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# **INCENTIVES AND SERVICE QUALITY**

## **AN ASSESSMENT GUIDE**

**(DRAFT)**

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# INCENTIVES

## Purpose of this manual

This manual should lead you to a clearer understanding of the following:

- What the incentives in your organization are.
- How those incentives affect behavior of the staff.
- How those incentives especially affect service quality.
- How you might use the incentives, as they now exist, to get a quality improvement program started in your organization.
- How to gain more control, yourself, over the incentives.

You may be surprised at how broadly "incentives" are defined here. We do not limit ourselves to the usual list of incentives that people immediately think of (such as pay, dismissal, travel); we also include subtler aspects that affect the way staff behave. The reason for doing this is that the subtler aspects may be the ones that are the simplest for you to work with (you already know that it is difficult to do much with pay, dismissal, promotion, etc.)

## Who is this for

This manual is intended for two groups of people in health care organizations:

The first group includes those who would like to get an organized quality improvement program started. If you are in this group you will find the manual speaks most directly to you.

The second group is composed of those health professionals who have some supervisory or management responsibilities — such as clinic directors, department chiefs, hospital administrators — and who want to improve service quality in their unit. As you well know, if the staff, or the management, do not see any rewards for doing quality work, quality will start to slip. The final section in the appendices, **An Incentives Based Strategy**, may give you some ideas on how you might conduct small experiments with incentives to try to raise interest in service quality and improve the level of service quality as well.

## Organization of the manual

This manual contains five sections:

First there are some general comments on incentives and service quality (**Motivation to Quality**).

These are followed by a questionnaire to help you determine how the incentive system in your organization works for or against service quality (**Assessing the Incentives**).

Following each question you will find several sections that discuss how to interpret your answers to the questionnaire and how to develop a strategy for introducing quality assurance.

The appendices contain six sample **Strategies** that both demonstrate how a quality assurance strategy may be implemented and present common approaches.

The final section is a **Planning** form where you can bring together the different elements of the manual to establish your own strategy for introducing quality assurance into your organization.

The size of this manual may be alarming. Be reassured that you will need to read only the relevant sections — perhaps a third of the total pages. The questionnaire will direct you to specific sections of the manual for a discussion of what your answer means for introducing QA into your organization and how best to go about that. These discussions may, in turn, direct you to specific appendices.

In any event, you will not begrudge the effort. As you are well aware, many good programs and ideas fail because people simply do not carry through with them; these failures often reflect a lack of understanding of the incentive structure of the organization. This manual cannot promise you total insight into how and to what ends people are motivated in your organization; however, its systematic approach should ensure that important areas are not ignored and that a comprehensive picture will emerge.

## Motivation to Quality

A manager or clinician can be trained in quality improving techniques — and master them — but nothing will happen unless he or she wants to use those techniques. That is, there must be some *motivation* to put the quality improving ideas into practice.

When we mention motivation we often think of it in terms of the presence or absence of a positive personal quality; a person with low motivation is, we readily assume, a lazy person. Consider however, the following examples and their effect on motivation.

*The auxiliary nurse, Miss Alvarez, rarely came to work in the clinic on time. She did, however, arrive a few minutes before the doctor/clinic director who was usually one hour late (he tried to see a few private patients in the morning). When asked to defend her chronic tardiness, she said "There's not much point getting patients started when the doctor won't see them until after 9:00. And it gives me a few minutes more in the morning to take care of my house."*

We can speculate about the many motives the nurse might have for coming in late; however, it is clear that the example set by the director of the clinic does not encourage punctuality.

*A recently graduated Medical Technician, Mr. Bhutto, was assigned to a large Health Center and attacked his new duties with vigor, putting in extra hours and taking minimum breaks during the day. His supervisor commented favorably on his efforts but Bhutto was unable to make friends among the other staff. It even seemed that obstacles were put in his way as he often could not find things that he was just working with (they had mysteriously been moved) or he was given especially time consuming and meaningless tasks to perform. His work grew harder and less productive and he wondered if it was worth it.*

Peer pressure can be very powerful in determining our motivation. If the unofficial standard is to take it easy in a clinic, anyone who visibly exceeds that standard will come under pressure to step back into line.

*After five years in the Ministry Dr. Chandhra had seen a number of less able and devoted physicians than himself receive promotions and desirable transfers. Why, he often asked himself, was he working harder than everyone else and getting less recognition. He started seeing private patients and cut back the hours he spent at the MOH clinic.*

Theoreticians use the term "equity" to cover situations of this nature. When a worker thinks others are receiving greater rewards for less effort than the worker is making, the worker often reduces his own level of effort.

*Health Promoter David stopped mentioning measles vaccination. He had once been insistent that mothers take their children in for all vaccinations but several mothers were turned away when there was no measles vaccine available (an embarrassment for Mr. David) and he started to lose interest in that aspect of the immunization program.*

It is very hard to keep up motivation when one lacks the basic tools and support to do the job. It may be challenging to improvise around such lacks for a while but frustration will soon wear most people down.

*Every six weeks Nurse Encina was visited by the Nursing Supervisor. The supervisor spent considerable time on the clinic reports and records and was critical of omissions. The supervisor looked at little else. Over the years Nurse Encina found herself dedicating more time to record keeping and less to patient care.*

An organization has many subtle ways of telling workers what is important — and sometimes sends the wrong message. If the supervisor seems interested in administrative matters and not patient care, supervisees will tend to shift their efforts toward administrative work.

*When Dr. Fernandez left an NGO and joined the Ministry of Health as a district supervisor, his new assistant told him, "This must be quite a come down to have to work for the Ministry. Everyone here wants to get out." The assistant, and others, went on about the low status of the Ministry and Dr. Fernandez soon discovered a change in his own perceptions of his professional role. He used to think of himself as a saver of lives, a bringer of comfort, and these heroic self-images were reflected in his dedication. After a year in the Ministry he saw himself as someone collecting a check and waiting for a pension; his dedication to providing health care had also declined.*

When an organization is down on itself it's hard not to let that affect the way we see our own work. If the general belief is that the organization does poor work and is staffed by second rank workers, this belief will come true.

*Miss Gupta was the health center pharmacist. What she disliked most about her job was the complaints from patients when the clinic did not have a prescribed medicine and she had to send them to the private pharmacy. The wealthier patients seemed especially abusive when they were told that a prescribed medicine was unavailable. She hoped that fewer patients would even bother to check with her and she had erected small barriers to discourage them: she sat out of sight of the dispatch window, she was slow to respond to calls, she was a little rude when she did appear, and she tried to make the patients feel inferior so they would be less likely to complain to her. These small tricks seemed to reduce the number of complaining patients so she continued them.*

When your job is to give service to people, a great source of satisfaction in any field is a grateful person. A great source of frustration is an un-grateful person. When a patient says our best efforts are not good enough, we can't help wondering why we tried so hard in the first place; not surprisingly we may try less hard next time.

## Objective

The preceding seven examples all make the same point in different ways: motivation can be destroyed by forces and factors within an organization. Certainly there are people on this earth who are just bone lazy, but there are also many normally energetic health professionals who are no longer motivated to provide quality service because their efforts have not been rewarded in the past or their good work has been discouraged or even punished.

The objective of this guide is to examine the factors in health care organizations that motivate and de-motivate concern for service quality. After some general introductory comments about the many aspects of motivation, a questionnaire will help you assess the factors in your organization that promote or discourage service quality. Based on your responses to the questionnaire, you will be directed to specific sections of the guide that contain information and suggestions that are relevant to the motivational problems of your organization.

In the management literature, more has been written on the topic of motivation than any other topic. Strong motivation makes for successful organizations; its absence spells disaster; and so it is no surprise that the topic of motivation commands considerable attention. For purposes of improving service quality, we will look at three components of the organization: the culture of the organization, the incentive system of the organization, and your personal ability to influence (motivate) the behavior of others. This is also the sequence in which you will need to analyze the incentives for quality service in your own organization:

We will start with the broadest panorama, the organizational culture, and determine what aspects of it encourage a concern for quality and which

work against concern for quality. Many aspects of the culture cannot be changed but there are others that can.

Then we will turn to an examination of the incentive system. This includes both the obvious rewards and sanctions that the organization has (promotion, pay, dismissal, etc.) as well as the less obvious ones (what is measured, how supervision is conducted). Knowing what is rewarded and how it is rewarded (or punished) is basic to marshaling incentives for greater quality.

Finally, what influence do you have, or can mobilize with others, to achieve positive changes in quality? The success of many quality improving efforts depend on the will and ability of one or two pioneers.

Before turning to the questionnaire, some general remarks on each of these three aspects of motivation in organizations . . .

### **Organizational Culture**

Culture is to humans as water is to fish. We are usually unaware of it until we are removed from it. The culture of an organization is the beliefs the organization has about itself and how people are supposed to behave in the organization.

We will discuss beliefs in terms of the *values* and the *climate* of the organization.

How people are supposed to behave is further affected by the subtle (and sometimes not subtle) cues or hints provided by the organization. Those cues can come from the behavior of leaders, from what gets rewarded (how do people get ahead), from what gets evaluated and measured, from the goals that are set, and from what outsiders (for example, patients) expect of people in the organization. Considering each of these topics in turn . . .

### Organizational values

The true values of an organization are rarely the ones mouthed by its leadership. The leaders can be counted on to publicly say that the organization is dedicated to only the loftiest ideals; the reality may or may not reflect those ideals. What really matters is how the average employee feels about the organization. If he's proud to be associated with it, that's a good sign. If he thinks he's part of the finest health care organization in the country, that's an even better sign.

To put some flesh on these conceptual bones, imagine two doctors, one works for a prestigious teaching hospital, the other for a MOH clinic. Imagine the characteristics of these two physicians. If you were asked to write down a list of characteristics that might be true of each one and you came up with the following lists, it would reveal a great deal about your perceptions of the culture and values of the MOH and the teaching hospital.

Teaching Hospital Doctor	MOH Doctor
<i>Educated</i>	<i>Security minded</i>
<i>Energetic</i>	<i>Lazy</i>
<i>Competent</i>	<i>Not rigorous</i>
<i>Scientific</i>	<i>Incompetent</i>
<i>Articulate</i>	...
<i>Well-dressed</i>	
<i>Up-to-date</i>	
<i>Arrogant</i>	
...	

These perceptions of yours would have extra meaning for the culture and values if you were, in fact, an employee of the MOH or the teaching hospital. We can see that in this fictitious teaching hospital it may be easier to introduce a quality improvement program — especially a program focused on clinical aspects of care — since the provision of high quality care is probably a strong organizational value.

Please don't assume that the lists above are the only ones possible. The list for the MOH doctor could have just as easily read . .

*Dedicated*  
*Public spirited*  
*Not driven by money*  
 . . .

If this list were an accurate one, it might be fairly easy to introduce quality improvements that would increase patient satisfaction (reductions in waiting time, more convenient hours, more thorough counseling, etc.) since the values of the organization seem to be consistent with a public service outlook and concern for patient welfare..

Understanding the values of the organization done by answering a handful of questions:

- What do organization members think the organization is good at — if anything?
- What makes the organization distinctive from other health care organizations?
- What are sources of pride in being a member of the organization?
- What are sources of embarrassment from being a member of the organization?

The answers to questions such as these may reveal that quality improving efforts will be easy, difficult, or have to be channeled along certain lines.

Which culture? Glossed over, so far, is the question of which set of values and which culture is being talked about. Certainly in health care organizations there

are multiple cultures. There is the culture of the organization, just discussed above; there are different professional cultures — physicians, nursing, paramedicals, etc. — and there may be values that come from the sponsor of the organization, say a church or a university. These “cultures” can introduce values that reinforce or contradict one another. Consider this case:

*A young surgeon works in a church supported hospital. The hospital staff are proud of the fact that they refuse service to no one and they treat all patients with dignity, especially the poor and disadvantaged. A mentally retarded girl is brought to the physician. She has had one baby— the father is unknown — and the girl's parents want the girl sterilized*

*The church that sponsors the hospital opposes sterilization on any grounds; the medical association has defended a doctor's right to make judgments on the basis of his/her own conscience; and the community is generally in favor of sterilization in cases like this.*

*What should the physician do?*

This example shows us value systems in conflict but you may also find that the presence of different value systems provides you with opportunities. For example, if the organization's culture seems to provide no support for quality improvements, the professional (physician/medical) culture might.

### Organizational Climate

Linked to values, but somewhat more operational, is the notion of organizational climate. Several studies carried out in the 1970s demonstrated the effect of climate on employee motivation. If the climate was formal, employees tended to be interested in control and influence; if the climate was relaxed and sociable, employees tended to be primarily concerned about interpersonal relationships; and if the climate was achievement oriented, employees were likely to be concerned about reaching goals. Some of the important questions about climate for service quality are:

Does the organization have widely accepted goals?

If so, are they . . .

coverage?

service to all?

equity?

quality?

How do people get ahead?

How do they stay out of trouble?

What is the response to the diligent worker . . .

from his or her supervisor?

from his or her peers?

Is professional competence commented on?

Does anyone within the organization pay attention to service quality?  
 Does anyone within the organization pay attention to anything at all?

While values are difficult to change in the short term, many aspects of organizational climate can be influenced by supervisors and managers. Goals can be set, meetings can be held to discuss professional qualifications and standards, performance against goals and standards can be recorded and posted, superior performance can be recognized, and so on.

**The Incentive System**

There is a continuum of incentives. At one end are powerful tangible incentives such as pay, dismissal, or promotion; their effect can be immediate and, because of their strength, they are used sparingly and consciously. At the other end are subtle incentives such as the kinds of information collected by the service statistics system; their effect is gradual and they are often not regarded as incentives by managers. Any of the incentives available in an organization can affect the quality of health care provided.

Overt Incentives

Every organization has an overt incentive system of some kind, parts of it formal, other parts informal. Consider the possible range of rewards and sanctions that an organization can use:

Rewards	Sanctions
Salary	Dismissal
Bonuses	Delayed promotion
Per diem	Demotion
Promotion	Reprimand
Travel/conferences	Verbal
Training	Written
Transfer to better facility	Reduced budget
More budget	Transfer to worse facility
Status/prestige	Public embarrassment
Pilgrimage (Haj)	Loss of status
...	...

Incentives tend to be under-utilized. Many managers are quick to deny that they, personally, have access to these rewards and sanctions, and that may be true (however, someone controls them). In all likelihood, mid-level managers feel that without control over the major incentives like dismissal and salary, they have no real incentives at their disposal and they don't place much importance on the incentives they do have. The senior managers that do control major incentives are reluctant to use them as they create equity problems (those who don't get rewarded are unhappy). The result is that neither strong nor weak incentives are used as fully as they might be. In fact, every manager and

supervisor has some incentives to work with although they may not be strong incentives.

As a final note, control over incentives is often distributed in surprising ways. Ministers may have little control over personnel actions (and many other major incentives); those incentives may be controlled by the Director General (Permanent Secretary); a lowly planner in another ministry may control budgetary allocations; a donor agency may control travel; the District Director may control attendance at training; and so on. As a result, the Minister may feel that he or she has no more control over major incentives than does a field supervisor.

The moral is simple: There are incentives in the organization, someone has access to their use, and control over them may be distributed in unexpected ways.

What is Rewarded?

Of central interest to quality improving efforts is the question: when the incentive system is used, what is it used to achieve? The table below lists some possibilities. There are two divisions: task vs. non-task, and within task-related behaviors, service quality vs. other tasks. The column on the left lists the non-task related behaviors that may be rewarded. A person doesn't need to be a cynic to agree that in many organizations these are the behaviors and personal attributes that are rewarded (or their absence is punished). The middle column lists several task related behaviors and the right-hand column lists several attributes or behaviors that make a contribution to service quality.

Not task-related	Task-related	
Non-task	Task	Quality
Family connections	Effort	Professional qualifications
Doing personal favors	Punctuality	Professional contributions
Charm/personality	Meet numerical goals (coverage)	Maintain technical currency
Flattery/toadying	Hold down costs	High tech. standards
Seniority	Prompt attention to crisis of the hour	Well liked by pts.
Loyalty	Administrative detail	
Create no problems		
Visibility		
...	...	...

Just as different people within the organization control different incentives, these people are also probably interested in encouraging different behaviors. It is possible, as an illustration, that the Minister would like to see coverage numbers go up (that increase would make his battle with the budget office easier), the Regional Director — for his own reasons — rewards personal loyalty, the District Director rewards cost control, the Clinic Director wants punctuality and technical competence, and so on. Each manager, because of differences in personality and the demands of his or her position, is looking for different behavior and attributes. This may be to your advantage. If you can determine who is interested in service quality, the incentives controlled by that person might easily be used to stimulate higher levels of quality.

### Subtle Cues

When we think of incentives, we usually think of the items on an earlier table — salary, dismissal, etc. There are other less obvious ways that behavior is massaged and manipulated in an organization; these include leadership behavior, peer pressure, the evaluation and control systems, supervisory attention, goals, and the expectations of outsiders.

Leadership behavior. There is **Leadership** style — which may be due to charisma, expertise, appearance, etc. — and there is leadership behavior. In the area of service quality the charisma of the leader is less important than the example he or she sets. As an example: if the clinic director performs only a perfunctory physical examination and provides no counseling, we may expect the rest of the staff to follow this example. Only by providing a personal example of concern for quality and commitment to it can a manager or supervisor change the behavior of those beneath.

Peer pressure. The values of the organization imply a large number of behaviors such as how to dress, whether to be formal or informal with one another, how hard to work, whether to gossip, and so on. Enforcing those standards is usually the task of peer pressure. If you violate one of the standards — say your dress is inappropriate — the response of other workers is likely to be indirect (“Couldn’t find a clean uniform today?”). Peer pressure relies on its own special set of rewards and punishments which include cooperation (or the withholding of it), social contacts, social isolation, material and moral support (or their absence), and so on. It takes a hardened individual to resist the effects of peer pressure. While it is unthinkable that there would be peer pressure to provide low quality service to patients, it is possible that the informal standards and values of the organization work against quality service in less direct ways. As examples:

If there is no standard against revealing patient problems, potentially embarrassing information might circulate around the community. A clinician who refuses to discuss patients might be seen as aloof by the other staff.

Or if one of the dearly defended beliefs is that the health providers are more god-like than the patients (this kind of arrogance is not unknown), any provider who treats patients with dignity and respect may find his or her co-workers less than friendly.

Control systems. If your boss frequently asks you, pleasantly; about your time of arrival that morning, your punctuality will improve. If he or she starts to inquire where you parked your car you may start to wonder what the right answer to that question is. The point is, we are alerted to the organization’s priorities when the organization asks for information. If the service statistics system focuses on curative case load and asks nothing about preventive health activities, practitioners will give fewer lectures on nutrition and look down more throats. While many clinical personnel do not like the information system, still the constant

reminder that the organization might be paying attention to X and not to Y has an effect over time; more of X gets done at the expense of Y.

When these indicators are included in the evaluation system they have more than a marginal effect on behavior. We really take notice. Curious items creep onto personnel evaluation forms over the years, often because of momentary interest in some aspect of organizational life. These fads may include communication skills, community services, professional contributions, attendance, and so on. There is usually nothing wrong with these items but they may have been elevated in importance at the expense of other items due to public or official interest that later disappeared.

If we tend to do more of the things that the organization measures or records in our personnel files, what happens to the activities that the organization does not take notice of? We start to neglect them. If professional competence or service quality is not explicitly evaluated, an opportunity has been lost to signal the organization's concern with these areas.

Supervision. Many would argue that the management system with the greatest potential for improving service quality is supervision. This potential is often wasted, however. Supervisors often do no more than visit a clinic (rarely), examine the records (perfunctorily), look into the stock room (briefly), quaff their tea, and head for home to collect their per diem. What is the message to operating personnel of this supervisory behavior? Whatever else the staff may read into this lackadaisical performance, certainly there is no strong incentive to be concerned about service quality.

Goals. There seems to be little debate over whether goals can motivate behavior (although there is still discussion over how best to set those goals). One of the clearest signals an organization can communicate is through goals — such as: contraceptive prevalence, vaccination coverage, morbidity reduction, ponds drained, post-surgery sepsis rate, etc. The effectiveness of goals can be lost if they are unrealistic, not challenging, or senior staff pay no attention to their achievement.

Expectations of outsiders. As a final item on this incomplete list of subtle motivators, health professionals are influenced by the expectations of outsiders. The outsiders may be patients, professional colleagues in other organizations, community members, etc. The expectations of patients are particularly important and often poorly understood. Health providers have many theories — often self-serving — about what patients want but these theories seem to arise out of the profession's mythology rather than from inquiry. It is not uncommon to hear, "If you take their pulse, they think they've been examined." "The patients don't think it's a cure unless it's injected." "We always have placebos handy as no one is satisfied until he gets a prescription." Whether the staff's perceptions of patient expectations are accurate or not, they do play a role in determining how providers will behave.

## Personal Influence

For many quality improvement efforts it may come down to the interpersonal skills and influence of the manager (you) who wants to achieve progress. You may extend your personal influence through the involvement of others and you will draw on your own store of influence. Clearly it is important to know the extent and bases of your own influence and how you can increase your influence.

