public sector and deals with structures, systems and staffing. As mentioned in section 1.3, to ensure administrative development and implementation in the public sector, the MoAD has identified its relationship with governmental departments through the institution of administrative development units in each ministry. Article 4 of the Ordinance Regulating the Administrative Organization of the Ministry of Administrative Development states the following.

Each department, in cooperation with the Ministry, shall undertake the following:

- define its goals and duties assigned to it in order to achieve these goals with diligence and efficiency and utilize available communication methods to acquaint the employees and the general public with these goals and duties;
- design a project related to its administrative organization for enhancement whenever necessary;
- implement the concept of delegation of authority in accordance with levels of responsibility, allowing the lowest capable administrative unit to make decisions;
- implement organizational methods that ensure good work performance, avoid duplication, overlapping and complexity, and simplify procedures in order to obtain an economic, fast and effective delivery of public services to the public;

- define specific job descriptions and duties, responsibilities, and qualifications of each required job;

- qualify and guide employees "in training", in the first six months of their appointment and acquaint them with the departments' cadres, goals, duties administrative development regulations, civil service issues and legislation and train them on duties and job methods employed by the different administrative units;

- enhance the practical and scientific capabilities of employees to improve their level of performance and prepare them to undertake larger responsibilities including the scholarships and training courses.

Examining the duties of the ministries toward meeting the development (reform) objectives, we find heavy emphases on strengthening the capacity of the institutions with full support of the human element as the core of the development process which has been stressed by the MoAD (section 1.2).

In terms of policies and as mentioned before, policies related to the civil service in the Five Year Plan of 1993-1997 were mainly presented under the public administration section which still form the basic policies of the MoAD. They include:

- restructuring public administration through an ongoing process of reorganization of ministries, central departments and public organizations in line with the principle of administrative development in order to achieve the required efficiency;

- completing job descriptions pertinent to public and setting up a description system for services;

- simplifying procedures at ministries, central departments and public organizations providing direct services to the public;

- grouping government departments in administrative complexes in governorate and district administrative centres;

- completing the National Information Centre and developing a national information system;

- undertaking a detailed study to explore the most feasible options for moving towards privatization on clear foundations;

- formulating and implementing a national training plan that would provide for: specialized programmes, sectoral seminars and workshops, middle management executive programmes, recent appointee training programmes for staff in administrative inspection programmes;

- formulating a by-law on the selection, appointment, training, and terms of retention of administrative leadership;

- formulating a comprehensive incentive system based on a subsystem for performance evaluation on the basis of clear, measurable, and practical indicators, and another subsystem for rewards and disincentives linked to performance assessment;

- reviewing existing legislation governing administrative work and laying down a methodology for its regular review to ensure that it serves its purpose and does not impede management;

- formulating an integrated system covering all relevant legislative and organizational aspects including financial and human requirements with the aim of gearing local administration and local government concepts and tools towards administrative decentralization; and consolidating the principle of popular participation.

1.5. Overall achievements, constraints and failures

The beginning of the 1990s witnessed political and economic development at both regional and international levels that affected the economic and social situation in Jordan. Most prominent among these developments were: the Gulf crisis, the subsequent war and economic sanctions; the political, social, and economic transformation in Eastern Europe and the republics of the former Soviet Union, and the growing significance of regional economic blocs which focused on the principle of cooperation among their members. In order to avoid the negative implications of these developments and to address the structural imbalances in the national economy, Jordan adopted an amended economic adjustment programme for the period 1993-1997 after the suspension of the first one as a result of unforeseen developments, most important of which were the cessation of Arab assistance, closure of the Iraqi and Kuwaiti markets, and return of a large number of Jordanian expatriates from the Gulf region. In addition, the slow and unstable movement of the peace process impacted negatively on the political and economic development.

The Five Year Plan of 1993-1997 showed some success at the beginning but was interrupted in the third year as it was affected by the aforementioned reasons. The gross domestic product (GDP) growth rate dropped to 1 per cent in 1996 and 1.3 per cent in 1997 resulting in a decrease in the standard of living, a rise in unemployment rates, a larger deficit in the general budget, a higher percentage of population living below the poverty level, and a greater external debt burden.

Plans for decentralization and privatization have not been successful. The MoAD as well as The Five-Year Plan of 1993-1997 called for setting up an integrated system with the aim of gearing local administration and local government concepts and tools towards administrative decentralization and consolidating the principle of popular participation. This is not yet achieved due to economic and internal difficulties that have faced the country as well as lack of managerial skills and qualified personnel at the central and local levels. Of more importance, people were not trained on how to do it. Another principle was

to strengthen and promote the private sector in Jordan. Once again, this is moving very slowly and has not yet been achieved due to the aforementioned reasons.

In spite of all difficulties, many improvements have been made in health care in the recent past as evidenced by a reduced maternal mortality rate from 60 in 1990, to a current rate of 44 per 100,000 and an infant mortality rate from 34 in 1995 to a current rate of 28 per 1,000 live births. Further, there have been improvements in life expectancy which is currently 68 years for men and 70 years for women. Improvements in education and the social status of women have increased the literacy rate of women to 80 per cent in 1997.*(3)*

Further, major revisions were made due to restructuring the civil service.*(7, 8)* These include:

- introduction of early retirement to employees;
- appointment of personnel under contract conditions to be entitled to social security instead of retirement benefits;
- monitoring of personal performance evaluation;
- inclusion of leave of absence without pay;
- extension of maternity leave from 40 to 90 days;
- appointment of personnel through selected competition.

Other achievements include development of the organizational structure at different levels in the public sector and the implementation of administrative and development units in all ministries and reducing the number of ministries from 31 to 24. In terms of development of human resources, training programmes for senior administrators were conducted to strengthen their managerial skills. Some training courses were offered to employees at the local management level. However, follow-up on the impact of these courses on the performance of employers and quality of services was absent.

The MoAD and the Public Administration Institute as well as other international donors, such as the World Bank, have conducted a series of economic, administrative, political and public assessment studies. These studies reviewed the structure and work force of some ministries and made recommendations for change. Coordination, collaboration, and decentralization issues were highly emphasized in the studies. Findings are under discussion to identify strategies for reforms such as the current health sector reform proposal of the World Bank.*(9)*

Finally, the major achievement in Jordan is the democratization experience, which has been very challenging and successful.

2. The impact of public service reforms on health sector employment and working conditions

2.1. Implications for human resources policies in the health sector

2.1.1. General organization of the health sector

According to the country's Five-Year Plan of 1993-1997, the policies of the health sector role included:

- concentration on preventive medicine and broadening the base of participation in providing services which have an impact on community health by:
  - increasing the contribution of public institutions – in particular municipal and village councils – to preserving the environment;
  - urging voluntary sector and professional organizations to be active in the field of health to provide local communities with health services;
- raising the standard and quality of primary health care (PHC) by:
  - increasing the efficiency of PHC centres so as to reduce direct resort to specialized clinics and hospitals;
  - establishing incentives for the private sector and expanding the services of PHC coverage;
  - staffing PHC centres with nurses and midwives as well as paramedical personnel in the fields laboratories and radiology;
- promoting the role of the Ministry of Health in ensuring that public health and safety requirements are met in medical and paramedical practices;
- revising treatment and health insurance costs so as to cover a larger portion of actual costs, taking into account the limited- and lower- income groups;
- revising pharmaceutical policies so as to ensure a permanent supply of drugs and an adequate reserve for emergencies and disasters.

Recently, Jordan's health sector has performed well in terms of access and health outcome, and is considered among the best in the region and among other middle-income countries. Services are delivered through an extensive network of public and private facilities, and overall capacity in terms of hospital beds and physicians is high. Considerable progress has been made in maternal and child health care. Immunization coverage is above 95 per cent, under-five mortality related to diarrhoea is less than one death per 1,000, and the under-five mortality rate (U5MR) is now 25 per 1,000 live births. It is estimated that most infant deaths now occur in the neonatal period underscoring the importance of addressing maternal health and care (neonatal death rate: 14.4/1,000, foetal death rate: 11.8/1,000, perinatal death rate is 25.8/1,000). The major causes of neonatal death and their proportional mortality ratios were respiratory distress syndrome (40 per cent), sepsis (14 per cent), and asphyxia (12 per cent). It is believed that if existing human and infrastructure resources in Jordan are properly mobilized, the neonatal mortality rate can be reduced by one-third. Moreover, if modern equipment and an adequate supply of surfactant factor are available, these rates can be reduced even to one-half (or around 8-9 per 1,000 live births), which is near that of the developed countries.*(3, 10, 11)*

