Assessing Quality Outcome and Performance Management

Javier Martínez

INTRODUCTION

This paper address a number of questions. What is the evidence and what are the valid methods for improving the quality of care and outcomes through the use of human resources interventions? What are the different models of human resources related to quality improvement and performance management systems in the health sector at national/strategic level and at local/operational level? How are human resources performance indicators at national and operational levels derived, applied and used? What are the methods used to assess the performance of individual workers and teams in health care?

MAPPING OUT THE TOPIC AND THIS REVIEW

Performance management is or should be an eminently practical process closely aligned with other aspects of general management, and does not sit easily as an isolated subject for academic scrutiny. For example, much of the literature from the 80s and early 90s makes a separation between quality a service outcome, and performance a human resource outcome. In practice, such separation does not seem to make sense, since both performance management and quality enhancement ultimately rely on human resource interventions, and both pursue the goal of delivering better services.

This review will focus on the use of performance management – an increasingly popular human resource intervention – as a means to improve the quality and outcomes of health care. The approaches used to improve staff performance and increase service quality are many and have quickly become an integral part of general management theory and practice. These include Quality Assurance, Quality Audit, Total Quality Management, Quality Cycles, Benchmarking, Accreditation, Certification, and Performance Appraisal, among others. These approaches in turn share some of the tools used to ensure quality, such as treatment protocols, definition of

quality standards, user satisfaction surveys, or personal development plans, among many others. All these approaches require the introduction of human resource interventions of one type or another since they all ultimately rely on the skills, motivation and performance of health care professionals.

This review will attempt to cover the topic by answering three main questions: what is performance management? How have the concept and practice of performance management evolved over time? How is performance management being applied to health care organisations? What are the main models, approaches and indicators used? What are the essential prerequisites for applying performance management to national health systems?

THE CONCEPT AND PRACTICE OF PERFORMANCE MANAGEMENT

DEFINITION

Performance management is a term borrowed from the management literature that has only recently been adopted in the health care field. The term 'performance management' was first used in the 1970s, but it did not become a recognised process until the latter half of the 1980s (1). The meaning of performance management has evolved and continues to evolve. While in the sixties and seventies performance management was often equated to some form of merit-rating, in the eighties and nineties it has been linked to 'new' management paradigms such as Management by Objectives, Performance Appraisal, Behaviourally Anchored Rating Scales and Performance-related Pay.

Even today, authors differ in their understanding of performance management. The following definitions allow us to view the changes that the concept of performance management has undergone during the 1990s.

Fowler (2) defines performance management as: "...the organisation of work to achieve the best possible results. From this simple viewpoint, performance management is not a system or technique, it is the totality of the day-to-day activities of all managers".

The (then) Institute of Personnel Management (3) produced a similar definition: "A strategy which relates to every activity of the organisation set in the context of its human resources policies, culture, style

and communications systems. The nature of the strategy depends on the organisational context and can vary from organisation to organisation."

Storey and Sisson (4) define performance management as: "…an interlocking set of policies and practices which have as their focus the enhanced achievement of organisational objectives through a concentration on individual performance."

Fletcher provides a more organisational definition of performance management :"an approach to creating a shared vision of the purpose and aims of the organisation, helping each individual employee understand and recognise their part in contributing to them, and in so doing manage and enhance the performance of both individuals and the organisation."

Finally, Armstrong and Baron(1) define performance management by eliciting the characteristics of a performance management system (table 1). This is a conceptual, organisational and operational definition that has been found useful by authors researching performance management in health systems.

Table 1. Characteristics of a Performance Management System by Armstrong and Baron

It communicates a vision of its objectives to all its employees.
It sets departmental, unit, team and individual performance targets that are related to wider objectives.
It conducts a formal review of progress towards these targets.
It uses the review process to identify training, development and reward outcomes.
It evaluates the whole process in order to improve effectiveness.
It defines a managerial structure to look after all the characteristics above, so that individual staff and managers are assigned specific responsibilities to manage the Performance Management System.
In addition, performance management organisations:
Express performance targets in terms of measurable outputs, accountabilities and training/learning targets.
Use formal appraisal procedures as ways of communicating performance requirements that are set on a regular basis.
Link performance requirements to pay, especially for senior managers.

The Recent Evolution of the Concept and Practice of Performance

Performance management is essentially about measuring, monitoring and enhancing the performance of staff, as a contributor to overall organisational performance. It must be said at this stage that while staff and organisational performance are closely inter-related, the nature of this relationship is complex and subject to many external variables often beyond the scope of performance or general management (5).

While the earliest forms of staff performance management focused on performance management tools, modern approaches have emphasized the need to combine various tools in order to achieve an integrated and coherent performance management system. Hence, performance management was initially equated with tools such as work study (which gave way to today's task and job analysis), Critical Path Analysis, or Merit Rating of various forms (6). In the public sector, the most popular approach to performance management has been the use of staff appraisal.

Efficiency drives in the public sectors of many countries during the 80s and 90s further contributed to emphasise the notion that the performance of individuals should not be taken for granted (7), and that higher productivity a dimension of performance could only be attained through people (8, 9). This led to the principle that good performance should be rewarded, and that bad performance should not be tolerated and should be promptly addressed by management. This required the setting up of means to measure performance, and the subsequent development of performance indicators. Indicators enabled linear comparability changes in performance that can be measured over time and cross sectional comparability how does my organisation's performance compare with that of other organisations of similar kind and trade?

All these concepts emerged from commerce and industry and soon permeated into the public sector. Initially, attempts at evaluating performance in the public sector were based on the assessment of value for money, and were normally conducted by external auditors. Gradually, a whole range of measures and indicators of performance followed, in an attempt to identify examples of good and poor resource usage and the setting of standards for complete service areas. Achievement against set criteria was then used as the basis for external accountability and became over time a common framework for resource allocation formulae, so that

organisations performing well would be rewarded with more public money. In the UK and the US, this process soon reached the health and education sectors: the Research Assessment Exercise in higher education and the league tables for publicly funded schools are two examples of how the performance philosophy has begun to drive resource allocation in the education sector (10). Clinical audit, quality assurance, accreditation and benchmarking are similar attempts to establish standards for health care now fully established within many European health systems and within the USA following the introduction of managed care.

Performance management has been constantly changing in recent years. Conceptual changes have usually followed changes in implementation. It is interesting to look at some of these changes for us to understand where performance management stands today. Based on their research between 1991 and 1997 Armstrong and Baron (1) summarize the key changes that performance management has experienced over time. These changes are shown in the following table and will be used as a basis for defining what performance management initially was, and what it is today.

Table 2. Evolution in the concept of Performance Management between 1991 and 1997.

