Nigeria's public health sector reform and health workers' perceptions of and responses to organisational change: A case study of Abia State Federal Hospital

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Abstract

This thesis analyses policy reform in the public health sector implemented between 2000 and 2007 in Nigeria. It does this by exploring the perceptions of different categories of public health workers in tertiary hospitals of the policy formulation and implementation process itself and the implications of these perceptions for the desired changes in service delivery. Changes in salaries and benefits were introduced at the same time as the reforms and form part of the analysis here. These changes in the benefits for public workers were expected to motivate and incentivise cooperation with the reforms. These reforms involved changes in hospital procedures but more importantly, a shift in the culture of public service delivery from one driven by the provision of excellent medical care and led largely by the clinical professions, to a demand-led system within which the public become clients purchasing services to meet their needs and interests.

The promotion of demand-driven public service delivery has been promoted in a wide range of different economies and there is a growing interest in this policy for improving the operation and efficiency of public health systems in developing countries. However, it has been widely argued that the way in which this interest has been formulated in policy and its mode of implementation has been highly prescriptive and top-down and this has implications for policy outcomes. It is also argued that the socio-political context in which the reforms are being sought, the policy implementation process, and the attitudes of clinical workers who are often the target of such reforms, all determine policy outcomes and need to be considered in both policy formulation, implementation and in monitoring and evaluation procedures. This thesis addresses these concerns.

This study deploys an actor-oriented approach to the analysis of organisational change and therefore seeks to capture the perceptions and behavioural responses of those directly involved, including hospital managers and frontline doctors and nurses, and the relationships between clients and providers. Using the case of a single hospital, the Abia State Federal Hospital that has functioned as a hospital since 1976 the thesis provides a detailed account of procedural changes, perceptions of changes by key workers, and some insight into the processes of change, especially in relation to the interaction between key frontline workers and clients. For this the study uses semi-structured interviews of doctors, nurses and members of the hospital management team, in addition to members of the implementing agency and policy makers. It also details a number of reported events that point to the complexity of change, and suggest ways in which policy implementation processes might have facilitated the change process for those involved in service provision. The changes in incentive structures are also detailed.

The thesis supports a number of the conclusions from other studies, that the professional or frontline clinical workers were not sufficiently consulted in the policy formulation, and that the monitoring and evaluation procedures contest their professional values about good service, and suggests that these policy processes have resulted in high levels of mistrust between the health workers and the service performance audit agency.

In terms of incentives, the analysis suggests that while there is a general feeling that pay packages are largely inadequate given the state of the Nigerian economy, a

greater source of discontent is that the changes did not address a longstanding issue of pay differentials between doctors and nurses, and in addition, the monetisation of benefits earlier provided in kind, reduced their overall social status in society. As a result, this study suggests that by introducing these new reward systems in parallel with the health policy reform, the process of policy implementation may have been made more difficult, rather than easier. Providing incentives to this particular category of workers would appear to be more complex than the policy-makers envisaged, Although not investigated in great detail in this study, the findings suggest that a view of professional frontline workers as having a vested interest in their work that goes beyond pay, needs to be adopted in policy formulation, rather than one of self-interested individuals with minimal interest in the service they provide.

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List of Abbreviations

BPSR	Bureau of Public Sector Reform
CBN	Central Bank of Nigeria
DfID	Department for International Development
DoHS	Director of Health Services
FMCU	Federal Medical Centre Umuahia
FMOH	Federal Ministry of Health
HEM	Executive Manager
HOM	Operational Manager
HWD	Health Worker (Doctor)
HWN	Health Worker (Nurse)
IMF	International Monetary Fund
NBS	National Bureau of Statistics
NEEDS	National Economic Empowerment and Development Strategies
NLC	Nigeria Labour Congress
NMA	Nigeria Medical Association
NPC	National Planning Commission
OPSR	Office of Public Sector Reform
PRSPs	Poverty Reduction Strategy Papers
SAP	Structural Adjustment Programme
SERVICOM	Service Compact with All Nigerians
WB	The World Bank

1 Introduction

1.1 Background

This thesis is about public sector service reforms that are at the centre of public debate in many countries. The aim of the thesis is to increase the understanding of the processes of policy reform. It focuses specifically on health sector reforms implemented in Nigeria between 2000 and 2007, and on changes introduced in tertiary hospitals. In Nigeria, these tertiary hospitals are key organisations responsible for the delivery of health care, and therefore are central to the reform process.