Bases of influence. Your personal sources of influence are five:

- control over rewards,
- control over sanctions (punishments),
- expertise,
- personal liking for you, and
- your position in the hierarchy.

It is possible to increase the amount of influence associated with these. We have all seen clumsy attempts by individuals who have claimed more authority for their position than was justified or who have pretended control over rewards that they did not have; these don't work. There are, however, long term strategies to increase personal influence; these are not Machiavellian, nor devious — simply sound organizational work.

It is also possible to obtain an immediate increase in influence through the involvement of others in your quality improving efforts. An early step in the problem solving process is to put together a team to work on the quality problem; this team — properly chosen — can help develop a better response to the problem, and also lend its own influence to the implementation of the solution.

## ASSESSING THE INCENTIVES

This section contains groups of questions which will direct you to the relevant sections of the manual for a brief discussion of how to introduce QA into your organization. The questions will help you identify key organizational factors that affect the quality of service. Note that the questions are phrased in terms of how people see things, not necessarily how things really are. This is an important and useful distinction for your work in quality. If the doctors in your organization see themselves as dedicated professionals then they are likely to respond to your call to that sense of professionalism. Never mind that in reality they may all be a bunch of hopeless incompetents; if they think they are professionals, then you will have a basis — their sense of professionalism — for involving them in improving quality.

Following most of the responses to the questions below, you will find a section referred to; those sections immediately follow each question. If you agree with a particular response (and you may agree with more than one response to a question), go to the referenced section(s) of this guide for suggestions on how to implement a quality improvement activity in your organization. (If you think some other, not listed, response better fits your organization, let us know; your suggestion may appear in the next edition of this manual.)

In answering the questions don't give in to cynicism or defensiveness. Neither an excessively gloomy nor rosy assessment of your organization will provide a useful starting point for your endeavors.

After you have answered a question and read the section that explains the implications of your answer, you will be directed to the **Planning Document** at the back of the manual. You may enter your own brief comments in the Planning Document. There is a sample Planning Document that has been filled out (it precedes the one you will use) to provide you with an idea of how the Document might be used.

### Values

**General purpose.** These responses address the general purpose of your organization . . . what do people think the reason for its existence is.

Most people both inside and outside my health care organization would agree that the general purpose of the organization is to -

- set the example for other health care organizations (see **Section 1.a**)
- provide excellent care to a select population (**Section 1.b**)
- provide special health care services to a small population (**Section 1.c**)
- provide general care to a large population (**Section 1.d**)
- play a pioneering role in delivering health care services (**Section 1.e**)
- serve those who cannot obtain health care anywhere else (**Section 1.f**)

**Section 1.a.** Organization members think that your organization sets the standards for other organizations and one of its roles is to exhibit that leadership.

If this statement applies to your organization it is a propitious beginning for a quality improvement activity, but there is a pitfall: people who think they're on top may not instantly welcome the suggestion that they need to improve. The general approach you will have to take is to stress the theme that this (quality assurance) is how the best get better and leadership in attention to quality is consistent with the leadership the organization exhibits in other areas.

This self-perception of excellence carries implications for how problems are found. Keep two possibilities in the forefront of your thinking:

1. There may be a willingness to embrace a thorough examination of all activities — essentially a quality audit — where every facet of service is examined and rated against explicit standards and guidelines. This would be most welcome and would reflect a sense of security seldom found in organizations; therefore don't count on it.

2. A more likely scenario is that you will have to start in one activity and it may be the activity that the organization already feels is strong. That's good. Such a start may not lead to the greatest immediate gain in service quality as the room for improvement may not be as great as elsewhere; however, it will provide a laboratory for gaining experience with QA methods and growing confidence in their usefulness. You would do well to avoid starting with the hotel services and administrative side of the operation. These are important areas but to start there may mean that QA will later encounter barriers to moving into clinical services — it will always be something for improving billings, reducing waits in the cafeteria, and so on.

Enter a summary of any relevant points on the general purpose of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 21 and answer the question on quality of service.

**Section 1.b.** The general purpose of your organization is to provide excellent services to a select or special population.

In most cases the population would be not only select, but also selective; that is, they could take their business elsewhere if they lost confidence in your organization (competitors always exist, perhaps outside your country, and if you are seen to start to slip you will invite competition closer to home). This suggests that a good starting point for a QA program would be patient satisfaction. Of course not every one of your colleagues will feel that the organization should be driven by client expectations, and few may enthusiastically welcome the notion. However, if you are trying to retain the loyalty of customers who have options, too cavalier an attitude regarding their treatment will

have dire consequences for the survival of the organization. An incentive for quality improvements, in sum, is client expectations.

There are many suppositions about what patients want, but little firm evidence. Your organization might be the one to start gathering that evidence. Patients may want faster access to specialists, more in-patient services, a less rigorous diagnostic process ("stop doing tests and start curing me"), home care, invasive procedures, high technology procedures, laying on of hands, steady information and education, etc.; there is enough latitude in the way medical services are delivered to make small but perceptible changes to improve customer satisfaction.

It is difficult to know what patients want without asking them and asking turns out to be difficult. Shallow inquiry into patient satisfaction tends to turn up comments about hotel services (food was good/bad, television didn't work, noise at night). Those services are worth improving upon. However, these are items that the patient feels competent to complain about and possesses the language to express his or her opinions. Away from the intimidating presence of the professional institution the released patient may tell family and acquaintances that the diagnosis was slow in coming, the intervention was the wrong one, the procedure was botched, the attitude of the providers was arrogant and condescending, and the cost was extortionate. Getting at these perceptions is not impossible but it usually cannot be done with a questionnaire handed to the patient at checkout.

Enter a summary of any relevant points on the general purpose of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 21 and answer the question on quality of service.

**Section 1.c.** The general purpose of your organization is to provide special health care services to a small population.

Disease specific programs or organizations would fall into this category: caring for leprosy victims, certain mental illnesses, perhaps tuberculosis, and so on. Typically this means that you have a captive market since it is a small one and there is likely to be little pressure from your patients as they a) recognize that they have special needs, and b) usually have no where else to go to have those needs served. If that is so, the pressure to improve quality has to come from within the organization.

This is a difficult situation as there will not be other organizations against which to compare your own service quality. Additionally, since your patients are in a special category, your relative success or failure with them will also not be held up to comparison with other health care providers. This particular general purpose does not work against quality; it does, however, make people in your organization less likely to think about it and less likely to recognize quality problems when they begin to fester.

And there is a danger that a destructive pattern can develop. There are examples of organizations serving special patient populations — victims of AIDS, leprosy, mental disorders — that have treated their patients in bestial ways. The powerlessness of the patients and the absence of standards of care conspire to let the worst elements in human nature emerge.

Where are the positive incentives? Three possibilities come to mind:

1. The uniqueness of the organization and its services may provide a weak incentive. The fact that no one else is doing what you are doing may encourage a closer look at how services are provided. In fact, you are engaged. — you might claim — in an on-going clinical experiment. If that notion is accepted, then it becomes desirable to document procedures, set experimental standards and conditions, track cure rates, and so on. The search for and provision of high quality care becomes almost a scientific game.

The uniqueness factor may be strong if the organization is also a pioneering one, accepting risks by providing controversial services (at one time contraception was controversial, now pregnancy termination is at the center of much controversy). If this is the case, there is a twin appeal to quality that may be made: First, the pioneering nature of the organization lifts it above other organizations and the pursuit of quality fits well with the other noble aims of your organization. Second, if the service provided is controversial, it is prudent to ensure that the quality of the services is unassailable. An abortion or sterilization procedure that ends tragically for the patient may be the opportunity the opponents of the organization have been waiting for.

2. A second possibility is to build on altruistic and public service values. Since your organization is serving a group that is neglected by others, redressing this neglect can be one argument for providing the best care possible.

3. Finally, the simplest incentive may be to take the organization out of its isolation by feeding in information on how this patient group is dealt with in other countries. This effort must go beyond subscription to a journal; you will need to promote active discussion of procedures tried elsewhere, success rates of comparable programs, and an examination of how your own procedures and cure rates compare with others. Supplementing, or as an alternative to, making comparisons with external organizations is to encourage internal comparisons of performance across operating units. Which district has the lowest default rate? Which has the highest cure rate? And so on.

All three of these possibilities may be tried simultaneously. Given the nature of your organization, multiple weak incentives to service quality are probably needed.

Enter a summary of any relevant points on the general purpose of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 21 and answer the question on quality of service.

**Section 1.d.** Your organization provides general health care to a large population.

This is a difficult organizational purpose from which to build a quality program but it is also a common one. The familiar phrases about "providing the best care possible for the citizens of our land" soon ring hollow. The clients are so many (and they often have few alternatives to your organization) that they are faceless and unending. A provider will view the throngs in his or her waiting room with the same attitude with which a trash collector approaches his job; once the bins (waiting rooms) are emptied for the day, they will start filling up for tomorrow. The chore is unending and changeless.

The mission, in effect, provides only the weakest basis for placing a premium on quality. How to proceed? Three suggestions:

1. There may be other cultures within the organization that provide built-in values that do support quality improvements. Consider the attitude of many professionals regarding their organization. They may — and often do — regard it with open cynicism; this is a common observation on university campuses as well as in health care organizations. The professional, whether physician, engineer, professor, or scientist, will often identify more closely with the values of the profession than the organization. (That is not to say that the values of the organization have no effect on the professional; they do. He will, on the one hand, reassure himself that he is part of a larger, noble profession only passing through a second-class organization. On the other hand, he will, in moments of candor, acknowledge that his abilities are not far superior to the average in the organization.)

These professional values may be a better base for quality improvements.

2. A second possibility may arise from frustration with the routine. A quality assurance effort provides novel activities — novel for awhile — and this novelty might provide motivate staff to participate in a QA program. If so, it would be advisable to make certain that the QA activities are in fact novel and not mere extensions of current activities. As examples:

Data collection should not be built into the current information system (although that might be desirable over the long term). Conducting special small studies can provide a welcome alternative to the mind-numbing routine of endless patients with similar complaints.

The problem solving teams could include members other than the immediate staff of the facility (who may meet together often enough already). Consider an academician or a member of a different health care organization.

3. A third response to the built-in obstacles to QA in your organization would be careful selection of problems. If, as is extremely likely, there is widespread belief that everyone is overworked, select quality problems that may result in improvements in efficiency. You will probably find, for example, that there is

keen interest in projects dealing with patient education and self-management. This interest may reflect in some degree an unwillingness of providers to have their clinical practices scrutinized; never mind. Go with patient education projects as they can improve quality; if they reduce workload they will give QA a good name; and improved efficiency releases resources that can be used to resolve other quality problems. There are, of course, other efficiency improving areas than patient education. If the problem appears to meet other criteria (important, visible, fast turn-around, etc.), then select it.

These three approaches may be combined. 1) Identify other cultural currents in your organization (professional, religious, tribal, familial) that encourage a concern for service quality. 2) Strive to make the activities of the QA effort interesting and unusual. 3) Solicit and select quality problems that, if solved, will lead to increased efficiency.

Enter a summary of any relevant points on the general purpose of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 21 and answer the question on quality of service.

**Section 1.e.** Your organization occupies a pioneering role in delivering health care.

This is a very promising basis for introducing quality assurance. The obvious theme you may wish to stress is the innovative nature of quality assurance. Health care has always been concerned with quality (we hope), but QA elevates that concern and makes constant quality improvements an explicit goal of the organization.

Beyond this general complementarity between your organization's purpose and QA, what kind of pioneering work do you do? Three possibilities:

1. If the organization is pioneering in the sense that the services it offers are controversial — say abortion or sterilization — there should also be a sense that any perceived lapse in quality can open the organization to attack. Thus, you can couch the appeal to quality in terms of the danger to the organization of not taking quality more seriously than do other health care organizations.
2. Alternatively, if your organization pioneers health care technologies, many of the monitoring mechanisms associated with QA will already be in place and there should be widespread commitment to evaluating the results of the care provided.
3. Finally, if your organization is a pioneer in the sense that you reach previously unserved populations, you may have to combat the sentiment that any service is better than no service, and the newly served patients should be grateful for whatever quality they get. This, clearly, is a dangerous sentiment, and one that needs to be confronted directly. Presumably moralizing on the issue is going to be less effective than will be an appeal to service values. To do that, the focus of your QA efforts would be, perhaps, less on the activities you

provide and more on the benefits to the people served. This leads to the suggestion that perhaps you should not spend too much time examining the details of service delivery, but rather, focus on the health problems of your patients first. Recall that one important dimension of quality is access; you are providing that. A second dimension is effectiveness; are you curing and preventing disease? Or is your organization simply going through the motions of health care provision, perhaps with a delivery model that is ill-suited to the context in which you are working? These questions may strike a responsive chord among many in your organization and provide a firm basis for improving quality.

Enter a summary of any relevant points on the general purpose of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 21 and answer the question on quality of service.

**Section 1.f.** Your organization provides health care services to those who cannot obtain care elsewhere.

There is ample room for mischief here since there probably is not much pressure from the patients to improve (or even maintain) service quality. What internal pressures (values) can be tapped?

1. The first is to try to draw on non-organizational values such as professional ones. "Physicians provide the same level of care to all patients." (That's the value; perhaps not the reality.)
2. A second possibility is to work on service values. Where paternalistic sentiments are prevalent, it may be possible to capitalize on the notion that the strong should look after the weak.
3. Recall that one of the dimensions of quality is accessibility. This opens a third possibility which is to focus on what your organization says it already does well: provides access to those who otherwise cannot get care. Your initial QA efforts could be in the direction of determining whether you are, in fact, reaching those who have no alternatives. Or are there subtle barriers to service within your own organization (there often are) such as inconvenient hours, poorly located facilities, intimidation of the patients within the facilities (staff hostility, reliance on written instructions for semi-literates, incomprehensible counseling, etc.), lack of female practitioners for women, and so on. Such an approach would challenge the organization on whether it lives up to its purpose so this will be a potentially threatening approach. On the other hand, once the organization has begun to examine whether it is living up to its fundamental mission, there is a strong value to sustain that inquiry.

Enter a summary of any relevant points on the general purpose of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 21 below and answer the question on quality of service.

**Quality of service.** These responses are about the perceptions people in the organization have concerning the quality of care provided.

When people in the organization think of the quality of care provided, they see it as -

- an example for other health care organizations to aspire to (see **Section 2.a**)
- above average in our country (**Section 2.b**)
- about average in our country (**Section 2.c**)
- adequate for basic health needs (**Section 2.d**)
- we do the best we can (**Section 2.e**)
- poor (**Section 2.f**)
- they don't think about quality at all (**Section 2.g**)

**Section 2.a.** Your organization sets the example to which other health care organizations aspire.

This should be fertile terrain for nurturing QA unless the staff is uncertain about their claim to excellence and that uncertainty makes them defensive. Generally, if this belief is widespread, it should be fairly easy to make a great parade of your superiority in service quality by stressing that your organization does not take quality for granted. You will have to be careful to couch your efforts in terms that do not suggest that a quality improvement effort implies any concern about falling standards; rather, the implicit slogan will be "how the best get even better."

Since the perception of excellence is a comparative one (you are much better than the rest), you can also subtly use comparisons with other good organizations to maintain pressure on service quality. It is convenient to single out weak organizations and take smug satisfaction in your superiority over them but they should not be your point of reference. You may have to look outside the country for a challenging standard against which to compare yourselves. The question is not whether you are better than an impoverished municipal hospital; it's whether you provide the same quality of care as do the major research and training centers in the developed world. If you can bring information into the organization that shows that in some areas your care is as good as is provided in internationally prestigious institutions, you reinforce a useful self-perception, indicate what the standards for comparison are, and encourage emulation of the highest service standards.

Enter a summary of any relevant points on the quality of service of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 28 and answer the question on professional competence.

**Section 2.b.** The prevailing belief is that the quality of service in your organization is above average.

This is a difficult starting point since this attitude may reflect indifference to standards of quality; there is something dismissive in the statement that one is above average. On the one hand, selection of this alternative is an admission that your organization is not in the first ranks; on the other, comfort is found in the belief that there are other places that are much worse.

Two possibilities:

1. If a measure of pride is taken in the belief that the organization is above average, comparisons with other domestic health organizations may inspire interest in maintaining that margin of superiority. One of your tasks could be to produce valid (not anecdotal) comparisons with similar domestic organizations.

Generally, however, the rank and file workers are going to find such external comparisons annoying. Since the organization is not a contender for the top spot, most people will not be interested in knowing where they stand among the "also-rans". As a consequence, you may want to try to develop a system of internal comparisons, measuring the quality of service in one district or hospital against another.

2. As an alternative, there may be pride taken in certain aspects of care. These should be aspects that many people can identify with, such as coverage, courtesy, low cost, availability of medicines, availability of in-home services, and so on. If such exist — or, more accurately, are perceived to exist — you can concentrate your initial efforts on those. Think, for a moment, about other organizations — social, civic, educational, or whatever. If they have a distinguishing characteristic (give the best parties, are the most democratic in their functioning, have the nicest members, etc.) there is a strong tendency for these organizations to protect their superiority in that one narrow area and to flaunt it. If social club A throws the wildest parties, they will knock themselves out every time a party comes around to ensure that their image in this regard remains intact. So it is with your organization. If there is an area in which people take pride, exploit that by focusing special attention on it.

Enter a summary of any relevant points on the quality of service of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 28 and answer the question on professional competence.

**Section 2.c.** People feel that the quality of care you offer is about average for the country.

The good news here is that there is some awareness of the quality of services provided. The bad news is that this perception, by itself, does not provide much of a basis for gathering support for improvements in service quality. Yes, there is an acknowledgment that there is room for improvement, but, unlike some of the other answers to this list of questions on values, this answer does not provide the motivation that some of the others do. Unless there is also an element of dissatisfaction about being average, you will have to find other values on which to develop your quality improving strategy.

Enter a summary of any relevant points on the quality of service of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 28 and answer the question on professional competence to see if something more encouraging is found there.

**Section 2.d.** It is felt that the organization provides services that are adequate to meet basic health needs.

This sounds like a defensive position and that makes it especially difficult to change. Does the underlying reasoning run as follows?

Our mission is to provide only basic health care.  
Basic health care is, by its nature, not sophisticated.  
Technically unsophisticated health care can not really be done wrong.  
Therefore virtually any level of quality will be adequate.

A true challenge. As long as staff adopt the position that their efforts are appropriate for the modest task set them, there is little hope for change. Appeals to their sense of professional pride may generate brief interest in improvement but you will have to get away from this particular mind-set if you are to launch a sustained search for higher service quality. Similarly, attempts to glorify the *mystique* of basic health care are unlikely to bear much fruit.

Consider the following possibilities; the common element is that they either tap into a different set of values or they rely on powerful incentives other than values:

Identify a set of values that might support higher quality. For example, if practitioners regard themselves as frustrated scientists, a quality research program might succeed. See Appendix E for a description of such a program.

A heavy-handed approach might be needed if the control mechanisms are in place. See Appendix A for a QA strategy based on routine audits of service. Appendix C describes a strategy based on the supervisory system.

If you have control over significant tangible incentives, a strategy based on goals and rewards might succeed (Appendix F). This has been tried in other programs. Challenging (but realistic) goals have been set and cash incentives offered to those who attain those goals. Clearly this can become a costly strategy.

Enter a summary of any relevant points on the quality of service of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, go to page 28 and answer the question on professional competence.

**Section 2.e.** The prevailing belief is that the organization does about the best it can.

This borders on an open admission of defeat. Questions of why the organization can't do better are likely to be met with a string of excuses based on resource lacks. It is possible to argue effectively against those excuses, but this is an arduous way to win converts to quality. There is no denying it; you have a difficult task ahead of you. Consider the following possible ways around this problem:

1. Seek out those individuals who are dissatisfied with the status quo and who want to raise service standards. Work initially with those people but beware of the trap of becoming isolated from the rest of the organization. It is seductive to work only with those who share your vision; it's easier and self-reinforcing. It also leads to a self-limited QA program. Little can doom a QA effort faster than the growing perception that it is the purview of a few smug people who are intent on showing others in a bad light. To combat this, constantly — weekly — enlarge the circle of people with whom you work. Apathy is difficult to overcome single-handedly; you will have to consciously recruit in widening circles, starting with those who do not share the general defeatist attitude, following with those who are not strongly defeatist, and so on.

2. Another slender reed . . . It is easy to say that a demonstration of success will convince people that it is possible to raise quality. (It may also increase their defensiveness.) A series of such demonstrations in widely spread sites and circumstances may shake the fundamental gloom with which people regard service quality. When you select problems to work on, pay special attention to the criterion of visibility; the problem should be visible; the results fast in coming; and the improvement easily seen. Yours is not a situation where subtle improvements are going to win people over.

Again, you may wish to recruit those who do not share the prevailing pessimism. Bear in mind that people do not think that quality is within their reach and that will be self-fulfilling. Breaking that mentality will be difficult but it must be eroded in large measure if you are going to have a sustained QA program. If you cannot change overall perceptions of what is possible in quality, behavior will not change.

