Assessing Performance Management of Human Resource for Health in South-East Asian Countries Aspects of Quality and Outcome

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INTRODUCTION

Performance management is best defined as the development of individuals with competence and commitment, working towards the achievement of shared meaningful objectives within an organisation that supports and encourages their achievement (1). Ideally these individuals should be considered as members of a team. Performance management is basically concerned with optimizing the quality of work and technical efficiency in the health system through quality assurance strategies and mechanisms including built-in accountability at all levels of service provision, leading to accreditation, regulation of access to practice and surveillance of practice by professional councils (2). It is not a confrontational, one-way encounter with management or a formal interview for disciplinary action. It must commence with an acknowledgment of the overall vision, aims and objectives of the organisation, the lines of accountability, and a clear understanding of how the individual (or team) can best contribute. It must essentially include career planning or personal development and may also be linked to an incentive scheme.

When applied to organisations, the process relates to the goals and targets set by the organisation and the subsequent measurement of the outputs and outcomes by means of performance indicators. The measurement of performance as it relates to individuals has two main components. The first is in top management, where the managers are often on performance-based contracts. They are accountable for ensuring that the performance targets of the organisation are met and their performance measures are closely linked to those of the organisation. The second group refers to other employees who may not have direct accountability for organisational performance targets, but whose performance is still important

for the overall performance of the organisation. This is the larger group for whom performance appraisal systems apply.

Performance appraisal (PA) systems based on modern principles of human resource principles can enhance accountability by demonstrating success in achieving policy aims efficiently and effectively. They can also highlight service aspects where further inquiry and explanation are needed while making the responsibilities and achievements of staff explicit. The main difference between traditional PA and the assessment process as employed in performance management is that in the latter there is more rigour and a definite link with organisational objectives, incentives and individual development plans. It may also include self-appraisal. The traditional appraisal system sustains the hierarchy of authority by confirming the dependence of staff on those who manage them, and underlines who is the boss. This is not the emphasis in performance management, where these aspects are least important among all the other reasons for appraisal such as human resource considerations, training, promotion and planning (3).

In many countries in the south-east Asian region the concept of performance management has not taken root. Rather, at best it is traditional performance appraisal that is being applied. There have been recent efforts in a few countries in this region – Thailand and Sri Lanka, for instance – to move away from the traditional system. Performance management is not merely the appraisal of an individual's performance, although it has attracted criticism because of its appraisal function. It has unfortunately often been seen as merely replacing performance appraisal with no change in the actual process, just as human resource management in general has been seen as replacing personnel management without any change in approach (4).

It is pertinent to consider performance management in the context of the so-called New Public Management (NPM) movement. In addition to performance management, the core ideals of NPM include the separation of the policy and financing functions of the government from its operational functions, especially service delivery. It places great emphasis on the introduction of performance incentives and financial control and on the measurement of outputs of both individuals and organisations, in line with stated objectives. Moore (5) has indicated that in the longer term NPM will be more influential in developing countries than the traditional approach.

In the educational sector, performance appraisal or teacher evaluation is becoming mandatory as a consumer-oriented economy insists on obtaining value for the education dollar. The same cannot be said for the service sector, where even basic peer review efforts have not been easy to initiate. The more enlightened schools are adopting a process of performance appraisal where, at the commencement of an academic year, each teacher with his/her administrative head identifies goals and priorities for self-development for that year. At least one more meeting is held at the end of the year to ascertain to what extent these goals have been reached. This process gets close to the concept of performance management. Such methods have not been adopted to any great extent in developing countries (6).

MEASURING PERFORMANCE

The measurement of performance related to quantified objectives and remuneration according to results is one of the guiding principles of the NPM. Measuring outputs/outcomes of the activities of many public health agencies may be very difficult or even impossible, and such efforts may consume already scarce resources. Even in the best-developed organisations or systems it is difficult to measure health outcomes. They require a long-term perspective and indicators that cope with the influence of other variables or confounders. The measurement of outputs is relatively easier where a good computerized information system is available. Although client-generated records are the main source of information for performance appraisal in medical care, specific performance indicators (PI) could benefit by the inclusion of qualitative data based on observation. Appropriate performance measures should primarily ensure that client or customer requirements have been met. They must provide standards or baselines against which meaningful comparisons can be made and highlight the areas that require priority attention. The development, use and sustainability of performance indicators at individual or service levels will be possible in developing countries only if those involved at all levels can gain some benefit from them. Benefits should be for the organisation as a whole as well as at an individual level, e.g. the introduction of a merit-based career advancement and reward system.