Tertiary care services

Tertiary services have expanded dramatically in recent years: the number of hospitals has increased from 35 in 1978, to 55 in 1989, to 65 in 1995 and 80 in 1998. Hospital beds have increased from 3,633 to 5,154, 7,440 and then to 8,035 over the same period. In Amman (the capital of Jordan) there are now 25 beds for every 10,000 people, while in other governorates and rural areas the ratio ranges from eight to 18 beds per 10,000 people. The public health system remains focused towards curative care, as illustrated by the Ministry of Health budget for 1991 where 55 per cent of current spending and 76 per cent of capital spending was allocated for secondary and tertiary health care, and only 39 per cent of current spending and 22 per cent of capital spending for primary health care. Systems of referral and linkages between the primary and tertiary care sectors are generally weak. Again, this fact, coupled with the low level of public confidence in the primary health care system, results in many patients going directly to fully equipped but expensive hospitals for all their health care needs.*(3, 12)*

Primary health care system

The Government put a great deal of time and effort to support the PHC toward health for all for the year 2000. It has done this through fair distribution of resources, support of non-governmental organizations (NGOs), provision of training for health PHC personnel in maternal and child health (MCH) (immunization, prevention of disease, and family planning) and community involvement. Community involvement includes local councils in some areas as well voluntary groups to support promotion of the strategy for health for all at the year 2000. Special attention has been given to increase involvement of women in different health projects as required by the external donors and funders.*(13)*

The primary health care system now reaches 97 per cent of the population; 98 per cent in urban areas and 95 per cent in rural ones. However, while it seems clear that access to primary health care is no longer a major problem in Jordan, underutilization of services remains an important issue. The expansion and geographic coverage of health PHC services have impacted positively in the improvement of health status in Jordan especially

maternal and child health. However, regional variations still exist and a structured referral system is absent.*(3, 11, 12)*

According to the MOH (1998), there are currently 1,181 health centres: 42 comprehensive health centres (CHC) staffed by general practitioners and specialists, 326 primary health care centres, 316 maternal and child health (MCH) centres, and 274 peripheral health care centres. Reproductive health/family planning are mainly provided through CHC, PHC and MCH centres and only 103 MCH centres provide IUD (intrauterine device) insertion services. In addition, there are 204 dental clinics and 11 chest disease centres.*(3)* The most peripheral level at which health care is delivered is the village clinic, which provides services to populations of 500 to 2,000 people. The village clinic has limited hours on certain days of the week, and functions with a minimum of one health worker or nurse. Village clinics are supported by a health centre serving 2,000 to 5,000 people and staffed by general physicians, nurses, sometimes a dentist, and auxiliary personnel. MCH centres serve a population size similar to that of a health centre. Nurses and/or nurse-midwives who are responsible for prenatal care, growth monitoring, and immunization, staff MCH centres. Sick children are referred to physicians at the health centre. Finally, CHCs serve a population of 25,000 to 50,000 people and provide only outpatient services. Each is staffed with several general physicians, specialists in the areas of paediatrics, obstetrics and gynaecology, and internal medicine, nurses and nurse-midwives, a dentist, a pharmacist, and auxiliary health personnel.*(14)* However, throughout the plan of 1993-1997, MOH efforts were not successful in the area of providing quality services, performance evaluation, and relationship with the private sector.

Thus, the current health strategy for 1999-2002 emphasizes the development of human resources and standards of care as well as the management component and relationships with the private sector.*(15)* The strategy includes the following:

1. The mission of the Jordanian Ministry of Health and Health Care

   The mission of the Ministry of Health and Health Care is:

   - to achieve the highest level of health possible for all citizens with their participation;
   - to apply modern health care financing practices and effective management of the health sector in order to provide equitable access to health services and to relieve pain and suffering.

2. Basic role of the Ministry of Health

   The basic strategic role of the Ministry of Health is as follows:

   - providing preventive and primary health care; this includes vaccinations, educational services and awareness campaigns, mother and child services, school health services, safety of food, environmental health, safe disposal of

waste, occupational health services, prevention and treatment of infectious and non-infectious disease and mental health services.

- control and guidance that aims at elevating the level of performance of the overall health system in the country;
- assuring educational health and training programmes are available to all the members of the Ministry;
- dealing with emergencies and crises that will be carried out in cooperation with the concerned parties;
- encourage scientific research and technological development.

3. Social and economic benefits from undertaking strategic health care planning and revision of the health care system

The improvement of health care services requires a preliminary investment that will yield the following benefits:

- decreasing the economic damage caused by employee illness that could be prevented by early detection and treatment;
- improving the general efficiency of human resources by increasing the health status of the population;
- decreasing the cost of treatment of illness;
- minimizing costs to the country by investing in the decrease of health risks thereby decreasing the risk of disease outbreak;
- increase the per capita productive age as well as the community at large;
- increase and enhance the orientation of the individual and the community in their advanced scientific and technological performance in the future;
- giving Jordan the prestige of being a distinguished and advanced country with a safe and health environment as a healthy nation, which would reflect positively on tourism businesses and investment.

4. Main objectives of the strategy

The strategy of the Ministry of Health and Health Care is based on the following objectives:

- transferring emphasis from supporting curative health care to prevention of illness through primary care and patient education;
- improving managerial, technical and professional performance in the public health sector;
- enhancing the partnership between the private and public sectors to assure the provision of adequate health services;
- implementing a national health insurance system;
- improving the health care finance situation in Jordan and implementing the best standards of performance;
- preserving Jordan's status as a pioneer centre for advanced medical care in the region;
- strengthening the humanitarian aspects of the provision of health services by all Jordanian health institutions and health professionals.

However, many health leaders think that the new health strategy in Jordan lacks scientific basis and does not take into consideration the assessment and available studies conducted in the health sector such as the World Bank study for the health sector in Jordan (1994) and the assessment studies conducted by USAID and other agencies.*(16)*

Jordan has a well-developed physical and human health infrastructure with substantial overall capacity, despite regional disparities in availability of services. The significant capital and manpower infrastructures of the major public programmes overlap and are uncoordinated. There is little coordination with, and regulation of, the large and growing private sector. Management information systems and computerization at all levels of the system are lacking. Management in the individual public programmes is highly centralized, and there is virtually no overall policy coordination for the entire sector. The 63 per cent occupancy rate is indicative of substantial excess capacity. The large number of referrals to hospitals and the overuse of hospital outpatient facilities relative to primary care clinics are indicative of the lack of an effective referral system as well as potential quality problems at the clinical level.

Reform of MOH's organization, management, financing, and planning capacity is one of the objectives of the ongoing health management project.*(16)* Introducing qualitative improvements in MOH's primary and hospital services and Jordan University Hospital's (JUH) referral services is a second objective of the project. In addition, a health sector reform proposal has been submitted by the World Bank to MOH in 1999 addressing all areas related to capacity-building of MOH, quality of care, and relationship with the

private sector. This project is based on assessment studies conducted in the health sector by the World Bank (Health sector in Jordan, 1994) and other assessment studies conducted by PHR, USAID and other agencies.*(9, 16)* Moreover, primary health reform has also been proposed and sponsored by the World Bank and is in the preparatory phase.*(17)* Interestingly, the World Bank reports were based on meetings/taskforce representing physicians with no input from nurses.

Contracting out services

The MOH contracts the private sector, university hospitals, and the Royal Medical Services (RMS) to cover public service employees who are entitled to first-degree insurance, and in case of unavailable procedures, surgeries, lab tests, medical equipment, as well as referral of clients upon lack of beds in the hospitals of the public health sector. Other hospital services that have been outsourced are kitchen and cleaning services. One private hospital contracted out administration services, and other hospitals, i.e. the Catholic Rosary Hospital, and the Italian hospitals, are sharing national and international administration services.

Delinking health sector staff regulations and benefits

Radiologists are given a special allowance of 30 per cent from their basic salary in addition to extra an 15 vacation days over and above the regular 21 vacation days that all personnel are entitled to in the public sector. In addition, physicians enjoy special incentives for overtime work. Some nurses have low incentives to work overtime (eight hours per day) while other nurses who have been appointed after 1 June 1996 were denied this right. However, nurses are provided with free housing and free meals at the hospital.

Another model of the delinking is unique to the relationship of Jordan University of Science and Technology (JUST) and MOH hospitals in the northern part of Jordan. At JUST, as part of the responsibility of the Medical School towards the community and its students, medical education has been integrated into the health services in the region of the university. This has been providing joint appointment opportunities to highly qualified specialists in the MOH hospitals and health centres to be involved in mentoring medical students in the clinical areas and collaborative health services with the academic staff. Nominal payment is provided by JUST and MOH for physicians in both sectors. The results were:

- improvement of quality of teaching, especially in clinical settings;
- exposure of students to community problems;
- development of teaching skills and knowledge of MOH staff;

- incentives for both groups;
- better quality of services.

2.1.2. Overall costs, fiscal restraints and availability of resources

Jordan's health system is a complex amalgam of two major public programmes, the Ministry of Health and the Royal Medical Services, which both finance and deliver care, some smaller public programmes, including several university-based programmes, e.g. Jordan University (JU) and JUST, a large private sector, in terms of both the financing and delivery of care, and several NGOs, the largest of which is the United Nations Relief Works Agency (UNRWA) which provides care to Palestinian refugees. The MOH is responsible for the separate civil insurance programme for civil servants as well as the usual public health activities and health system regulatory functions.