From	To
System	Process
Appraisal	Joint review
Outputs	Outputs/inputs
Reward oriented	Development oriented
Ratings common	Less rating
Top-down	360 degree feedback
Directive	Supportive
Monolithic	Flexible
Owned by human resources manager	Owned by users
Profession/Cadre-based	Service-based

SOURCE: Adapted from Armstrong and Baron (2000) by the author (1).

From tools to system, and from system to process
Initially, performance management systems were viewed almost as stand-alone processes by which objectives were assigned to individual staff members and then reviewed periodically. The most commonly used approach to performance management in public sector organisations was

staff appraisal. From the use of individual tools, performance management adopted in the 1980s a more systemic approach by integrating it with other planning and management systems. This required the breaking of the walls that had long separated the human resource and other organisational functions, and their respective departments over many years. Hence, performance management became a process by which all managers and staff look at the performance of individuals and teams in the context of organisational objectives. The focus of performance management became the linking of individual with organisational targets, and the means to set, measure (and sometimes reward) the attainment of such objectives. (4,6,10).

At its simplest, performance management is a process that involves: setting strategic objectives and targets for the organisation and for its different units before attempting to establish individual staff performance targets; identifying and implementing tasks to achieve those objectives, and aligning individual targets to the fulfillment of those tasks; monitoring performance of those tasks at organisational, unit and individual levels; reviewing objectives and targets in the light of the outcome.

From individual appraisal to joint review
Staff appraisal is the most commonly used approach to performance management in the public sector, although many authors have highlighted that, in practice, it was more often related to behavioural issues than with performance as such. For many years, staff appraisal relied heavily on the interaction between a supervisor and the person appraised, to the extent that the outcomes of appraisal interviews were often kept confidential and were not even known to the later (11-13). Although personal interaction is highly desirable in any performance management system, it does not per se facilitate the necessary integration and matching between individual and service/organisational objectives. In contrast, performance management is today viewed as an open process where teams, rather than individuals, set and discuss openly objectives and targets set, and where staff and line managers participate equally in such discussions. Wherever individual staff appraisal is part of the performance management process (as in the British National Health Service through Personal Performance Planning review) it should always be based on prior setting and discussion of targets as described before.

Modern performance management systems put greater emphasis in team work, and in established planning review processes, than they do on individual appraisal which is, at its best, only one aspect of the performance management system. Nevertheless, research has highlighted that a comparatively small number of organisations have made special arrangements to operate performance management for teams (1).

From 'outputs' to 'outputs and inputs'
Initially, the emphasis of performance management and of quality assurance approaches was on objective-setting and on the appraisal of results against goals (outputs). The difference now is that there is a realization that a fully rounded view of performance must embrace how people get things done as well as what gets done, i.e., inputs and processes as well as outputs (1,14). In any organisation staff members may be unable to meet targets because they lack the right skills or because work processes are not effectively streamlined. In performance management terms this involves identifying what inputs are required following the failure to meet the expected outputs. In any case the responsibility no longer falls exclusively on the "poor performer" but on other staff and managers as well. This tends to change the focus of performance management completely, allowing it to adopt a greater developmental dimension. In sum, modern performance management recognizes that performance is a result of a combination of factors (staff, resources, protocols, systems) and not just the sum of performances by various individuals (15).

The shift from 'outputs' to 'outputs/inputs' has run in parallel with rethinking the nature, range and number of indicators used in performance management. There are essentially two extreme schools of thought. One claims that many 'boxes' must be provided for managers to fill in. The other advocates the use of a blank sheet of paper, giving managers freedom to do their own thing. An approach somewhere between these extremes is desirable (1).

From reward orientation to staff development
Although many performance management systems still include some form of individual or team reward (in cash or in kind) most analysts agree in stating that rewards are not as central to the notion of performance management as used to be considered. Rewards have been closely

associated with performance since the days of performance-related pay, when no performance enhancement could apparently be expected unless some form of reward was in place. However, many authors have argued that it is not so much the reward but the combination of incentives, positive (to reward good performance) or negative (to discourage poor performance) that make staff more open to performance management. It is the combination of positive and negative incentives the main characteristic of performance-oriented organisations rather than the existence of rewards for good performers

From what little evidence is available, performance-related pay presents managers with a number of practical problems and can act as a serious disincentive for staff. For example, it can introduce tensions and grievances whenever achievement of outcomes is the responsibility of a team rather than an individual responsibility, or wherever rewards are highly substantial or insignificant relative to the salary package. Evidence from a case study in a large health centre in Barcelona revealed that staff perceived any form of individual rewards as unfair, so much so that they had reached an agreement with managers that the cash rewards fund should be distributed evenly among all staff (16). In the same case study, and in another one undertaken in the British National Health Service (17) staff perceived that the greatest asset of performance management was its ability to highlight and act on staff development needs. In their own research Armstrong and Baron (1) describe how by 1998, from the initial association to performance-related pay in 1991, most performance management systems had shifted emphasis towards continuous staff development and self development.

In conclusion, while performance management can be a way to reward good performers (as long as all good performers are rewarded somehow) its focus has changed toward a staff development orientation that should enable staff and managers identify and act on staff (and management) development needs. Ensuring that staff are competent and motivated in their jobs is or should therefore be the central feature of performance management. The topic of reward and cash incentives is broad and complex (18, 19, 20).

From 'ratings common' to 'less rating', and from monolithic to flexible
Initially, performance management and performance appraisal were synonymous with performance or merit rating (7). Essentially, they consisted in assigning scores against agreed targets and indicators. This proved labour-intensive for human resource managers, and did not always lead to the expected improvements in individual performance. It was soon realized that performance rating was only meaningful when broader, overarching objectives had been defined, against which individual merits could be compared. Hence the shift from individual assessment to joint review described above. In health care, setting individual indicators was further complicated by the nature of health care, where many input, output, process and outcome indicators can be fixed for individual staff, teams, service units and departments, thus considerably increasing the potential for complication as regards the final measurement. Individual performance indicators can be controversial. For instance, productivity (output by input) targets are emphasized to the detriment of indicators relating to the quality and the personalized nature of care, where the same problem can present in a variety of ways and requires different service strategies.

Assigning indicators to jobs that rely heavily on group work was an additional problem in basing performance management on the measurement of indicators. Although most people recognize that some form of measurement and some indicators are clearly necessary in health care performance management, the nature of the indicators to be used is still the subject of much debate. In any case, the initial focus on rating soon gave way to other considerations that put the characteristics of each service at the core of its performance management system. The emphasis in performance management therefore soon shifted towards checking whether, for instance, staff possessed the required individual abilities and were able to work effectively in teams so as to provide a predefined set of services along agreed quality standards. What performance management was doing was simply to adapt to the new trends affecting the health care industry around the world, where benchmarking, service protocols and quality cycles, among many others, were becoming the norm. Ratings became less important than inputs, outputs and processes.