Commonly used performance indicators represent selective and imperfect attempts to assess performance in particular areas using mainly subjective methods. Furthermore, most performance measures in current use are results-based and do not give any information on how the results were achieved. In the provision of health services the process of providing the service could be as important as the results. The measures employed may not give precise information about the performance of individuals as opposed to team efforts, and success could be attributable to factors outside the system itself. These measures should therefore relate to individual competences referring to the dimensions of behaviour that result in competent performance; these measures should also focus both on inputs (what competences each individual brings into the total service) and outputs or accomplishments. Impact measures such as beneficial changes in quality, standards of service, behavioural effects and innovation are equally important. It is often difficult to measure individual contributions to the service as a whole. Measures therefore may include individual productivity indicators, as well as service utilization rates and service provision relative to demand. A checklist of skills that identifies a competent worker may include relationships, communication, knowledge, judgment, teamwork, attitude, effectiveness, initiative, prioritized decision-making and accuracy in achieving work objectives on time (4). A performance appraisal format currently used by the International Council of Nurses for their performance management scheme lists competences in alphabetical order as: communication; corporate image, policies and protocols; customer service; equipment; information; interpersonal relationships; learning; leadership; networking; teamwork; planning/work practices; safety. Each of these competences has several indicators, e.g. the safety competence indicators are listed as: knows fire safety procedures/equipment; knows occupational risks; practices safe techniques; understands basic first aid (7).

A project for the implementation of performance indicators and evaluation pilot study conducted recently in the service sector in Sri Lanka (8) has indicated clearly that performance indicators imported from developed countries cannot be applied in toto in developing countries, although some core elements may be used in framing a country-specific set. Such adaptation and application of indicators was found – not surprisingly to require the commitment of national senior management staff and the availability of trained technical staff with analytical skills. The authors also

indicate that the application of performance indicators is of no use in itself unless managers are empowered to act on those deficiencies that have been identified. For such actions to take place there must be clear definitions of responsibility, accountability structures, and authority for local managers in a decentralized system. The study concludes that it was essential to understand the local management culture, apprehensions and sensitivities when such indicators are developed. The use of performance indicators also requires some central guidance and initiative supplemented by specific objectives in terms of management and standards of service provision. Most of these observations would apply to the development and implementation of individual performance management indicators in south-east Asian countries. The same team also looks at the possibility of applying the indicators in Nepal and concludes that it is not currently feasible at this very early stage of decentralization in the health system. The situation has been further complicated by a recent change in government and by uncertainty about the speed of introduction of planned service reforms.

Performance at an individual level cannot be divorced from incentives. In the NPM movement remuneration may be based mainly on financial or material incentives. In a situation where workers receive a decent wage, non-material rewards may be more acceptable as employees value them more in the long-term; these include peer recognition, a sense of making a contribution to the overall impact of the service, and companionship/solidarity with fellow workers. (9). The economic criterion of "value for money" is unlikely to be the only or even the main criterion in a public health service. The above-mentioned study in Sri Lanka (8) finds that for central and provincial managers in the health system, non-financial incentives such as career development, training opportunities and fellowships and even simple recognition are more appropriate, while hospital managers prefer financial incentives.

At a time when gender equity is high on the agenda in all countries of the region, the question of gender bias in terms of existing performance appraisal systems will need to be addressed. Although there is no empirical evidence, the current purely subjective systems of performance appraisal appear to disadvantage female workers at least in some countries. The introduction of a merit-based scheme will undoubtedly be more equitable. The abuse of performance appraisal methods based on subjective assessments of supervisors, a fact of life in many developing countries, can