The general budget, premium contributions, and user fees finance the public programmes. MOH, civil insurance and RMS budgets are determined annually through the Government's budgeting process. There are major cross-subsidies built into the budgets among public programmes as well as from the General Army Budget to the RMS. UNRWA is financed through donor contributions. There is no available information on the financing sources of private insurance. An important potential source of financing is through private firms via article A.3.4 of Jordan's 1978 Social Security Law. This article provides for firms to contribute to health insurance for their employees through payroll taxes, but it has never been implemented. Private spending accounted for 53 per cent of total health expenditure up from a 51 per cent share in 1989. According to the World Bank report (1997), overall spending has increased in nominal terms over the past five years and has grown slightly more rapidly than GDP.*(12, 16, 18)*

Public programmes generally cover a comprehensive array of services including pharmaceuticals with very limited patient cost sharing. However, uninsured individuals, even those purchasing subsidized care in MOH facilities, must generally pay the full price of pharmaceuticals. Private insurance benefits are more variable and the usual forms of medical underwriting (e.g. pre-existing condition exclusions) are widespread. There are limited financial resources available to meet the growing demand for health services and the disparity between treatment fees; the actual cost of providing health services has taxed the budget of the MOH. There is also a lack of coordination among PHC centres and hospital settings, which lead to higher costs. In many cases higher costs are due to unjustified referrals from health centres to central hospitals. In spite of the changing emphasis in favour of preventive care, major expenditures are still directed toward curative services.*(12, 16, 18)*

Ministry of Health

The Ministry of Health (MOH) is the largest sector in providing health care at the primary care level and secondary care level with a budget of only 5.6 per cent of the total government budget.*(3, 12)* The total expenditure on health is 7.5 per cent of GDP.

Administratively, the Ministry of Health consists of a central administration located in Amman, supported by 12 governorate-level offices. District level offices at the local level support the governorate offices in turn. Reporting directly to the Minister of Health are the secretary-general, several advisers, the directors of civil insurance, the information centre, and public relations. The Planning and Development Committee reports directly to the Minister. Reporting to the secretary-general are the directors-general representing primary health care, curative services, general administration, Al Basheer Hospital (the largest public hospital), and the governorate health offices. The MOH operates 40 per cent of all hospital beds in Jordan and has an occupancy rate of 68.5 per cent with an average length of stay of 3.5 days.

Table 1. Jordan government budget, 1993-97 (JD1000)*

Item/year	1993	1994	1995	1996	1997
General budget	1 328 000	1 481 000	1 674 000	1 745 000	1 916 000
MOH budget	76 949	79 515	86 100	95 957	106 819
Percentage (%)	5.8	5.4	5.1	5.5	5.6
Health insurance budget	12 650	18 416	21 240	22 784	22 070

* JD0.70 = US$1.
Source: MOH Statistical Report, 1998.

An estimated 80 per cent of Jordan's population has formal "health insurance" coverage. The largest publicly funded health insurance programme is delivered through the Ministry of Health's Civil Insurance Programme. The MOH also provides coverage for the poor and disabled through this programme and is also the safety net for those without coverage. Over 80 per cent of MOH expenditures are financed through the government budget, 6 per cent from insurance premiums of civil insurance enrolees, and the remaining amount from user fees. Civil servants pay low premiums (2 per cent of their monthly income with a maximum contribution of JD8 per month) and receive care in MOH primary care centres and hospitals. In addition to managing the civil insurance system, the MOH is responsible for public health, quality, standard setting, medical education and training, etc., but beyond setting standards and approving charge schedules has little control of the private sector.

Royal Medical Services

The second largest public programme in terms of expenditure (1 per cent of total expenditures in 1994) but largest in terms of individuals covered is administered by the RMS for military personnel and their dependants (approximately 35 per cent). About 85 per cent of expenditures are financed through the government budget, 9 per cent through premium payments and the remainder through user fees. Premiums are based on rank and duty status (JD0.75-1.5 per month) and insurers receive care in RMS and MOH primary care centres and RMS hospitals. The RMS operates 81 ambulatory care centres, 14 per cent of hospitals, and 24 per cent of beds and has an occupancy rate of 75 per cent. It employs 12 per cent of physicians and 18 per cent of the country's registered nurses.*(3, 12, 19)*

Jordan University Hospital

Jordan University Hospital (JUH) covers its employees and dependants of Jordan University (JU), less than one-half of 1 per cent of the population, and serves as a "fee for service" referral centre for the other public programmes and private payers. Their expenditure in 1994 was 3 per cent of total health spending. The Ministries of Finance and Health and Jordan University account for about 60 per cent of all financing and user fees account for almost 40 per cent. JUH accounts for 7 per cent of hospital beds, has an occupancy rate of 54 per cent and employs 4 per cent of physicians, as well as 7 per cent of the nurses in Jordan.*(3, 16)*

United Nations Relief Works Agency (UNRWA)

The UNRWA provides care to over 400,000 Palestinian refugees, many of whom are also covered by the MOH and RMS. This accounts for about 2 per cent of total health spending. UNRWA is financed by outside donors and operates its own system of health centres and refers patients to MOH and private facilities for hospital care.*(12, 16)*

Private sector

Privately financed services accounted for an estimated 53 per cent of all health spending in 1994. Many private firms provide health care coverage for their employees through self-insuring or the purchase of private health insurance. Many individuals, including those with public coverage, purchase services privately through direct out-of-pocket payments. The private sector accounts for about 55 per cent of hospitals, 30 per cent of total beds with an occupancy rate of 49 per cent; 52 per cent of physicians, 92 per cent of pharmacists, 77 per cent of dentists and 41 per cent of professional nurses are employed in the private sector. Also, it contains much of the country's high-tech diagnostic capacity and in the case of financing is a significant component of the health care system in Jordan.*(3, 12, 18)*

Pharmaceutical sector

The consumption and production of pharmaceuticals are important components of Jordan's health spending as well as industrial structure and export base. Pharmaceutical expenditures through both public and private sectors accounted for 27 per cent of total health expenditure, JD88 million, and 2 per cent of GDP. While most pharmaceuticals are readily available and there are few quality problems, there are a number of significant problems with their procurement, management, dispensing, pricing and consumption.

The lack of a comprehensive modern policy framework is an obstacle to better management and development of the sector. There is significant overuse of expensive drugs due to the absence of an essential drug list, generous coverage policies of public programmes, lack of generic prescription or substitution, lack of pharmaceutical treatment protocols for physicians, and the regulatory pricing practices in the private sector.

Overall, each major programme has its own delivery system, and there is little coordination among them. There are significant inefficiencies in the service delivery system. These include an excess overall bed capacity as evidenced by a hospital occupancy rate of 63 per cent (69 per cent in the public sector and 49 per cent in the private sector) as shown in table 2.

Table 2. Hospital utilization, 1997

Health sector	No. of beds	Occupancy rate %	Average length of stay (days)
MOH	3 207	68.5	3.5
RMS	1 787	68.9	4.4
JUH	506	70.0	4.8
Private sector	2 535	52.1	2.7
Total	8 035	63.3	3.5

Source: MOH Statistical Report, 1998.

There is no single managerial entity responsible for the overall health system. Each health sector has its own pharmaceutical procurement, management, and distribution system. Other inefficiencies include large geographic disparities in the availability and use of services; inappropriate hospital use resulting from lack of an effective referral system and a hospital-based orientation for treatment. Regional disparities in the distribution of physicians and nurses are evidenced by a 3:1 difference in physician population ratios among Amman and some of the rural governorates. While the MOH has done a great deal to place clinics in these rural areas, it continuously faces the usual obstacles of placing professionals. Policies and appropriate incentives should be developed to attract and retain physicians in rural areas.

International funds being provided to support the initiative of PHC from USAID, UNFPA, WHO, UNICEF, and World Bank for the health sector, concentrate on the improvement of the health services infrastructure, equipment, and training of health care providers. Lack of coordination and overlapping of activities have been reported on many occasions.*(14)*

The country's Five-Year Plan of 1993-1997 for the health sector took into consideration the major problems facing it. The plan emphasized that the disparity between treatment fees and the actual cost of providing health services has taxed the budget of the Ministry of Health. Revenues covered only 12.7 per cent of overall costs and about 18.3 per cent of current costs in 1991. Costs of secondary health care account for 62 per cent of the budget of the Ministry of Health.