In spite of the popularity of public sector reforms, a number of studies have expressed concerns that despite the growing recognition of the transformative potential of these reforms, outcomes are rarely as straightforward as suggested in the documentation (Syed *et al*, 2008[1]; Syed and Hyder, 2007). Adeyemo *et al* (2008) argue that past public sector reforms in Nigeria have seldom focused on the reality on the ground. Other studies (e.g. Feldman, 2000; Feldman and Pentland, 2003; Becker, 2004), have argued that there is inadequate understanding of reform as a change process from an organizational perspective, especially in terms of capturing the dynamic processes and interactions of organizational life (Pettigrew, 1985; Senge, 1990).

Increasingly, debates about public service provision in developed and developing countries have focused on the public health sector more than on other service sectors (Arah *et al*, 2003; Pollitt and Bouckaert, 2004; WHO, 2006; Kruk and Freedman, 2008). There are a number of reasons for this. First, the issue of healthcare services has wide appeal because of the widespread supposition that good health is fundamental to social and economic development. Finlay (2007: 1) notes that "healthy people are more vibrant, energetic and have a more positive outlook on life". Better health has also been identified as a major pathway to improved life

[1] The exploratory case study was conducted in Bangladesh, India, Afghanistan, Uganda and Nigeria

expectancy (Bloom *et al*, 2004) and extended participation in the workforce (Barro and Lee, 1984).

Second, access to good healthcare services has been shown to have wider implications in developing countries, such as for poverty reduction and equity (Canagarajah *et al*, 1997; Aigbokhan, 2000; Canagarajah and Thomas, 2002; Ravallion, 2001; Ferraira and Ravallion, 2008). All the studies referred to show that the majority of those without access to quality healthcare are poor.

Third, increased interest in health systems is connected to the growing call to integrate workforce-related issues such as motivation and how work is carried out into health policy analysis (Martinez and Martineau, 1998; Buchan, 2000; Dubois and McKee, 2006). This emanates from often uneven outcomes of health reform programmes implemented in the 1990s across developing countries which focused on administrative management (Berman, 1995; Tendler, 1997; Berman and Bossert, 2000; Mills *et al*, 2001; Rowe *et al*, 2005; Mills *et al*, 2006). Finally, health accounts for a big share of public spending and employment.

Moreover, although there has been an increasing interest in the performance of government organizations including hospitals (WHO, 2000; Rowe *et al*, 2005; Mills *et al*, 2006), there is only limited empirical data regarding the specific operation of health policy reforms. Thus, while the crucial role of public hospital organizations in improved healthcare service delivery is recognised, specific evidence about how hospitals provide services, especially at the supply-end remains surprisingly scanty (McKee and Healy, 2002). Furthermore, there is a perception that understanding about public health service performance rarely encompasses the perspectives of the service providers, a situation which as past researchers argue, has resulted in misinterpretations about how public health workers do their work (Morris and Pond, 2007, Lee *et al*, 2000). As Franco *et al* (2002: 1265) declare:

> *There is currently very scarce empirical evidence on what the key determinants of worker motivation are in developing countries' health-care system contexts. Worker motivation is a critical component of health system performance, and yet, it is largely understudied in the context of health sector reform and across different organizational contexts*

Overall, the conceptualization of health sector reforms appears to have been driven by a high-powered administrative mandate supported by technical advice from donor

agencies. All this emphasizes the fact that while it is often contended that the functioning of public hospital organizations can easily be changed, these organisations are highly complex and outcomes are likely to be variable (Berman, 1995; Cassels, 1995; Mills *et al*, 2001).

To improve the performance of Nigeria's public health sector, the government initiated a series of public sector reforms between 2000-2007 (NEEDS, 2004; Okonjo-Iwuala, 2005; Adegoroye, 2006; Soludo, 2007; Adeyemo *et al*, 2008). The health reform focused on improving the performance of health service organizations, and the key concepts and approaches of the health reform was similar to those reforms implemented in other developing countries (e.g. see Russell *et al*, 1999; Mills *et al*, 2001; Lloyd-Sherlock, 2000; Witter *et al*, 2007a). The objective was to achieve a "sustained, purposeful, and fundamental change process which seeks to improve the efficiency, equity, and effectiveness of the health sector" (Berman, 1995: 15). In Nigeria specifically, the health sector reform seeks to improve the performance of health workers, and aims to achieve this by providing incentives to motivate changes in the way they work.