antagonize employees against the organisation, particularly if this appraisal is linked to an incentive scheme. The introduction of a reward system based on improved performance of the service or institution as whole but reserved only for managers is common practice in many developed countries. This too can lead to employee frustration and even hostility towards management, since employees will rightly feel that their own contributions are not being acknowledged. Rewards to senior staff from superiors for good performance on political grounds can eliminate beneficial but politically unacceptable independent judgment and initiative (5). Accountability is a key requirement in performance management. It means holding public officials responsible for their actions. Accountability can be thought of as financial transparency, a focus on the aims and objectives of the total programme, as well as quality issues to do with health care procedures and activities. Process accountability is also critical in measuring the outcomes of clinical care (10). Accountability is based on the job description and responsibility to line management. It can also be extended to other, more general organisational policy objectives. For example, in Bangladesh, community involvement at all levels of service planning and delivery is stated as a policy in the Health and Population Sector Programme (HPSP) (11). Those directly involved in such activities can be held accountable for delivering services that demonstrate community participation.

Quality Assessment and Quality Assurance

The ultimate aim of performance management (or performance appraisal) is to optimize the quality of work and efficiency in the health system. Quality may simply be defined as fitness for purpose (12). Assessment of the quality of an individual worker's output, the product of a team effort, or the service as a whole is practised increasingly within health care systems in most countries. Quality assessment and quality assurance are closely related. The former is an essential first stage in identifying what action is required for attaining the latter. Assessment is a process of evaluation that does not by itself guarantee the outcome of a quality service unless some action is taken on the findings.

All approaches to quality assurance share the common theme of measuring actual performance and its comparison with either expected or normative standards. The ultimate aim is to create a "culture of quality" in

the workplace. For this to happen however it is essential that the institution or service is at the right stage of development and ready for changes that initially may appear, and usually are regarded, as being punitive. quality assurance initiatives can take root and flourish best in an environment in which everyone involved in health care activities is supportive of quality, alert to problems of performance and opportunities for improvement, and prepared to take responsibility for setting in motion the changes needed to improve care.

Total Quality Management (TQM), a relatively recent development, is applied at an organisation or unit level in which all employees regularly and systematically use quality assurance tools and methods to improve their work. Initially applied in industry, it incorporates a culture of worker empowerment, employer support, and incentives for continuous improvement. TQM emphasizes the importance of considering (and rectifying) the defects and deficiencies in the system and its components in the effort to optimize individual and service performance (13). It uses a proactive approach that calls for continuous improvement in the whole process and not only in the actions of individuals that provide the care. This concept is already being used in some countries in the health care setting. Although the attainment of a reasonable standard of health for all is the ultimate objective for a good health system, it is not enough. There will always be concerns about how that objective is met, i.e. how the health services are run. Such concerns are very much informed by local social values, and the social relationships that underpin the fabric of society. It is the process as well as the outcome that demands quality. TQM is very much concerned with these aspects of process. The links between process (intervention) and outcome cannot be taken for granted and must be rigorously tested.

Large scale quality assurance studies in both education and service sectors, unlike what happens in clinical trials or experimental studies, often encounter major and even insurmountable difficulties in controlling for intervening variables. The service-oriented structure-process-outcome paradigm of Donabedian (14) and the decision-oriented model of Stufflebeam *et al.* (15) in the domain of education are both useful to consider in systems research efforts for quality assurance. Both models focus on outcomes and attempt to validate outcomes by demonstrating causal linkages with the process. Retrospective studies have become more

accepted in this context, although not all outcomes are necessarily "caused by" stated inputs; a physicians' expertise in practice, for instance, cannot be assumed to be a direct result of education. To reduce the complexity of such studies only a few outcomes are usually studied at a time. The "tracer concept" (16) is a successful method to study several key outcomes simultaneously while maintaining validity and keeping confounding to a minimum.

A report from the WHO Regional Office for South-East Asia on quality assurance activities in the blood transfusion services has indicated that they are at different levels of development in Member States. Some countries e.g. Thailand, are striving for ISO norms with vibrant well-developed systems. Others, are experiencing a number of constraints that prevent them from making quality assurance activities fully operational (17). Not all countries have implementable national policies. Countries that do have such policies also have a better infrastructure in terms of budget, trained personnel, donor recruitment, appropriate screening, and quality. However despite the existence of such policies, the blood safety record in some countries is poor due to lack of government commitment, frequent government changes, limited financial resources, and lack of trained personnel (18).