3. Finally, consider how quality is currently defined. It is likely that it is equated with the technical quality of services where the implicit standard is a well-equipped, professionally staffed facility. As you know, service quality goes beyond technical competence to include as[pects such as accessibility, efficiency, confidentiality, and effectiveness. If you can bring the organization to adopt a wider definition of quality you may be ultimately successful. As examples of means and ends:

Recognize clinics that have the lowest cost-per-patient ratio to underline efficiency as a quality goal.

Generate estimates of the proportion of each community that uses the services of your organization. This would be consistent with a focus on access.

Collect data on cure rates for TB or other difficult diseases as a measure of effectiveness.

Citing these examples does not mean that we advocate ignoring professional competence. Rather, you may find that these are areas that the organization will respond to and try to improve upon as some staff may feel that these goals are within the present capabilities of the organization. Success in these areas of service quality may break the defeatist mentality and permit you to move on to clinical services.

Enter a summary of any relevant points on the quality of service of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, go to page 28 and answer the question on professional competence.

**Section 2.f.** People acknowledge that service quality is poor.

This bleak self-assessment may provide a basis for a QA program simply because it reflects dissatisfaction with the status quo. This will be especially true among individuals who are embarrassed about the current state of service quality. Work with those individuals first.

Unlike other organizations that do not acknowledge quality failings, you may be able to go to work in areas where the problems are most severe. There should be support for addressing those situations that, if resolved, would lead to the largest gains in quality.

Enter a summary of any relevant points on the quality of service of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, go to page 28 and answer the question on professional competence.

**Section 2.g.** People don't think about quality at all.

This would be somewhat unusual — health professionals tend to grouse a lot about the restraints they experience on quality — but it is certainly a bad sign. If a concern for quality doesn't figure into the organization's culture at all, you have a large job ahead of you.

There are two strategies you could follow: 1) Try to build on current pockets of support for QA. 2) Try to generate broad, if shallow, support for QA

1. If there are individuals and groups who are concerned about quality, and there usually are, you could start with them. There is the danger of becoming isolated from the rest of the organization. It is seductive to work only with those who share your vision; it's easier and self-reinforcing. It also leads to a self-lim-

ited QA program. Little can doom a QA effort faster than the growing perception that it is the purview of a few smug people who are intent on showing others in a bad light. To combat this, constantly — weekly — enlarge the circle of people with whom you work. Apathy is difficult to overcome single-handedly; you will have to consciously recruit in widening circles, starting with those who are concerned about quality, then moving to those who are not indifferent to it, and so on

2. As either an alternative or complementary activity you could try to generate broad support for QA. How you go about that will depend on the resources you can bring to the task. Some of the conventional approaches are training, direct incentives, goals, piggy-backing on another value, and supervision.

Training. One (expensive) response is training and this is commonly recommended for getting a QA program underway. The question remains, however, training in what?

One school of thought is that trainees will be eager to apply new skills. This reasoning underlies much of the opposition to sex education in schools. Train someone how to solve quality problems (or have sexual relations) and the trainee will rush out to apply the new knowledge.

If that argument seems naive you may wish to add a second component to the training: exhortation to improve quality. It is certainly possible to convince people of the value of doing something; the size and success of the advertising and evangelical industries are testimony to this fact. It can be argued to trainees that quality is important, quality can be improved, and the trainees have it within their own power to improve quality. See Appendix D for a description of a training based QA strategy.

Goals. If you have access to senior management (or are senior management) you can set explicit quality goals. These might be set in terms of process goals (no variations from standard protocols) or outcome goals. The latter may be easier to promulgate, leaving the former to lower levels within the management hierarchy. For example, you might set goals of a 50 percent reduction in post-operative sepsis or waiting time for service. It is obviously simpler to set goals that are already tracked by the information system; that spares you the necessity of having to change a major support system.

Direct incentives. What happens when you reward people for reaching those goals? Wonderful things, presumably. The National Health Service in one area of England has started making cash payments to groups of providers who meet challenging quality goals (£1,000,000 will be paid out). Such lavish rewards may not be within the reach of your organization, but more modest forms of recognition might be possible. See Appendix F for further discussion on this point.

Piggy-backing. If quality is not a central value, perhaps another value can be exploited. For example, if many physicians in your organization

see themselves as frustrated scientists, you may want to establish a quality research program. That might entail provision of minor resources for research on quality (a budget for data collectors) and a forum for presentation of results. Such a program is currently being tried in Chile (not because of the values within the Chilean MOH but because of its fragmented structure). See Appendix E for a description of a research based strategy. Other complementing values that might be exploited include:

- Self-perception of practitioners as life-long students.
- Value of being current on latest technologies.
- Altruism/public service.

Supervision. If it is within your power to redirect the activities of supervisors and field supervision is effective, the surest way to improve quality may be through the insistence of supervisors on service quality. A supervisor who, on a monthly basis, checks each facility for adherence to standard protocols and the achievement of quality outcomes will certainly modify staff behavior in the desired direction. Appendix C describes a QA strategy based on the supervisory system.

You should be alert to the fact that these approaches will, if successful, lead to the performance of quality enhancing activities, but not necessarily to a commitment to quality service. While it is possible that habit will lead to commitment, do not assume that it will occur quickly; you may need to support the activities just discussed for several years before they are self-sustaining.

Enter a summary of any relevant points on the quality of service of your organization in the first chart in the **Planning** document. Then, to further sharpen the focus on quality related values, turn to page 28 following and answer the question on professional competence.

**Professional competence.** These responses address how the physicians in your organization perceive their professional competence. While the self-perceptions of other professional cadres within your organization are important, the physicians often set the tone and their beliefs regarding service quality will be influential.

In moments of candor our doctors think of themselves as -

- among the finest in the country (see **Section 3.a**)
- about average (**Section 3.b**)
- those who can't make it elsewhere (**Section 3.c**)
- inexperienced (**Section 3.d**)
- looking for an easy (but modest) paycheck (**Section 3.e**)

**Section 3.a.** The doctors in your organization think of themselves as among the finest in the country.

This should be a good sign, especially if they see their excellence as the result of their constant attention and effort. (If they see their preeminence as the result of seniority, your task will be less easy.)

Given this attitude it seems unlikely that they will respond well to a QA program built on checklists and audits; they expect to provide leadership in quality of care, not be constantly examined on it. A better avenue might be that of a traditional TQM program where the responsibility for identifying and resolving problems is placed on the practitioners. Typically this means formation of quality teams that will meet frequently to improve service quality. In the absence of other support for quality, however, the members of these teams can quickly lose interest in the task set for them. In at least one major health care organization TQM was abandoned when the novelty wore off and practitioners settled back into old habits. This danger might be avoided if you collect data on service quality, data that establish implicit areas of interest and goals. These data can range from hotel services (patient complaints, promptness of meal service, cleanliness of patient rooms, etc.) to health outcomes (a variety of sepsis rates come to mind, incidence of vaccinizable diseases, cure rates for difficult diseases such as TB, etc.). With indicators of service quality in hand such as these, the solving of quality problems becomes more than a parlor game for bored physicians. Of course, official recognition of improvements made in the quality of service will help sustain the program.

Enter a summary of any relevant points on professional competence in your organization in the first chart in the **Planning** document. Then turn to page 32 and answer the question on personal rewards.

**Section 3.b.** The doctors in your organization think of themselves as about average in terms of technical competence.

Before discussing this answer, think again about your response. It is common to state that one's skills are "about average;" in many societies it would be boastful to claim anything more. Do the physicians in your organization really see themselves as "about average?" If you still feel the answer is yes, we can proceed (otherwise, return to the question on page 15 and re-examine the alternatives).

Does it worry them that they are only average? If they would like to be better than average and they find it somewhat embarrassing to be only so-so, your task is greatly simplified. They should respond well to a program that contains training and agreed upon standards against which they can register their improvement. Presumably the training would contain significant content directed to raising the technical competence of the doctors.

If, however, they are mediocre and unashamed of it, a more heavy-handed approach may be necessary. You may want to initiate quality audits, based on standardized checklists. Supervisors or special audit teams could apply these. (See Appendix A on quality audits.)

Enter a summary of any relevant points on professional competence in your organization in the first chart in the **Planning** document. Then return to page 32 and answer the question on personal rewards.

**Section 3.c.** An unhappy image: the physicians see themselves as doctors who can't make it elsewhere.

Your most important task may be to help them shake off this image as a group of losers. Two possibilities:

1. While they may never see themselves as among the elite of the profession, you may be able to re-define the bases on which they evaluate themselves. Such a re-definition is probably already in progress. If they do not see themselves as technically competent they may, to protect their own egos, see themselves excelling in some other area, for example, as able to process a large number of patients in a short period of time. We see this happening and hear staff taking grim pride in the number of patients that were run through the clinic in a few hours. Alternatively, the doctors, and other staff, may look outside the organization for reassurance. They may take pride in family membership, neighborhood activities, social involvement, and so on. While there are certainly cultural variations in this regard, it is a rare society where a person feels comfortable if he does not believe that he is useful at something.

This line of thought leads to the following: Is it possible to redefine the standards of excellence away from the conventional ones of medical/technical competence? As an illustration, is it possible to shift the focus toward the achievement of health care outcomes (i.e., the rate of vaccinizable diseases, TB cure rates)? Or toward coverage goals (percent of catchment population receiving health care at the facility)? Or toward service goals (reduced waiting times, reject rate)? The common denominator in these is that they don't ask the

physician to try to excel in an area — technical skills — where he or she has already acknowledged failure.

2. An alternative: It might be possible to erode the self-perceptions of “losers” by providing confirming data to facilities (things done right), or by staging joint events with other, higher prestige organizations. You will instantly see that these stratagems can backfire so you should employ them tentatively and carefully.

Enter a summary of any relevant points on professional competence in your organization in the first chart in the **Planning** document. Then return to page 32 and answer the question on personal rewards.

**Section 3.d.** The doctors in your organization see themselves as inexperienced, presumably because they are.

This could be a very useful self-perception. It suggests that they are not defensive and perhaps open to support from more seasoned practitioners. If your supervisors do have field experience (as opposed to years of administration), you could implement your QA program through the supervisory system. See Appendix C for a description of how that might be done.

Lacking an adequate supervisory system, you might be able to embark on a program of distance learning and self-evaluation. This would be an innovation in QA but the general structure of quality assurance lends itself well to such a strategy. You would need to develop training materials and methods for self-assessment of performance.

Enter a summary of any relevant points on professional competence in your organization in the first chart in the **Planning** document. Then turn to page 32 and answer the question on personal rewards.

**Section 3.e.** Your doctors have become cynical about their position and regard their employment as a sinecure with no higher purpose.

The response here may be to crack down. Like all harsh responses, it will be resisted but it will also be expected (since they feel that they are getting away with something they will not be surprised if the organization tries to bring them to heel). An audit based strategy (Appendix A) may work as may a strategy based on close supervision (Appendix C). You may wish to wrap these initiatives in the rhetoric of public service and the higher calling of health care, but don't delude yourself; if the staff are indeed cynical, do not count on an appeal to their nobler instincts to imbue them with concern for service and quality.

One of the great disadvantages of taking a directive, perhaps punitive, approach to improving quality is that it may be difficult to transition later to a more enlightened approach.

Enter a summary of any relevant points on professional competence in your organization in the first chart in the **Planning** document. Then turn to the following page and answer the question on personal rewards.

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**Personal rewards.** The answers in this brief section address the perceived personal rewards provided by the organization. What, aside from a paycheck, does the organization offer its members?

Most of the professional staff feel that our organization provides them (recall that more than one may apply) -

- secure employment (**Section 4.a**)
- challenging work (**Section 4.b**)
- an opportunity to perform public service (**Section 4.c**)
- an opportunity to use their skills (**Section 4.d**)

**Section 4.a.** The organization offers secure employment.

If that security is based on organizational loyalty to its employees, good. It appears that an organization that is loyal to its employees receives loyalty from the employees in return. Loyal employees do not wish to see the organization embarrassed (for poor quality, among other things) and they should be willing to correct publicly visible quality problems. It may be no coincidence that high quality products are associated with the same Japanese firms that provide life time employment to the work-force. Loyalty to the organization and concern for its public image may support a broader appeal to concern for service quality.

If, on the other hand, secure employment is the result of legal restraints on dismissals, you may want to avoid the more coercive approaches to quality assurance. Inspections and audits may work only if there is already a commitment to doing well in these audits or fear of embarrassment keeps staff on their toes.

This is rather thin support on which to proceed. Do any of the other responses to this question offer a stronger basis? If you would like to review the options, return to page 15 for the question on personal rewards. Otherwise, enter any relevant points in the personal rewards section of chart 1, **Planning** document, and then proceed to the first question on organizational climate, goals, page 34.

**Section 4.b.** The organization offers challenging work.

Let us assume that the challenge you are thinking of is a professional one. If so, this is an encouraging signal. Your task will be to help define the challenge in terms of service quality. That can be done along any of the quality dimensions: technical competence (the most probable), access, effectiveness, and so on.

A desire for professional challenge often is accompanied by a desire — or expectation — of professional autonomy. That has implications for the approach you take. A rigid top-down system may not succeed as well as one that supports and rewards the initiative of individual clinicians or facility teams. To illustrate: Rather than send out supervisors with checklists and predetermined priorities, you may wish to send out supervisors with a variety of diagnostic instruments in their kits. The facility staff would decide, with the supervisor, which areas would be worked on and they would assume the major responsibility for

monitoring progress toward quality goals, goals that had also been negotiated with the supervisor.

Enter a summary of any relevant points on the personal rewards offered by your organization in the first chart in the **Planning** document. Then return to page 34 and answer the question on goals.

**Section 4.c.** Your organization offers the staff an opportunity to perform public service. First, are you sure that the staff still see it that way? They may have entered the organization with high ideals, but those may have since waned. If this is still your preferred answer, read on:

An obvious — although not the only — basis is to focus on public service and client needs. Patient expectations are poorly understood. Yes, they come to the clinic to be cured (although even that is sometimes forgotten) but their preferences regarding the manner of being cured are the subject of many myths and little concrete evidence. Too many of those myths serve the convenience of the providers. Perhaps your organization could conduct some landmark research on what the patients really want from their health service and strive to increase the level of patient satisfaction. See **Section 1.b** for further discussion on this point.

Enter a summary of any relevant points on the personal rewards offered by your organization in the first chart in the **Planning** document. Then return to page 34 and answer the question on goals.

**Section 4.d.** At some level most health care professionals want to exercise their skills and are frustrated at the routine that characterizes the provision of much health care. If, as you have answered, this is a fairly strong expectation of the staff, they may be ready to exercise leadership in the area of professional competence. As examples of how you might capitalize on this:

- Collect, and report back to staff, information on health care outcomes such as cure rates, repeat infection rates, and so on.

- Support, through distance learning programs, training and re-training to keep practitioners current.

- Institute peer supervision and exchange of information on case management.

- Support the introduction of alternative disease management protocols.

The common thread in these examples is this: If practitioners are interested in utilizing their medical skills, keep the focus on the skills.

Enter a summary of any relevant points on the personal rewards offered by your organization in the first chart in the **Planning** document. Then turn to the next page and answer the question on goals.

## Organizational Climate

**Goals.** One of the most powerful influences of behavior in an organization is the goals that employees perceive. If the organization does not take the initiative in establishing what it wants achieved, staff will substitute their own goals.

The goals that most people in the organization are aware of usually concern the

- volume of activities performance (**Section 5.a**)
- coverage of target population (**Section 5.b**)
- service quality (**Section 5.c**)
- efficiency and cost control (**Section 5.d**)
- nothing . . . they are not aware of any particular goals (**Section 5.e**)

**Section 5.a.** The goals that most people are aware of in your organization concern the volume of activities. Those activities would probably be things like the number of patients seen, the number of educational talks given, the number of procedures performed, and so on.

Given the tendency of service/management information systems to record the number of activities performed, yours is a common situation. Activities are easy to count and they have some presumed relationship to health outcomes. This relationship, however, is often an inverse one; that is, an increase in the number of patients seen or the bed occupancy rate usually signals a worsening health situation, not an improving one. Nevertheless, more activities are usually seen as good in the eyes of program managers as they signify more health care . . . if not more health.

If staff think in terms of volume and that bears only a tenuous relationship to quality — at best — how can you shift the emphasis to quality? The answer depends on how goals have been communicated in the past. Consider four possibilities:

1. The simplest case to resolve — and not an uncommon one — is that no goals have been set by the program and staff have assumed, in the absence of explicit goals, that the program is interested in activities since they understand that they are paid to perform activities. The solution is very simple: set quality goals. This may be done collaboratively with staff or the goals may be imposed (other sections discuss which method of setting strategies is superior; research evidence demonstrates that even imposed goals, if they are realistic, are better than no goals at all). Other sections of the manual suggest one area of quality over another for the goals. It may be appropriate to set patient satisfaction goals (i.e., "Patient waiting times will decline by 50 percent to an average of 20 minutes for scheduled appointments."); or technical performance goals ("No patient presenting with symptoms of malaria will have less than 90 percent of the procedures detailed in the standard protocol performed on him or her."); or health outcomes ("The TB cure rate will double during the next year to 60 percent.") The examples could go on. In all instances the goal should be expressed as a

measurable indicator that the providers can track themselves, although you may also want to conduct an independent check on progress.

2. Goals may have been communicated through the MIS. As noted above, these information systems tend toward collection of data on activities, rarely data on service quality. There are two responses to this situation, one easier than the other to implement.

You could try to change the MIS. This would be the most direct attack on the problem. Unfortunately, even the most obviously inadequate MIS often proves resistant to change and reformers are able to do little more than load further reporting requirements on to a staff that are already fed up with the number of forms they have to complete. Nevertheless, if the level of discontent is extreme and the MIS is about to topple, see Appendix B for some suggestions on how to implement an MIS based QA strategy. Some of the indicators you might wish to build in could cover patient satisfaction items, technical performance items, health outcomes, and so on. It would be wise to sample judiciously among the quality indicators, given the virtual impossibility of recording every event and outcome related to service quality.

An easier approach is to ignore the MIS. Staff are prepared to do this anyway, if they are not ignoring the MIS already, and you may wish to simply bypass the current system. The quality goals may be introduced much as in suggestion #1 immediately above.

3. Supervisory behavior provides a clue to staff regarding what the organization wants. If supervisors show great interest in the number of patients seen the staff will have to assume that volume is a priority concern of the organization. On the other hand, a supervisor who directly observes the treatment of patients and cogently (and constructively) critiques the quality of the service provided will certainly encourage staff to become more conscious of service quality. Further, the supervisor is usually well placed to discuss explicit quality goals in any area — technical competence, patient access, efficiency, effectiveness, or patient satisfaction.

If your supervisors show little interest in quality, this is an important cue for staff and one that you may need to correct.

4. There may be explicit volume goals. These are frequently encountered in preventive programs (vaccination targets, promotional talks, prenatal visits, etc.) and are certainly not to be dismissed. However, they can be complemented with quality targets. It now appears amply proven that patient acceptance of preventive health programs is heavily influenced by the quality of the service. Given the lower urgency patients feel for preventive health care, they are less tolerant of substandard service.

If volume goals have been set, it may be fairly easy to attach complementing quality goals.

Read **Section 5.f** before entering comments in the **Planning** document.

**Section 5.b.** Your organization has coverage goals — perhaps expressed as percentages of the target population. These are fairly common in outreach or preventive health programs and reflect the need to actively solicit patients rather than to passively await their arrival at the health facility. In short, the patients, for whatever reason, lack the motivation to seek out the service.

If this describes your situation you may need a set of service quality goals to complement the coverage ones. The burden of research evidence now clearly indicates that patients in preventive health care programs are less tolerant of substandard service. In effect, if you don't meet high quality standards, it will be more difficult to meet your coverage goals.

You may also have coverage goals for a general health program. This is indeed enlightened and reflects a concern for bringing patients into your facilities. If this is the case — and is evidence of a strong pro-service orientation — you should encounter little difficulty in expanding these to cover other dimensions of quality (coverage is often labeled as a dimension of quality in the literature).

Read **Section 5.f** before entering comments in the **Planning** document.

**Section 5.c.** Your organization has explicit service quality goals. You're in excellent shape.

Read **Section 5.f** before entering comments in the **Planning** document.

**Section 5.d.** There do not appear to be any particular goals.

In these situations the employees often develop goals that suit their own purposes or they try to guess, from slight cues, where the organization's priorities lie. The good news is that there are likely to be no competing goals; the bad news is that the organization has no experience in setting and communicating goals. Looking at the bad news first:

There are two issues to be addressed in introducing goals: setting them and getting them accepted.

**Goal setting.** Collaborative goal setting requires special skills on the part of supervisors and managers if true participation is to be achieved in the process. Imposed goals require a different set of skills in data analysis so that the goals are within the capabilities of staff to meet them.

**Goal acceptance.** It is often argued that goals that are jointly established by supervisor and supervisee will be enthusiastically embraced by the latter. Maybe. The mere existence of goals introduces a new area of accountability which many may resist — regardless of how the goals are established.