1.2 Aims and Objective of the thesis

This study is about policy reform in the public health sector implemented between 2000 and 2007 in Nigeria. The purpose of this study is to throw light on how health sector reform works by investigating how frontline health providers perceive, and respond to, reform as an organisational change process.

The study addresses three distinct but closely related research questions about the reforms:

1. What changes did the health reform introduce with respect to work practices and pay systems?
2. How do frontline health providers perceive the change process as it relates to their day-to-day work practices?
3. How the different categories of workers in the hospital perceive the reforms have influenced their motivation to perform their jobs?

In order to answer the above research questions, this study adopts a case study approach. The case study provides a means of gaining a holistic view of how reform works as an organisational change process. Specifically it analyses changes from the view of frontline doctors and nurses working in the Federal Medical Centre Umuahia (FMCU) based in south-eastern Nigeria.

1.3 The Reforms

The thesis concerns itself with the comprehensive health sector reform implemented in Nigeria by the Obasanjo-led administration in 2000-2007, and which linked public sector reforms in pay and benefits.

The health reform involved changes in hospital procedures and more importantly, a shift in the culture of public service delivery from one driven by the provision of excellent medical care, and led largely by the clinical professions, to a demand-led system within which the public become clients purchasing services that are expected to meet their needs and interests. Operationally the creation of a demand-led service has involved providing clients with adequate information and self-directed signs and leaflets to improve operational effectiveness (e.g. reduce overcrowding), and to enhance awareness of available services and customer choice. Changes in work practices on the part of frontline workers have involved the introduction of a target culture within which performance is measured according to strict criteria. Clients are deliberately encouraged to report on whether their needs have been met, and workers are held directly accountable. These changes have involved the establishment of a performance audit agency, in this case called SERVICOM. The role of SERVICOM is to ensure worker compliance with the reform, and to guarantee quality assurance, both to the public, and government.

The pay reforms that were introduced in the public sector as a whole consist of changes in actual levels of pay, reductions in the differences between pay levels of doctors and nurses, monetisation of fringe benefits in kind, and performance-related pay. The main interest of this thesis is in the performance related pay elements of these pay reforms since this issue is directly linked with the health service delivery reforms already noted. These changes in pay are expected to motivate and incentivise cooperation with the reforms.

The thesis is based on fieldwork completed in Nigeria in 2007 over a twelve-month period. The thesis is based on information collected from a number of sources including policy documents, semi-structured interviews, and direct observation by the researcher.

1.4 Theoretical Approaches to the Study

This study sits within the context of debates about poor public service delivery and how this can be addressed. The present study is mainly informed by two bodies of knowledge: New Public sector Management (NPM) and elements of organisational change theory that address the issues of worker motivation and behavioural change.

NPM provides an understanding of how public sector reform can occur through top-down rational prescriptions, and is based on the assumption that one size fits all. Therefore, while the theory sheds light on how reforms can come about, it lacks detailed insight into the drivers of change, and the role of various actors in the process. As outlined by past organisational studies (e.g. Delaney and Huselid, 1996; Feldman, 2000; Becker *et al*, 2005), organisational change theory argues that organisational change reflects what actually happens within an organization, and does not provide of what needs to be done.

In line with the thinking of organisational theory, the thesis adopts an actor-oriented approach that involves exploring the perceptions and behavioural responses of different actors directly involved in change processes. In its policy analysis, it uses the approach outlined by Walt and Gilson (1994) of capturing of the policy *context, content,* and *process.* It therefore examines the policy drivers as well as detailing the policy content, and focuses in particular on policy implementation processes.

The remainder of the thesis is organised as follows. Chapter 2 reviews in detail the theoretical context for the study. Chapter 3 presents the research methodology including the research methods, data sources, and ethical considerations. This is followed in Chapter 4 by the content and context of the health reform policy and the pay reforms. The FMCU, which is the case study hospital on which the thesis is based, is also introduced. Chapter 5 details the implementation process of the health

reforms at FMCU, and its link with the pay reform, while Chapter 6 presents the views of the various FMCU hospital actors on the organisational changes introduced. The last data chapters, Chapters 7 and 8, examine the way in which the different categories of workers are affected by the change process. The thesis ends with conclusions in Chapter 9.