When attempting to provide a high quality service, it must be appreciated that some factors that lie beyond the control of the individual. In all developing countries there are infrastructural, procedural, climatic, political, and communication factors that affect outcomes and quality. A recent assignment report on biochemical laboratory services from the Maldives states that "the assessment of quality is non-existent". It identifies some of the reasons for this state of affairs in relation to the regional hospital laboratory service. In addition to transport difficulties, these reasons include the detection of slides and reagents long since out-of-date and the observation that the target values on quality control material were unknown because the relevant package insert was not available. The author states that "given the weakness of the infrastructure, the commencement of an external quality assessment (EQA) scheme is not a feasible proposition. The notion that EQA can be a high priority in such circumstances is wrong" (19). Perception of problems in laboratory-based clinical microbiology were reported following consultation with key informants in an assignment report from India. These were identified as under-funding,

lack of training, poor career structure, uncertainty as to the quality of reagents, lack of quality standards and procedures, lack of effective central planning and leadership, lack of consensus and coordination among professions, and lack of tools for measuring quality and stimulating improvements (12). Although these were service-based quality assurance reports in specific situations, such concerns and constraints are likely to apply in some of the other countries in the region. They are also undoubtedly pertinent to the issue of performance appraisal for individual employees.

Feasibility of Introducing Performance Management in Developing Countries in South-East Asia

The possibility of introducing performance management in the developing countries of south-east Asia could usefully be discussed by taking into consideration the wider concept of New Public Management (NPM) as described in the foregoing section. The introduction of NPM requires several pre-requisites, the most important of these being the existence of a reasonable "basic" public health sector with a high technical capacity and transparency. In most developing countries such requirements may not easily be met.

Segall (9) has indicated that NPM ignores the basic ideals of a humanitarian public health service and that not all workers will value financial gains in the new management system. There is however a possibility that the idealistic expectations of the workforce for employer approval and peer-recognition may no longer apply in the new millennium. Job satisfaction is essential but, given that base, many of the younger generation of employees in both the public and private sectors prefer financial incentives to the so-called "inner generated ethic of service".

The critical requirement here is the existence of a "reasonably funded health service". The non-tangible rewards of recognition and self-esteem are only applicable in situations where workers receive a decent wage, a condition that does not obtain in many developing countries. In these countries the main incentive is financial reward. Many private organisations reward satisfactory performance, as judged by a rigorous appraisal system, with special bonuses and recognition. Bonus-linked performance management systems in general have been established and

continue to produce results in the private and public sectors in most developed countries. By and large such practices have not been adopted in the state sector in developing countries to any great extent, primarily for reasons of affordability. Since benefits accruing from such schemes can be substantial, more research is necessary in this area.

Many problems are inherent to the developing countries. They include: weak management capacity; inadequate management rules and practices; lack of planning, supervision, evaluation, and control; absence of accountability mechanisms; lack of understanding of responsibilities, regulations, and line relationships; and poor management training combined with inadequate tools for proper management. Supervision is taken mainly as an authoritarian task and not seen as a strategy for staff development and a supportive mechanism for both improvement and maintenance of quality. The reported implications of the above deficiencies include a widening of the gap between service needs and service provision, the expenditure of an inordinate amount of energy on addressing targets while neglecting the needs of individuals, the dissatisfaction of staff and their clients, a shift of clients to the private sector and a high rate of vacancies in the state-funded service sector (11).

The introduction of any management change that threatens established patterns of work and performance norms is difficult even in developed countries. Maintenance of the "status quo" is often seen as less threatening than the adoption of a new system, particularly for the more senior personnel and those in positions of power. The system of automatic promotion based on seniority is well-embedded in most developing countries of south-east Asia. There is a strong possibility that those already in senior positions or aspiring to be so might lose out if merit criteria were to be introduced as a requirement for promotion or wage increment. In such circumstances, antagonism to the introduction of a performance management or a modified performance appraisal system may also be expected to originate from the more senior personnel. These are also the people who can block any change. Those who might really want change will have no voice and hence no input into policy decisions.

The most successful application of performance management as observed in some private companies has occurred where all staff categories were brought into the scheme. Applying performance management only to the "lower" staff categories results in a greater divide between managers and

employees, as well as a further enhancement of the hierarchical system that pervades the service in developing countries of south-east Asia. However, performance management can be used only for the higher or professional staff categories, including most importantly top-level managers. As already stated, at the top management level, the indicators used for measuring performance would be based on the objectives and targets of the service as a whole for which they are held accountable. The Sri Lankan approach in performance appraisal seems to be restricted to the professional cadres.