From 'top down' to '360 degree feedback', and from directive to supportive
In the 80s and early 90s many organisations still attempted to improve performance and service quality by ensuring staff compliance to objectives set at the top that then cascaded down various organisational layers. The rationale was that the "manager knows best" and that quality and performance management were largely managerial responsibilities. Nowadays, few performance and quality-oriented organisations operate in that manner. There has been a realization that quality and performance management must become part of the organisational culture, and that achieving such culture requires managers and staff to work closely together, identifying bottlenecks and acting on them. This in turn has led to looking more closely at staff needs and ensuring that staff members get all the necessary support and feel valued for what they contribute. The top down, directive approach has given way to more horizontal and supportive structures where everyone has a role to play to achieve best practice. Staff members are no longer expected just to 'do things right' but to 'do the right things' (10).

From 'owned by human resources managers' to 'owned by users'
For many years performance management has been viewed as the primary responsibility of human resource managers who had the responsibility for undertaking performance appraisal as part of their 'personnel function'. Human resources managers would seldom be involved in service planning or strategy development, while line managers seldom participated in the setting of individual targets or in dealing with staff development needs. Odd as such separation may seem, it has been reported in many organisations and can still be found in health care organisations from the developing world (21). Today, performance-oriented organisations have upgraded the personnel function and placed it within strategic management levels while devolving responsibility for performance and quality management to line managers and staff. Human resources managers are still critical for the implementation of performance management. For instance, many human resources managers are still responsible for acting on staff development needs and for administering the training budget, but such responsibilities are no longer performed in isolation (17).

From professional-based to service-based performance management

Many staff appraisal systems have been traditionally linked to individual professions and occupational groups (doctors, nurses, paramedics, administration, clerical staff). The rationale was that only doctors can appraise doctors, only nurses can appraise nurses, and so forth. Such rationale derived from deep-rooted perceptions in civil service and public sector organisations, and from the differences that have always existed and continue to exist among the medical professions in terms of roles, status, pay, subordination and gender, among others (21, 22). Performance management clearly exceeds the boundaries of professional or occupational groups. The team and service focus of performance management requires that various staff categories work in unison: doctors and nurses, reception staff and telephone operators are equally important at the time of delivering a user-friendly, quality service. Furthermore, health services are increasingly expected to comply with the changes in our societies and provide certain services almost around the clock. This has in turn required the application of a considerable degree of flexibility to the hitherto rigid job descriptions that used to prevail among professional groups. Performance management has become in practice a means to enable flexibility in service provision, respecting the distinct characteristics of different professions but aligning these within a single service delivery strategy. The cross-sectional nature of performance management must not be equated with a 'one-size-fits-all' approach. Doctors, nurses and other professionals must maintain their essential characteristics and strengths intact, and performance management implies no loss of professional identity whatever. In fact, some aspects of staff appraisal may well take place within professional group boundaries, as long as individual staff objectives are linked to broader service or organisational objectives.

MODELS METHODS AND INDICATORS TO HEALTH CARE ORGANISATIONS

PERFORMANCE MANAGEMENT IN THE PUBLIC SECTOR AND IN NATIONAL HEALTH SYSTEMS

"Not too long ago, it was generally considered impossible to measure performance in the public sector" (10).

Although the measurement of performance in the public sector is relatively new, a substantial body of literature on performance management has developed since the late 70s, encompassing terms such as performance measures, performance indicators, performance appraisal and review, value for money and, more recently, quality assurance. Public sector (service) organisations differ from their private sector counterparts: there is no profit-maximising focus, there is little potential for income generation and, generally speaking, there is no bottom line against which performance can be measured.

It was not until the appearance of organisational and managerial reforms in the 80s and 90s that public sector performance measurement became fully established. In relative terms, however, performance management "is still in its infancy (or at least, its adolescence). Consequently, the approaches used are still in need of further investigation and development, particularly in terms of understanding the actions arising from the measurement and evaluation process" (10).

All the above is also true and even more so in the context of health care. The use of performance management is still largely limited to a handful of national health systems from western European countries and to the managed care companies in the USA and Canada. Performance management is broadly absent from national health systems in the developing world, and few references have been found in the published literature about its application in this context. However, this situation is changing rapidly as several studies and meetings have highlighted the importance of further understanding how staff performance can become a central aspect in the management and organisation of health services in the developing word (24).

The increasing adoption of 'western' concepts in health care – such as the separation of financing and provision, the establishment of service agreements and contracts or the shifting of emphasis on demand rather than supply are all bringing performance management to the core of policy making.

Some forms of performance management, such as quality assurance, are already part of several developing country health systems, at least in so far as these approaches appear in policy statements (14). Accreditation, benchmarking and evidence-based medicine are also concepts and tools that are permeating rapidly into the developing world. It is only a matter of

time until these approaches become more firmly established. However, no matter how imminent such changes may be, the fact remains that it is far too early to derive conclusions about the use and application of performance management in developing country health systems. From the limited amount of research available it is clear that there are many more questions than answers. The performance management models so far introduced are in pilot stage, and it is not at all clear whether their use is delivering or will deliver the expected outcomes in terms of overall organisational performance, improved service quality or health outcomes of the population. Given that performance management is (or can be initially) very labour-intensive, its introduction into under-funded health systems where managerial capacity is in short supply poses a number of ethical and practical implications.

In conclusion, the approaches and tools described in this chapter apply to a handful of public sector health care organisations from well-funded and developed national health systems in the western world. While there is evidence that performance management is becoming increasingly incorporated into a larger number of national health systems, its introduction is far too recent to enable a complete retrospective evaluation. Transferring performance management approaches from industrialised to developing countries will require careful assessment of the status quo of such health systems.

SETTING UP PERFORMANCE MANAGEMENT SYSTEMS

There is no single agreed, acceptable model of performance management or quality improvement. In fact, the term 'model' appears farfetched, since performance management is more often some sort of a framework or underlying rationale for the organisation to enhance performance or quality. Fletcher suggests that, at its simplest, performance management comprises the following: developing the organisation' mission statement and objectives; enhancing communications within the organisation to that employees are not only aware of the objectives and the business plan, but in a position to contribute to their formulation; clarifying individual responsibilities and accountability lines; defining and measuring individual performance what is meant by performance in a particular organisation, and how do performance management processes will enhance performance?

implementing appropriate reward strategies; developing staff to improve performance and career progression in the future.

It is easy to underplay the practical difficulties that implementing each of the above components has in practice, particularly in health care organisations where planning and management skills at the local level are scarce, and where levels of staff pay and access to resources are much below minimum standards.