2 Theoretical Foundations

2.1 Introduction

The purpose of this study is to throw light on how health sector reform works by investigating how frontline health providers perceive of, and respond to reform as an organisational change process.

Specifically, it explores the perceptions of different categories of public health workers in tertiary hospitals of the policy formulation and implementation process itself and the implications of these perceptions for the desired changes in service delivery. As noted in Chapter 1, the study adopts three main theoretical approaches – New Public sector management (NPM), policy analysis theory, and organisational change theory.

This chapter begins with an examination of literature on health policy reform in developing country contexts (section 2.2). It then considers the literature on key concepts relevant to this study: organizations change theory (section 2.3); organizational change (section 2.4); performance (section 2.5); incentive systems (section 2.6); motivation (section 2.7); and behaviour (section 2.8). The final part of the chapter reviews the literature on the linkage between incentives, motivation and performance, and on procedural justice.

2.2 Health policy reform in a developing country context

Over the last three decades, there has been an evolving trend of market-driven health sector policy reform across developing countries. Much of the debate has revolved around the issue of how to transform the structures of public health organizations to make them perform better. In general, health sector reforms across developing countries have been far-reaching. For Berman (1995: 15), such reform is a "sustained, purposeful change process seeking to improve the *efficiency, equity and effectiveness* of the public health service delivery system". Notably, health sector reforms generally spread from developed countries (Mills *et al*, 2001; Pollitt and Bouckaert, 2004).

In the literature, health policy reform is seen as a change process (Oliver, 1991; Osborne and Gaebler, 1993), laden with competing rationalities, interests, power/politics and roles, and operating in a given historical context (DiMaggio and Powell, 1983; Scott, 2001; Townley, 2002). As in the current Nigerian context, the key debates converge around how to improve organizational efficiency and performance. Thus, there are strong indications that policy reforms are not only concerned with transforming organizational structures. They are also about reshaping the configuration of the transition state to better manage resources, provide services and deal with exposure to global market interactions (World Bank, 1997).

It is worth noting that international organizations like the World Bank (World Bank; 1993; 1997; 2002) have been key players in supporting and financing health sector reforms across many developing countries like Nigeria. The structural reforms of the 1980s, which focused on improving the economic efficiency of public organizations, and the 1990 decentralization reforms with neoliberal inclinations towards the use of fees and private sector initiatives, are good examples. In the 21st Century, the World Bank's renewed support for reforming institutions (World Bank, 2002) seems to be a current policy instrument intended to improve work structures and incentive systems. This, perhaps, reflects an indirect acceptance of failure of the reforms of the 1980s and 1990s, which the Bank attributed to weak and inadequate institutions to support government programmes. In addition, the 21st Century reforms seem to be gaining ground because of the ways they focus on issues of service delivery, governmental accountability and responsiveness to people as a mark of good governance (World Bank, 2004a).

The literature suggests that policy reform seeks to influence existing organizational structures and the status quo by introducing new work practices, incentive systems and rules and procedures (e.g. Aiken *et al*, 2001; Witter *et al*, 2007a). However, despite the growing recognition of the importance of reforms for organizational success, there is still inadequate empirical evidence about how they operate in practice (Berman and Bossert, 2000). Moreover, there is growing awareness that across developing countries, knowledge of the effectiveness of reforms remains inconclusive and often contentious (Sen and Koivusalo, 1998; Lloyd-Sherlock, 2005).

This lack of clear evidence often makes it difficult to arrive at a concise conclusion as to the impact of health sector reforms. Past studies have noted that the health sector reforms in the 1980s and 1990s tended to be unfavourable to the poor and in fact contributed negatively to health outcomes across developing countries arising from difficulty of access due to inability to pay (Ogunbekun *et al*, 1999; Russell, 1996; 2004). However, evidence of such links remains elusive due to the problem of attributing causality of change in a dynamic environment.

Lethbridge (2004) also points to the fact that health sector reforms in developing countries seem not to have really addressed the specific issues of the workforce (human resources), a problem also highlighted by other studies (e.g. Martinez and Martineau, 1998; Buchan, 2000; Steijn, 2002). In general, and as noted above, the understanding of the intricate nature of the operational processes of health sector organizations suggest that no two hospitals or countries are the same. This study, therefore, focuses on a specific case hospital organization (Abia State Federal hospital). Thus, a detailed survey of the literature on health sector reform across developing countries demonstrates that while change has often been presented as a sweeping process, it seems to have been driven more by theoretical and ideological arguments and lacks empirical evidence (Franco *et al*, 2002).