Communication and coordination

Communication and coordination at the MOH between central and local level are inadequate as the MOH management in highly centralized. Communication and coordination become worse when it deals with the Department of Nursing, as it is always given the lowest priority in actions and plans. A report was recently published in a well-recognized Jordanian newspaper (*Al-Rai*, 5 April 1997) on the status of MOH, which was based on research study prepared by the Public Administration Institute in Jordan.*(20, 21)* The report indicated that the MOH suffers from multiple organizational and structural problems which include: duplication and overlapping of services and roles among some directorates; lack of coordination among different directorates; broad lines of responsibility

for the Secretary-General (who is responsible for about 16 directorates) which reduce the effectiveness of his monitoring and supervision; lack of opportunities for development of human resources; shortage of human resources; absence of job descriptions; presence of outdated rules and regulations which are not consistent with current and future visions of the MOH.

Health care professionals

In terms of health care professionals, Jordan has 0.93 nurses, 1.6 physicians, and 0.75 pharmacists per thousand population. One-third of Jordan's physicians are specialists. Since 1989, the number of hospital beds has increased by 18 per cent with the largest increase occurring in the private sector, 37 per cent, compared to an increase of 12 per cent in the public sector. The MOH operates over 1,181 health centre clinics, approximately 30 per cent of all hospitals, and 40 per cent of total hospital beds and has an occupancy rate of 68 per cent. The MOH employs 32 per cent of all practising physicians compared to more than 52 per cent in the private sector, and 40 per cent of all nurses. Interestingly, only 25 per cent of registered nurses in the country work at the MOH, which is the largest health sector. Currently, about 70 per cent of practising nurses are women. The majority of the Jordanian nurses are employed in hospitals followed, in numbers, by those in educational institutions.*(3, 12, 18)*

Shortages of all types of health personnel are evident across all specialty areas. Ongoing improvement in health care and the recent introduction of better and "high tech" medical care have created a strong demand for well-qualified medical specialists and nurses which has added to the existing shortage of both groups in Jordan. Findings from the Public Administration Institute's study revealed that there is a shortage of human resources in the MOH as shown in table 3.

Table 3. Shortage and surplus by category of health care providers

Category of health care providers	Shortage	Surplus
Specialized physicians	545	–
Nurses	1 398	–
Paramedics	179	–
Aide Nurses	–	2 404
Support services	–	32
Total	2 122	2 436

Source: Public Administration Institute study, 1996.

It is interesting to know that there is an imbalance in numbers between the professional and non-professional groups at the MOH especially for nurses, where for instance, aide nurses, which constitute the majority of nursing staff in the MOH require only 12 months of education or less. The appointment of these unqualified nurses, who have a low level of education, was stopped in 1993 because of the ineffectiveness, inefficiency and low quality of services provided by this group.*(20)*

The MOH employs almost 19,500 staff, of which about 35 per cent are in administrative positions. Salaries are considered as being the major drainage for the MOH budget. Expenditure on employees' salaries was 61.2 per cent in 1992 and reached 67.3 per cent of the MOH budget in 1996. However, expenditure on services was 38.8 per cent in 1992 and decreased to 32.7 per cent of the MOH budget in 1996. The imbalance between

expenditure on salaries and services might impact negatively on the quality and quantity of available services for clients, which hinder the MOH role in providing quality health services to the population.

The Public Administration Institute study reported that there was lack of fairness among different health care providers in relation to salaries, allowance and incentives.*(20)* Salaries of different category of health personnel are shown in table 4.

Table 4. Salaries by category of health care providers

Category of health care providers	Salary first year of appointment (US$)	Salary 25 years after employment (US$)
Specialist	714	1 672
Specialized dentist	598	1 055
General practitioner	510	891
Dentist/pharmacist	462	774
Staff nurse	364	528
Midwife	262	424
Lab technician	262	424
Assistant lab technician	218	342

Source: Public Administration Institutes study, 1996.

Finally, as for policy-making, budget, and operational decisions and programme management, they are all highly centralized.

2.1.3. Intended and unintended staff movement

There are two kinds of staff movement in the health care sector, occurring internally as well as externally. Internally, health care professionals move from the public sector (MOH, RMS) to the private sector and from one hospital to another within the private sector based on better job opportunities and salaries. Some workers from all health disciplines (physicians, dentists, pharmacists, nurses, and lab technicians) in the public sector also work illegally for the public sector. This practice has ethical as well as safe practice implications. Interestingly, health care workers who are usually reprimanded for this practice are the nursing staff. Retired personnel, from the public sector, are also moving into the private sector where wages and benefits are much better, especially among physicians.

High staff turnover, intention to move to urban centres and low motivation among medical staff has been found among professionals in rural areas. High turnover is a particular problem among female physicians and nurses in MCH centres, not only in rural areas, but also in cities of three hours' distance from the capital. The poor state of the equipment and buildings, a closed social system (specifically for female health professionals) and lack of incentives are major problems of the rural areas.

Externally, movement is seen from Jordan to the Gulf area, in particular among nurses and physicians where wages and benefits are more attractive than in Jordan. According to the Directors of Nursing of the MOH and JUH, 18-21 per cent of their nursing workforce has left for the Gulf States.*(22, 23)* The percentage of physicians moving outside the country is not reported but still high. Further, physicians who are

sponsored abroad to complete specialties often do not return to Jordan on completion of their studies.*(22, 23)*

It should be mentioned that Jordan is facing a severe shortage of qualified nurses. This shortage is one of the fundamental causes of low standards of nursing care. The movement of nurses both internally and externally adds to the nursing deficit. Furthermore, nurses in Jordan spend more time in performing non-nursing activities due to shortages of other support staff in the health sector. Interestingly, nurses who are not willing to undertake shift work, or who prefer light work, usually move to the PHC, which affects the quality of care provided by the PHC services. Given that professional nurses make up only 25 per cent of the nursing workforce at the MOH, issues such as quality of care and quality of work life should be evaluated.

The Public Administration Institute study reported that there were no policies or regulations in existence for transferring or deployment of employers from one area to another. It also emphasized the absence of job descriptions and standards for staff performance or the incentive to evaluate the efficiency of different areas of the health sector as well as the quality of care.*(20)*

2.1.4. Educational system

Pre-service programmes

Jordan has a strong higher education system for physicians and nurses and has two medical schools with an average admission of 300 medical students per year. There are also high-quality hospital residency programmes offered by different health sectors (MOH, RMS, universities, and private) in all specialty areas as well as one family practitioner programme, and two community medicine programmes. The residency programmes strengthened the training activity of the schools of medicine in different medical specialties to provide the country with the much needed manpower in medicine.

The Master of Public Health Programme at the Jordan University of Science and Technology (JUST) is offered for graduates of nursing and medicine. MCH, administration, health education, and nutrition are important specialization areas offered by the programme. To maintain quality the universities offer incentives to keep their own medical staff and to attract personnel of high standard. The incentive varies between 140-400 per cent of the basic salary. Other major incentives include allowing private practice for physicians. The country's universities currently offer their medical staff the chance to work during their free time on private basis within their premises under certain conditions, in order to attract them to stay at the university and provide more job satisfaction.*(24)*

At JUST, as part of the responsibility of the School of Medicine toward the community and its students, medical education has been integrated within the health services in the region of the university. This has been supported by providing joint appointment opportunities to all clinicians in the Ministry of Health hospitals and health centres to be involved in mentoring medical students in the clinical areas and provide collaborative health services with the academic staff. Nominal payment is provided by

JUST and the Ministry of Health for physicians in both sectors. This was a great achievement for both parties and has led to:

- improvement of quality of teaching especially in the clinical settings;
- exposure of students to community problems;
- development of teaching skills and knowledge of ministry of health staff;
- incentives for both groups;
- better quality of services.

Nursing education in Jordan is varied and diverse. The multiple entry levels to nursing are very confusing and to the public eye, nurses are seen as being "the same level and orientation" regardless of their educational preparation. Lack of accreditation and licensure procedures for nurses further complicates the preparation of nurses. Nursing education programmes include two masters programmes (MSN), four baccalaureate programmes (four-year programme), two RN-BSN completion programmes (two-year programme), three diploma programmes (three-year programme), one associate programme (two-year programme), and two midwifery programmes (two-year programme). Hospital-based programmes include practical and assistant nursing programmes (up to 18-month programmes). The MOH also offers a PHC programme and the clinical preceptor programme (9 months) to registered nurses. In addition, the Ministry of Education has two-year vocational high school programme after the 10th grade. More than 400 BSN and 150 diploma prepared nurses graduate yearly. Male nursing students are approaching more than 55 per cent of nursing students at some universities and community colleges.*(25)*

A gap between education and practice exists. One major reason is that improvements in nursing education have been isolated from nursing practice. Students are prepared in relation to the role of the professional nurse, professional standards and policies of practice, and the importance of nursing power, autonomy, decision-making, and collaborating with other health care professionals. In nursing practice the role of the nurses is not well articulated, national nursing standards are lacking, role models are absent which has adversely affected the nurses' socialization process. The gap between education and practice is considered to be one of the major challenges for nurse educators and leaders. The diversity of the institutions that control nursing education programmes coupled with the various levels of nursing education have slowed nursing development and improvement. In spite of these obstacles and challenges nursing education has rapidly progressed in Jordan.