DIMENSIONS AND APPROACHES TO PERFORMANCE MANAGEMENT IN HEALTH CARE TAKEN FROM

THE BRITISH NATIONAL HEALTH SERVICE

In the British National Health Service, performance management has implied the integration, at both conceptual and practical levels, of what had hitherto been a series of diverse initiatives (15) (Box 1).

Box 1. Performance Management in the British NHS

Business Planning – the process of developing a plan that maps out how various organisational and service targets will be achieved over time (usually one year).
Quality assurance and benchmarking – defining quality indicators for services and for units, often in the context of nationally defined and agreed criteria. Quality assurance is a planned and systematic approach to monitoring, assessing and improving the quality of health services on a continuous basis within the existing resources (15).
Competence-based education and training – ensuring support to all staff in order that they show/attain the levels of competence required to undertake service tasks. This is crucial in a changing service scenario where staff adopt an increasing 'multi-purpose' orientation that requires them to undertake new tasks, or to undertake tasks in different ways.
Clinical audit - including evidence-based medicine, patient-based diagnostic and treatment protocols.
Performance indicators – these can take many forms and relate to individual staff, units or service areas. In all cases, they must be rooted on a prior assessment of problems and gaps.
Use of assessment techniques and of development centres – whether in the form of appraisal systems, Personal Performance Planning reviews or whatever form of assessment, performance management requires a periodic review of achievements against targets set, as well as the practical means to address staff development needs in staff development centres.

Fletcher explains that the integration of all the above initiatives, often owned and managed by different parts of the NHS, represents the real challenge of establishing a coherent performance management system in the context of the National Health Service. The fact that these initiatives were already present in some form or other is another point for reflection, since it is easier to build on what already exists than to attempt to develop everything from scratch as is often the case in many developing country health systems. National Health Service units have added their own initiatives to the performance management system. For instance, Martineau (17) highlights the importance of a number of features: induction programme, performance monitoring and personal performance planning.

INDUCTION PROGRAMME

When staff are recruited to a service trust they are provided with a formal induction process to ensure that the individual is clear about his/her job, and to brief her/him about the aims, objectives and working practices of the Trust. A detailed checklist has been developed to ensure all steps are covered. New staff attend a 3-day induction programme sometime during the first few months of their employment. Nursing staff have a formal 3-month preceptorship programme for all newly qualified nurses.

PERFORMANCE MONITORING

The contract between the North Mersey Community Trust and the purchasing health authorities specifies some of the workload for community-based services in terms of face-to-face contacts between health workers and clients. This does not take into account the complexity of the contact and a unique routine visit may be very short; a visit dealing with sensitive issues related to palliative care may need more time. The health worker enters each contact into a networked computer on a regular basis, together with additional information about the nature of the visit.

PERSONAL PERFORMANCE PLANNING (PPP)

Formerly known as P, this is mandatory across most of the Trust and has been in use since the early days of the National Heath Service Trust. The basic format is very similar across the Trust, though variations appear in

different localities, directorates, staff groups and even by manager. For the 40 or so senior managers there is also an element of financial bonus linked to PPP. The outcome is a written agreement of key objectives for the following year and for other actions to be taken. This is often in the form of a confidential letter from the manager to the individual and may also include a summary of the discussion. A table with objectives and possibly specific actions, a time scale, success criteria etc may also be produced and typed up. This is then used for guidance in the following year and discussed at the subsequent PPP meetings to review progress.

PERFORMANCE STANDARDS AND INDICATORS

Despite the constant reference to performance indicators in the literature, the best performance management systems have been found to put greater emphasis on processes and standards that they do on selected performance indicators. Indicators, in any case, relate to the models, approaches or tools used in the context of performance management. Stewart (25) states that emphasis on indicators can be unhelpful, and that it is better for management to focus on enabling and disabling factors before attempting to introduce performance indicators. The following are some examples taken from Stewart (25): the system should identify minimum standards to be achieved, a floor below which no one has an excuse for falling, rather than a ceiling beyond which no one can rise; the system should start with a basic assumption that people want to do a good job and are trustworthy. A system designed to check and double-check performance will not encourage people to give of their best; the performance management system should be expressed, as far as possible, in terms of a set of principles that people will need to follow, rather than rules that they have to obey; the touchstone for judging the success of the performance management system should be the extent to which it helps the organisation deliver a better service to the customer; the system should be minimalist, and not generate mountains of data. The 80/20 principle should apply what are the 20 per cent essential data that are needed? The choice of data should be subject to constant update and review depending of the objectives and new priorities being set; performance management systems should be designed and driven by line management, with staff involvement, the human resources function being to provide support in ways that line management deems important; the

performance management needs to be piloted and adapted in different parts of the organisation, with the understanding that the purpose of piloting is to adapt the system rather than to question whether it should be introduced at all; performance management systems (particularly performance appraisal) need to fit into the natural rhythms of organisational life the existing peaks and troughs of activity, often associated with the financial year and the business planning cycle; Edmonstone (15) provides several other criteria for assessing the success or failure of performance management and appraisal systems.

ESSENTIAL REQUISITES FOR INTRODUCING PERFORMANCE MANAGEMENT TO NATIONAL HEALTH SYSTEMS

DO HEALTH CARE ORGANISATIONS NEED PERFORMANCE MANAGEMENT?

Performance management is a means to an end. It is based on the assumption that organisational performance is closely related to the performance of its individual staff. Even this apparently uncontroversial assumption has been the topic of much research and, as Bach points out, the link between organisational and individual staff performance remains elusive (5). Such elusiveness is the result of many organisational and contextual factors that should be in place before the whole (the organisational performance) can be usefully considered the sum of its parts (the individual performance). But individual performance does clearly matter and can make a difference. The important issue is to establish how much attention to individual performance should be in place for organisations to perform better, and what forms such attention can take in practice. Most of the findings in this section stem from as yet unpublished research reviewing practice across 16 different organisations, 14 of them health care organisations and 10 of them based in developing countries. Most published references relate to the application of performance management in industrialised countries. The fairly sophisticated level of their health systems, at least in comparison with the situation of many developing countries is what limits the generalization of conclusions. Research has shown that only a handful of health systems whether public or private from developing countries use performance management systems. Even fewer (none in the research study funded by the European Union) uses performance management as the "interrelated set of policies and

practices that, put together, enable the monitoring and enhancement of staff performance", as referred to earlier in this paper. In most countries performance management still is made up of a set of disconnected policies and practices, often not clearly related to performance. In some of these organisations the rating of staff dominates over efforts to help them work better. As a result, performance enhancement in these organisations is more of an afterthought or, as some authors have remarked, a means to blame staff for what represents essentially a great deal of managerial incompetence (1). The focus on enhancing performance characterises the most successful or promising approaches to performance management in the European Union research study. This is because focus on enhancement immediately changes the nature of performance management from the often quoted 'to verify that staff are doing their jobs properly' to the far more positive 'to ensure that staff get the necessary help to do their jobs well'. While the first approach favours control and measurement, the latter emphasizes positive supervision and staff development. In consequence this section of the report adopts the view that looking at individual performance is a useful way to attain organisational objectives as long as the organisation uses the appraisal of performance to act on staff needs and on the outcomes of appraisal. Consequently, we shall attempt to derive lessons from our research that can be used by any health care organisation aiming at putting staff performance at the core of organisational strategy.