It is also important to emphasize that while health sector reform has often been presented as part of wider social policy recommendations, often alongside the demand for development cooperation by donors, this ignores its context-specific nature:

> *"The effectiveness of a given health policy will depend, not only on country level analysis, but also on facility level context. In addition, the impact of policy reform even within a hospital organization will differ significantly mainly because of the differentiated nature of individual worker characteristics and organizational context"* (Franco *et al*, 2002: 1265)

Moreover, there is inadequate context-specific policy analysis that focuses on exploring dependent issues about how hospital organizations operate (Walt and Gilson, 1994; Mckee and Healy, 2002). Of specific importance to this study is the argument by Van de Ven and Huber that:

> *"Policy analysis needs to capture the question of how policy reform develops and continues and the general sequence of events that unfold within the*

> *organization wherein the policy is implemented and including how the policy is perceived and why, and why the organization changes or fails to change in the context of the change."* (1990: 213)

In addition, as Franco *et al* (2002) note, the understanding of how and to what extent health sector reforms impact on health workers is not an attribute of the health workers alone, but also of the reform and organizational context, including the interactions and relationships that emerge in the day-to-day work processes. Thus, to capture the dynamics of health sector reform as an organizational change process, the conceptual framework for this study follows a process (Pettigrew, 1990; Van de Ven and Huber, 1990) and systems approach (Ackoff, 1971; Checkland, 1999; Flood, 2000).[2]. However, there has been little of this type of attention on the implications of health sector reform. As noted by Flood (2000) systems thinking as an interpretive research approach entails going beyond observation and theory to explore the authentic explanations about what is happening and how it is interpreted by those involved. It facilitates the exploration of the "whole process" and the "interpretations and perceptions that individual people form within their work context, social system and rules, practices and underlying constitutive meaning" (p. 726).

More importantly, key policymaking and implementation studies (e.g. Barrett and Fudge, 1981; Barrett and Hill, 1984; Barrett, 2004) have highlighted how the continuing top-down perspective of policymaking and analysis bypasses deeper knowledge of organizational processes. Thus, there remains inadequate recognition of the policy processes (policy in action) particularly at the level of the organization wherein policy is implemented, and including the activities and actions of primary (micro-level) actors involved in implementation (i.e. frontline health workers). Other studies suggest a huge gap between what is known as policy as prescribed (policy intentions) and policy in action (Pressman and Wildavsky, 1973; Van Horn and Van Meter, 1975). These studies argue that policy, often presented as a top-down change package, is prone to failure because of the lack of consideration as to what happens after it has been packaged and promulgated.

[2] According to Checkland (1999: 3) a systems approach offers a holistic approach to analysis capturing people's perceptions and interpretations (humanistic aspects) of change in their workplace. It treats the organization as a system consisting of individual worker characteristics and perceptions, which constitute the software of organizational structure.

Based on this review, and in line with the aim and objectives of this research, a process-based approach to policy analysis is adopted here. This, as supported by numerous studies (Pettigrew, 1990; Walt and Gilson, 1994; Collins *et al*, 1999), is about exploring policy as a process and developing insights into its context, content and process, including the underpinning of complex organizational arenas, structures, processes and human action and interaction, all of which converge to determine how policy operates in practice and its likely impacts.

Table 2.1 below summarizes the policymaking and implementation theories. This study is located within the continuum of bottom-up, bargaining and evolution perspectives (Pressman and Wildavsky, 1973; Van Meter and van Horn, 1975; Mazamanian and Sabatier, 1989; Barrett, 2004). More specifically, the analysis takes the form of a case study of specific policy process and attempt to explore what happens after policy has been designed and implemented and including the complex processes arising from interactions interests and actors involved in organizational phenomena.