In the last decade, six private pharmacy schools have been established in Jordan in addition to the two major public pharmacy schools established since 1980. It is estimated that a total of about 1,000 pharmacists are graduated annually which exceeds the country's need for pharmacists. In addition, there are two masters and one PhD programmes in pharmacy. Pharmacy schools and drug companies mainly perform training of pharmacists.

Some major changes in the curricula were introduced to emphasize the "patient-oriented" concept in the education and training of pharmacists.*(29)* In addition, there are two six-year BSc dentistry programmes offered by two public universities (JUST and JU). Dental assistant and dental technology programmes have been recently established at the university level by JUST in 1997.*(27)*

Allied health workers such as laboratory dental technicians, radiologists as well as dental assistants, public health and pharmacy assistants are currently prepared at the community college level in the RMS and MOH. Other radiology, optometry, dietetics, and physiotherapy programmes will be established in two public universities in the year 2000 due to the severe shortage of these specialties in Jordan.

Continuing education (CE)

Although there is a directorate for medical continuing education at the MOH in addition to medical schools and professional organizations, continuing education in Jordan is still at an early stage of development and many Jordanian hospitals and health institutions lack adequate continuing education programmes for physicians and nurses. These programmes frequently consist of educational activities based on administrative rather than employee needs. This is particularly true for the Ministry of Health, which is the largest employment agency in Jordan. As a result, a large number of practising nurses, the majority of whom are graduates of non-degree programmes, lack further education to enhance their nursing practice.

The MOH has been aware of the lack of qualified managers at all levels. As a result, nearly the majority of the directors at the central level have completed workshop training in higher management skills designed for senior administrators and covered general administration issues.*(5, 13, 20)* However, the vast majority of staff from the central Government, and local MOH levels, specifically PHC and MCH/FP staff, lack administrative and management skills with regard to RH/FP service in particular. In contrast to managerial capacity, increasing technical capacity was heavily emphasized by the activities of all international donors.

A study of management functions among 31 PHC managers in Jordan revealed that the majority of managers were relatively young in age, new to their posts, lacked awareness of their role and lacked organizational skills. The deficiencies in role knowledge and organizational skill appear to reflect a lack of management training. At the organizational level, the study also documented an absence of job descriptions. This deficiency, in turn, affects the distribution and the completion of work activities and ultimately complicates the process of monitoring and evaluating performance among this group of workers. In addition, physicians were often serving in dual roles, one as provider of care and one as manager. The typical pattern of practice for these manager-physicians was to invest more time in the provider role. It could be asserted that this is because their provider skills were stronger and led to a more active role in the area, which they knew better. All of these findings support the need for managerial training across all professional levels.*(28)*

Another factor, which has limited CE in Jordan, is that a common form of nursing license is granted automatically to persons graduating from any nursing programme. To

become licensed, nurses only need to pay a nominal registration fee and submit verification of completing their respective programmes of study. Continued licensure is dependent upon annual payment of licensing fees. Thus, no incentive exists at the regulatory perspective for nurses to update their skills or obtain additional education. A study on the assessment of nurses continuing education needs in Jordan revealed that the majority of the respondents (64.3 per cent) did not attend a single CE activity in the year prior to the study that was conducted in 1997. With respect to self-directed learning activities, the majority (66.7 per cent) of respondents stated that they had not read a professional nursing journal.*(29)*

As for physicians to become licensed, they need to pass the national exam and then pay a nominal registration fee every year. Continuing education and training of practising physicians, nurses, dentists and pharmacists is maintained through scientific workshops and professional conferences conducted by schools of pharmacy, professional associations, MOH, RMS, JUH, private sector and drug companies in Jordan. Continuing education programmes (such as conferences jointly sponsored by the MOH, RMS, JUH, and the private sector) need to be strengthened as well, making them more readily available to physicians, nurses, paramedical technicians, and other support staff.

2.1.5. Professional standards, registration, code and scope of practice

The Jordan Medical Council (established in 1982) chaired by the Minister of Health, supervises, controls, and maintains professional medical training and practices, including registration and licensing for physicians. The roles and responsibilities of health care professionals are not explicitly outlined in Jordan. Professional standards, registration, code and scope of practice have not been formalized nor mandated by the MOH for nursing.

In 1997, the MOH instructed a committee of nursing leaders to look into the registration and licensing of nurses. A proposal was submitted to the MOH that recommended the establishment of a nursing council to regulate nursing practice. To date, there has not been a response to this proposal, which has added to the frustration felt by the nursing community. The nursing profession has adopted a code of ethical behaviour but it has yet to be approved by the MOH.

As for pharmacy, professional standards, registration, code and scope of practice are maintained through the Ministry of Health and the Jordanian Pharmaceutical Association established in 1957. Recently, ethical issues and dilemmas have been a major concern among all health care providers.

Quality and consumer satisfaction

As in the case of clinical effectiveness, there are few hard data to evaluate the quality of care and consumer satisfaction. Quality, in general, appears to be acceptable and the physical condition of institutions is good. However, there are some apparent problems, especially in MOH facilities. Based on structural standards, credentials and certification, there may be quality problems regarding physicians trained outside Jordan as well as from

the small number and inadequate training of certain categories of nurses. Hospitals must be licensed, but there are no quality indicators collected that would allow comparisons of hospital outcomes or processes of care.

In the MOH projects under consideration, very few appropriate standards for health facilities have been formulated. The Quality Assurance Department was established in 1993 at the MOH through the family health services/quality assurance project supported by the USAID with the main emphasis on reproductive health care. The following obstacles to progress were identified by the Director of the Quality Assurance Department*(30)*:

- lack of well-trained personnel;
- limited size of the working unit;
- different approaches and work styles of experts serving as consultants;
- scarcity of material capabilities such as the availability of transportation; and
- absences of incentives given to health care personnel working in this area.

Although quality assurance units were recently established at the local level in the health sector, emphasis has still been placed on hospital settings. For other PHC and MCH/FP there is no structured mechanism to assure high quality and cost effective care. There is dearth of information regarding quality of care and data collected are insufficient to monitor and evaluate the quality of care.

Data should guide managers in identifying important indicators of effective monitoring and evaluation of services. These data would further facilitate planning and decision-making concerning different aspects of care at different levels (management, provider, and client). Collectively, managers and providers would use this information to monitor and evaluate the services they provide on an ongoing basis.

2.1.6. Labour relations

The bargaining units for professional disciplines (nursing, medicine, dentistry, and pharmacy) are their professional associations. Not surprisingly, physicians have the strongest association while nursing the weakest. The Jordanian Association of Nurses does not have a power base to negotiate working conditions and wage benefits for nurses. Working conditions, salaries and benefits are controlled by each institution including the Government and private sectors. There is no minimum wage legislation in Jordan and wages vary among institutions specifically in the private sector. Workers have legal protection in terms of job security, salaries and benefits; however, in some institutions, they are poor. Physicians and nurses have repeatedly gone on strike since 1997 for better wages and benefits. New legislation (1994) mandates that all new public service employers

are offered an annual contract and receive social security benefits. Prior to 1994 employees were not on contract and received retirement benefits.

2.1.7. Gender policy and gender outcomes

In Jordan disparities still exist between men and women in relation to specific allowances; for example, women are not entitled to receive a child allowance and in some institutions pay more than men to insure their children. Few women are appointed to high-level administrative positions and more men are offered educational scholarships. Mainstreaming of gender issues is seen in reproductive health-funded projects for women, which are mandated by international donor agencies. For students, there is no sex discrimination in the student admission policies. All students of either sex are selected for university courses based solely on their attainment in their secondary school certificate. Similarly, admission to graduate studies and residency programmes in medicine is competitive and based entirely on achievement.

2.2. Impact on the health workforce (private and public sectors)

2.2.1. Changes in the pattern of employment (structure and level, decentralization)

In 1988 the classification system of working levels was modified and based on scientific qualifications. Prior to this education, qualifications were not considered as a criterion for classification, only years of experience. Furthermore, the classification system has been broadened to include four levels:

- first level: senior administrators;
- second level: professionals;
- third level: non professionals (secretarial staff);
- fourth level: staff of support services (such as photocopiers, cleaners, etc.).

The classification system was valued by health care professionals and is considered to be an incentive, especially to physician specialists who start at the higher level upon their appointment.

Another major change was mandated to pharmacists, due to the fact that all administrative positions in the health sector are controlled by medical doctors. The Jordanian Pharmaceutical Association awarded the title "Doctor" on pharmacists in 1996.

However, the impact of this change on the satisfaction and performance of pharmacists has not yet been studied. Many pharmacists believe that incentives and promotion to higher posts would have impacted better than the "Doctor" title by itself.