It is rather tempting to apply an appraisal system to those staff categories invariably the "lower" level field workers who have to meet quantified targets on a defined time scale e.g. so many home visits per month. This is being done already in some countries including Bangladesh. It is however a far cry from a recognized performance management scheme. The question of performance appraisal is one that will appear at the top of any list of priority issues in human resources development (HRD). Experience in Bangladesh has indicated that external assessment of performance is usually unwelcome.

In the medical education sector, staff evaluation by students is seen as being inappropriate and unnecessary. In addition to a genuine fear of being identified as a poor performer, this attitude may be seen as another indication of a strongly hierarchical culture. In the service sector, the existing annual performance review, occasionally referred to as "a waste of both time and effort" (11), is seen as being adequate, and current efforts to introduce a new system will undoubtedly meet with firm resistance.

The greatest barrier to reform is rarely the cost or complexity of organisational change. There are several systems in existence that can be adapted to suit the specific requirements of a given country – including its social and cultural norms. The organisational culture and well-entrenched management systems are likely to be the greatest constraints to change. In bureaucracies that rely heavily on hierarchical systems based on archaic rules and regulations governing discipline, authority and power, even a well-planned attempt to institute change is unlikely to meet with much success. Sri Lanka introduced a new performance appraisal system for the public sector in 1997. This was extended with suitable modifications into the whole health sector and launched country-wide (20). A WHO-sponsored study to review this system has indicated that it is not operating as expected due to a lack of commitment from top management. Although

the reasons for such a lack of commitment have not been indicated it is likely that some of the foregoing constraints may have applied.

New systems involve participation of the person being appraised, and are based on performance assessment methods that utilize non-subjective validated measures rather than personal factors. Expected competencies and indicators are clearly defined and understood by both the person appraised and the supervisor. If the culture of the organisation is not geared to such a view of performance, performance-based appraisal or management systems are therefore unlikely to succeed. Recent research evidence following a pilot study of a trial of performance management system in South Africa indicates that in organisations that are not "performance conscious", attempting implementation may do more harm than good. Other reports from case studies in developing countries have indicated that efficient staff management is not perceived as having high priority in health systems that are starved of staff, equipment and supplies (21).

Given both will to change and motivation, the question of timing becomes all-important. Even in highly developed countries, initial at tempts to introduce performance appraisal systems have failed because the organisation was not ready for change. The optimal time for introduction of a performance appraisal system is when the organisation as a whole functions as one cohesive unit with clear aims, vision and objectives, and when all members of the workforce know and appreciate what is required from each of them. Such conditions may not apply in the state sector in most developing countries where employees struggle with low wages, poor job satisfaction, lack of guidance and fear of redundancies, all of this in a climate where information is lacking.

Major health sector reforms require a well-established communication system so that all employees are kept informed and indeed are given an opportunity to participate in discussion and debate. In Bangladesh for instance, where the implementation of such reforms is currently underway, many employees, including senior academics, do not know much about the reasoning behind policy decisions. At recent orientation meetings on the Health and Population Sector Programme (HPSP) , conducted in all state-funded medical colleges, a preliminary questionnaire to determine current knowledge indicated that less that 20% of participants even knew what the Essential Services Package was. Even

fewer could state what the letters HPSP stood for, even though this is the main structural reform currently being implemented. In such situations, where the employees have not been "taken on board" at the outset, it is extremely difficult to motivate them to adopt new human resources procedures that are seen as being part of the reform package.

A check-list of essential preconditions for the introduction of a performance management scheme in south-east Asian countries is given in Box 1.