Table 2.1: Policy-making and implementation theories (Pressman and Wildavsky, 1973; Van Meter and van Horn, 1975; Jordan, 1995; Mazamanian and Sabatier, 1989; Barrett, 2004)

Context	Top-down	Bottom-up	Bargaining and evolution
Aim	To improve organizational performance (achieve set goals)	To explain what actually happens as policies are implemented	To explain how policy is the product of bargaining between interests
Dominant theme	Hierarchy, control and compliance	Complexity, messiness and devolved power	Bargaining, exchange and negotiation
Dominant actor	Policy-makers, government, policy experts	Workers and organizational managers	Workers and organizational managers
Focus	Effectiveness of achieving set macro goals	Operational processes and practices that realistically influence day-to-day actions and interactions	Bargaining interplay between goals and local conditions, constraints and opportunities
Policy formulation and implementation perspective	Policy is a distinct and discrete event made by top executives, which others must obey.	Unclear distinction between policy and policy implementers as policy may be remade or restructured through prevailing structure and shared beliefs	Policy needs to be understood in a policy-action continuum and seen as a series of intentions around which bargaining and interactions take place
Policy view	Policy as an independent variable with a starting point, a benchmark and end point	Policy is dependent upon existing interactions, structures and actors at the local organizational level	Policy is dependent on the process of bargaining
Criteria for measuring policy success	Based on output/results along a priori objectives or standards	Complex change process, messy and difficult to objectify, but attempt can be made to understand it	No benchmark – policies restructured as a result of negotiation
Policy outcomes	Predictable and results-oriented	Unpredictable; depend on local interactions and structures	Unpredictable; dependent on bargaining
Research methodology	Focuses on modelling of what should happen and comparing with reality (deductive, positivist view)	Dependent on what situation on the ground reveals based on empirical evidence and from the perspectives of those involved	Deductive and inductive

Summarizing the above, policy reform remains critical to developing economies as a means of outlining what should be done and the incentives for doing it. Yet, its actual realization as prescribed remains intricate and messy. Policy is essentially an intervention that seeks to transform the structures and operations of public organizations, human action and behaviour, and in the context of health service delivery remains critical to improving organizational performance. Thus, the argument here is that one way of understanding policy reform is to treat it as a process, but one which needs to be understood within context.

This study seeks to develop an in-depth view of the policy implementation process at the local level of public organizations. To do this, it draws from the perspectives of organizations as systems consisting of diverse worker categories operating within set organizational structures and processes.

2.3 Organizational Change Theory

Organisational change theory argues that organisational change reflects what actually happens within an organization, and not prescriptions of what needs to be done (Delaney and Huselid, 1996; Feldman, 2000; Becker *et al*, 2005).

A hospital organisation as used here is an exemplar of public organizations. As North (1990) notes, organizations are both components of the structural framework that supports human action and interaction, and organizations are groups of individuals who work towards a common goal or objective and have common interest. This simplified definition is however in line with the very early view of Gauss (1936: 66 *cited in* Selznick, 1948: 25), which considers "organizations" as "the arrangement of personnel for facilitating the accomplishment of some agreed purpose through allocation of functions and responsibilities". In this regard, Selznick (1948: 25) sees formal organizations as a "structural expression of rational (policy reform) action".

The fundamental issue is that organizations' activities are concrete social structures, embedded in the rubric of underlying social systems, and contexts (Meyer and Rowan, 1977; Scott, 1992); power and trust (Luke, 1974; Knight, 1992). For Selznick (1948: 27-28), the public organization is both an economy and an adaptive social structure. As an economy, it represents a system of institutions and

relationships, which define resource availability and centre on improving efficiency and effectiveness. As an adaptive social structure, it is construed as consisting of a structure, human relations and actions, and made of elements (workers) with different personalities. While the economy (institutions) provides the rules, the functioning is determined by human action, interaction and relationships. Thus, understanding the interplay of institutions, structures and human actions requires a detailed exploration of what is happening as perceived by those involved (Klein and Myers, 1999).

An important element of organization is its structure. This relates to the shared beliefs, patterns of interaction, processes and culture that underpin how workers function to do their work (Ouchi and Wilkins, 1985; Schein, 1996; 2004). As noted by Deshpande and Webster (1989: 4) it reveals, "why things happen the way they do". The early literature on organizations (e.g. Bernard, 1938; Selznick, 1948), shows that the structure of an organization explains why there are differences in organizational outcomes. Organizational structure, as a concept, is embedded in shared values and beliefs, work identities, and the way workers perceive their work. It can also explain prevailing work practices, procedures, responsibilities and patterns of relationships among workers (Geertz, 1973; Weick, 2001). These past studies also show that organizational structure is embedded in historical context. For example, the hospital as a public organization operates on the logic of bureaucracy and professional orientation. This implies that work practices and structures are interwoven in the traditional idea of chain-of-command, authority and power and job specialization as well as being influenced by professional discretion (Lipsky, 1980; Schneider and Ingram, 1993).