The implicit policy of the Government is decentralization of services and decision-making. All functions, decisions, power, responsibilities, and services are supposed to be centralized at the local level to ensure better planning, monitoring and decision-making. However, roles and lines of responsibility are still not clear at the local and central level of the MOH. Therefore, policy-making, budget, and operational decisions and programme management are all highly centralized. Due to a lack of quality managerial skills at the local level as well as at the government level, the decision-making process tends to be carried out at the central level. In addition, the MOH has a centralized system of data collection, which defeats the purpose of a decentralization policy.

Currently, the data (which already lack sufficient quantitative information and contains no qualitative data) are processed at the central level, thereby totally removing the decision-making process from the local level. The centralized allocation process for supplying and equipping facilities and paying personnel in the public sector provides few incentives for the efficient delivery of services at the individual institution level. Lack of standard treatment protocols often leads to costly in-patient treatment and excessive use of expensive drugs for conditions that could be treated on an outpatient basis. There are inefficiencies in terms of overall management, procurement, storage, distribution, and pricing policies.

The goals of the MOH can be enhanced through developing, strengthening, and enhancing the managerial, technical, and research capability of all professional health care providers at the local level as well as government and central levels.

The economic recession, maldistribution of staff, and the expenditure of the MOH have impacted on the employment of health care professionals. Policies of limited recruitment coupled with no recruitment at other times, regardless of the increased demand on the health care services, have negatively affected the workload of health providers and the patient/health provider ratio. This was significant in areas located outside three major cities in Jordan. The movement of highly specialized, qualified staff to the private sector was significant, resulting in more underqualified staff at the MOH. Until 1992 all specialists were required to sit for the national exam according to each specialty area. Currently, specialist graduates from outside the country are waived from the national exams leaving a bulk of unqualified graduates of some eastern countries at the MOH since the highly competent and qualified individuals leave to the private sector.

As for nurses, it is interesting to note that graduate diploma nurses who are sponsored by the MOH throughout their studies, and who are obligated to pay back their education by serving the country double the time they spend at the diploma schools of nursing, suffer from the reluctance of the MOH to employ them. This means that they are free from their obligation after a six months' period of non-employment by the MOH.

Some support services are contracted out by the health sector. Workers of these services are mainly non-Jordanian who work for minimum wages and are not unionized. They suffer from poor working conditions and temporary employment.

Two important occasions that could have impacted on health reform in Jordan resulting in major changes in the employment conditions in the health sector include:

– The Curative Medical Institution

The Curative Medical Institution, established in 1988, was set up to monitor and coordinate all curative services (hospitals) from different health sectors in Jordan in order to promote better quality of care and services to people. Numerous taskforces and committees had difficulty in identifying the role of the institution, scope of services, and laws and regulations to unify the different sectors of the military, MOH, university, and private institutions. While the committee was working on this, the Prime Minister declared the end of the curative medical services (1991) as he was convinced that it would not be effective. Reasons given for this include: the disparity of different roles and regulations, employment schemes, benefits and status of different sectors; examples of this include:

- The military sector is highly organized, powerful, and has many benefits from the military services.
- The university sector operates from its ivory tower, and has unique and prestigious status as an academic institution.
- The MOH is considered as being the inferior, and the poorest in money and resources.
- The private sector was in its infancy stage, at that time and weak and unorganized.

Thus, each party had its own agenda, interests, and enjoys its status and power (some more than others), which have contributed to the collapse of the system. However, many senior health leaders believe that the institution could have impacted on new health reform in Jordan. A former Minister of Health stated in May 1999 that "through the Curative Medical Institution, Jordan could have had a real health reform in the country, but the dream did not come through since each party was concerned about its empire and the political will and support was absent".*(32)* Interestingly, during the Gulf War in 1991, emergency measures were taken in all health sectors and little money was spent on curative health services; consequently, the heat was taken off the issue of disbanding the Curative Medical Institution, including the cost and effort of setting it up. Thus, the Gulf War provided an opportunity for great growth in the private health sector in Jordan.

– The Higher Council for Health

The Higher Council for Health was established in 1976 for the purpose of monitoring, regulating and coordinating the health sector in Jordan, including medical education, specialization, licensure, and international health projects. Unfortunately, this Council was dependent on the grace of the Minister of Health and was activated and disbanded at his wishes. The Council included representatives from medicine, dentistry, and pharmacy from the different sectors (military, MOH, university and private) but no secretary-general or administrative staff were appointed to the Council. Thus, there was no single person responsible to follow up on the activities of the Council. In 1992, a modified proposal of

the Higher Council for Health was submitted to the Minister of Health emphasizing the need for a supportive body and a secretary-general for the Council. Recently, the Higher Council for Health was approved by Parliament; however, it has yet to be implemented since the advocate for this Council, the Minister of Health, was replaced four months ago. Many health leaders think if there is a political will and support to activate the council, implementation should begin immediately. Interestingly, nursing is not represented on the council and this impacts on the autonomy of the nursing profession, feelings of powerlessness among its members, and the performance of nurses.

2.2.2. Legal status of staff

Previously the selection and appointment of staff was done through the central public service office. In 1998 this role was delegated to the different governorate level and just recently, on 17 May 1999, it returned back to the central public service office because of abuse of power. The minister, director-general, and direct supervisors have the authority to reprimand employees and refer them to a disciplinary committee. The decision to dismiss any person is made by the Minister of Health. The Cabinet of Ministers should approve the decision of retirement and early retirement. As for the private sector, the directors of hospitals are responsible for appointments, setting salaries, exercising disciplinary measures and removing employees from the hospitals.

Despite the fact that strikes and demonstrations are unlawful in Jordan, physicians and nurses have repeatedly gone on strike since 1997 for better wages and benefits. After long negotiation with the MOH and professional organizations, new legislation (1998) mandates new overtime allowance for both groups. Interestingly, the nurse's allowance, as usual, was not satisfactory.

2.2.3. Training and retraining, career opportunities, mobility

One of the philosophies of Jordan is to invest in the people themselves and develop the human resources of the country. This logic has been reiterated and supported by the late King Hussein on many occasions. Although, the MOH emphasizes human resource development, it has yet to formulate a long-term plan to achieve this goal. Need for such a plan is already outlined in the MOH and MoAD mission and responsibilities stated in sections 1.2 and 1.3. The RMS has a better-developed plan in relation to human resource development and they have already implemented the clinical ladder for health professionals.

In the MOH there is no clinical ladder and the status of long-serving registered nurses (RN) is no different to that of the new graduate RNs on the floor. As for physicians in the MOH, the career ladder does exist but upward mobility on this ladder is based only on years of experience spent in the MOH. Similarly, management and leadership posts in the MOH are based on the years of experience rather than competency level and managerial skills.

The RMS initiated a career ladder for physicians and dentists in 1980 but it was not until 1994 that this initiative was offered to nurses, pharmacists, and other paramedics. There are wide disparities seen between the groups in terms of monetary remuneration. The MOH and the private sector do not offer any incentives for career mobility for nurses. In a quality of worklife study (Al-Ma'aitah et al., 1999) male and female nurses expressed many concerns about their career future, a powerful indicator of job satisfaction and propensity to leave.*(33)*

In spite of limited opportunities for upward mobility among nurses, a small but growing cadre of baccalaureate graduates and nurses with advanced degrees prevail in Jordan. The majority of nurses with master and doctoral degrees earned their baccalaureate degrees in Jordan and later earned graduate degrees from universities in the United States and the United Kingdom. Most are junior faculty members who were offered scholarships in return for a specified number of years of service as a faculty member of the sponsoring university. Their numbers, however, are still relatively small and fewer are found in practice roles outside the university setting. As might be expected, their needs tend to be more academic, oriented to scholarly concerns and dictated by their roles as faculty members in major university settings.

Medical and nursing schools have been aware of the lack of management and communication concepts in their curricula. Thus, curricula are being reviewed to integrate these concepts with much emphasis on ethical issues. Pharmacy schools and drug companies mainly perform training of pharmacists. Some major changes in the curricula were introduced to emphasize "patient-oriented" and ethical concepts in the education and training of pharmacists.

Personnel from the MOH, RMS and universities who are granted training and/or educational scholarship are required, by contract, to pay back their obligation by service. For example, for every year of scholarship two years of service must be completed. However, shortage of money for training is a real problem in the MOH. Thus, projects by international donors always emphasize the training of health professionals. Poignantly, only US$140,000 were allocated from the MOH budget in 1996 to development of human resources. Such an amount of money will not cover the expenses of two people to undertake a one-year post basic qualification (diploma) outside the country or even a limited number of people for short courses inside the country.*(20)*

The current health strategy places great emphasis on developing human resources by providing professional training and experience including:

- developing standard estimates of the number of staff necessary in each area to provide the required amount of care in their specialty, and developing standards for training and competency indicators for personnel in their specialty;
- concentrating on investment in educational specialization in the medical field, administration and information systems and in health economics for medical and supporting staff;

- preparing plans and policies to assure the appropriate structural distribution of manpower;
- developing modern and economic systems of incentives;
- establishing research centres.