This is not the place for an exhaustive discussion of how to introduce goals into an organization (and the advice often tends to be platitudinous.) We can summarize that advice however:

Expect resistance and attempt to reduce it by 1) using credible data on past performance on which to base the goals, 2) participate with staff in establishing the goals, 3) ensure that staff can monitor progress toward goals.

Ensure that staff have the means with which to achieve the goals (i.e., materials).

Be quick to provide positive feedback for satisfactory progress toward goals.

Review the goals continually for their realism and adjust them, in consultation with staff, so that they are both feasible and moderately challenging.

Read **Section 5.f** before entering comments in the **Planning** document.

**Section 5.f.** A final word on the nature of quality goals. As noted above, they may be in any quality area, patient satisfaction, technical competence, etc. With only slight intellectual effort you should be able to develop long lists of service goals that would relate to quality. Some examples of goals:

**Patient satisfaction:**

Average wait for service of 30 minutes and no wait longer than one hour.

For scheduled appointments, every patient to see same provider as previous visit.

A female provider in attendance for every visit with a female patient over the age of twelve.

**Access:**

No appointment with a general practitioner for a date later than two weeks from the request.

No fees charged any patient from a family with less weekly income than Rs.150.

Outreach vaccination team to visit every village every thirty days.

**Technical competence:**

At least 80 percent of standard protocol items to be completed on every prenatal visit.

Ninety percent of mothers of children who are due for additional vaccinations to know the date of the next vaccination within plus or minus one week.

Post-operative infection rate to decline by one-third to one infection per 120 procedures.

**Effectiveness:**

Tuberculosis cure rate to increase to 60 percent of the enrolled cases.

Rate of malaria re-occurrence to decline to one in every 15 cases (re-infection within one year).

Incidence of vaccinizable diseases to drop to one case per ten thousand population.

Provider satisfaction (not to be forgotten):

No physician to be on call for two consecutive weekends or more than two weekends in any calendar month.

Thirty day supply of all drugs on Essential Drugs List available in all facilities at all times.

No more than 42 individual patients to be seen by a practitioner in an eight hour working day.

Enter the relevant points on goals in the **Planning** document, second table, and then return to page 39 for the question on organizational formality.

**Formality.** An aspect of the organization that may affect how you proceed is the degree of formality and respect among people at different hierarchical levels.

Staff tend to treat more senior staff and managers -

- formally and respectfully (**Section 6.a**)
- informally and respectfully (**Section 6.b**)
- they tend to ignore senior staff and managers (**Section 6.c**)
- staff tend to resist those with authority (**Section 6.d**)

**Section 6.a.** A high degree of formality exists in hierarchical relationships within your organization; this is accompanied by respect. Formality is neither good nor bad; lack of respect is bad.

The implications of this facet of organizational climate for QA are fairly straightforward.

Supervisors may be an effective medium for introducing quality assurance but they will normally have to be hierarchically superior to the supervisees. It is also likely that they will have to have the same professional background as the supervisee; as an illustration, nurses would have difficulty critiquing the performance of physicians.

A top-down approach to QA may be possible. Service quality goals may be imposed, if that makes sense for other reasons. This is not to endorse a top-down approach if other avenues are open. However, a fully participative approach may take longer to implement and you may not have the luxury (or senior support) to invest much time before having to show results.

Certain participative methods such as brain-storming or quality circles may be difficult to implement. These methods require full and open participation from all members of the working group. If junior staff tend to defer to senior staff, that kind of participation will be difficult to achieve.

In general, although there are a few limitations on how you can proceed, formality, by itself, does not preclude an effective QA program.

Enter any relevant points on formality in the **Planning** document (second table), then return to page 42 to answer the question on organizational clarity.

**Section 6.b.** Staff treat superiors with respect and there is little formality in hierarchical interactions.

This is somewhat unusual in health care organizations but it certainly makes your job easier. It opens the door to all of the participative methods associated with TQM and QA such as brain-storming, quality teams and quality circles, MCUA, etc. This is an ideal situation for the introduction of QA.

Enter any relevant points on formality in the **Planning** document (second table), then return to page 42 to answer the question on organizational clarity.

**Section 6.c.** Superiors are generally ignored.

This limits your options. If field supervisors are also ignored you may have to resort to a strategy that permits ample autonomy to practitioners such as a research based strategy (Appendix E) or a training based strategy (Appendix D).

It should be emphasized that a QA program should focus on quality and not be seized upon as a vehicle for addressing all of the organization's ills. It is tempting to load new items on the QA agenda such as restoring management control or solving old personnel problems (in this instance the lack of respect given to superiors). Resist the temptation. To the extent that you can introduce QA within current organizational constraints, do so. There may be dividends in other areas as quality improves, but these should be welcome byproducts and not objectives. That admonition having been stated, let us turn to what you can do.

In the absence of legitimate authority to impose a QA program, it will have to ride on other incentives. Those include the following:

Purchased compliance. The involvement of staff may be bought with incentives such as travel, research support, transfers, or prestige.

Informal authority. There may be informal leaders within the organization who can persuade others to become involved in the program. (Note that "involvement" here goes beyond token participation such as attendance at meetings or courses.)

Strong values in support of quality. If your answers to questions two and three were consistent with strong values within the organization for service quality, you can exploit those.

Enter any relevant points on formality in the **Planning** document (second table), then return to page 42 to answer the question on organizational clarity.

**Section 6.d.** The staff tend to resist those in authority (perhaps passively). This, lamentably, is not an unknown situation in health care organizations. It does, however, limit your options.

1. If you have solid control over major incentives such as promotions, dismissals, etc. you may be able to impose a QA program. Such a heavy-handed approach is inconsistent with the general positive climate that you would like to ultimately foster. Nevertheless, if the climate is poisoned, you have to make the best you can of the situation.

2. If you do not have good control on major incentives but can bring minor ones to bear on the task, you can try to "buy" the participation of the staff with travel, training, transfers, status, and so on. Alternatively, you might use your resources to support a research based QA strategy (Appendix E) or an incentives based strategy (Appendix F).

3. If there are informal leaders within the organization, you can focus your efforts on them. Perhaps through persuasion or personal influence you can get them to lend their authority to the undertaking.

It should be fairly clear what you probably can not do. You cannot rely on a QA strategy based on supervisors, audits, or the information system. You might be able to employ a research based strategy, an incentives based strategy, or a training based strategy.

Enter any relevant points on formality in the **Planning** document (second table), then return to page 42 to answer the question on organizational clarity.

**Clarity.** The following question on organizational clarity may seem a little . . . unclear, and you may find yourself asking, what is being referred to as clear or unclear. There are two reasons for this ambiguity: First, precision here would have come at the cost of numerous sub-questions and qualifications; the issue is not worth that much effort. Second, if the interpretation of the question itself is unclear, that probably means that expectations within your organization are not clear and your answer would direct you to section 7.b

When it comes to what we are supposed to do -

- it is perfectly clear what is expected (**Section 7.a**)
- it isn't very clear what is expected (**Section 7.b**)

**Section 7.a.** It is clear what is expected of you.

This is good if those expectations include high standards for service quality; bad if they don't. In the latter case, you will have to change those expectations. The means for communicating high standards for service quality include:

- Pronouncements from senior officials.
- Commitment of program resources to quality.
- Commitment of time and energies of senior officials to QA.
- Supervisory attention to service quality.
- Collection of data on service quality.
- Training courses on quality.
- Recognition of quality improvements.

The list could be extended. Since expectations are clear, it may take a variety of inputs and time to change them. And beware of uneven dissemination. Different media reach different audiences. The statements and activities of senior managers will not be known (or equally convincing) to everyone. Similarly, not everyone will interpret the collection of data on quality or the new-found interest of supervisors the same way.

Enter any relevant points on organizational clarity in the **Planning** document (second table), then return to page 44 to answer the question on peer pressure.

**Section 7.b.** The expectations of the organization are not that clear.

This is probably the more common answer to this question. The organization seems to have multiple, shifting, and sometimes conflicting expectations. This is hard on the staff, but may, perversely, turn out to help you introduce QA.

First, you may expect initial resistance to "another vertical program." Staff are understandably weary of the fads of donors and senior management who discover a new disease or emphasis every few months. The strength of QA, in this regard, is that once staff lose their initial apprehension about it, they will probably see that it fits into their current routine.

common response to this question; this aspect of climate may arise out of the special mix of personalities in each facility.

QA provides a focus and clear expectations for program activities. This is demonstrated in several areas: Supervision gains a rationale and point of focus. The MIS ceases to be a mindless gathering up of numbers for an unarticulated purpose. Evaluation takes on a consistent theme. And so on. While it is an exaggeration to say that the staff will rush forth to embrace QA, resistance to it should decline as you communicate expectations in terms of service quality. Your means of communication include:

- Pronouncements from senior officials.
- Commitment of program resources to quality.
- Commitment of time and energies of senior officials to QA.
- Supervisory attention to service quality.
- Collection of data on service quality.
- Training courses on quality.
- Recognition of quality improvements.

In that you will be trying to introduce order into chaos, use as many of the means of communication as are available to you. Also, expect that dissemination will be uneven and that you will have to use a variety of channels to get the word out to all staff in all facilities.

Enter any relevant points on organizational clarity in the **Planning** document (second table), then return to page 44 to answer the question on peer pressure.

**Official support.** It's difficult for staff to keep up their interest in service quality when the resource lacks are so basic that they have to improvise constantly. The answers here take it as inevitable that there will be some shortages, or at least that practitioners will not have everything they want.

As far as providing facilities with the basic resources needed to do their jobs -

- senior managers have made this a high priority and will do whatever is necessary to ensure that essential drugs and supplies are available  
(Section 9.a)
- senior managers will try, within the limits of the program, to take care of the need for essential drugs and supplies (Section 9.a)
- senior managers pay lip service to the problems of supply shortages  
(Section 9.b)
- problems of supply shortages are ignored by senior management  
(Section 9.b)

**Section 9.a.** The responses to the first two options are combined since they reflect differences of degree, not kind. Either situation indicates that there is a clear perception that managers are aware of resource needs and are constantly trying to resolve the shortages that plague every health care program.

You are relieved of a major constraint on your QA program.

Enter any relevant points on official support in the **Planning** document (second table), then return to page 48 to answer the question on major incentives.

**Section 9.b.** The responses to the last two options are combined since they reflect differences of degree — or cynicism — to the supply problems of the organization. While it is an over-statement to say this presents an opportunity, it may indicate an area that staff are likely to identify as contributing to service quality problems.

Resources are never adequate. In your organization the staff do not feel management is working hard enough on this problem. In such a situation staff have two options:

- 1) they can use the resource constraints as an excuse to duck responsibility for service quality, or
- 2) they can try to resolve the resource problems for themselves.

Getting them to tackle the problem is often difficult but recall that efficiency is one dimension of quality. More efficient use of some resources, through patient self-management, shorter hospital stays, lower re-infection rates, etc. may provide a partial solution. If you can get staff to identify the most pressing resource constraints, perhaps with a Pareto chart that depicts the frequency of stockouts of various supplies, you may have a ready-made service quality problem waiting to be resolved. Such a problem would have the advantages of a "good"

problem of being felt, important, visible, and susceptible to rapid change (improvement, we hope).

Enter any relevant points on official support in the **Planning** document (second table), then return to page 48 to answer the question on major incentives.

200  
201  
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## Major Incentives

This section asks you to gauge the effect of major incentives on service quality. You may be dismayed to find so few choices available for the four questions that follow. The reason for that is simple: the number of unique cases is limitless; we cannot even begin to consider the possible variations. What you will find are the broadest and most common categories. Major incentives are normally used very sparingly — if at all — to encourage one set of activities over another. The reason is simple: major incentives are so powerful that any tinkering with them can distort service.

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**Promotion.** One of the most powerful incentives is promotion.

In our organization people are usually promoted on the basis of -

- seniority (**Section 10.a**)
- their effectiveness in their jobs (**Section 10.b**)
- "political" considerations (**Section 10.c**)

**Section 10.a** Promotion is largely on the basis of seniority.

This is probably the most common case. The reasons for this are largely practical ones. While most organizations would like to encourage performance by tying promotion to superior performance, they find it difficult to evaluate performance in a reliable enough fashion to keep out of trouble. The result is that they fall back on the simplest of all assessment systems: counting years of service.

There is a positive and negative effect of this situation on service quality: On the one hand, a strong incentive to provide quality service has not been exploited. On the other hand, this incentive is not being used to promote some end other than service quality (such as toadying, loyalty, concealing errors, etc.). You should not lament too loudly. Since promotion can be such a powerful incentive, its use in pursuit of some end can distort staff behavior.

Enter any relevant remarks on promotion in the **Planning** document (third table), then return to page 16 to answer the question on personal recognition.

**Section 10.b.** Staff are promoted on the basis of their job performance. This leads to two further questions, the first on the credibility of the evaluation system.

Staff generally regard the evaluation of performance as -

- fair and consistent (**Section 10.b.1** immediately below)
- unfair, biased, or inconsistent (**Section 10.b.2** on page 15)

**Section 10.b.1.** Staff trust the fairness of the system on which performance is evaluated and promotions are made.

Good. If you are able to incorporate service quality into the system as one element of the evaluation (not the only element), this can have a powerful effect on behavior.

Do beware of the great power of this kind of incentive. If service quality becomes predominant in the evaluation of personnel, those particular components of quality that you are able to assess will be done assiduously by staff . . . to the neglect of other things. As examples, if you monitor and reward effectiveness (curing patients), your costs may begin to climb as practitioners "over-treat" patients. Or, if you base promotion on following clinical norms, patient satisfaction may be adversely affected. This advice may seem gratuitous, but you have to strike a difficult balance when dealing with a powerful incentive. That doesn't mean that it should not be done; however, it can not be done casually or cheaply.

You need to answer a further question here regarding what performance is evaluated.

The performance or behaviors now being evaluated for promotion is -

- achievement of numerical targets (**Section 10.b.1.i**)
- achievement of a range of behaviors such as technical skill, administrative skill, leadership qualities, communication ability, etc. (**Section 10.b.1.ii**)
- non-specific/non-quantified "performance" (**Section 10.b.1.iii**)

**Section 10.b.1.i.** Promotion is based on performance against numerical targets.

This is a situation that is rife with opportunities to ignore service quality. One of the most frequent complaints against numerical targets is that their single-minded pursuit comes at the expense of quality service. Whether this is the case in your organization or not, you may want to try to balance the concern with quantity with an equally weighted concern for quality. This is not easy but it is worth doing and you may well find a ready audience of staff who have been concerned about the emphasis on quantity. (Numerical targets are most often found in preventive health care programs such as vaccination, prenatal care, family planning, etc.).

Pay careful attention to the likely impact of your assessment of quality. You don't want to trade one problem for another. Since you won't be able to assess all areas of quality at once, you will have to be selective. And, in being selective, you will indicate to staff the areas where they need to excel in order to advance in the organization. If you start to assess counseling for purposes of promotion, counseling should improve — but clinical diagnoses may not improve and might even suffer from neglect.

To minimize these potential problems you may wish to start with the areas most likely to be slighted by staff who are in full pursuit of numerical targets. For an illustration: if the program is family planning, and the goal is number of sterilizations, you would want to introduce quality checks on counseling re irreversibility and patient knowledge of alternative methods of contraception. You could set standards that had to be met in those two areas — as examples: 90 percent of all interviewed sterilized men and women can cite two alternative long term methods of contraceptive protection and 100 percent said they understood the procedure was irreversible when they adopted it.

Enter any relevant remarks on promotion in the **Planning** document (third table), then return to page 52 to answer the question on personal recognition.

**Section 10.b.1.ii.** A range of behaviors is currently assessed for purposes of promotion.

Good; this is as it should be. Adding in service quality should not greatly distort a system where the effect of each component evaluated is diluted by the large number of total components that the organization takes into consideration in promotion decisions. You may find it most expedient to evaluate a group of outcome measures if they reflect a large number of activities. For each such outcome measure, consider the likely consequences on behavior. To illustrate, if the outcome measure is TB cure rate, what are staff likely to do to improve the cure rates? As you go through the options, look for possible staff behaviors that might adversely affect other legitimate goals of the organization such as keeping costs down, respecting patient dignity, and so on.

Enter any relevant remarks on promotion in the **Planning** document (third table), then return to page 52 to answer the question on personal recognition.

**Section 10.b.1.iii.** Promotions are based largely on assessment of performance but the system is informal.

This is not uncommon. Organizations have great difficulty coming up with explicit systems that are unambiguous in their application. Should you try to introduce an element of formality via the vehicle of service quality? Perhaps, but you are attacking on two fronts. It's hard to introduce QA into an organization (hence all this attention to how the incentives affect your efforts) and it's very hard to change the personnel evaluation system. There is a tendency to stick with the system one knows and has prospered by. The more influential members of the organization — those closer to the top or with good prospects of reaching the top — will have done well with the current informal system. Will they want the rules changed now? Hardly.

They are less likely to resist, however, the addition of service quality as another informal element. Try that. See if you can get senior officials to make pronouncements to the effect that service quality is important in evaluating professional performance. If this can be buttressed by inclusion of some items and boxes on whatever personnel performance rating sheet may exist (Technical

competence: Superior . . . Excellent . . . Good . . . etc.) so much the more convincing.

Enter any relevant remarks on promotion in the **Planning** document (third table), then return to page 52 to answer the question on personal recognition.

**Section 10.b.2.** Staff do not trust the system to assess and reward their performance accurately or fairly.

You would do well to disassociate QA from this evaluation system. ; On the one hand it might be argued that QA will provide a consistent and reliable basis for evaluating performance. And it can. Further, you might try to reassure yourself that you can slay two dragons simultaneously: low service quality and a defective personnel evaluation system. Don't try it. Improving service quality is a difficult and important enough goal in itself without saddling it with other organizational problems to solve.

Enter any relevant remarks on promotion in the **Planning** document (third table), then return to page 52 to answer the question on personal recognition.

**Section 10.c.** Promotion seems to be based on "political" criteria. If this is the case, the prospects for harnessing this system in behalf of service quality are remote. You would be wasting your time trying to introduce quality criteria into such a system.

Enter any relevant remarks on promotion in the **Planning** document (third table), then return to page 52 to answer the question on personal recognition.

**Recognition.** We are quick to acknowledge that recognition costs little to grant and can have a positive influence on behavior. What is recognized in your organization?

Individual staff members are singled out for special recognition -

- for excellent performance (**Section 11.a**)
- for poor performance — the recognition is a reprimand (**Section 11.b**)
- no one is singled out for recognition (**Section 11.c**)

**Section 11.a.** Individual staff are recognized for their excellent performance.

Good. Try to ensure that they are also singled out for excellence in the area of service quality. If there is formal recognition, for example, a plaque or an honor roll or a Practitioner of the Month or whatever, try to establish a parallel recognition for quality. Or, if you can, have service quality added to the current criteria for recognition.

Enter any relevant remarks on personal recognition in the **Planning** document (third table), then return to page 54 to answer the question on other tangible rewards.

**Section 11.b.** Recognition of performance tends to be, primarily, recognition of poor performance. It may be tempting to try to include quality criteria. And there may be short term gains in quality from rapping the knuckles of a few poor performers. But the weight of opinion is currently on the side of encouraging service quality through positive reinforcement, not negative. This is not to rule out criticism of sloppy quality, but it is to discourage it as the primary incentive for improving quality.

Enter any relevant remarks on personal recognition in the **Planning** document (third table), then return to page 54 to answer the question on other tangible rewards.

**Section 11.c.** There is little recognition of individual effort. Is this due to the absence of interpersonal support? If any recognition of individual effort simply gets the recognized employee in trouble with his or her co-workers, then there is little value in providing that recognition. On the other hand, if there is no recognition because the organization has not bestirred itself to provide it, you may want to remedy this. Consider three levels of recognition:

The casual expression of approval. Anyone can make approving remarks about another. If you do this there are two positive benefits: First, the behavior that you express approval of is reinforced and is more likely to be repeated. Second, your own influence over the individual you are expressing approval of increases. To illustrate how the second works: If someone tells you that you are doing a good job when you are, in fact, trying to do well, you can't help but think that the person is perceptive and supportive. This kind of insight and support doesn't have to be demon-

strated to you too many times before you come to value the person's (positive) judgment. Therefore, it is no surprise that when this insightful and supportive person makes other statements about you or your work, you tend to listen. This effect will be more pronounced when almost no one else is providing these positive comments. Note that there is little danger of inciting the envy of others with these kinds of approving remarks.

Formal recognition. Beyond the casual expression of approval, letters sent to your personnel file or immediate superior expressing admiration of your good efforts can have a positive effect on behavior.

Awards. Finally, there can be awards — a plaque, an honor roll, a certificate presented at a meeting — that provide tangible (although inexpensive) evidence of the organization's approval of an employee's efforts. These can be competed (only one award per month) or they can be given to any person or group that surpasses a set standard. Establishing a standard and making the award on that basis can avoid some of the jealousy and pouting that a competed award can produce.

Direct recognition of individual and group efforts is a cheap and effective incentive. There's no good reason not to exploit it.

Enter any relevant remarks on personal recognition in the **Planning** document (third table), then return to page 54 to answer the question on other tangible rewards.