In sum, from the perspective of organisational structures, the focus of this study is on day-to-day activities within the structures of the organization. It relates to how workers as primary organizational actors attribute meaning and interpret their experiences within the structures of the organizations where they work. The analysis of organizational processes also emphasises the social aspect of work alongside formalized work practices, procedures and incentives. The data emerged as a product of individual experiences of policy changes, organizational processes and structures. The focus on the workers as primary organizational actors is therefore considered paramount to this analysis. With the public hospital organization

representing an arena where policy institutions operate (Zucker, 1987), it represents a mechanism by which government seeks to achieve its aim of meeting the service needs of the populace. Yet, as noted by Meyer and Rowan (1977: 252) how public organizations "conform to existing institutions" could influence their capacity to realize the policy reform objectives. Other studies (e.g. DiMaggio and Powell; 1983; Lawrence, 1999) noted that the consequence of human action and interactions in a changing institutional context is complicated. It is therefore important to note that policy reform can introduce both opportunities and challenges, and therefore the consequences of interactions between policy institutions and organizations (human action and interaction) can be both intended and unintended.

2.3.1 Theoretical Approaches to Public Organization Management

There are different theoretical approaches to understanding and managing organizational life, each of which influences work practices, incentive systems, work motivations and performance differently (Pfeffer, 1982; Oliver, 1991; Jawahar and McLaughlin, 2001). Public sector management styles include approaches that are referred to as classical (using a bureaucratic and mechanistic metaphor) (Fayol, 1949; Carroll and Gillen, 1987); structural and neo-liberal (Williamson, 1975; 1990); human relationship-focused and political (Barnard, 1938; Simon, 1983) and systems based (Ackoff, 1971; Checkland, 1981). This section examines each of these in turn.

2.3.1.1 The Classical Approach

The classical approach sits within the earliest organizational bureaucratic settings with a defined hierarchy and bureaucracy (Fayol, 1949; Weber, 1947), and a mechanistic perspective based on clearly defined scientific planning procedures (Taylor, 1911). It builds on the understanding that rational economic principles guide worker behaviour and ignores the societal or external environmental influence. According to Morgan (1986), this approach is grounded on the conceptualization of public organization as a rational system which is run according to top-down bureaucratic principles (hence the ‘‘bureaucratic metaphor’’) and the defined scientific process of planning, coordination and control using basic techniques of

Management by Objective (MBO) and Planning, Programming, and Budgeting Systems (PPBS) (ibid: 29). The classical model conceptualizes public organizations as agencies of government and means of social control through orders, structures and regulations, managed by bureaucrats and experts, operating within set rules and regulations with defined hierarchies and spans of control (Pfeffer and Salancik, 1978; Pfeffer, 1982).

Within this approach, the problems of public sector workers' are perceived as technical issues requiring technical solutions (Scott *et al*., 2003) thus legitimizing the model as an indispensable form of public management based on bureaucratic rules and technical functions (Presthus, 1975). Thus, public workers are critical instruments to achieve economic and productive goals within a closed organizational system. However, as agents, they need to be institutionalized into the existing organizational structure. As rational individuals, their behaviour is predetermined within the bounded rationality of the organization, a well-defined bureaucratic administration and a reward system structured into grade levels.

However, the classical approach has been severely criticized for not encouraging innovativeness and instead encouraging people to obey 'orders' and 'rules' without question (Morgan, 1986). Morgan (1986: 39) argued that it is often presented, as "this is the way government want you to do your work, so you must do it exactly". As noted by Morgan, classical approach "reinforces power and control" of government over the organizations. Meanwhile, Myerson (1994) and Kooiman (2003) argue that it could result in feelings of alienation, tension and conflict in the workplace.

2.3.1.2 The Structural and Neoliberal Approach – 'Market Metaphor'

The structural approach is underpinned by a neo-liberal perspective and the understanding that the market is the most efficient and effective way of allocating public resources (Williamson, 1985). This sees restructured organizations (e.g. those that have been decentralized) as enhancing performance and efficiency, which in turn guarantees quality services to clients. This also involves exposing customers to

user fees, decentralization and introducing competition in hospital organizational processes (Propper, *et al*, 2004; Gaynor, 2004; Maynard, 1993). It is exemplified by the structural adjustment programme implemented in many developing countries in the 1980s and 1990s as public sector-and specifically health sector reforms (Mills *et al*, 2001; Russell *et al*, 1999).