PREREQUISITES FOR INTRODUCING PERFORMANCE MANAGEMENT IN HEALTH CARE ORGANISATIONS

Central to the findings of research into performance management in health care is the notion that not all organisations are performance-oriented or that they value performance in the same manner. For example, achieving high levels of employment or job security may be pursued by some national health systems as a primary objective over and ahead of staff performance, even if this is implicitly rather than explicitly pursued. Similarly, efforts to focus on staff performance may be rendered fruitless or see their effectiveness limited through inappropriate organisational design or inadequate management systems. In this section we reflect upon a series of pre-requisites without which performance management will not work or will do so ineffectively or for a limited period of time only. We differentiate organisational or internal prerequisites relating mainly to the structure,

culture and management systems of the organisation and environmental or external prerequisites relating to the policy environment in which the organisation operates. We are fully aware of the multiple overlaps between internal and external factors but still find this distinction simple and didactic enough for managers and policy makers to assess the extent to which performance management approaches can be established with some guarantee of success.

Organisational (internal) prerequisites
The following internal or organisational prerequisites will now be reviewed: there is an adequate level of pay or pay package; staff have the equipment, tools and skills to do their job; there is a balance of incentives to motivate staff; managers have the power to make decisions and plan on the basis of local (service) needs; managers and staff are familiar with planning tools such as target setting and achievement monitoring; communications between and within management and staff are effective; a culture of accountability and openness prevails. Each of these prerequisites will be now reviewed in some depth.

Adequate pay levels
Pay levels in some of the organisations covered in the study were so low that they did not enable staff to make a living and forced many staff members to resort to 'moonlighting' to make ends meet (26). In these circumstances staff will have little incentive to perform better, since increased effort will not result in better work or pay conditions. This situation was found in the Mozambican public health care sector and, to a lesser extent, in the government health services of Ghana, Guatemala, Zambia and South Africa (11,12, 27-29).

Even if adequate pay levels do not per se guarantee performance, they are essential prerequisites without which performance management will simply not work. This feature has led in some countries to stringent reductions in staff numbers as a means to increase the staff share of the salary bill. While staff cuts may or may not be the best approach to increase the salary bill, it is equally true that maintaining the status quo will not solve the problem. It is not a coincidence that organisations showing the most effective approaches to performance management in our study were also those where staff were getting a 'fair' salary in terms of what the market offers or what equivalent staff earn in other sectors. Defining what constitutes a fair salary is problematic and staff may never agree that the

level of pay is high enough, but pay must reach a certain level below which managers will be reluctant to ask not to mention demand higher or better performance.

Equipment, tools and skills to do the job
As is the case for salaries, this is an area that is often taken for granted in many developing countries. A case study from Guatemala records that while workers in a private health care organisation have the essential means to do their work, the same cannot be said for the public sector health services were staff are constantly faced with budget cuts and resource shortages of every kind. Such shortages mainly regard drugs, diagnostic equipment and transport, but can extend to shortages in skills levels or skills-mix among staff (28). Skills and material 'tools' are closely interrelated, since the former can hardly be developed in the absence of the latter. The study in Guatemala shows staff lacking such essential equipment as stethoscopes and surgical soap; this, combined with lack of drugs, has the effect of worsening the reputation of public health facilities. Low service coverage and low resolution capacity at primary level are two of the consequences. The reasons why equipment or drugs are not in place may not always be related to poor supply but to factors such as misuse by staff and their relatives instead of patients. The point is that it is futile to expect staff to diagnose and treat diseases properly or to conduct staff supervision when diagnostic equipment, petrol, vehicles or public transport are not available. Well-resourced health care organisations are many steps ahead in the starting line of performance management when compared to others where resource shortages are a daily feature.

The right balance of incentives for staff to perform well
The distinction between reward - and development-oriented performance management has been discussed briefly. Evidence suggests that while cash rewards can act as incentives for improved performance, they are not a central feature of performance management. We have also highlighted that how the provision of cash rewards is highly linked to the organisation's culture and context, and that staff do not necessarily appreciate cash rewards, particularly if they are unsure of getting them or if others get rewards for what is essentially a team effort (2, 15, 30). The need for staff to have the right incentives to do the work is however undeniable and the more performance oriented organisations in our study are also those where

the right combination of incentives has been achieved. This includes both positive incentives to encourage higher performance and negative incentives to discourage undesirable practices or behaviour. The most frequently quoted positive incentives include: clear criteria for promotion; job stability and security in employment (not necessarily equivalent to permanent jobs for life!); a good working environment with humane staff relations; and the existence of attractive career ladders that accommodate staff aspirations. It is interesting to note from the UK case studies (30) that career ladders are not always directly tantamount to the provision of higher salaries. Thus, senior nurses taking up management posts might be paid less that if they had continued their work as nurses, but a career in management may offer better job opportunities in the long run than are possible as a practising nurse. In the Barcelona CAPVO case study, another positive incentive quoted by staff is the existence of a well designed induction period for new staff that is highly focused on ensuring staff are clear and felt comfortable with their new responsibilities (16, 30)..As regards negative incentives, three organisations (in the UK and in Barcelona) have developed means to fight absenteeism from work. Interestingly, even these incentives take a positive form, rewarding those workers that have not used the number of leave days to which staff are entitled each year for illness or personal reasons. In NMCT (UK) for instance, all staff absent from the service for a day or more without prior notice are expected to report to their line managers when rejoining duty in order to justify the reasons for their absence. While this approach does not prevent staff to take sick or personal leave when needed, it does send a message across the organisation that absenteeism is not tolerated without proper justification. In contrast, public sector health care organisations in Zambia, Ghana and Mozambique report absenteeism as a major problem but do not seem to have the means to deal with it. In the case of Mozambique absenteeism is often related to moonlighting of staff because of low pay (12). While organisations must be able to deal with problems like absenteeism and may use performance management to do so, performance management should not be the way to deal with serious misconduct or with staff grievances. The rationale is that misconduct can be better addressed through specific grievance, complains and discipline procedures that are kept separate from the performance management system. This allows performance management to focus on performance in a positive manner, avoiding the confusion found in several

case studies where performance management and dealing with misconduct are often considered one and the same (11).