It is interesting to note that the MOH, in its current strategy, has realized the need to integrate the human dimension and the scientific process in providing health services and all training activities provided by the MOH.

2.2.4. Organizational change and participation of the workforce

Overall, all health disciplines are controlled by physicians who have high status and visibility. They control all decision-making processes at the central and local levels.

For nursing posts, it is interesting to note that female nurses in Jordan mainly control management positions as it is endorsed and encouraged by physicians and upper levels of management of health care providers. The male nursing workforce is rapidly increasing and a study was conducted in Jordan on the interpersonal behaviour of Jordanian nursing students.*(34)* The findings of the study showed that male nursing students tend to control and influence interpersonal relationships more than the female students. The authors suggested that these findings could indicate that male nurses would exert more influence and control of the nursing profession in the future. This may result in changes in the control, power, and leadership capabilities within the nursing profession. Consequently, more male nurses may pursue leadership positions that will impact positively at a macro and micro level of nursing status in the country.

In terms of financial remuneration, physicians receive a larger share of allowances and benefits from the health sector than any other health care professionals. The least powerful players in the health sector are nurses and paramedics. In the public sector physicians, nurses and other health care professionals are salaried and have scheduled working hours. However, physicians have more flexibility in rearranging their hours of work compared to the other groups. Personnel working for the MOH and RMS are not allowed to do private practice; however, some do extra work illegally in the private sector.

The six-eight working hour policy has become an issue to health care providers. It is interesting to note that nurses who were appointed before 1 June 1996 are entitled to overtime allowance. They work eight hours, which is more than two hours in excess of the approved working hours. However, those who were appointed after 1 June 1996 are not entitled to take the overtime allowance and work for eight hours. This is still a hot issue among nursing professionals. Nurses and other paramedical personnel are not given the opportunity to work part time in the MOH or the RMS, but those working in the private sector can do so.

In a quality of work life study conducted in 1998, 36 per cent of nurses who worked full time reported that their work preference was for part-time work.*(33)* These nurses reported lower satisfaction with various aspects of their work and working conditions, greater emotional exhaustion and a higher turnover rate. Nurses have minimal flexibility in work schedules and must do all shifts (days, evenings, and nights). Nurses who are in managerial positions work mainly day shifts for 48 hours per week. Rest periods are given only for night duty nurses. Nurses, full-time physicians and other health care workers who work in the private sector are regulated by the institution. In some cases they are given wide latitude and in others the latitude is minimal.

The current health strategy places great emphasis on structural and administrative issues that include:

- restructuring the Ministry of Health in line with the new organizational structure and adopting its amended by-laws by the cabinet;
- computerizing all the Ministry's functions;
- dividing the Kingdom into three major health regions: the north, the central and the south, so that each region would become an independent health area, linked to the centre by the major strategic decisions;
- modernizing the administration and developing the monitoring system for administrative performance in line with international standards and in accordance with the needed technical development;
- linking the overall administrative performance with the economies of health.

2.2.5. Staff performance, remuneration

Previously, staff performance evaluations were confidential with staff denied access to their own evaluations. This was changed in 1988 when the Government allowed workers to read and sign their evaluation forms and in the cases of conflict, workers were allowed to appeal to a special committee at the MOH from which the decision was final. With this policy the MOH found that 97.5 per cent of the staff were rated from "excellent" to "outstanding" and the question was raised whether this was an accurate reflection of performance. Thus, in 1998 the policy was changed back to being confidential with the exception of staff who was rated "below average" and "weak".

There are no effective monitoring plans or evaluation tools used to measure the quality of care, patient outcome, staff performance, managerial capacity, and clinical efficiency of health care providers. Recently, some standards of care enacted under the quality improvement project in the MOH sponsored by USAID have been implemented by a few health centres.*(31)* In addition, the Quality Assurance Department has recently developed job descriptions in certain areas but according to PHC managers they have not yet be implemented.*(31)*

All health care providers who were appointed prior to January 1995 were entitled to retirement benefits while those appointed after January 1995 were entitled to social security benefits. This latter group was also appointed on an annual contract basis. Retirement benefits are lower than social security benefits, but include the basic salary and exclude the technical allowance. Social security benefits include both the basic salary and the technical allowance. However, in the case of death, the family is able to collect benefits if the employee was on retirement benefits, which is not the case for those on social security. In addition, the group on social security does not have job security as they are on contract while the other group has more job security. Both groups perceive their situation as being unfair. An adjustment was made to those in higher level positions and specialist physicians on social security as they were granted permanent jobs.

Early retirement is divided into two categories. The first occurs when an employee asks for early retirement. In this case, the employee is then required to pay 8.75 per cent of the basic salary in order to collect social security. In the second category, the Government can decide on early retirement for employees; in which case employees receive 50 per cent of their salary and allowance until they complete the years required to collect social security. This is attractive to physicians and nurses who want to work for the private sector or abroad.

As noted in section 2.2.3, physicians are receiving the lion's share of the incentives and wages in the health sector. Wages for nurses in the MOH start from JD225 per month to JD369 per month based on years of service. The range in the RMS is from JD230 to JD400 (based on the clinical ladder) and in the private sector from JD220 to JD300 based on years of experience. Incentives for nurses in the public sector are low. Incentives offered include free housing and meals to nurses and on-call physicians.

The current health strategy emphasizes the need for promoting performance standard and quality of care provided to clients. The strategy includes:

- the improvement of the level of professionalism among all members and personnel in all specializations (technical, administrative, financial economies) involved in health;
- the implementation of a comprehensive and integrated computerized health and management information system in the Ministry of Health at all levels;
- the improvement of the technology used in the system in accordance with modern scientific and technical development, which would preserve an edge for Jordan in the region;
- the improvement of the level of services at hospitals and health centres ensuring optimum use of resources through quality control;
- the promotion of the humanitarian dimension of providing health services in all training provided by the MOH.

2.2.6. Work environment, staff perception, equal opportunities, attitudes, and absenteeism

Numerous factors affect the work environment in Jordan. These include inadequate staffing and distribution of physicians and professional nurses, a high concentration of physicians in main cities, lack of supervision, ineffective regulatory mechanisms, limited resources in the public sector, lack of standards of care, absence of procedure manuals, and absence of procedures for quality improvement.

Due to the expansion of health care services in the country, the condition of many MOH buildings is not acceptable, mainly in rural areas and rented buildings. However, strengthening the capacity of infrastructure and rehabilitation of health physical facilities in Jordan are important components in nearly all international projects in Jordan. For example, one of the major components of the World Bank proposal regarding Jordan's health sector reform is the rehabilitation of health facilities.

Lack of qualitative and quantitative data coupled with weakness in processing and using these data undermine decision-making at all levels. Hospital management and autonomy, finance, health information systems and management health systems are other areas of current concern in the World Bank's proposal for health reform in Jordan.*(9)* Management of PHC services and referral system is emphasized through international projects supporting PHC initiatives such as WHO, UNICEF, UNFPA and the current World Bank proposal for PHC reform in Jordan.

In terms of quality of work life many studies have been conducted among professional nurses.*(33)* Overall findings reveal that nurses are dissatisfied with their jobs and experience a high rate of burnout. Furthermore, baccalaureate nurses as well as male nurses experience a higher rate of burnout and dissatisfaction with their jobs. Both groups reported an increased rate of intention to leave their place of employment. In one study, high levels of burnout and an increased likelihood of resignation was reported in male and female nurses.*(33)* It is more likely that nurses leave the hospital sector to work in educational settings, private sector (a rapidly growing sector in Jordan), or the Gulf area. It is a point of note that physicians working in public hospitals are also looking for similar opportunities outside the public sector.

Satisfaction with supervision received was a significant indicator of job satisfaction for men and women. Because of limited opportunities for staff development and further education, many supervisors are promoted based on length of service. As satisfaction with supervision was demonstrated to be a powerful predictor of job satisfaction, there is a need to increase opportunities for advanced training education on communication and management skills to those in supervisory positions. Strategies should consider the evaluation of the supervision process of nurse administrators, the identified role of nurses from different levels, the skills and educational preparation of nurse administrators and supervisors, and the opportunity for promotion based on educational preparation and qualifications.

For male nurses, hospital identification was also a significant indicator of propensity to leave, that is, nurses who had a negative attitude toward the hospital for which they worked (i.e. felt that the hospital treated its employees poorly, was a poor place to work,

and discouraged them from doing their best) were more likely to leave the hospital. Thus, positive feelings toward the employing hospital were important for male nurses but not for female nurses. The fact that most hospitals prefer to hire female rather than male nurses may be a consequence of this and sometimes they offer different contracts to male nurses from that of female nurses, which may also have a deleterious effect on job satisfaction and attitude toward their place of employment.

