Performance, working conditions and coping strategies: an introduction

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One of the basic reasons underlying health care reform efforts, however varied these may be in scope or comprehensiveness or speed or intensity, is the widely-shared suspicion that health services perform less well than they should and could do. As health systems are essentially made up of people, improving performance would first have to focus on them – even acknowledging that working environment plays a crucial role.

The management of human resources is one of the most important determinants of the success or failure of health sector reform. Despite management reforms and staff training efforts, many public sector organisations have had little success in improving the performance of their staff. With increasing demands for accountability and value for money from public sector services, it is at least necessary to improve our understanding of what makes health personnel perform well – and of what stands in the way of good performance.

Many governments automatically recruit all health professionals upon graduation to work in the state health care sector. All too often this means wages below subsistence level and working conditions without the basic material and equipment. Policy developments in the health care sector usually ignore these realities, either because of a lack of planning capacity at the central level or because of overriding political concerns or civil strife. In
the meantime, cities witness an explosive growth of ‘wild’ private health care, sometimes legal, sometimes not, but always unregulated. A characteristic of this particular private sector is that it ‘shares’ the human and material resources of the public sector: personnel, facilities, drugs, etc. State sector health personnel become less available to work for the public sector, but do not resign. They remain state employees, and enjoy the relative advantages of status, fringe benefits and study opportunities.

An attractive alternative, particularly for doctors, are job offers from international development agencies or (international) non-governmental organisations. Such job opportunities contribute to an internal brain-drain of human resources by reducing the number of personnel available for state sector health service provision but, on the other hand, may help to retain good and competent professionals in the country.

The predicament of the public sector health worker can be mapped as a vicious circle. Health workers with relatively high professional and material expectations are working in a resource-poor environment with little support or supervision. They have little incentive – and means – to maintain or improve their performance within the frame of their public service duties, and at the same time they have to develop individual ‘coping strategies’ to fulfill their professional and material expectations. This works, at least to some extent, and allows the public authorities, hard-pressed for scarce resources, to ignore unrealistic claims for salary increases, since their employees are helping themselves. The bureaucratic system is in relative equilibrium, as long as public frustration does not voice its dissatisfaction as a political challenge. And the civil servant is left to pursue his individual coping strategies, whereas his investment in his job proper becomes increasingly symbolic. This further discourages and undermines attempts to build a public service that lives up to the legitimate demand for quality care. Thus the vicious circle is complete. In the short-term it is in the interest of all actors (health workers, policy makers and donors) to behave as if it did not exist, or to discuss it either in terms of downsizing or of provider-blaming. The underlying realities or to the precise consequences for public health sector service delivery are rarely analysed.

These issues were discussed at an international conference in Lisbon (October 9-10, 1998)\(^1\), in an attempt to stimulate a rational dialogue free of

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\(^1\) The conference was organised by the Centro de Malária e Outras Doenças Tropicais da Universidade Nova de Lisboa (Portugal), the Prince Leopold Institute of Tropical Medicine (Belgium) and the Associação para a Cooperação e Desenvolvimento Garcia d’Orta (Portugal). It was made possible through the financial support of the INCO-DC Programme of Directorate General XII of the European Union.
the moralising finger-wagging they often seem to generate. The objective of
the conference was to describe practices in a range of countries and to
identify the implications for health policy makers seeking to improve health
personnel performance.

The conference was attended by policy makers and researchers from in-
ternational organisations and from 28 countries in Europe, Africa, the Mid-
dle East, Asia and North and Latin America. The conference participants
described coping strategies and their consequences in their countries, as-
essed the problems and limitations with existing mechanisms of managing
personnel performance in the health sector in the context of such coping
strategies, and debated the positive and negative effects of the human re-
source policies of international organisations. This resulted in a collection
of papers with very different viewpoints and formats, reflecting the different
professional and geographical backgrounds of the participants. We have
grouped them under three headings. First a set of papers describes the per-
formance of health personnel in a number of countries and attempts to im-
prove it. A second part looks more closely at the various coping strategies
health care workers, medical and paramedical, clinical and managerial, ac-
tually apply to deal with difficult working and living conditions. A third part
looks at how policy makers and technical assistance agencies deal with the
predicament of health personnel – with the necessary distinction between
policy and practice. This part ends with two field experiences, from Thai-
land and South Africa. They relate how practitioners have managed to find
a good and pragmatic compromise between their professional and other as-
pirations, and their vision of a public mission for health services.

It came as no surprise that the evidence on the nature and impact of West-
ern-style performance management systems is limited and of little relevance
for the public health sector of developing countries. As several participants
noted, it is somewhat academic and futile to evaluate the performance of
public health staff when they do not have a minimum of supplies or equip-
ment, nor a decent living wage. But even in more favourable environ-
ments, public sector services are not necessarily open to improvement by
such management systems. These latter are potentially relevant only to the
extent that performance matters in these services. A necessary condition
seems to be to render the organisation performance-conscious before sad-
dling it with a performance management system of any kind. Examples from
South Africa, Spain and from quasi-governmental hospitals in Ghana seem

Commission, BADC (Belgium), the Fundação Luso Americana para o Desenvol-
vimento (Portugal) and the Fundação para a Ciência e Tecnologia (Portugal).
to indicate that, on a small scale, and in adequately resourced working environments, a team approach, clarity as to what is expected of people and some incentives (e.g. financial rewards and educational opportunities) may result in more job satisfaction and better performance.

In this context it was rather intriguing to note the recurrence of references to the "inner motivation" of health personnel. Whether described as "professional ethos", "sense of belonging to a team", or "working for the public good", it was clear that fostering a sense of commitment to the public good and ensuring fairness and peer collaboration are critical elements to improvement of health personnel performance. On the other hand, evidence presented suggested that incentive schemes based on financial rewards for reaching pre-identified measurable objectives may result in a loss of professional values and may cause health care provision to become just another market item, to be sold according to the availability of material incentives. In this context the public health care sector may become merely a place for professionals to recruit clients for their private activities.

Officials of international development agencies present at the meeting acknowledged that their organisations had not always adequately addressed human resource issues and strategies in the countries in which they provide aid. They recognised that their own employment policies have at times aggravated personnel-associated imbalances and problems. On the other hand, they face a kind of prisoner's dilemma: participate in the vicious circle, and help perpetuate it, or sacrifice performance in the short term. Hence a call for more intensive deliberation and collaboration between development agencies, government officials and academics to find adequate solutions.

Government officials present at the meeting stressed the need to recognise health workers as a productive part of society, and not just as drains on scarce public resources. They pointed out that as the private sector grows the need for regulation increases, but that policing a large and sophisticated private sector may be even more difficult than managing the public sector. Mere downsizing is not a solution, if the public sector is to switch from a focus on service delivery to one of regulator and purchaser of health care.

The papers in this book show that it is possible to discuss these delicate issues without moralising. Providing evidence and documentation, will, we hope, help to manage the current impact of the health sector crisis on the performance of the health personnel. Solutions are not self-evident, but a number of points are clear as of now. First, it will not be possible to address these problems without actively involving the major international development agencies. Second, the private sector is a reality that cannot be ig-
nored: the times of exclusive public provision of health care are gone. Third, salary increases for public sector personnel are not affordable on the scale that would be necessary to redress the situation. Fourth, financial incentives are only part of the solution: professional and social value systems are poorly understood but underestimated motivators.

It would be naïve to hope for blueprint solutions that would break the vicious circle that characterises the performance of public health care providers in many countries. A few of the case studies reported here, however, show that at least piecemeal and incremental solutions are possible.