Local autonomy and decision making
Performance management requires a close relationship between management and staff, together with the ability on the part of managers to act on the results of appraisal. This implies a degree of local decision-making powers that is often absent from public sector health systems covered in the case studies of the research funded by the European Union. The decentralization of health systems is therefore an essential prerequisite for performance management, as is the need to avoid unnecessary bureaucracy when dealing with the results of performance appraisal. The practice of sending the results of appraisal higher up in the organisation, where little or no action is ever taken, is often reported among those organisations that are least performance-oriented. This eventually leads to downgrading staff appraisal, since neither managers nor employees will eventually feel bound by the outcomes. Managers conducting appraisal must work closely and interact frequently enough with the staff they appraise, and act swiftly on the outcomes of appraisal. The latter requires the ability to allocate resources, particularly (but not exclusively) training resources, according to need. The need for local autonomy also suggests that performance management should not be attempted across large organisations until such global effort can be matched with a bottom-up approach to implementation. National health systems must therefore avoid the rapid establishment of performance management systems that do not take into account, or build on, local decision-making powers and capabilities. In general, identifying where staff are with regard to performance orientation is important in order to judge how far staff will have to move to accept a different concept of performance, particularly where ineffective appraisal systems have been in place for a long time. The starting point will largely determine the pace at which performance management can be introduced. Staff familiar with ineffective appraisal systems will naturally be skeptical and wary of the introduction of new systems linked to individual performance.

Familiarity with planning methods

Performance management needs objectives and targets to steer individual performance. This will also facilitate the linking of individual targets to broader service and organisational objectives. Unless staff and managers are familiar with the process of setting and monitoring targets they may not be able to undertake performance management effectively. The local planning culture is absent in many health care organisations from the developing world covered in our study. Lack of a local planning culture and capacity is due partly to the lack of effective decentralization (and the consequent reliance on targets set from above), and partly to the fact that much of the planning in national health systems from developing countries is not grounded on resource availability. This may result in the setting of targets that are unrealistic, or for which achievement is hard to assess or quantify; both problems in turn affect the effectiveness of performance management.

It would therefore appear that when a local planning culture is not in place, the introduction of performance management must wait until staff has become familiar with planning tools. This will result in increased planning capacity and facilitate the eventual setting of interlinked individual, team and service targets. Just as importantly, this familiarity will put staff in the right mindset and reduce staff apprehension. Developing a planning culture can also be an excellent way to improve communications, accountability and teamwork within the service, all of which can significantly improve organisational and individual performance.

Effective communications

All authors highlight the importance of good organisational communications for performance management, to the extent that some of them consider performance management nothing more than a dimension of internal organisational communications (29). Attempts to introduce performance management will founder without clear and effective communication channels within staff, and between staff and managers. Many organisations, particularly in the public sector, disregard the importance of open and clear communications, and the impact these have for effective planning and management of health care. Armstrong and Baron emphasise the importance of communications and the sharing of the organisation's vision among employees, which is further emphasised by the findings of the EU-funded research study.

Sharing the vision of the organisation has become so much part of the management jargon that it is often equated to the production of grand statements in policy documents. What the case studies show, however, is that the sharing of vision must be a continuous almost daily task.

Means and channels of communication must be tailored to the prevailing organisational culture and structure. In small, flat organisations, formal and informal communications may not be a problem, but there is still a need to ensure that informal communication channels are matched with more formal and structured ones. In larger organisations with many management tiers it is the distance between staff and people with decision making powers that really counts. The NMCT case study in the UK took place in an organisation with 3500 employees, yet staff had and valued formal and informal means of communications with supervisors and line managers. In the Emergency Services organisation of the Basque autonomous region on the other hand, a relatively small and flat organisation with less than 75 employees experienced amazing barriers to communication between management and staff. This led to poor staff morale and was probably linked to very high staff turnover (31). In contrast, Pholosong was a small managed care organisation in South Africa where staff appreciated the open and informal communication channels (28).

Transparency and openness are two important features of effective communications that are perfectly compatible with the need for confidentiality of information originating in individual appraisal. In the context of performance management the results of appraisal must be kept confidential, but confidentiality should not prevent staff and managers from openly discussing and debating the accuracy and relevance of service and individual performance targets.

Finally, communications with legal representatives of staff such as trade unions is essential and may turn initial resistance to the introduction of performance management into support. The resistance of the Zambian trade unions to de-linkage of staff from the civil service is in contrast with the involvement of unions in the development of performance management and staff development initiatives in NMCT in the UK and Pholosong in South Africa (28,29,30). In the latter, unions in Zambia were formally involved in the process of reviewing the performance of the managed care organisation in terms of it meeting both patient and staff needs.

Leadership and effective management systems
An important ingredient to bring about change and improvement in systems is effective leadership. This involves having a vision of what is needed, sharing the vision with fellow managers and staff, and steering the process of realising that vision. In the ZESCO (Zambia) (28), NMCT (UK) (31), Pholosong (South Africa) (29) and CAPVO (Spain) (16) case studies this kind of leadership was present, but it would be wrong to expect such skills and drive to be available in public sector health organisations from many developing countries. Although there is a danger in relying on just one person since that person may move on (or be moved on) evidence that an organisation can respond to leadership is another good sign of the readiness to accept new systems such as performance management.

The same case can be made in relation to the degree of sophistication and effectiveness of the management systems used by the organisation to handle areas such as information, personnel, reporting or communications between different organisational levels. The public sector of many countries in the developing world suffers from many limitations in its management systems: information flows slowly and late and may not even be used; personnel records may not provide the information needed, or may not be updated; communications may be formal and bureaucratic, with no or hardly any feedback; etc. While we are not suggesting that performance management relies on highly sophisticated management systems, it is important to consider that its introduction may just add to the burden of service staff without attaining the desired focus on performance. On the other hand and by the same token, performance management may contribute to the improvement of management systems design in an organisation by identifying which aspects relating to performance are not being adequately addressed. In any case, policy makers must be aware of the trade-offs of attempting to build performance management within a weak health system.

A culture of accountability and openness
The prevailing culture in the organisation where performance management will be attempted (32, 33) and the 'societal culture' where organisations operate (34) are as important as management systems and leadership. In civil service (or ex-civil service) organisations, the main obstacles to performance management may originate in the attitudes of civil servants

and in the hierarchical nature of power and decision-making. It is a paradox that many civil service organisations may end up being so much staff-centred and so little client-oriented that staff easily develop a 'culture of entitlement and dependency' that becomes the main obstacle for performance management. The situation may be made worse when staff have been exposed to many years of ineffectual appraisal systems focusing on behaviour rather than performance.