The majority of male nursing students entering nursing school do so with mixed emotions since nursing is still identified as a woman's job. Although the negative image toward nursing is still an issue in Jordan, opportunities for employment have encouraged male high-school students to enrol in nursing schools. However, the retention of men in the nursing profession will require attention to male nurse/employer relations now and in the future.

Physical working conditions and type of work performed were significant predictors of the turnover intention in female nurses who were more likely to consider leaving if their physical work conditions were unpleasant and they were dissatisfied with the type of work they were required to perform. In addition, the kind of work was a significant indicator of burnout in men and women.

Job-enhancing characteristics significantly predicted job satisfaction and burnout in female nurses. Lack of opportunities for autonomy and decision-making and opportunities for growth appear to present significant difficulties. This finding further supports concerns regarding the gap between administrators and nurses and the limited education of nursing leaders in the hospital settings. The findings also appear to reflect the powerlessness of Jordanian nurses.

In a comparative study between Canadian and Jordanian nurses, quality of work life, nurses in Jordan were significantly less satisfied with the kind of work they were performing, the amount of work and their working conditions.*(34)* They also reported significantly higher levels of emotional exhaustion and a greater intention to resign from their positions. This may relate to the fact that in Canada all nurses are unionized.

The absenteeism rate is not well documented but does exist among all health professionals as reported by the Director of Nursing, MOH. Absenteeism becomes significant in the rural areas due to lack of monitoring which impacts negatively on quality and quantity of health services in rural areas.

2.2.7. Workforce occupational safety and health

The only provision is the labour injury in the Labour and Employees Act, which applies to health institutions. Lack of orientation programmes as well as ineffective infection control programmes at the majority of the hospitals and health centres increase the degree of risk for health care professionals. Thus, health care personnel are open to risk from infectious diseases.

2.3. Reform effects on public-private mix in the health sector

There are inefficiencies at the microeconomic level in the health system which include: the totally centralized budgeting systems for running facilities; high overhead costs; the salary-based payments for physicians, nurses and others in different sectors; lack of effective referral systems; individuals who bypass lower levels of the system without penalty; minimal financial accountability on the part of both physicians and patients for services rendered; lack of coordination among public and private delivery systems; movement of qualified health personnel to urban areas; the significant excess capacity overall but especially in the private sector; limited use of generic drugs; lack of treatment protocols; and future hospital bed construction plans bearing little relationship to actual needs. The excess overall bed capacity is evidenced by a hospital occupancy rate of 63 per cent (69 per cent in the public sector and 49 per cent in the private sector).

The rapid growth of the largely unregulated private sector is indicative of access and quality problems in the public sector. The substantial excess capacity of the private sector, limited regulation of quality and price, and lack of relevant information on the private sector utilization, capacity (especially for some 3,000 private physician practices), and expenditure are problematic and obviate the development of policies that maximize cost-effective use of total health resources. The unregulated private sector accounts for over 30 per cent of service delivery capacity and over half of all health spending, and its shares are growing, resulting in a two-tiered system of care. Lack of a coordinated policy apparatus and relevant data for decision-making precludes effective policy and has a negative impact on Jordan's multiple public and private financing arrangements and delivery systems.

Movement of qualified health care providers from the public to private sector and illegal working hours in the private sector, by some of the MOH employees, complicate the issue of trust and mutual relationship between the two sectors. In addition, the issue of the conflict of interests among health care providers should be raised which might affect the quality of health services. In fact, while Jordan has adequate numbers of physicians (excluding some specialty areas), the quality of their educational preparation varies widely and those with good practice tend to leave to the private sector. As for nurses, they are still in short supply and many look for opportunities outside the country.

Overall, both public and private sectors have their own delivery system, and there is very little coordination between them. A reform strategy is needed to strengthen the capacity of the health sector and improve the efficiency and effectiveness of the service delivery system and must focus on structure, management, manpower, and physical infrastructure. Finally, the current health strategy for 1999-2002 as well as the MoAD emphasizes the management component and places high value on cooperation, collaboration and productive relationships with the private sector.

3. Lessons learned

Examining the different factors that have affected the development of the country as a whole and taking into consideration that the implementation of the development measures

is still in its infancy stage; judgement on this experience and the lessons learned is still premature. However, major issues can be identified.

Reform is a complex, inevitable and ongoing process:

Different ministries, departments, sectors, and staff are concerned with the reform and need to coordinate, collaborate, and interact with each other. Thus, the establishment of a coordinating body like the MoAD is a positive step toward monitoring and attaining the development objectives side by side with other ministries, as far as it is granted decision-making authority and high status.

Powerful coordinating body for dialogue and monitoring:

High status and visibility ensure better monitoring and provision of the process as well as continuous dialogue about the development and its process among the policy-makers, executives, legislators, and stakeholders including private sector as well as the public sector. Reform of the country is a political issue that should be planned, handled, and monitored very carefully throughout the process. Consequently, bridging the trust between the Government, services and the public is crucial to success.

Reform must be identified, specified, and publicized:

Awareness of the reform (emphasizing what is going on and what and how it will be) among all sectors as well as the public is a must. Every single ministry, department, sector, and staff member should be aware of the reform objective and process. Interestingly, many people, including leaders, were not really aware of the development process that Jordan is going through. In fact, people thought of economic development without connecting it with the need for cross-sectoral development of the country, including health.

Management capacity:

Management capacity at the central, intermediate and local levels is essential, and capabilities of managers are vital to the enhancement of the development process. Thus, managers must be selected on a competitive basis consistent with the government initiative. Immediate action and implementation of this initiative, without being limited to a single group (e.g. physicians) will be instrumental in promoting decentralization, collaboration, and sound planning as well as enhancement of the development process.

Government support (political will) for decentralization:

Government support for decentralization and strong management is evident in the second objective of reform: institutionalization, sound planning, and team work in the performance of governmental organs must be enhanced, and decentralization must be firmly established.

Decentralization and consolidation of popular participation have not yet been achieved due to the lack of managerial skills and qualified personnel at the central and local levels. In addition, the MOH has a centralized system of data collection, which defeats the purpose of the decentralization policy. Currently, information is processed at the central level, thereby removing the decision-making process from the local level. Training is also important. So far, staff is not yet prepared on how to implement reform; yet, know-how for new responsibilities resulting from reform should be included in all training activities, pre-service and in-service education to facilitate the reform process.

Reform must be attainable and measurable:

Reform measures must be realistic and should be based on the country's resources (financial, staff, and infrastructure). The reform should have a clear mission, goals and objectives based on solid data. Since monitoring is vital for evaluating the impact of the reform, a strategic framework for evaluation needs to be agreed upon prior to implementing reform measures. The lack of such a framework in Jordan, for example in the MOH, makes it difficult to assess the impact of the development process on health care providers as well as clients. Moreover, availability of scientifically sound data is essential for monitoring. Lack of qualitative and quantitative data coupled with weakness in processing and using this information undermine the monitoring process as well as decision-making capacity at all levels. Speeding up the efforts to establish a management information system as well as a framework for monitoring and follow-up is crucial for the MOH to strengthen its role in the provision of quality health services in Jordan.

Empowerment of staff is essential:

Health care providers and personnel need to be empowered and be aware of the need for reform and its strategies and process since they are main players in this process. The assessment of their *perceived needs* as well as the review of their salaries and working conditions, of their involvement in planning and evaluation, performance evaluation, career opportunities, flexibility, job security, training, and continuing education would all be measures to empower staff and make them accountable for excellence. Looking into the duties of the ministries toward achieving the country development we find a lot of emphasis on the empowerment of employees and institutions. After all, human resources have been identified by the MoAD as the core of the development.

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Appendix

Health in Jordan

Country demographic and health data (1997)	Value
Population	4 600 000
Adult male illiteracy rate (% of 15+yrs of age)	8.8
Adult female illiteracy rate (% of 15+yrs of age)	19.1
Average	13.8
Crude birth rate (per 1,000 pop.)	30
Crude death rate (per 1,000 pop.)	6
Infant mortality rate (per 1,000 live births)	28
Maternal mortality rate (per 1,000 live births)	41.4
Population growth rate (%)	3.4
Total fertility rate	4.4
Average persons per family	6
Life expectancy at birth (yrs.) female	69.9
Life expectancy at birth (yrs.) male	66
Average	68
Dependency ratio	1:4
Unemployment rate (%)	13.3
Population per physician	604
Population per dentist	2 042
Population per nurse (all categories)	338
Population per pharmacist	1 292
MOH and HC health centres	
1. Comprehensive health centres	42
2. Primary care health centres	326
3. Village health centres	247
4. MCH centres	316
5. Dental clinic	203
6. Chest disease centres	11
Hospital number	75
Hospital beds	8 129

– Ministry of Health and Health Care	3 207
– Royal Medical Services	1 787
– Jordan University Hospital	506
– Private sector	2 629
– Population per hospital bed	604