**Other tangible rewards.** Organizations typically have at their disposal a variety of other tangible rewards such as training, attendance at conferences, allowances, and so on. These may be the only tangible rewards that management can control and use as incentives if the major incentives such as pay, promotion, and dismissal are so bound up in bureaucratic procedures that it is almost impossible to use them as incentives.

Training, travel, conference attendance, etc. is distributed -

- randomly (**Section 12.a**)
- on the basis of performance (**Section 12.b**)
- on "political" considerations (**Section 12.c**)

**Section 12.a.** There seems to be no pattern in your organization regarding how training, travel, etc. are distributed.

This is a mistake and a missed use of important incentives. In a later section we will ask who has some control over these decisions (that control often tends to be spread among several people) with an eye to directing their use toward raising interest in quality. If there is no pattern in the distribution of these rewards, there probably is little interest in them and this may be an opportunity to increase your own influence over their distribution.

It is important to distinguish between remedies and rewards. Training often falls into both categories and we see the people who least need training being sent off for another course as a reward for their excellent work; meanwhile those who need the training are left behind because they haven't "earned" it. This is a tough problem to resolve when training (with its per diem and opportunities for travel) is one of the few rewards available. Try to identify training that truly is for remedial purposes. If you are able to get more of the needy into those courses, the high performers will become less interested in attending courses that clearly bear a remedial image; that image will become obvious if only the less capable members of the organization are sent to them. There will still be plenty of courses and conferences that you can send people to simply as a reward.

Enter any relevant remarks on "other tangible rewards" in the **Planning** document (third table), then return to page 57 to answer the question on budgetary allocations.

**Section 12.b.** Training, travel, etc. appear to be awarded on the basis of competence.

Training is one of the more frequently used rewards and requires special handling. It may be useful to divide training activities into remedies and rewards. Remedial training is designed to help people acquire knowledge that they should have, but don't. Unfortunately, when training is used as a reward, the high performers are sent off to these courses where they gratefully collect their per diem and find the material only moderately interesting; meanwhile, the truly ignorant are left behind. There are also training courses that are not re-

medial; they introduce new information into the organization and it is more appropriate to send high performing staff to these.

The trick for you, to improve quality, is to get the ignorant into the remedial courses and the deserving into the "reward" courses. This is easier to do if you can shape the image of the courses. While you don't want to label the remedial courses as such, you can change their image by placing an increasing number of people who need the training into the course. The high performers, unless the other benefits of attendance are powerful (high per diem, travel), will not be flattered by the company of so many low performers in the course..

QA courses are susceptible to this remedy-reward dichotomy. The "reward" courses introduce the techniques and philosophy of QA. These would be suitable for the high performers in your organization. As the QA program unfolds and some quality problems are traced to knowledge failures, remedial courses can be established to address those problems.

Enter any relevant remarks on "other tangible rewards" in the **Planning** document (third table), then return to page 57 to answer the question on budgetary allocations.

**Section 12.c.** Training, travel, etc. are distributed according to political criteria; that is, loyalty or family relationships or return of a favor usually determines who will receive these benefits.

You have two avenues open to you. The first, and easiest, is just to forget this group of incentives. However, you may be reluctant to do that since these rewards are often the most accessible to managers; but, you will be taking on an "Augean task" if you attempt to clean up the incentive system while simultaneously introducing a QA program.

The second avenue is to try to retain control over any new training, travel, etc. resources that come in with the QA program. If this is feasible, you might separate those resources that you will use as rewards from those that you will use as remedies. Training is a case in point. Training, in theory, should be used to correct lacks of knowledge; however, we often send off the most competent and hardest working for training to reward them for their efforts. This is actually defensible when the training is to bring new skills and ideas into the organization. However, when you are trying to bring the staff up to speed by giving them the skills that they should already have, you need to send the least educated, not the most. The solution in QA is simple: Start your training programs in QA with the best and brightest staff; these are the people that you want leading the program anyway. As the QA process uncovers problems, some of which will almost certainly be traced to knowledge lacks, provide remedial training to resolve those problems.

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\* This refers to the Augean stables of Greek mythology where 3,000 oxen had resided for thirty years. Hercules was assigned the unappealing task of cleaning out the stables. The parallels should be evident between Hercules' task and your own in trying to clean patronage and favoritism out of the incentive system.

Enter any relevant remarks on "other tangible rewards" in the **Planning** document (third table), then return to page 57 to answer the question on budgetary allocations.

**Budgetary allocations.** It makes good sense for the organization to give more resources to the managers and units that use those resources the most effectively. This increased allocation will also be seen as a reward.

The budget of the operating units (facilities and programs) is -

- fixed and cannot be changed by management (**Section 13.a**)
- variable and can be changed by management (**Section 13.b**)

**Section 13.a.** It is not feasible to change the budgets allocated to facilities and programs. Too bad. That kind of flexibility is a useful management tool.

Enter any relevant remarks on budgetary allocations in the **Planning** document (third table), then return to page 59 to answer the question on control of incentives.

**Section 13.b.** It is possible to change the budgets allocated to facilities and/or programs. This opens up some opportunities, but ones that have to be exercised with care.

The assumption here is that a larger budget is an incentive; that is, a manager who does a good job will feel rewarded if, among other things, he or she receives more resources to continue the good work. This re-allocation toward the more effective units also makes sense from the standpoint of the organization; you want money in the hands of those who use it most effectively.

The problems that come with this re-allocation will be instantly evident to you. The patients who depend on the less effective facilities will be penalized when their facility, which is not providing very good service to begin with, loses resources. There is no comfortable way out of this dilemma. The argument may be fairly made that by giving resources to the most effective units the most health care is provided. But, at the same time, those patients who depend upon the least effective units are doubly penalized by the re-allocation of resources away from them. The philosophical argument can go on; one of the debating points is whether these re-allocations provide incentives for better service in all facilities. If you feel they do, then it may make sense to introduce service quality into the formula for budgetary allocations. This is perhaps one of the more benign elements in the formula. These formulae for allocation of budgets often are heavily weighted toward volume of service. Experience has shown that practitioners catch on to this game quickly and invent a host of ingenious ways to increase the volume of activities (multiple control visits for routine problems and preventive programs is usually the first thing they do — service quality is an early victim when this happens). By introducing service quality indicators into the formula you can provide a measure of protection against the worst abuses of an activity-based allocation system and you can provide rewards to practitioners for doing what most of them would prefer to do: provide quality of service rather than just quantity of service.

Enter any relevant remarks on budgetary allocations in the **Planning** document (third table), then return to page 59 to answer the question on control of incentives.

## Control of Incentives

The format of these questions differs from the preceding ones. Here the emphasis turns more directly to what you can achieve yourself, rather than what is possible within the organization. There are three elements that need to be brought together: the incentives that can be manipulated, the individuals who have control over them, and the interests of those individuals. A summary of the process you will follow:

The starting point is your own influence: Who within the organization can you hope to persuade or influence? The Minister? Some District Directors? A director of a major vertical program?

Then, what incentives does that person control? Transfers? Dismissals? Written reprimands?

Finally, what are the ambitions and interests of that person? A tranquil and undisturbed career? Lower costs? Publicity? Broader coverage?

When these three questions are answered you may see how you can extend your own influence to harness incentives for higher service quality. You may be surprised to read that some of the common incentives cannot be used in a positive fashion to improve service quality. Many managers lament the lack of incentives at their disposal with which to whip staff into line; but analysis of the effect of major incentives shows that many of them are unlikely to work in favor of better service quality.

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**Who you can influence.** Go through the list of positions — often found in health care organizations — in the table below and decide whether you have any chance of influencing the person or persons in each line. If you feel that you have access to the person and feel that you have a reasonable chance of persuading that person, place the letter “P” in the left hand column for Persuade. For those who depend upon you for collaboration or some resources, place the letter “R” for Resource-based influence. And for those who are supervised by you put the letter “S” for Supervised. These three letters stand for three kinds of personal influence. A blank entry means that you feel you have little chance of influencing this person (or you may be that person).

P,R,S	Position in the Organization
	Minister or most senior official of the organization
	Director General/Permanent Secretary or most senior manager of operations
	Senior staff directors (personnel, finance, training, etc.)
	Senior program directors (curative services, vaccination, family planning, etc.)
	Directors of geographic areas (regions or districts)
	Directors of hospitals
	Directors of other service facilities
	Field supervisors
	Facility staff

Once you have entered the information (P,R, and/or S) into the above table, transfer this information to the fourth table in the **Planning** document (in the first, or left-most, column). Then, for each person you have identified as potentially "influenceable", complete the following two steps: First identify the incentives controlled by each individual you have marked, and second, their known or suspected interests.

**Incentives controlled.** The following is a list of common incentives, each one followed by a reference to a later section. In the **Planning** document (fourth table), write down, for each individual you have identified as someone you might be able to influence, the incentives they control. For each incentive that you note, go to the listed section for a brief discussion of how that incentive can (or cannot in some instances) be used to promote service quality.

Dismissal - <b>Section 14.a</b>	---
Promotion - <b>Section 14.b</b>	---
Salary - <b>Section 14.c</b>	---
Reprimand - <b>Section 14.d</b>	---
Written	
Verbal	
Transfer - <b>Section 14.e</b>	
Variable budgetary allocation - <b>Section 14.f</b>	
Public embarrassment - <b>Section 14.g</b>	
Status/prestige - <b>Section 14.h</b>	
Praise - <b>Section 14.i</b>	
Training - <b>Section 14.j</b>	
Pilgrimage (Haj) - <b>Section 14.k</b>	
Travel/conferences - <b>Section 14.l</b>	
Awards - <b>Section 14.m</b>	

**Section 14.a Dismissal.** Someone whom you can influence has control over dismissal. This is the most heavy-handed of all incentives and most managers rely on its threat as they are reluctant to fire an employee, particularly a professional.

The standard of quality to which a practitioner would have to sink to lose his or her employment is so low that it scarcely bears consideration in a quality assurance program. You want service quality to move to new heights, not just stay out of the depths. Therefore, you probably would not want to squander your influence and effort trying to get someone fired for substandard performance.

There is, however, an exception. You may confront a situation where the continued low standards exhibited by a professional constitute a direct challenge to the integrity of the QA program. In this instance, and probably only in this instance, would it be worthwhile trying to bring this individual to task, dismissing him or her as a last resort.

In general, control over dismissal is a weak incentive to improve quality other than to ensure that quality does not sink to new depths.

You have entered "dismissal" somewhere in the third column of the fourth table in the **Planning** document, right? Return to page 17 and examine the remaining items on the list of incentives.

**Section 14.b Promotion.** Someone whom you can influence can affect the promotion of employees. This is a very strong and positive incentive. Read, if

you have not done so already, **Section 10.b** (page 47) above. Then return to page 17 and examine the remaining items on the list of incentives.

**Section 14.c Salary.** This is usually, but not always, tied to grade and the comments on promotion (**Section 10.b**) may also apply.

There has been a lively debate over the effectiveness of pay as a motivator and the results are only suggestive; a few are summarized here.

The expectation of increased salary is an incentive; the actual receipt of the salary may not. Workers being considered for pay increases tend to increase their effort. This level of effort falls back to "normal" shortly after the salary increase has been received.

Piece-rate schemes increase the level of effort. Health workers paid for what they produce in quantitative terms tend to outperform those paid a straight salary.

Piece rate payments can be based on the quality of effort as well as quantity. In an interesting experiment in Bangladesh, the pay of community health workers was based on the knowledge of village women in mixing oral rehydration solution. The workers seemed content with this arrangement. It was a little cumbersome to administer as it required constant testing of the knowledge of samples of village women.

Bonuses paid above a basic salary for performance seemed to lead to superior performance in the Philippines.

In-kind bonus payments (in one experiment food was used) can have the same motivating effect as a direct cash payment.

Differentials in pay often bring problems with perceived equity in their wake. If an employee believes that someone else is receiving more money for the same work, the employee has four options:

He may revise his perceptions of his own efforts downwards and work harder in order to receive the same reward as the other employee. This is the outcome desired by management; however, it does not always occur.

He may reduce his effort to the level that he feels is proportionate to the salary differential between himself and the other employee. He works less than before.

He may begin to compare his own efforts and salary with a different, often less hard-working, employee.

He may decide that the organization is unable to accurately assess and reward effort. This reassures him that a reduction in his own efforts will not be penalized.

These comments reinforce what you already knew. Salary is a powerful, but tricky, incentive. The safest course may be payment of a bonus for any individual or group that achieves a certain level of performance. But even here, some may feel excluded from this opportunity and you will earn the greater effort of some members of the organization at the cost of the alienation of others.

Return to page 17 and examine the remaining items on the list of incentives.

**Section 14.d Reprimands.** A reprimand, as used here, means a formal rebuke for unsatisfactory performance. It may be verbal or written; in either instance it takes on a certain official force as an action taken in the name of the organization.

Reprimands are usually reserved for willfully unsatisfactory behavior: someone is doing something wrong, they know they are doing it wrong, and they persist in doing it wrong. As such, reprimands play only a minimal role in promoting service quality. Only if you encounter someone who is dragging his or her heels and undermining the QA program would a reprimand be in order. You would not, as an illustration, reprimand a physician for failing to touch the fontanelle of a child with diarrhoea; you might point out the omission and discuss the value of the procedure in assessing degree of dehydration; but you would not reprimand a physician for this kind of failure.

Return to page 17 and examine the remaining items on the list of incentives.

**Section 14.e Transfers.** In many programs one of the few blessings that can be bestowed upon a deserving employee is transfer to a desirable facility. This can often be made to work in favor of service quality. There is a potential conflict, however: If transfers are granted on the basis of demonstrated ability to improve quality, you may want to transfer staff with those skills to where they are most needed, that is, where service quality is low. In many instances that is just where the employee will not want to go.

Considering the positive possibilities. Transfer requests seem to arise from two different motives: 1) the desire to be located closer to home/friends/urban life/etc.; and 2) the desire to move to a facility that offers greater professional rewards and challenge (a teaching hospital, a research clinic, a well-equipped facility). Both motives can work to your advantage.

1. It may seem a fitting reward that a diligent practitioner be promoted to a better facility and this can work to the advantage of the organization. As long as this avenue of career advancement appears to be open, the more ambitious practitioners will strive to work their way into choice facilities. The result for the organization is greater effort in the less desirable facilities and the creation of centers of excellence in the sought-after facilities.

2. Regarding transfers for personal reasons, such as proximity to family, etc., this can also work to the advantage of the organization, although the benefits are not as great. The key in this, and the preceding case, is that the transfer be

conditioned on demonstrated ability to provide high quality service. The link between quality and transfer to a center of excellence is more obvious and you won't need to belabor this connection to staff. Less obvious will be the connection between high quality and transfers for personal convenience. Here you will have to go to some lengths to ensure that 1) such transfers are made first to those who have achieved high levels of service quality, and 2) staff understand that transfers are based upon providing high quality service. For this incentive to be implemented, like most of the others, you will need a clear and straightforward method of assessing the quality of the service provided by individuals; this method of evaluation will have to go beyond anecdotes and impressions.

**Section 14.f Budgetary allocations.** See **Section 13.b** for a discussion of flexible budgeting. Then return to page 17 and examine the remaining items on the list of incentives.

**Section 14.g Public embarrassment.** Generally this is the kind of disincentive that one hopes to avoid using, particularly in societies where it will breed lasting ill-will.

Some of the fundamental QA strategies open opportunities for public embarrassment. As examples, quality audits or a MIS-based strategy create numbers that can be used to generate rankings by quality of service. If the published rankings are continued to the bottom of the list, staff of those facilities may find themselves subjected to professional, public, and journalistic scorn for their poor showing. Should this be done? The answer depends upon the context. Will fear of the negative consequences lead to a determined effort to undermine the credibility of the rankings? This is not unusual; those who fare poorly often invest more effort attempting to discredit the findings than to improving their performance. Or will the threat of publication of a result that falls below X serve as a goad to facilities to monitor service quality more closely? This might have the effect of promoting concern with maintaining at least a minimum level of service quality (presumably you want more than the minimum).

Public embarrassment of individuals is something that you may want to avoid except in exceptional circumstances where you do not fear the long term enmity of the victim and need to make an example (assuming that the offender deserves the punishment).

Return to page 17 and examine the remaining items on the list of incentives.

**Section 14.h Status/prestige.** Do as much of this as you can. The more that service quality is associated with personal status and prestige, the more likely it is that you will have a sustained QA program. Status and prestige often come — in the professions — from other associations such as the school attended, the facility in which one is employed, or the societies one belongs to. This is a good beginning but it is not enough. You will want to encourage an association between status and professional contributions to quality across a broad range of activities such as technical competence, patient satisfaction, coverage, technical innovation, effectiveness, and efficiency. An even-handed attempt to confer greater status on individuals and units that excel along any of

the dimensions of service quality is necessary. Some methods of conferring status are the following:

Arrange official visits to individuals and facilities by senior managers to extend personal congratulations for the quality of the service provided.

Dispatch journalists to document success stories.

Provide opportunities for those who provide excellent quality to tell their story — such as conferences and internal publications.

Publicly praise these individuals and teams, especially to groups of people who are important to the praised individual(s) and with whom any elevation in status or prestige would be most appreciated (this could include the immediate community, facility staff, or the profession).

Publicly seek the advice of these individuals — and be sincere in your request for their counsel since they evidently have discovered something.

Return to page 17 and examine the remaining items on the list of incentives.

**Section 14.i Praise.** This costs nothing, can be done by anyone, and has a modest but often cumulative effect on performance (people don't tire of hearing pleasant truths told to them). As discussed in **Section 11.c** praise not only improves performance but also increases your ability to influence the individual you praise.

Return to page 17 and examine the remaining items on the list of incentives.

**Section 14.j Training.** See **Section 12.b** for a discussion of how to use training as an incentive for higher quality service. Then return to page 17 and examine the remaining items on the list of incentives.

**Section 14.k Pilgrimage.** In some Moslem societies organizations support a few members making the pilgrimage (*Haj*) to Mecca. There are a number of bases for this reward, such as demonstrated devotion or seniority and one must approach changing this pattern with great care since the reward does not fall within the normal incentive structure of the organization. If employees believe that the provision of the highest quality health care is consistent with — and perhaps demanded by — Islamic teachings, then a fitting reward for service quality is to further one's religious duties with support for the *Haj*. As always, the basis for the award should be as objective as possible.

Return to page 17 and examine the remaining items on the list of incentives.

**Section 14.l Travel/conferences.** This is similar in effect to prestige and praise but carries the added incentives of per diem and a break from the routine. These incentives, if you can gain some control on them, can be powerful but fragile. They are usually awarded to those who have made a unique contri-

bution and, as a consequence, an element of subjectivity enters into determining who will receive them. If it is perceived that travel and conference attendance is reserved for the same group of senior officials who are always on the road, occasional inclusion of someone who has done a good job on the quality front will have only a slight impact. Only if you are able to set aside a fair percentage of these plums for operating personnel and supervisors who have made major contributions to service quality will you have a credible incentive.

Return to page 17 and examine the remaining item on the list of incentives.

**Section 14.m Awards.** These can be easily over-used, but they still should not be ignored. It costs little to engrave someone's name on a plaque or ask them to stand up during a meeting for recognition. A common organizational mistake is to establish an award and then, because it takes a little effort to figure out who is to receive it, let the award lapse for a period of time. When it re-emerges, unexpectedly, it has lost its motivational power. This is especially true if the award is not competed but is tied to achievement of a standard; failure to give an award to all who exceed the standard will undermine the effectiveness of the award as an incentive.

Anyone can provide an award. The leader of the country or the mayor of the municipality or the mothers' club.

Return to page 17 and answer the question on personal objectives.

**Personal objectives.** What are the personal objectives or interests of each of the individuals whom you have identified as people you might be able to influence and who have some control over incentives (in effect, anyone for whom you have made an entry in the third column of the **Planning** document)? This is a key question. If their objectives do not include an interest in service quality, you will have your work cut out for you.

For each of these individuals, determine if any of the following figure large among their interests; more than one interest may apply to an individual. If so, please read the section referenced and enter relevant notes in the **Planning** document.

Rapid advancement in the organization - <b>Section 15.a</b>
Prestige - <b>Section 15.b</b>
Tranquility (no problems) - <b>Section 15.c</b>
Little work - <b>Section 15.d</b>
Professional challenge - <b>Section 15.e</b>
Social interaction - <b>Section 15.f</b>

**Section 15.a Rapid advancement.** The advice here is simple and self-evident: No one's chances for advancement in a health care organization were ever hurt by being a constructive crusader for quality. Note the deliberate inclusion of the word "constructive". Your official will not want to be identified as someone who is hyper-critical of current quality. But the more benign aspects of a QA program should be attractive to this official: the emphasis on standards, the rewards for improvement, the broad definition of service quality, and so on. It should take no great genius to fashion an appeal to this person based on the constructive aspects of a QA program.

Enter any relevant comments in the **Planning** document and return to page 67 to complete this question.

**Section 15.b Prestige.** It is possible that a QA program may offer prestige to those involved in it but prestige usually attaches to mature, successful programs or projects. However, you may be able to lend greater prestige to your undertakings with the following:

Present the program as uniquely innovative. (Beware, however, of elevating unique elements of TQM and QA at the expense of the less spectacular but more productive ones.)