Research in public sector organisations of Ghana, Zambia and Mozambique (11, 12, 28) reflect some of the issues mentioned above. Although Ghana has effectively de-linked health staff from the civil service Zambia only attempted to but was faced with stiff resistance the case studies show many civil service attitudes among staff. The use of close appraisal, where staff are not aware of the results of appraisal interviews, is common to the three case studies, although it is being abandoned in Mozambique in view of its irrelevance. It is hard to say how efforts to increase performance orientation would work in these three settings, but a degree of 'cultural rejection' should probably be expected.

As said for other prerequisites, phased introduction of performance management could render this type of organisations more performance oriented and could facilitate the process of change, particularly where health staff is no longer part of the civil service. But the changes that organisations undergo may be too great to allow for the installation of a performance management system requiring much preparation and careful implementation. For example in the Odi health district, there were confused reporting structures and a process of redeployment of staff from hospital to clinics was under way. In such a situation, the emphasis on performance may get lost (28). In contrast, NMCT (30) has undergone similar changes and is now facing the need for further radical changes. This organisation saw that active change management was necessary from an early stage and has identified this as a specific management process that requires its own strategies and skills. This has provided more stability in the organisation, and hence facilitated the development of the performance management system.

GENDER ISSUES

References to gender are hardly found in the performance management literature, but the gender dimension of health care implies that certain approaches to performance management can reinforce gender inequalities (22,35). For instance, in health systems where managerial positions are overwhelmingly held by men or where (mostly male) doctors still take most

service-level decisions, the introduction of performance management is likely to mirror and reinforce the existing gender bias.

EXTERNAL PRESSURES AND TRIGGERS FACILITATING PERFORMANCE MANAGEMENT

The findings of our research suggest that health care organisations do not always have the means to develop greater performance orientation on their own. They need the synergistic support of external environmental factors that at times act as triggers and facilitate the establishment of performance management. The following are some external factors that were particularly significant in the context of organisations covered in the research study funded by the European Union. Somewhat arbitrarily we have divided external factors into the following categories: political pressures and health care reforms; financial pressures; decentralization client/user pressure; quality assurance introduction of purchaser/provider split and of service contracts.

POLITICAL PRESSURE AND HEALTH CARE REFORMS

Political pressure may take many forms and can be a trigger for greater emphasis on performance management. In the United Kingdom, the reforms introduced during the Thatcher years to the National Health Service forced service managers and senior executives to focus on performance and productivity targets. This focalisation has remained throughout the 90s and has been complemented by highly publicised scandals relating to failures of the National Health Service to deliver acceptable levels of service. Examples include: the Bristol Paediatric Surgery scandals; reports of patients dying unattended in ward corridors; or

the failure of the National Health Service to cope with the flu epidemic in 1999. These and similar accounts of malpractice and incompetence have kept NHS executives on their toes to demonstrate effectiveness of a service that is close to the heart of the British public and which forms a regular fighting ground at every general election. In Zambia, the pressure for reforms in the early 90s was initially strong, but has become seriously diluted as the government found the implementation of reforms increasingly difficult. It also met with opposition from the unions, which turned out to be much more powerful than had been predicted. The unions' threats of strikes forced the government to rethink its plans for de-linking staff from the civil service. This in turn has negatively affected plans to introduce performance management across the Zambian public health sector. Also in Zambia, the energy act enabled ZESCO to operate like a private company and introduce performance management (25).

Political pressure may act as a trigger but does not always force the health system to adopt effective staff performance, particularly if such pressure is short lived. The creation in the mid 90s of the Ghana National Health Service (partly) as a means to de-link service staff from the civil service is one such example. To this date, the establishment of performance management across the service has been attempted but remains elusive. This is exemplified in our case study from Ghana where an old fashioned, ineffectual staff appraisal system inherited from the civil service is still in place.

Although the two are often reported to go together, health care reforms are not necessarily an effective trigger for performance management. This is often linked to the fact that implementation of reforms is rushed through the system without due consideration of the organisational prerequisites that have been earlier discussed, including the need for effective leadership and management systems for performance management to work.

FINANCIAL PRESSURES

Budget cuts and the efficiency drive affecting national health systems throughout the word have brought about greater interest in performance management. Such interest, however, has seldom led to the establishment of effective performance management as illustrated in our case studies. For instance, budget cuts have often led to staff cuts that have negatively

affected service delivery, particularly when staff cuts are made across the board without due consideration of the need to maintain adequate complements of staff and skills mixes. Staff and budget cuts also negatively affect the attitudes and motivation of staff, particularly if pay levels remain low, by creating an environment antagonistic to the establishment of performance management (35).

INTRODUCTION OF PURCHASER/PROVIDER SPLIT AND SERVICE AGREEMENTS

Purchaser/provider split and service agreements may or may not be part of financial pressures, but separating funding from provision clearly provides opportunities and pressure for improved performance management. It is no coincidence that the most performance-oriented organisations in our research study have separated funding from provision, even if under different forms and for different reasons. In some cases, such separation has paved the way for competition to emerge within service providers. In the NMCT (UK) (31), CAPVO (Spain) (16) and CARE (Guatemala) (27) case studies, competition with other providers forced managers to provide attractive pay and reward packages in order not to lose good staff to other provider units. Thus, higher pay and rewards led to the development of performance management as a means to ensure value for money.

The NMCT (UK) (31) example depicted a provider organisation where the provision of resources is conditional on the attainment of service targets that are in turn linked to productivity indicators. This means that the only way for the Chief Executive to deliver on targets is to have well-motivated staff working in a positive environment. The competition for good staff among Community Trusts also forces the Chief Executive to pay staff at or slightly above market rates. The performance management system is therefore the means to ensure the achievement of targets.

When the funding and provision functions are not separated and remain part of a single organisation it is still possible to draw attention to performance through the development of service agreements. The term agreement suggests a different type of binding between the provider and funding sides of the organisation and refers essentially to an internal contract. Service agreements are too new for their effectiveness to be assessed. In theory, they should work as well as contracts between purchasers and providers. In practice, however, many service contracts are

too vague and remain poorly monitored, and staff do not relate to them, partly because increased delivery of services does not translate into increased availability of funds or improved working conditions. It remains to be seen whether service contracts of this nature can facilitate the introduction of performance management or at least focus the minds of providers towards individual performance.