Box 1. Core Questions an Organisation Will Need to Ask Before Implementing any Performance Management Scheme:

Does the organisation have a well-articulated vision from which specific objectives and targets have been derived and both understood and accepted by all workers?
Are there clear job descriptions for each employee (or category) that indicate specific responsibilities and lines of accountability?
Is there a defined career structure with specific criteria for movement up the ladder and are these criteria based on merit/satisfactory performance rather than simply on seniority?
Is it possible to introduce a performance incentive scheme or reward system if one does not already exist?
What is the scope for the introduction of a personal development plan linked to an annual appraisal scheme?
Are there sufficient numbers of committed senior staff who are trained as managers and value the basic principles of a performance management scheme?
Do the managers have sufficient authority within the existing system to take key decisions in order to rectify deficiencies detected either at an individual level or in the service as a whole?
Can the existing organisational culture be changed from one that is based on archaic rules and regulations governing discipline, authority and power, to one which values good performance and a client-focused service of high quality?
Is there an accurate, up-to-date, computerized personnel data-base?

The existence of even the most highly trained, competent, well-motivated and adequately remunerated personnel in any organisation in no way guarantees the quality of the end product. There may be major constraints to performance that are outside the influence of the workforce and even outside the organisation or system itself. Such constraints prevail in most developing countries. Performance needs assessments can readily identify financial, material, and human resources constraints that hinder

optimal performance. Such efforts however rarely identify the more important and usually more sensitive obstacles such as political demands, policy issues, and inter-personal relationships that pertain to an institution or situation. Any performance appraisal scheme that does not take these factors into consideration may not be acceptable and will do more harm than good to the organisation as a whole. Before we can suggest the introduction of a performance management process at the service level it should be mandatory that these non-technical factors affecting performance be identified.

Even as major structural changes are taking place, process initiatives such as the introduction of a performance management system may be initiated with appropriate preparation. Some countries have indeed focused on reforms in human resources management as a first priority to go hand-in-hand with re-structuring, in particular with a move to decentralization. The latter provides a valid reason for introducing reforms in human resources management, including performance appraisal or management systems. Indeed there is a need for using such measures in keeping overall strategic direction and control in a decentralized system that will result in more rather than less decision-making foci. Since such reforms are already taking place in many countries in the south-east Asian region, the implementation of reforms in human resource management has become an urgent necessity. Whether such reforms should include a performance management scheme is another question.

CONCLUSION

The concept of performance management is not sufficiently well understood nor appreciated in the health systems of most developing countries in the south-east Asian region. If initiated in its current format and in the existing organisational environment it is unlikely to be a success. The experience in Nepal shows the reality in the service sector and such constraints may apply to other countries in the region. Even in Sri Lanka the introduction of a new performance appraisal system, rather than performance management, has not been a total success, with less than optimal support from management. The rigid hierarchical structures that obtain in most developing countries in the region will also act against the initiative unless there is no threat to those in positions of power. This in

effect may mean the introduction of such new systems – by compulsion – at the lower levels only, resulting in a further emphasis and encouragement of the existing power structure. Such a result would be very much against the philosophy of performance management and its ethical principles.

In the absence of a reasonable "basic" public health sector with a high level of technical capacity and transparency, the introduction of even a modified performance appraisal scheme is almost certain to be seen as a threat and met with resistance at all levels. Although there is a move to introduce new concepts and implement performance management systems in some developing countries with the assumption that such introduction itself will change the culture of the organisation, there is no evidence to support this assumption.

Basic orientation programmes are an essential first step in any attempts to introduce even minimal change in the whole area of performance assessment. The initial introduction of a merit criterion as the main requirement for promotion, consideration for fellowships, or wage increment would be a good beginning in the overall human resource management process. Such measures will undoubtedly have a effect in improving quality and performance.

The picture is somewhat different for a well-designed quality assurance process in both educational and service sectors. Ideally the institution or service should be at the right stage of development for optimal benefit from a quality assurance system. In fact, some countries in this region are already implementing quality assurance even in the absence of a suitable organisational culture and with some success, particularly in the educational sector. Further encouragement along these lines leading to formal accreditation mechanisms is feasible given the necessary legislative structures and support.

It is time for the more "advanced" organisations and health systems within the region to move into TQM. In any or all of these initiatives a comprehensive, timely and accurate information system is now an essential requirement. Such systems are not always available in the developing countries in the region although they are in the process of being developed or implemented. The importance of non-technical factors affecting performance in many countries cannot be over-emphasized. Some of these are seen as being outside the direct influence of even senior management. Unless transparency extends to such sensitive areas of undue influence,

performance and quality can never be judged fairly and, more importantly, cannot be optimized to enable the health care "customer" to receive maximum benefit from the service.

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