Seek out and exploit associations with prestigious organizations and individuals involved in QA.

Work toward early successes, especially in the areas of technical competence.

- Try to involve this official in aspects of the program dealing with technical competence as prestige in medicine more often arises from this area than from successes in increasing coverage or patient satisfaction.

Enter any relevant comments in the **Planning** document and return to page 67 to complete this question.

**Section 15.c Tranquility.** You feel that the official in question is interested in a minimization of problems; this is not an unreasonable ambition for a manager. Your task is to sell QA to this person on its strengths in problem preventing rather than problem finding. Much of the QA literature centers on finding and solving problems. There is another aspect to the program and that is designing systems that anticipate and prevent problems. Scan this literature and prepare a concrete program of activities that work toward the prevention of problems.

Enter any relevant comments in the **Planning** document and return to page 67 to complete this question.

**Section 15.d Little work.** Yes, there are lazy officials and managers whose interests lie outside their professional duties. While the obvious response here is to point up the fact to this person that the early detection and correction of quality problems will reduce the total problems that have to be dealt with, don't expect this to have much of an impact on the thinking of a truly lazy individual. A QA program requires extra effort to get launched; try to do it without depending on the lazy.

Enter any relevant comments in the **Planning** document and return to page 67 to complete this question.

**Section 15.e Professional challenge.** An easy one. This person may be one of your first and most zealous collaborators. He or she might show a preference for focusing on issues of technical competence; so be it. If you have a problem with this person, it might be with maintaining a fast enough pace to sustain his or her interest. This person may also find some of the group work frustrating.

Enter any relevant comments on professional challenge in the **Planning** document and return to page 67 to complete this question.

**Section 15.f Social interaction.** QA and TQM offer opportunities for group work that may sustain the interest and involvement of this individual. He or she may also be a disruptive influence in these groups if the only interest is socializing. If not, there are natural assignments for this individual working with groups on quality issues that should provide enough social interaction to last a lifetime.

Enter any relevant comments on social interaction in the **Planning** document and return to page 69 to address the questions on your personal influence.

## Personal Influence

Here the format changes again. This will start with an inventory of your resources to influence the behavior of others. (Obviously the answers can change as you consider different individuals you may wish to influence.)

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**Influence based on expertise.** Do you have personal expertise that will encourage people to listen to you and respect your opinions on quality improvements?

The staff members of health care facilities see your background as being primarily -

- administration (**Section 16.a**)
- medicine — such as research, teaching, specialist care (**Section 16.b**)
- the same as their own (**Section 16.c**)

**Section 16.a.** Facility staff see your background as primarily in administration.

You are certainly already aware of the limitations this places on your credibility. Facility staff see you as lacking adequate credentials in medicine to be accepted as an authority on medical/technical issues. Further the absence of recent or extended experience as a practitioner may mean that they will privately question your knowledge of "how things really work" in a health care facility. Even in administrative matters, as they affect facilities, there may be reluctance to acknowledge you as an authority. What to do?

1. Expert-based influence is not going to be your strong area. It might be safest to rely as little as possible on your "expertise" as you would have to invest a great deal in trying to establish it. If you claim competence where staff feel you do not have it, they may start to doubt your integrity. Please remember, we are talking about their perceptions of you — not the reality; you may indeed be current in several technical areas but until that has been established in the minds of staff, your claims to expert knowledge could easily backfire. Place first reliance on other sources of influence.

2. If you have to intervene in technical matters — and many supervisors do — rely to the extent possible on recognized authorities such as technical manuals, WHO publications, journals, known authorities, and the like. Your approach might be, "I'm no great expert on this myself; however, a recently published WHO protocol stated . . ."

3. Converting this minor liability into an asset: Given your weakness in this area — an important area in the minds of health care workers — you may find it wise to be more participative in your approach to problems than you might be otherwise. You actually enjoy a small advantage in that regard. A medical ex-

pert is expected to be directive and certain (no physician asks a patient what he thinks the disease is or how he thinks it should be managed); however an administrator can safely be non-directive. You will not be expected — as an “expert” would — to solve the problem. You can form teams, solicit opinions, guide the discussion, and seek consensus. These are legitimate activities for an administrator and they may be skills that you are expected to have and which you can exercise without challenge.

The next item in the questionnaire is on page 72.

**Section 16.b.** Staff see your background as in medicine.

This is an advantage and it permits you to be fairly directive in your pronouncements on medical matters. Two cautions that may affect how you proceed:

1. Field staff often feel that their reality is special and not understood by researchers and policy makers. They doubt that people such as yourself understand the resource constraints and problems they have to deal with (you may well understand all of those things but they don't see it that way). Consequently, they may see your advice as counsels of perfection, realizable only in some perfect world, and irrelevant to the world in which they work. Consequently, they may nod appreciatively and appear to agree with you . . . and not change their behavior when you leave.

To surmount this you may need to do two things:

- a) Make a visible effort to show that you have considered their situation. Ask questions about how much time they have for each patient, which supplies and medicines are available, how compliant patients are, and so on.

- b) Demonstrate that your approach is feasible. If, for example, staff feel pressed for time (where do they not?) demonstrate that the procedure you are advocating can be completed in the time they normally spend with a patient. Then have them practice it to further demonstrate that they can accomplish the procedure within the time available. It is always possible that you may have to modify your recommendations. It's usually better that you do that with them rather than let them make the modifications on their own later when they discover that your approach is unworkable.

2. As an “expert” there may be expectations that you will have The Answer. In point of fact you may not have a ready answer to a problem and will need to enlist the input of field staff in working out a workable solution. The trick here is to be knowledgeable without being directive. You should be quick to cite possibilities but not make recommendations; this is a difficult skill and one that you should try, consciously, to develop.

The next item in the questionnaire is on page 72.

**Section 16.c** Staff see your background as much like their own. This is good in that they will trust your judgment in many things; it's bad in that they may not feel that you know much more than they do.

1. Be wary of appearing pretentious. If staff see you as little different from themselves, any *Pronouncements* you make might appear as rather grand for your status. And if, by some fluke, you do convince them that you are greater than they are, you may do so at the loss of the perception that you understand them.

2. Play up access that you have to expert opinion and recognized authorities. Presumably you are better placed than are field staff to read the literature and attend technical discussions. Do so yourself and cite these references in technical recommendations . . . "Dr. Choudri of the Aga Khan University told a group of us last week that a 2 percent solution of . . ." Consistent referrals to such authorities will confer a measure of expertise upon you over time.

The next section of the questionnaire is on the following page.

**Influence based on rewards.** Before taking a more detailed look at specific rewards, let us consider some general recommendations on how you might use rewards to enhance your personal influence.

1. Scrupulously avoid pretending you have control over rewards that you do not have. This will work once . . . maybe. This advice would seem to be self-evident, but it is frequently disregarded. If you lead staff to believe that you can obtain rewards for them that you cannot then deliver on, you will be instantly discredited. It is better to pretend no control over rewards while diligently working to provide them for staff. When a reward is made, you may find several other managers or supervisors trying to claim credit for obtaining it. Don't become caught up in this rush for recognition; there are subtler ways of signaling your role.

2. If you cannot provide consistent rewards for staff, then, paradoxically, it may be better to reward staff on an unpredictable basis. A variety of laboratory experiments have shown that motivation is sustained better by rewards that arrive unpredictably (for desired behavior) than by rewards that arrive consistently and then are interrupted. This is welcome news as we usually don't have enough rewards to go around. The important thing to get across is that the deserving will be rewarded . . . but perhaps not every time and not in a predictable fashion.

3. You might be able to increase your influence over who gets rewarded by making it a habit to recommend people. There are a surprising number of rewards that go unclaimed in an organization simply because it requires effort to figure out who should receive them. If you have a good eye for spotting rewards, take the initiative in recommending who should receive them. Of course, do not recommend those people for rewards who will cause later embarrassment for you and the person making the reward.

And there are rewards that create equity problems. For some of these, more senior officials would like to be relieved of the burden of having chosen someone — to the annoyance of many other candidates. If you are willing to accept the grumbling of those who didn't get the reward you may be successful in pushing your candidate through.

4. Foot-in-the-door phenomenon. This applies to the preceding and many other influence areas. It has been found that a person is more likely to grant you a large favor if you have asked them for a smaller one earlier. To illustrate: if you plan to ask for a large favor, such as a transfer for someone, ask first for a lesser favor that can be easily granted. It is more likely that both the small and large favors will be granted. This runs counter to how most people view the granting of favors: that there is a fixed store you are in danger of using up. Apparently this is not the case. The lesson is: ask for small favors; it increases your chances of having larger ones granted later.

The same list of incentives you saw earlier when we were evaluating the rewards controlled by others is reproduced below. If you did not read any of the sections that apply to you, you may wish to go back cover that material now.

Which of the following incentives do you control yourself?

Promotion - **Section 14.b**  
Salary - **Section 14.c**  
Transfer - **Section 14.e**  
Variable budgetary allocation - **Section 14.f**  
Status/prestige - **Section 14.h**  
Praise - **Section 14.i**  
Training - **Section 14.j**  
Pilgrimage (Haj) - **Section 14.k**  
Travel/conferences - **Section 14.l**  
Awards - **Section 14.m**

If you control resources other than rewards, see **Section 17.a** which follows for a discussion of how those can be bartered for rewards.

**Section 17.a. Influence based on resources.** You control resources that can be bartered for rewards or used as direct incentives. These resources typically include supplies which are often abused in efforts to gain influence. Nevertheless, bowing to the way the world works rather than how we would have it work . . .

Resources are limited and you have certainly thought about how you want to use them to greatest advantage. Some comments:

1. Exchange of favors. Perhaps the most common is simple "log-rolling": I will do you a favor and you will do me a favor. As an example, I will process your request for X; you will give a training course in District A. In organizations where this is a usual way of obtaining cooperation there will be a sophisticated informal accounting system so that everyone is aware of favors due and owed. The more clever players will be those who can successfully inflate the value of the favors they perform.
2. Exchange of hostages. More often used to resolve conflict situations, you and another person may open up opportunities for collaboration by making yourselves equally vulnerable to one another. The objective here is to achieve equal influence over one another so it is hard to gain much of an advantage in those terms. However, by making collaboration possible, you may be able to accomplish some things that otherwise would not be possible.
3. Withholding of compliance. In professional organizations the hierarchical controls are often weak; staff do pretty much what they want within broad limits. As a consequence, going along with what your superior wants becomes a source of control that you have over that superior. If she (your superior) wants more emphasis on MCH, you may respond that you could only do that if you had a midwife assigned to your clinic. Staffs have been playing this game with supervisors of vertical programs since time began.

And of course much of the effectiveness of peer pressure rests on compliance and collaboration; if you don't go along, no one will cooperate with you.

4. Unraveling the mysteries. Doctors are often accused of deliberately mystifying what they do in order to preserve their position of authority. Administrators do the same; it is often impossible to get a simple explanation on how to process a leave request or supply requisition. Are these administrative procedures inherently complex? They shouldn't be. If you can figure out how these things are done you accomplish two goals: You reduce the power of the administrator to extract tribute from you for performing the service and you may be able to provide the same service yourself (and use it as an incentive).

The next item in the questionnaire is on the following page.

**Influence based on sanctions or punishments.** These are so limited in their ability to promote greater service quality that they should be used only as a last resort. If you would like to read brief descriptions, return to the sections listed below.

Dismissal - <b>Section 14.a</b>	
Reprimand - <b>Section 14.d</b>	
Written	3.0
Verbal	3.1
Public embarrassment - <b>Section 14.g</b>	3.2

**Influence based on being liked.** Many supervisors place great faith in this overused basis of influence. A few words in a manual are not going to make you well-liked. However, the potential for this source of influence varies by the intended target of influence and some comments may be made on that.

The persons you wish to influence are -

- co-workers with whom you have steady contact (**Section 18.a**)
- subordinates with whom you have occasional contact (**Section 18.b**)
- superiors (**Section 18.c**)

**Section 18.a.** You want to influence co-workers.

This is the group on which referent influence (they want you to like them) is most likely to succeed. Note that the basis of this influence is not them liking you — although that may help — but on their desire that you like them. The problem goes back to the first teenager in history\*; more than simply being liked, how do you make others dependent upon your liking them. The answer is probably greatly influenced by culture and personality; advice would be platitudinous. If you know how to do this, good for you.

The questionnaire resumes on page 77.

**Section 18.b.** You want to influence your subordinates.

This is tricky. Referent power means that they want you to like them — there is some psychological need that this fulfills — and it is separate from other rewards that you may have at your disposal. This can be a very effective basis of influence but it can also backfire if you are seen as capricious. The simplest advice is to behave in a manner that makes people look up to you; the conventional list of personal attributes applies: integrity, fairness, honesty, humility, and so on. If you are an admirable person, others will seek your

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\* In the Christian tradition the first two recorded teenagers, Abel and Cain, had tremendous difficulty with this issue, giving rise to great jealousy and the murder of Abel by Cain.

admiration. If your behavior is not admirable, no one will covet your good regard (they may fear you, however).

While this sounds corny, it is the basis for much supervisory influence

**Section 18.c.** You want to influence your superiors. Referent power (they want you to like them) may work but this seems a weak basis of influence. It is always good that your superiors respect your integrity and effectiveness since this will gain you a respectful hearing. But it is an unusual situation where your force of personality will be such that you will have influence over your boss.

**Influence based on your position.** One of the enduring issues for managers is how to expand the influence of their position, and daily life in organizations is characterized by frequent power struggles as managers squabble over who is responsible for making decisions. Expect opposition.

Everyone is in favor of service quality but this is an area where sensitivities can be easily offended. You will encounter challenges to your self-declared status as quality champion for the organization; even if you are duly designated as the leader of the QA program there will be others who resent this. Your options include:

You can define your interests in quality narrowly so as not to encroach on the terrain of others — and perhaps have too limited a program.

You can exhibit strong personal leadership, forging ahead alone, confident that the justness of your cause will prevail. Good luck . . . and farewell.

You can play up the team aspects of QA, defining your role as that of facilitator who brings the interested parties together. This is often the safest approach.

It is no accident that a team approach characterizes QA programs at every level. The trick is to be active, without exciting jealousy. It is, of course, commonplace for managers who are making a play for power to deny their ambitions and speak glowingly of the virtues of team play. Any similar words you might utter will fall, therefore, on skeptical ears. Only rapid efforts that demonstrate your sincerity in involving a broad spectrum will be convincing, and even then many will remain on guard.

## Sample Strategies

Six sample strategies follow, each one based on a different set of assumptions about the organization. Each described strategy is a "pure" type. In reality, you may want to borrow from more than one strategy and, in fact, it may be advisable to implement quality assurance through multiple control systems. Generally it is safe to assume that a QA program implemented through more than one control system will add up to more than the sum of the parts; the potential for synergy is real.

Even if you envision a QA program that embraces several control systems, you may still want to sequence their introduction to QA. As an illustration, if supervision is strong (this occasionally occurs) but unfocused (this often is the case), whereas the MIS is the usual gargantuan collection of incomplete forms and underutilized data, you may want to start with supervision; QA provides a clear focus and rationale for supervisors. Once the supervisory system has adopted QA, you could then bring QA to the MIS by incorporating supervisory reports on quality status into the MIS.

### Using the Planning Document

The **Planning Document**, you will have already guessed, is simply an organized approach to keeping notes on the content of this manual. If you have consistently entered your comments in the General Approach column you should have the basic ingredients of your strategy for introducing QA already outlined. The fourth page of the planning charts deals with whom you can hope to influence and how best to do that. You may have felt some apprehension about committing those ideas to paper, but, again, a completed page will indicate with whom you should work and how to approach those people. A completed sample set of planning forms precede the blank forms. The sample shows how a senior staff person (fictitious) in a leprosy/TB program might have filled out the planning document. Reading through the comments in the sample we can see the outlines of a QA strategy emerging.

## An Audit Based Strategy

### Overview

An audit based strategy is perhaps the simplest to implement as it requires the participation of the fewest individuals in the organization. A rolling or periodic audit of service quality in primary care facilities would be conducted by a team of field researchers. The fundamental elements of this strategy are 1) agreement on explicit process standards of service quality, 2) communicating those standards to service delivery personnel, and 3) gathering and feeding back information on service quality to primary care facilities. Specific steps for implementing the strategy follow.

### Conditions for Adopting an Audit Based Strategy

Many would argue that the best management control system for improving service quality is supervision. However, many supervisory systems do not function well (or at all) where they lack resources or support or have been perverted to the wrong uses. Thus, as a relatively inexpensive alternative to supervision, quality audits may be introduced. These audits will fare better in organizations where professional staff accept supervision of service provision. This approach will not work well in organizations where the staff expect to provide leadership in quality assurance — not to be checked up on by others. If many health providers in your organization are *prima donnas*, this may not be a very useful strategy.

### Implementation

1. Awareness. The objective of this step is to increase awareness of and support for QA among policy makers in the program and important related institutions. Two activities would be undertaken.

- a) A short workshop — perhaps no more than one day — for policy makers on QA.
- b) Attendance by senior program official(s) at international conferences on QA.

2. Development of Quality Standards. The objective of this step is to develop explicit definitions of quality for disease/intervention categories. Program personnel would adapt internationally accepted standards of service quality. Widely accepted standards exist for most primary health care interventions.

3. QA Baseline Study. The objective is to establish a baseline of service quality in the program. Research teams would collect data in the field and prepare the results for presentation.

4. Priority Setting. The objective is to use the baseline data to select the quality deficiencies for initial emphasis. Senior program officials would review the data in a workshop (two to three days?) and develop a Quality Improvement Plan.

Regional plans could be developed if the country is large and heterogeneous or there was marked variation in the quality of services as detected by the baseline survey.

5. Design of the QA audit system. This step is divided into three sequential activities:

a) Design of audit utilization procedures. The objective of this activity is to determine how audit information on quality will be employed to improve service quality. Questions to be addressed include: Who will receive the information? What means will they have to intervene to correct a detected problem? What means will they have to reward high service quality or improvements in service quality?

b) Design of the information on service quality that will be provided to officials. The kind of information, the frequency of presentation, and the form of presentation would be determined. The kind of information may be governed initially by the priorities established in step #4.

c) Design of data collection. The objective of this activity is to determine how the data selected in (b) above will be collected. The options include rapid household surveys, exit interviews with patients, direct observation of service delivery, mystery shoppers and record reviews.

6. Training of field personnel. The objective of this step is to introduce field personnel to QA and to communicate to them the performance standards that may be subject to audit. The results of the baseline survey would be presented as would the priorities established by the organization (the Quality Improvement Plan).

7. Implementation of the QA audit system. The objective of this step is to integrate the QA components into the organization's auditing system. Audit staff would be trained in the collection, analysis and presentation of data on service quality. A schedule of visits to facilities would be established. This step could be conducted concurrently with the preceding (#6).

8. Annual quality review. The objective of the annual quality review is to examine a broad spectrum of quality issues in service delivery. Aggregate data from audits conducted during the preceding twelve months would be prepared. The organization's officials would meet to review the results and the progress made during the preceding year as reported by the audit. Priorities in service quality would be re-assessed and revised as needed.

### **Key Issues**

The following are questions that may arise during the design of the project:

1. Can a quality audit reinforce professionalism and personal commitment to the provision of quality service? A hazard of relying on an audit is that, by its very name as well as by heavy-handed implementation, it may engender resistance and disdain for the behaviors it is trying to promote. Responses include:

- a) Attaching rewards as well as sanctions to audit results. Districts or facilities that show strong improvement or high service quality may receive recognition or tangible rewards.
- b) Changing the name to "quality review" or "quality assessment" or "quality standardization", etc.
- c) Involving field staff in establishing the audit standards and methodologies.
- d) Involving field staff as auditors on a revolving basis.

2. What information will the audit collect? Given the breadth of possible activities and outcomes on which to collect information, it may be unrealistic to check on all of these. The options include:

tracer disease/indicators,  
a random selection of quality indicators,  
indicators tied to disease incidence at time of audit (e.g., ALRI in winter, malaria during the rainy season),  
indicators on suspected quality problems,  
indicators based on priority areas, or  
indicators based on ease of data collection.

3. How will the audit results contribute to problem resolution? The options include, in order of increasing effort and likely effectiveness:

- a) No follow-up is contemplated. It is assumed that the attention to quality demonstrated by collecting information on it will have the desired effect. Although the lack of a specific mechanism to solve quality problems may seem naive, this may actually be a cost-effective alternative in some, rare, circumstances.
- b) The audit results will be sent back to each facility with comparison data from other facilities or ratings against expected standards.
- c) A list of deficiencies will be sent to each audited facility. The staff of the facility will be required to respond to each deficiency with a written plan for improvement (much the same as for a financial audit).
- d) Same as (b) or (c) with training for facility personnel in data interpretation and problem solving.
- e) The information will be given to supervisors who will use it to establish quality goals, team problem solving approaches, etc.
- f) The information will be given to program managers who will use it to assign resources, make personnel decisions, arrange training, etc.