DECENTRALIZATION

The decentralization of health systems is a sine qua non for effective management of staff performance. The most effective performance management approaches in our study all took place within decentralized health systems. However, what determines the feasibility of introducing performance management is whether decentralization has successfully achieved leadership, planning, flexible resource allocation practices and well functioning management systems at the local level. The reason why few 'decentralized' health care organisations in the public sector of developing countries have been successful in managing performance is probably that few of them have achieved such strengths at the local level

PRESSURE FROM SERVICE USERS AND QUALITY ASSURANCE

Public pressure, together with adequate legislation and formal complaints procedures, have increased the focus on quality, benchmarking and performance management in the British National Health Service. In our NMCT case study, for instance, every patient's complaint was replied to personally by the Chief Executive of the Trust. Quality assurance is not strictly speaking a performance management 'tool' but a common and possibly essential complement of performance management, providing a bridge between the focus on staff and the equally important focus on patients and service users. Many developing countries are beginning to adopt quality assurance approaches whose existence will undoubtedly facilitate the introduction of performance management for a number of reasons.

First, in quality assurance programmes, staff are familiar with the setting and monitoring of targets, and may have established formal review procedures very similar to the review of service and individual targets required in performance management.

Second, there is normally a person leading the quality assurance process whose role will have many similarities with that of steering the implementation of performance management.

And lastly, quality assurance provides structured means for service users to evaluate the quality of services. In these circumstances the views of service users can be a starting point for setting individual or team targets that can be incorporated into the performance management system.

REFERENCES

1. Armstrong, M., Baron, A. (1998). *Performance Management – the new realities.* The Institute for Personnel Development, London.
2. Fowler, A. (1990). Performance Management: the MBO of the '90s'? In *Personnel Management.* July.
3. Institute of Personnel and Development (1992). *Performance Management in the UK: an analysis of the issues.* IPD research series, London
4. Storey, J., Sisson, K. (1993). *Managing Human Resources and Industrial Relations.* Open University Press.
5. Bach., S., Sisson, K. (2000) (editors). Personnel Management: a comprehensive guide to theory and practice. Blackwell Publishers.
6. Walters, M. (1995). *The Performance Management Handbook. Institute of Personnel and Development.* London.
7. Flynn, N. (1993). *Public Sector Management.* Harvester Wheatsheaf.
8. Peters, J., Waterman, R. H. (1982). *In search of Excellence: lessons from America's best run companies.* Harper Collins.
9. Handy, C. B. (1976). *Understanding Organisations.* Penguin Books.
10. Boland, T., Fowler, A. (2000). A systems perspective of performance management in public sector organisations. *The International Journal of Public Sector Management*, 13 Issue 5. MCB University Press.
11. Dovlo, D., Sagoe, K., Ntow, S., Wellington, E. (1999). *Staff Performance in the Ghana Health Service.* Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.
12. Abdula, M., Adam, Y., Kahn, Z. (1999). *Assessing health staff performance in Mozambique: the perspectives of the public and private sector.* Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.
13. Martínez, J. (2000). *Managing Staff Performance in Developing Countries: Issues and lessons from an international research study.* Draft report from a research study funded by the European Union.
14. LSTM, (2000). Quality Assurance in Health Care. In : *Policy Briefings for Health Sector Reform series*, Health Sector Reform Work Programme, Liverpool School of Tropical Medicine.
15. Edmonstone, J. (1996). Appraising the state of performance appraisal. *Health Manpower Management*, 22 (6), 9-13.
16. Mompó, C., Rovira, J. (1999). *Rendimiento de Personal en el Centro de Atención Primaria Vila Opímpica de Barcelona.* Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.

17. Martineau, T. (1999). *Staff performance management in the North Mersey Community (NHS) Trust: a case study.* Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.

18. Donaldson, C., Gerard, K. (1989). Paying general practitioners: shedding light on the review of health services. *Journal of the Royal College of General Practitioners,* 39, 114-117.

19. Giuffrida, A. *et al.* (1997). The effects of target payments on primary care professional behaviour (protocol). In: Bero L, Grilli R, Grimshaw J, Oxman A (eds) *Collaboration of Effective Professional Practice Module – Cochrane Database of Systematic Reviews.* The Cochrane Collaboration - Issue 1. Oxford.

20. Hicks, V., Adams, O. (2003). Pay and non-pay incentives, performance and motivation. In: Ferrinho, P. and Poz, M.D. (eds.) *Studies in Health Services Organisation & Policy,* (pp…..-……). Antwerp: ITG Press.

21. Buchan, J. (1994). Paying for Performance. *Nursing Management,* 1 (6), 12-13.

22. Schreiber, R. S., Nemetz, R. N. (2000). Pay equity and nursing in Ontario: ten years later. *International Nursing Review,* 47 (2), 97-105.

23. Connock, S. (1991). *HR vision: managing a quality workforce.* Institute of Personnel Management, London.

24. Martínez, J., Martineau, M. (ed) (1996). *Workshop on Human Resources and Health Sector Reforms: Research and Development Priorities in Developing Countries.* Liverpool School of Tropical Medicine.

25. Stewart, V. (1990). *The David Solution.* Gower, Aldershot.

26. Van Lerberghe, W.., Conceição, C.., Van Damme, W., Ferrinho, P. (2003). When staff is underpaid. Dealing with the individual coping strategies of health personnel. In: Ferrinho, P. and Poz, M.D. (eds.) *Studies in Health Services Organisation & Policy,* (pp…..-……). Antwerp: ITG Press.

27. Flores, W. G. (1999). *Managing Staff Performance in Guatemala: a case study of one public and one private organisation in Guatemala.* Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.

28. CBH. (1999). *Measuring staff performance: case studies from Chainama and Zesco.* Central Board of Health, Government of the Republic of Zambia. Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.

29. Medunsa. (1999). *Performance Management in a South African Managed Health Care Organisation.* Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.

30. NMCT. (1999). *North Mersey Community Trust: a case study of staff performance management.* Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.

31. Sinclair, D., Zairi, M. (1995). Effective process management through performance measurement part I – applications of total quality-based performance measurement. *Business Process Management Journal*, 1 (1), 75-88.

32. UTE-CAV. (1999). *Rendimiento del Personal de Emergencias.* Unidad Territorial de Emergencias de la Comunidad Autonoma Vasca. Research paper produced for the study Measuring Staff Performance in reforming health systems funded through a research grant of the European Union.

33. Taylor, H. (1992). Public Sector Management in three African countries: current problems and possibilities. *Public Administration and Development,* 12, 193-207.

34. Jaeger, A. (1990). *The applicability of western management techniques in developing countries: a cultural perspective.* Chapter 7 in Management in developing Countries, Jaeger A and Kanungo R, eds. Routledge Publications.

35. Mendonça, M., Kanungo, R. N. (1996). Impact of culture on performance management in developing countries. *International Journal of Manpower,* 17 (4/5), 65-75.