### **Disadvantages**

This strategy has two clear disadvantages which should be considered before it is adopted and during design if it is adopted:

1. Its very name, even if disguised, may engender resistance.
2. There is no problem solution mechanism in audits, as they are usually defined. The legacy of fiscal audits is that the audited are responsible for working out the solution themselves. This assumes that the solution is simple compliance with procedures which will not always be the case. A problem solving mechanism will have to be developed and built into the process.

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## An MIS Based Strategy

### Overview

On the surface, it would appear that an MIS based approach to QA would have much to offer. The drawback is that MIS data are self-reported which often raises questions about the credibility of the information; these suspicions are heightened when the data touch on an important professional value like quality of care (and there is an incentive to exaggerate one's virtuosity). Thus, an MIS based strategy requires special circumstances or organizational culture to work. The implementation is straight-forward; process quality indicators may be appended to the standard reports or may be the subject of special studies.

### Conditions for Adopting an MIS Based Strategy

The organizational landscape is littered with ambitious information systems that were never fully implemented or utilized. Further, it is old news that it is difficult to change the MIS, regardless of how ineffective and underutilized it may be; they just seem to grow and grow, increasing the administrative burden on health providers who become increasingly disenchanted with the MIS. Thus, one of three possible conditions must exist if this is to be a successful option:

1. The current MIS already contains many service quality indicators that are credible to staff.
2. The current MIS has gone well beyond the breaking point and there is widespread support for scrapping it altogether. In such a situation you may be able to introduce a simple system that follows a few key service quality variables.
3. The current system is not burdensome (a rarity) and there is interest — or no opposition — to adding (another rarity) service quality indicators .

### Implementation

1. Awareness. The objective of this step is to increase awareness of and support for QA among policy makers in the program and important related institutions. Two activities could be undertaken.

- a) A workshop for policy makers on QA.
- b) Attendance by senior program official(s) at international conferences on QA.

2. Development of Quality Standards. The objective of this step is to develop explicit definitions of quality for disease/intervention categories. Program personnel would adapt internationally accepted standards of service quality. Widely accepted standards exist for most primary health care interventions.

3. QA Baseline Study. The objective is to establish a baseline of service quality in-the program. Research teams would collect data in the field and prepare the

results for presentation. If the MIS will collect comprehensive service quality data, this activity might not be necessary.

4. Priority Setting. The objective is to use the baseline data to select the quality deficiencies for initial emphasis. Senior program officials would review the data and develop a Quality Improvement Plan. Regional plans could be developed if the data should differences in quality levels across regions or areas.

5. Design of QA Data System. This step is divided into three sequential activities:

a) Design of data utilization procedures. The objective of this activity is to determine how information on quality will be employed to improve service quality. Questions to be addressed might include: Who will receive the information? What means will they have to intervene to correct a detected problem? What means will they have to reward high quality or improvements in service quality?

b) Design of data feedback. The objective of this activity is to determine the information on service quality that will be provided to officials and service providers. The kind of information, the frequency of presentation, and the form of presentation would be determined. The kind of information will be governed initially by the priorities established in step #4.

c) Design of data collection. The objective of this activity is to determine how the data selected in (b) above will be collected. The options include rapid household surveys, exit interviews with patients, direct observation of service delivery, mystery shoppers and record reviews.

6. Training of Field Personnel. The objective of this step is to introduce field personnel to QA and train them in the interpretation of data on service quality. The results of the baseline survey (or MIS) would be presented as would the priorities established by the organization (the Quality Improvement Plan). Emphasis would be placed on how to solve serviced quality problems on the assumption that there will be no or few mechanisms for assisting clinic staffs in correcting deficiencies under this strategy.

7. Implementation of the QA data system. The objective of this step is to integrate the QA components into the organization's information system. MIS staff would be trained in the collection, analysis and presentation of data on service quality. This step could be conducted concurrently with the preceding (#6).

8. Annual quality review. The objective of the annual quality review is to examine a broad spectrum of quality issues in service delivery. A quality assessment, similar to the baseline study in step 4 (if a baseline survey is conducted), would be conducted 12 months after initiation of quality improvement activities. The organization's officials would meet to review the results of the assessment and the progress made during the preceding year as reported by the MIS. Priorities in service quality would be re-assessed and revised as needed.

## Key Issues

The following are questions that may arise during the design of the project:

1. Who will collect data? In a typical MIS the service delivery personnel collect and report data on their own activities. Can this be done for quality? The spectrum of possibilities includes:

Service personnel collect all quality data and report selected or aggregated information. These reports are accepted as accurate and complete.

Service personnel collect all data but there is selective auditing or verification of some information. For example, an auditing team or supervisor could conduct direct observations and exit interviews.

Service personnel collect only those data that are verifiable through independent means. Non-verifiable data on quality — this might include much of the process data — would be independently collected. This, of course, brings this strategy close to an audit.

All data are collected by someone other than service personnel. This may require a staff of field researchers who would conduct surveys and observations on a rolling basis or the burden could be placed on local managers and supervisors. This approach is, basically, an audit.

2. Will the system always collect the same information? Given the breadth of possible activities and outcomes on which to collect information, it is unrealistic to check on all activities and outcomes with the same frequency. If an invariant data system is desired, program managers will have to limit the information to -

- tracer disease information,
- "short form"/key indicators, or
- aggregate statistics.

If the program can tolerate constantly changing indicators of quality, the decision must be made as to how current indicators will be chosen:

a random selection of quality indicators,  
indicators tied to disease incidence (e.g., ALRI in winter),  
indicators on suspected quality problems,  
indicators based on priority areas, or  
indicators based on ease of data collection.

3. How will the data contribute to problem resolution? The options, in ascending order of effort and likely impact, include:

a) No follow-up is contemplated. It is assumed that the attention to quality demonstrated by collecting information on it will have the desired ef-

fect. This may actually be a cost-effective alternative in some circumstances.

b) The information will be sent back to each facility with comparison data from other facilities or ratings against expected standards.

c) Same as (b) with training for facility personnel in data interpretation and problem solving.

d) The information will be given to supervisors who will use it to establish quality goals, team problem solving approaches, etc.

e) The information will be given to program managers who will use it to assign resources, make personnel decisions, arrange training, etc.

### **Disadvantages**

This strategy has several disadvantages which should be considered before it is adopted and during design if it is adopted:

1. The immediate concern that comes to mind is preserving the integrity of the data, if they are self-reported.
2. If they are not self-reported, then the sustainability of the program becomes a larger issue in that an independent information collection system — with its own recurrent costs — has been established.
3. Information systems, unlike supervision, do not have built-in problem solving mechanisms. Reliance may be on simple data feedback ("if they know they have a problem they will remedy it"). The validity of the underlying assumption merits testing. Indeed, the design of an MIS based strategy might include purposive experimentation in problem solving approaches.
4. Changing the kind of information collected is cumbersome in an established MIS. Given the breadth of quality information that might be collected, some selectivity will have to be exercised and initial errors will be difficult to remedy.

## **A Supervision Based Strategy**

### **Overview**

A QA strategy based on the supervisory system is perhaps the most natural approach that can be taken. Supervisors would use explicit standards to identify service quality problems and then would directly intervene with service providers to work out solutions to the problems.

### **Conditions for Adopting a Supervision Based Strategy**

The major drawback of this approach is that it falls prey to all of the ills afflicting supervision of primary health care: lack of personnel, lack of vehicles, lack of per diem, and absence of top level interest. The first condition is that you need a credible supervisory system.

Second, one great strength of supervision is that supervisors can focus on the process of service provision; they can directly supervise the work of practitioners. If you feel — or have documented — that many errors and omissions are committed in service provision, supervision is a good — perhaps the best — vehicle for finding these service lapses and correcting them. The second condition is that you should be interested in the process of health care provision, not just the outcomes.

### **Implementation**

1. Awareness. The objective of this step is to increase awareness of and support for QA among policy makers in the program and important related institutions. Two activities would be undertaken.

- a) A workshop for policy makers on QA
- b) Attendance by senior program official(s) at international conferences on QA.

2. Development of Quality Standards. The objective of this step is to develop explicit definitions of quality for disease/intervention categories. Program personnel would adapt internationally accepted standards of service quality. Widely accepted standards exist for most primary health care interventions.

3. QA Baseline Study. The objective is to establish a baseline of service quality in the program. Research teams would collect data in the field and prepare the results for presentation.

4. Priority Setting. The objective is to use the baseline data to select the quality deficiencies for initial emphasis for improvement via the supervisory system. Senior program officials would review the data and develop a Quality Improvement Plan. Regional or district plans could be developed if regional differences in service quality were detected.

5. Supervisor Training. The objectives of the training are: a) to introduce QA to all field supervisors; b) to communicate priority quality areas to supervisors; c) to train supervisors in the use of explicit quality standards for measuring and recording service quality; d) to train supervisors in solving quality problems as identified through use of explicit standards; and e) to train senior supervisors in techniques of supervising field supervisors.

6. Quality Monitoring System. The objectives are to provide continuous data on service quality and to corroborate supervisory reports with independent data collected by a QA research group within the organization. Two related data collection activities might be conducted: one based on supervisory reports as supervisors use the explicit standards, the other based on data collected by a group of independent researchers within the program. A QA research group may be established within the central offices which would function under the guidance of a quality assurance committee.

### **Ancillary Issues**

The following are questions that may arise during the design of the project.

1. Who will conduct the supervision? The possibilities include:

- peer supervision,
- supervision by senior managers,
- community supervision,
- supervision by paramedical personnel, and
- supervision by existing field supervisors (either singly or in teams).

The answer will be conditioned largely on acceptability and local resources. It may be noted that the use of explicit quality standards permits individuals with little medical training to reliably record service quality. The use of paramedical personnel (or community members) allows great economies and better utilization of scarce medical resources but may encounter resistance from clinicians and these supervisors may be less qualified to help solve quality problems. These issues may be resolved in training through role plays and discussions. Some clinicians have reported that a clerk with a checklist is less threatening than a physician colleague. These issues may also be resolved through small field trials (operations research).

2. What will supervision focus on? In the project described above the focus is on quality problems identified in the baseline survey and given priority by program management. Alternatives include:

- random selection of health interventions,
- a set schedule of interventions (e.g., ALRI during the winter, malaria following the rainy season, diarrhoea management during the dry season, and so on),
- topics selected by senior management, and
- topics selected by supervisor based on casual observation of potential problem areas.

3. How will supervision be supervised? Maintaining the integrity of any control system requires conscious effort. Possible mechanisms include:

cross-checking with the MIS,  
field supervision of supervisors by a second tier of (senior or central office) supervisors, and  
use of a random audit of service quality by field researchers.

4. How will supervision be integrated with other management systems? The number of possibilities is too large to attempt to list them. One obvious area of integration that may require a response is how supervisors will contribute to the MIS:

All QA supervisory reports are included,  
tracer/key events are reported ("Degree of dehydration determined in 74% of observations."),  
only the lowest performing activities/events are reported ("Least often performed TB activity was to examine lymph nodes; done in 4 % of observations.")  
priority events (as determined by management) are reported,  
unresolved problems are reported ("Clinic Z still was not informing mothers to leave BCG scab alone in 73 percent of observations."), and  
aggregated data are reported ("Average error rate for all 41 ALRI items in District X was 37 percent.")

5. How will supervisors resolve quality problems once detected? This is obviously a central issue and should be given explicit attention. In rough order of support to the supervisor:

- a) Supervisors won't resolve problems; they'll report them.
- b) They will use their own good judgment in working with service personnel (they're on their own).
- c) They will be accountable for service quality in their district as measured independently (they're still on their own and management is interested in their success).
- d) They will meet in training sessions periodically with other supervisors to be taught problem solving approaches in QA and to swap experiences.
- e) They will be accompanied periodically by senior supervisors whose primary responsibility will be to improve problem solving abilities.
- f) They may recommend training programs for individuals or units.
- g) They will be given limited access to rewards and sanctions that they may use to promote quality.

### **Disadvantages**

The primary disadvantage of this strategy may reside in the legacy of past supervision. If it has been ineffective or subverted to other purposes, it may be dif-

difficult to change that image without a wholesale change of supervisory personnel.

A second disadvantage resides in the difficult question of how supervisors will be supervised — how will the integrity of the system be maintained?

## A Training Based Strategy

### Overview

Although any QA or TQM strategy would have a training component, this approach relies almost exclusively on training to raise service quality. The approach might be thought of as the strategy of last resort as it would be turned to when other control systems were deemed unsuitable. The link between brief training exposure and behavior change is always tenuous and training is expensive and has high recurrent costs; therefore, this strategy would not normally be considered first. The key elements are design and delivery of an educational program for service delivery personnel to instill 1) interest in quality, 2) skill in identifying quality problems, and 3) commitment in resolving quality problems. Overall program progress would be measured through annual service quality audits.

### Implementation

1. Awareness. The objective of this step is to increase awareness of and support for QA among policy makers in the program and important related institutions. Two activities would be undertaken.

- a) A workshop for policy makers on QA.
- b) Attendance by senior program official(s) at international conferences on QA.

The commitment of senior officials is more important for this strategy - and hence deserving of a larger investment — for two reasons: 1) costs of continuing the program after withdrawal of donor funds are high; 2) the absence of "coercive" incentives for staff participation places a greater burden on positive leadership to sustain interest at all levels of the organization.

2. Development of Quality Standards. The objective of this step is to develop explicit definitions of quality for disease/intervention categories. Program personnel would adapt internationally accepted standards of service quality. Widely accepted standards exist for most primary health care interventions.

3. QA Baseline Study. The objective is to establish a baseline of service quality in the program. Research teams would collect data in the field and prepare the results for presentation.

4. Priority Setting. The objective is to use the baseline data to select the quality deficiencies for initial emphasis through training. Senior program officials would review the data in a three day workshop and develop a Quality Improvement Plan. Regional plans could be developed if that were felt appropriate.

5. Design of QA training program. This step is divided into three sequential activities:

a) Identification of training objectives. The objective of this activity is to establish the expected outcomes of the training program. Some of this will have been done during the priority setting workshop; however, staff will have to set objectives for a range of knowledge and behavioral outcomes for the program.

b) Design of training program. The objective of this activity is to establish the broad parameters of the training program so that resource planning may commence. A schedule of training activities to meet the objectives set in (a) will be established. This will include:

training for national trainers,

determination if a cascade approach will be required, and if so, the number of levels,

determination if independent or distance-learning will be employed,

identification of specific courses or educational interventions and target groups for each,

schedule of training activities, and

mechanisms for evaluating training effectiveness.

c) Development of materials. The objective of this activity is to supplement or adapt existing QA training materials to meet the objectives set in (a) consistent with the program established in (b). It may be expected that at least twenty percent of the materials used in the training program will be developed locally if, for no other reason, than to establish the relevance of the program to local needs.

6. Implementation of the training program. The objective of this step is to fully qualify national trainers in all of the training activities planned. Three sets of activities are contemplated:

a) Training of host national trainers. International consultants might be required to provide a course in QA followed by a brief orientation to training methods specific to the program (e.g., teaching cases, exercises, computer simulation)

b) Co-training in all courses to be offered. International consultants would co-train with host national trainers in all of the training interventions planned in 5 (b) above. After two iterations of each course or training intervention, national trainers would conduct subsequent offerings.

c) Evaluation and revision of materials and offerings. The objective of this activity is to correct flaws in the training designs, materials, and methods. After two iterations of each course the knowledge and behaviors of training participants would be objectively assessed through surveys and direct observation. The results would be used to modify the program.

7. Annual quality review. The objective of the annual quality review is to examine a broad spectrum of quality issues in service delivery. As part of this review, progress toward quality improvement goals would be evaluated and the correspondence of training in QA and changes in service quality would be tested. A

quality assessment, similar to the baseline study in step 3, would be conducted 12 months after initiation of training activities. The organization's officials would meet for one day to review the results of the assessment and the activities of the training program. Priorities in service quality would be re-assessed and revised as needed; changes in priorities would be reflected in changes in training curricula.

### Key Issues

The following are questions that may arise during the design of the project; most are common to other training programs:

1. Who will conduct the training? The answer may vary by topic, organizational level, and personal and professional credibility of candidates for the position of trainer. It is likely that a QA project that relies almost exclusively on training to improve quality will have to train heavily. This argues for either a corps of professionals dedicated primarily to training or to adaptation and simplification of training materials so that large numbers of ersatz trainers may be recruited to staff courses.

2. How will the training be evaluated? Given the emphasis in QA on constant assessment of process, the training courses should practice what they preach. Evaluation will require clearly stated training objectives (knowledge and behavior outcomes) that will guide the design of a continuous process evaluation system. The field methods employed in assessing service quality (direct observation, role plays, exit interviews) might be adapted with the double objectives of demonstrating those methods while gaining information on training effectiveness. Alternatives for evaluation during and after training include:

#### During training:

Creation and use of observation guides (aping the PRICOR II instruments) as an early training exercise to monitor trainer and trainee performance.

Knowledge benchmarks that must be completed before a participant can move to the next module.

Random and anonymous testing of trainee knowledge (analogous to exit interviews).

Simulations and role plays to observe and assess performance.

Individual and group exercises that require application of the information presented in a module.

#### Post-training:

Direct on-site observation of performance by -  
training staff,

peers in health facility, or  
managers/supervisors of health program.

Self-reports of performance.

Completion of questionnaires and tests administered through the mails.

3. How will program success be evaluated? The annual quality review will collect information on service quality. The universe of possible indicators is large; what subset of those indicators will be chosen?

a random selection of quality indicators,  
indicators tied to disease incidence (e.g., ALRI in winter) if that is when the review is conducted,  
indicators on suspected quality problems,  
indicators based on priority areas (the assumption in the draft program described above), or  
indicators based on ease of data collection.

4. How will successful problem resolution strategies be disseminated? During the initial training the trainees will have little to offer beyond opinions regarding problem resolution approaches. Presumably after gaining experience in improving service quality in their facilities, the ex-trainees will have devised often ingenious approaches to difficult quality problems; the health organization needs to catalog and disseminate these successful approaches. Options for collecting and disseminating these experiences include:

Information regarding successful approaches will travel via word-of-mouth.

Training staff will visit facilities at regular intervals to collect anecdotes regarding problem resolution efforts.

Ex-trainees will be encouraged to document successful quality improvement efforts.

Same as preceding plus resources (e.g., time away from clinical duties, travel, technical assistance in writing or study design) will be made available to facilitate documenting of successful quality improvement efforts.

Periodic "sharing" sessions of representatives of many facilities will be organized to disseminate successful approaches.

Initial training will include a module on how to document successful quality improvement efforts.

Initial training will include modules on how to conduct operations research.

Same as preceding plus provision of resources to support operations research projects undertaken by facility personnel.

### **Disadvantages**

This strategy, as a stand-alone effort to raise quality, has several disadvantages which should be considered before it is adopted and during design if it is adopted:

1. The over-riding weakness is the uncertain link between training and behavior change. The project will have to be at constant pains to demonstrate that link and to modify course content where needed.

2. Cost. Addressed under sustainability above, the incremental cost of a training program can be high.

3. Personnel rotation. An organization that has high rotation of personnel will have high training costs.

4. Weak or absent feedback mechanisms. In the absence of feedback mechanisms it will be difficult to identify general quality problems and successful solutions.

## A Research Based Strategy

### Overview

This approach is built around small research projects conducted by facility staffs on service quality. Staff of participating health facilities would receive brief training before requesting small grants to undertake research to improve service quality. Periodic dissemination events would provide an incentive for participation and completion of research projects as well as an avenue for diffusing successful responses to quality problems.

More detail is provided on this strategy since it does not attach to an already existing control system as do the others.

### Conditions for Adopting a Research Based Strategy

This strategy may be well suited to organizations where there is an evident interest among providers in improving service and controlling that process. Where providers have grown weary of the routine of providing health care this strategy offers them novel ways to approach old tasks. This strategy will not work well where the staff are incapable of carrying out simple research (a common error made by the inexperienced is to develop overly elaborate research designs) or where they are so fixed on a preconceived set of solutions to problems (often involving additional resources) that they will not use the results of the research.

### Implementation

Start-up. Start-up of the quality research (QR) based strategy comprises four steps.

1. Token involvement of senior officials. The objectives of this step are a) to establish a general understanding of the aims and activities of the project, b) to create broadly based (if shallow) support for the project, and c) to signal the existence of that official support to lower echelons in the organization. A conference for senior officials within and immediately related to the health care organization would touch on the following topics:

- Dimensions of service quality.
- Economics of quality care.
- Responsibility of senior managers for ensuring service quality.
- Quality Research (QR) project activities.
- Selection of facilities (if required) to participate in initial project activities.

2. Selection and orientation of the quality coordinating committee. The objective of this step is to create an operating staff that will serve as a) a secretariat for quality activities within the organization, b) the organizer of training activities, c) the review board for QR proposals, d) the monitors of research project progress, e) providers of technical assistance to QR projects, and f) the organiz-

ers of periodic (semi-annual?) QR conferences. A staff would be selected and trained in the following areas:

- Quality standards.
- Operations research.
- Management of research.
- Conference organization.
- Contracting for external assistance.

The skills of the individuals selected for this committee would include operations research, research dissemination, training, and quality standards in health care,

3. Adoption of explicit standards of service quality (primarily process indicators). The objective of this activity is to provide a common set of service standards for purposes of:

- a) Assessing organization-wide quality levels, should that be desired at any point.
- b) Providing a universal definition of what service quality means in the organization.
- c) Providing a common denominator for all QR projects that will speed QR project design and make results of individual projects comparable.

The coordinating committee would meet with small groups of practitioners and supervisors to review existing international quality standards for primary health care and adopt/adapt as needed.

4. Orientation of facility personnel. The objective of this step is to equip facility personnel to generate viable QR proposals and conduct the research. The principal activity is a short course — perhaps as brief as a single day — on the following:

- Dimensions of quality.
- Standards of quality.
- Finding quality problems.
- Generating alternative solutions to quality problems.
- Defining research objectives in terms of quality improvements.
- Collecting data.
- Analyzing data.

This is an ambitious training agenda for a quick course and is intended primarily to acquaint the participants in the course with the vocabulary and philosophy of QR. Research proposals could be guided by a programmed text that would ask the proposer to make choices and then direct him/her to additional information in the text required to complete the proposal. The course should be intensively evaluated and revised until it met its objectives.

Project operation. The normal operation of the project involves six activities, all conducted by the quality coordinating committee:

1. Call for QR proposals. QR proposals would be continuously solicited via newsletters, supervisors, and direct contacts with facility personnel. Any facility indicating interest in submitting a proposal would be scheduled for the training course and/or would receive the programmed guide for QR proposal development.

2. Review of QR proposals. The coordinating committee would meet periodically to review QR proposals. It would seem that lenient approval standards would be adequate and only in the cases of non-availability of funds or failure to follow the programmed guide would support be withheld from a proposed QR project. Note that the intention is to stimulate interest in quality issues in service facilities, **not** to launch a rigorous research program.

3. Support of QR. The coordinating committee could have three types of resources with which to support QR projects.

a) Financial support to cover direct research costs. Fundable expenses include any incremental costs incurred in data collection, analysis, and report preparation. A standard maximum amount (for example, less than US\$500) should be specified.

b) Technical assistance in QR project implementation. Coordinating committee staff may directly assist with research problem analysis, generation of alternative solutions, research design, and data collection and analysis.

c) Contracted research. Some QR projects may require data collection and analysis beyond the ability of facility staff to manage (e.g., a household survey or the statistical analysis of a large data set). The coordinating committee could have open contracts with research organizations to conduct such research when deemed necessary.

4. Monitor QR project progress. The coordinating committee would monitor the progress of funded projects against their stated time-lines and remind researchers of completion dates. Obviously tact and patience would be useful attributes.

5. Dissemination of QR results. The coordinating committee could disseminate the results of all completed projects through one or more of the following channels:

Monographs of QR projects and solutions to problems believed to be general.

Compendia of all recent research proposed and completed.

Newsletters on projects in progress and capsule summaries of results.

Semi-annual conferences of researchers.

6. Recognition of successful efforts. An independent group might review completed QR projects nominated by the coordinating committee and select the outstanding one(s) for special recognition. The selection panel might be community representatives, legislators, members of the medical association, professors of medicine, etc. The choice of panel members would be a function of the credibility of the group and the desire to co-opt their participation in and support of quality improving efforts in the organization.

### **Key Issues**

The following questions may arise during design and execution of the program:

1. How should resources be controlled? The two most visible resources are training and QR project funds. In resource scarce organizations, these can quickly become used as rewards for performance, patronage for the loyal, or, more benignly, to raise the credibility of a unit. The above design calls for centralized control of the QR funding. However, note that the review and approval process is deliberately perfunctory; the aim is to generate interest in QA and efforts to improve quality rather than rigorous research designs. Consequently, the review and approval process could be performed at many points within or outside of the organizational structure. The options include:

- Regional quality committees.
- Field supervisors.
- Community health committees.
- Mayors and municipality councils.
- Peer review panels (rotating membership).
- And so on.

The advantages and disadvantages of employing each of the listed groups should be sufficiently self-evident that there is no need to belabor them. In selecting the unit or personnel that will review QR proposals, considerations such as the following may enter:

- Existence of general policies on de- or re-centralization of authority.
- Desire to co-opt certain groups or individuals into the process.
- Perceptions that some individuals or groups may be fertile sources of QR suggestions.
- Ability to control the groups so that the process is not subverted.
- Desire to heighten the visibility or influence of some individuals or groups.

2. How constrained should the range of QR projects be? Should calls for proposals specify certain diseases or health interventions, aspects of clinical attention (counseling, examination, etc.), specific data collection methods (precluding expensive field surveys, for example), and so on. The trade offs between program priorities and feasibility may come to the fore here. The pro-

grammed guide needs to be fairly prescriptive if it is to succeed; general enjoiners on field research will be of little help to facility personnel. Therefore, an early decision on the domain of interest will permit distribution of a guide that not only specifies target areas of inquiry but that lays out clear research designs as well. The facility staff, in effect, would select from a menu of options.

3. How much top-level support can or need be generated? It is a canon of the TQM movement that firm top-level support is essential. The strategy above consciously invests in obtaining only token support. The reasons for this are two: 1) It is not certain that a training course, or other vehicle available to an externally funded project, can generate deep and lasting commitment to anything not already strongly supported within the host organization. Consequently, part of the strategy is to develop more general support through meaningful involvement of field personnel. 2) The "typical" health-organization lacks strong hierarchical controls; clinicians are fairly independent and the presence or absence of centrally held policies will have less influence on behavior than they might have in an industry without a strong profession. If the second condition does not hold, the designers may wish to invest more heavily in securing senior management commitment to the project. Common avenues for gaining this commitment include:

- Conferring expertise in quality assurance on senior managers through attendance at international courses.

- Providing direct identification of managers with the quality project through -
  - attendance at conferences
  - co-authoring of reports
  - ceremonial involvement in quality project activities
  - etc.

- Fostering expectations external to the organization (cabinet, presidency, media) that there is a commitment to quality in the organization.

4. What rewards will sustain interest and involvement? It is possible that the intrinsic rewards of conducting research will not sustain interest in the program. What can follow?

- Recognition of efforts. A non-competed award could be given to all completed QR projects.

- Recognition of results. A non-competed or competed incentive could be provided for achieving quality improvements or an established level of quality.

- Increased professional opportunities. Directors of successful QR projects may be given a large role in dissemination through direct presentations, publication of results, co-authoring for submission to refereed journals, etc.

### **Disadvantages of the Strategy**

This strategy has several disadvantages which should be considered before it is adopted or during design if it is adopted:

1. It may be difficult to sustain after external support is withdrawn as the funds required, although small, will be among the easiest to cut when there is pressure on the budget.
2. The decentralization involved in the strategy is a strength but it also makes it more difficult to identify and address system-wide quality problems. Top-down priority setting is made more difficult.
3. Participation is voluntary. Facility personnel may shun the additional work involved and pockets of low quality could persist in the organization.
4. It involves distribution of resources which will require some vigilance so that the project does not degenerate into a patronage scheme.
5. It assumes that the identification and solution of quality problems requires research. They may not; they may require only simple adherence to procedures — a less costly and more rapid approach.

## An Incentives Based Strategy

### Overview

This is a variation on the preceding. The research would focus on finding the incentives that contribute the most to improved service quality. The program would experiment with different rewards (perhaps a bonus, special recognition, training opportunities, etc.) for achievement of some quality result (a reduction in post-operative sepsis, improved compliance with diagnostic protocols, increased vaccination coverage, etc.) and see if the incentives worked. Given that the staff will see their livelihoods under experiment as well, they will have to agree on the performance measures and rewards.

### Conditions for Adopting an Incentives Based Strategy

You will need to have control over a wide range of incentives — or at least be granted that control — in an experimental site for the duration of your experiments with incentives. You will also need a staff that are not absolutely wedded to the current way they are rewarded. An increase in budget for collecting new data and additional incentives will be required.

### Implementation

Research. You will need to conduct research on three things before beginning.

1. What do staff see as useful or motivating rewards? More salary? time off? transfer? travel? etc. You may have your own guesses but it is best to ask them by proposing alternatives ("Would you rather have five percent more salary or two more weeks of annual leave?" "Would you rather receive a fixed salary plus a bonus for performance or be paid completely on performance?").

2. What outcomes or processes do they see as under their control? Do they see TB cure rates as something that they can affect? Incidence of immunizable diseases? General incidence of infectious disease in the community? In general, the more global the health outcome, the less risk you run that your incentive system will simply encourage staff to zealously perform one activity and neglect another. There is evidence that staff will accept outcomes as a basis for rewards. As an example, in Bangladesh outreach workers were paid only on the basis of the number of mothers that knew how to correctly prepare oral rehydration salts. The outreach workers believed they could reach and teach more mothers and increase their pay; they seemed to be comfortable with a salary totally determined by how much the mothers knew. If staff accept the idea, you could attach a bonus to improving TB continuation rates or cure rates. Or a reduction in child morbidity.

Since rewards are involved you will need independent confirmation of the outcomes; it would be nice if we could take the staff's word, but we can't.

3. What rewards can you control for the experiment? Travel? training? salaries? supplies? and so on.

Selection of an experimental site. This kind of experimentation cannot be conducted for an entire Ministry of Health or other large organization. The results are too uncertain and, if powerful incentives are used, a mistake could distort patterns of service in undesirable ways. Select a site where staff seem reasonably flexible about how they are rewarded. It may have to be a small district or medium sized facility as you will have to gather new data and these data will often have to be gathered or confirmed by independent researchers.

Selection of outcomes to be rewarded. Unless you are going to bring in additional resources to place on top of current rewards, you will need to reach an agreement with staff regarding what behaviors or outcomes will be rewarded. Experience in industry has shown that this is not an easy process. Employees will be justifiably concerned about their ability to control outcomes. They may quickly accept an incentive scheme that is based on activities (e.g., number of consultations per week) or attainment of skill levels (performance on a knowledge test). But they will balk when you first propose paying them on the basis of morbidity since they have no control over weather, nutrition, the state of the economy, patient compliance, etc. Perhaps it would be best to start with behavioral measures (rather than health outcomes) if the rewards you will experiment with make up a large part of total income for staff. Some example outcomes and behaviors:

#### Outcomes

- Facility induced sepsis
- Cure rates for specific diseases
- Incidence of immunizable diseases
- Incidence of communicable diseases
- Severe dehydration
- Re-infection rates
- Patient knowledge of preventive measures
- Patient practice of preventive measures

#### Behaviors

- Compliance with standard diagnosis and treatment protocols

#### Outputs

- Vaccination coverage
- Contraceptive prevalence
- Prenatal control coverage

Selection of rewards. Closely linked to the preceding is the kind of rewards to be used. Of the major incentives, there have been successful experiments with payment in kind (powdered milk in one case), a flat salary, a salary plus bonus (this often does well in motivating people), a straight piece rate (pay is directly tied to performance; twice the performance earns twice the pay), and an accelerating piece rate (twice the performance earns four times the pay). You may have to promise a minimum level of reward or that the experiment will not

run longer than a fixed period of time unless everyone is doing better than before. For a discussion of available incentives see **Section 14** (page 61).

Establishing standards. Most rewards will be given for achieving improvements over the current level of performance and this is a contentious point. Arriving at an accepted baseline of performance may be difficult. Because of this difficulty many experiments are conducted in areas where a reliable baseline for performance already exists. Beware of accepting standards of convenience and entering into experiments on variables that are really not of great interest or have little potential for improving patient care. As an example, you may have good data on many activities — patients seen, prescriptions filled, admissions, discharges — but there may be little value in asking staff to increase those activities.

Collecting data. Independent data collectors will have to gather data or confirm the integrity of data collected by staff. The frequency of data collection will determine the frequency of providing the incentive. We know that frequent reinforcement of behavior is better but this will be tempered by the cost of gathering data. It may be possible to base rewards on staff collected data if periodic audits of those data are conducted.

Staff review. Since the livelihood of the staff may be involved in these experiments, you will need to be especially solicitous of their reactions to the experiments. Conduct periodic review sessions with them to address the following topics:

- Is the performance standard still reasonable?
- Has anything occurred beyond their control that makes the task more or less difficult than they had initially anticipated?
- Do they have the necessary resources to perform the required tasks?
- Has the incentive change made them less attentive to other important tasks?

## **Evaluation**

You will want to look at four items:

1. Has performance improved in the target area of activity or output? As examples, has the TB continuation rate improved? have sepsis rates declined? are immunizations up?
2. How much did these improvements cost? Here you will have to calculate the cost of the incentives and the recurrent costs of operating the incentive program (typically the costs of gathering the additional needed data). These may be divided by the net improvement in results. There are better comparisons that might be made (for example, average cost per unit of desired outcome before and after introduction of the incentive) but these will not be feasible for programs where health workers have multiple responsibilities.

3. Unintended byproducts. Have other areas of care suffered? If there is genuine concern that this is happening you may want to start collecting data on those areas.

4. Staff satisfaction. This is the easiest to measure in most cases. Objectively you can determine whether staff are receiving a larger package of benefits than before. Subjectively you can ask them if they want the experiment to continue.

### **Dissemination**

Since this will almost certainly be a pilot project, conducted with a receptive group of people, rapid dissemination is not guaranteed. If staff like the incentive system it will almost certainly be because their package of benefits has increased. This increase might cost the organization more than it can afford when every member is eligible to receive it. One option is to extend the experiment to other units as rapidly as additional resources are obtained but that leads to equity problems: why should employees in district A receive more than those in the other districts? You may want to maintain the experimental identity of the new incentive scheme to justify offering it to some and not others.

### **Key Issues**

Direct manipulation of incentives can be the fastest route to improved service quality but it is also difficult. Consider the following:

1. Staff have to perceive a strong link across the following chain:

Their effort => improved performance => meaningful reward

At the first stage staff have to be convinced that they will have control over enough elements of the situation (adequate supplies especially) so that they are able, through increased personal effort, to improve performance.

At the second stage they have to be convinced that performance will be accurately measured so that the improvements attributable to their effort will be recorded and recognized.

At the third stage they have to be convinced that the reward will be given — that the organization won't back out of the deal at that point. And the reward has to be something important to the employee.

Unless the experiment is credible to staff on all of these points, no additional effort will be forthcoming from them. (Effort means more than working hard; it also means working creatively and efficiently.)

2. The incentive package has to be within the capabilities of the organization to support. That is not to say that pilot projects cannot provide exceptional incentives to gain a better understanding of what is possible within the organization. There will have to come a time, however, when the incentives

offered will need to be set at a level that the organization can sustain to see if they still make a positive difference.

3. Distortions. Special care has to be exercised against boosting performance in one area with incentives at the cost of a loss of performance elsewhere. This is why it is useful to have global outcomes — outcomes that include the broad health objectives of the facility. But no outcome can cover all of the multiple facets of service quality; trade offs may be required. It would be pleasant to believe that increased efforts to improve technical quality would have no adverse effect on coverage or cost but we know that is not necessarily the case.

### **Disadvantages**

The strategy has clear advantages because it has such great potential to influence behavior. There are, of course, some disadvantages that should be considered.

1. There is the potential for unintended consequences as noted in the preceding paragraph. Is it possible to boost service quality in one area without paying a price in loss of service in another area? Ideally, yes, but the reality is difficult to manage.

2. Probable need for an independent monitoring system. Since rewards will be tied directly to performance, the integrity of the performance monitoring system must be preserved.

3. A possible increase in total costs for the organization. It may ultimately be shown that an incentive program reduces costs per service by improving productivity; this is the common finding in industry. But when that increased productivity does not lead to increased revenues — because the organization charges little or nothing for services — the effect on the budget will be negative.

## Planning

Value	Alternatives	General approach
General purpose	<ul style="list-style-type: none"> <li>- set example for other orgs.</li> <li>- excellent care to a few</li> <li>- special services to a few ✓</li> <li>- general care to many</li> <li>- pioneering role in health care</li> <li>- care for those with no options</li> </ul>	<p><i>gather info for each district and facility on cure rates for TB and leprosy, also continuation rates for TB</i></p> <p><i>get int'l rates for these same things -- hold a conference comparing our cure and continuation rates with int'l data</i></p>
Quality of service	<ul style="list-style-type: none"> <li>- an example for other orgs.</li> <li>- above average ✓</li> <li>- about average</li> <li>- adequate for basic care</li> <li>- "we do the best we can"</li> <li>- poor</li> <li>- not a concern of ours</li> </ul>	<p><i>try to get staff to set cure and continuation goals that challenge the better intl programs</i></p> <p><i>try to get staff to look at facilities and areas that are below average and solve the problem areas</i></p>
Professional competence	<ul style="list-style-type: none"> <li>- among the finest in country</li> <li>- about average</li> <li>- those who can't make it elsewhere</li> <li>- inexperienced ✓</li> <li>- looking for an easy paycheck</li> </ul>	<p><i>bring in training materials on TB -- maybe have a distance learning course on TB management</i></p>
Personal rewards	<ul style="list-style-type: none"> <li>- secure employment</li> <li>- challenging work ✓</li> <li>- opportunity for public service</li> <li>- opportunity to use skills ✓</li> </ul>	<p><i>ask each district to set own cure and continuation goals</i></p> <p><i>try peer supervision</i></p>

Variable	Alternatives	General approach
Goals	<ul style="list-style-type: none"> <li>- volume of activities</li> <li>- coverage ✓</li> <li>- service quality</li> <li>- efficiency</li> <li>- no particular goals</li> </ul>	<p><i>maybe include continuation as part of the coverage calculations -- for example, a number that is person-months of coverage, perhaps as a percentage of known TB sufferers</i></p>
Formality	<ul style="list-style-type: none"> <li>- formal and respectful</li> <li>- informal and respectful ✓</li> <li>- tend to ignore superiors</li> <li>- tend to resist those with authority</li> </ul>	<p><i>probably not a factor for us</i></p>
Clarity	<ul style="list-style-type: none"> <li>- it is perfectly clear what is expected ✓</li> <li>- it isn't very clear what is expected</li> </ul>	<p><i>get all of the District Directors in at the beginning to talk about the goals and changes in how we compute coverage then lots of dissemination on the goals, training, and coverage formula</i></p>
Peer pressure	<ul style="list-style-type: none"> <li>- support the good work</li> <li>- try to bring the person down a notch ✓</li> <li>- too much variation among facilities</li> </ul>	<p><i>recognize <u>units</u> and <u>districts</u> that surpass their goals -- no recognition of individuals</i></p>
Official support	<ul style="list-style-type: none"> <li>- senior managers have made this a high priority ✓</li> <li>- senior managers pay lip service to or ignore the problems of supply shortages</li> </ul>	<p><i>not a problem for unless coverage and continuations grow quickly -- maybe should increase stacks of medicines at facility level to encourage belief that coverage will grow</i></p>

Variable	Alternatives	General approach
Promotion	<ul style="list-style-type: none"> <li>- seniority</li> <li>- effectiveness in jobs</li> <li>- "political" considerations</li> <li><i>other</i></li> </ul>	<p><i>no one stays enough years to get promoted - most medical staff out within ten years</i></p> <p><i>not an issue</i></p>
Recognition	<ul style="list-style-type: none"> <li>- for excellent performance ✓</li> <li>- for poor performance; the recognition is a reprimand</li> <li>- no one is singled out for recognition</li> </ul>	<p><i>but there is no good basis for recognition -- maybe use the coverage/continuation formula as a basis? Talk this over with District Directors</i></p>
Other tangible rewards	<ul style="list-style-type: none"> <li>- awarded randomly ✓</li> <li>- on the basis of performance</li> <li>- on "political" considerations</li> </ul>	<p><i>have to be careful about who goes to training since most will want it -- maybe do this by seniority -- needs more thought</i></p>
Budget allocated	<ul style="list-style-type: none"> <li>- fixed and cannot be changed by management</li> <li>- variable and can be changed by management ✓</li> </ul>	<p><i>maybe tie budget to coverage/continuation or cure rate? perhaps 0.5% more operating budget for each 1.0% increase?</i></p>

<b>P,R,S</b>	<b>Position</b>	<b>Incentives Controlled</b>	<b>Personal Objectives</b>
	Minister or most senior executive of the organization		
<b>P</b>	Director General/Permanent Secretary or most senior manager of operations	<i>hiring, promotion, firing budget</i>	<i>be remembered for some great accomplishment -- maybe a quality program</i>
<b>P, R</b>	Senior staff directors (personnel, finance, training, etc.)	<i>none</i>	
<b>n.a.</b>	Senior program directors (curative services, vaccination, family planning, etc.)		
<b>R</b>	Directors of geographic areas (regions or districts)	<i>leave, travel, training</i>	<i>they all want more resources and some personal recognition</i>
<b>n.a.</b>	Directors of hospitals		
<b>R,S</b>	Directors of other service facilities	<i>performance reviews</i>	<i>varies too much to say</i>
<b>S</b>	Field supervisors	<i>process request for leave, travel, transfer, etc.</i>	<i>generally they want to be seen as part of management</i>
	Facility staff		

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	Field supervisors		
	Facility staff		