While this approach allows for opportunities for improvement in service quality, there is no denial that rising costs of access to health services have been difficult to curtail across developing countries (Russell, 2004: Goudge *et al*, 2009). In addition, in a market driven organization, issues of comparability of rewards and opportunities within and across public organizations, and social system variables have remained factors that, though poorly understood, influence an organization's capacity to achieve the efficient market agenda. Equally notable is that decentralized health systems have in most areas failed to deliver expected health outcomes (Mills *et al*, 2001). Other studies have criticised the structural approach as neglecting the workforce (Martinez and Martineau, 1998; Buchan, 2000; Hongoro and McPake, 2003) and social aspects of healthcare provision (Frohlich *et al*., 2001; Williams, 2003; Moore *et al*., 2006).

2.3.1.3 The Human Approach-'Organizational Ecology Metaphor'

The human approach incorporates human relational aspects such as needs, motivation, behaviour and process, and the synergy between workers and their environment (Barnard, 1938; Simon, 1957). The popularity of this approach was influenced by what became known as the ''Hawthorne effect'', drawn from Elton Mayo's study in the 1920s and 1930s of public organizations. Mayo's (1933) work conducted at the Hawthorne electrical plant in Chicago, introduced human issues into the understanding of organizational operations. The development of the human relation model provided information that underlined the importance of a public organization first as a structured institution that supplies goods and services to the people, but more importantly as a place of interaction, which facilitates the integration of individual workers and the wider public service context (Reed, 1999). It provided information underlining the importance of organizational ecology. Thus – work and worker characteristics, relations and interactions are as important in

achieving organizational performance (Roethlisberger and Dickson, 1939; McGregor, 1960).

Besides contributing to the development of modern human resource management through incentives systems and other motivational factors (conceptualized as forms of job enhancement), and principally to encourage workers to improve their organizational roles, the human relation approach integrates aspects of workers' well-being into our understanding of organizational processes (Feldman, 2000; Feldman and Pentland, 2003). In addition, Ferlie and Mark (2003:313) in their qualitative study on new public organizational management draw attention to the fact that "work conditions and worker characteristics influence organizational performance''. Valuable insights into the importance of the relationship between the worker, work conditions, motivation and performance are also provided by Morgan (1986), Hannan and Freeman (1989), and Franco *et al* (2002). For example, Franco *et al*, 2002) indicate that there is relationship between worker motivation and performance, while Hannan and Freeman (1989) argue that changes in work conditions may have differential impacts on workers. Following on from this, Morgan (1986) is of the opinion that workers will perceive change differently depending on their situation and disposition. This reinforces the need for understanding differences in worker categories, work cycles and other characteristics of importance, which may have influence on their behaviour.

2.3.1.4 The Systems Approach – 'Systems Metaphor'

The system perspective conceptualizes the public organization as a collection of workers of different categories and socio-economic characteristics, and is an extension of the human relation approach, identifying public organizations as dynamic and open systems (Scott, 1992). Public workers are seen as agents whose choices and activities are restrained by formal organizational rules and available resources (Giddens, 1984; Holbeche, 2006). The perspective of a public organization as a self-organizing system extends our understanding of organizational elements (workers) through an integrated window of organizational ecology (culture and climate), cognitive science, economics, and social sciences (Schein, 2004). The systems approach is in line with the view that public organizations consist of groups

of individuals who work towards a common goal or objective and have common interest (Gaus, 1936:66 *cited in* Selznick, 1948:25).[3] As a system, it operates as "a coordination of interrelated behaviours of people who are working together to achieve organisational goal" (Lawrence and Lorsh, 1967: 3). As an "open system", a public organization may be influenced by inherent activities within its operating structure and changes in the environmental context (e.g. reform) (Scott, 2001; Holbeche, 2006). Earlier studies (Bernard, 1938; Selznick, 1948; March and Simon, 1958; Cyert and March, 1963), conceptualize an organization as a problem-solving mechanism. Thus, organisation serves as a unit of interaction of individual elements with set governing and operating structures.

From the perspective of this study, this approach offers valuable insights into the characteristics of organizational elements (workers), particularly in a service organization such as a public health provider. In that connection, a public health organization as identified in this study is adapted from the conceptualization of Meyer and Rowan (1977:340) as follows:

> *"[A] formal organization which operates along set institutions and structures and involves day by day processes, human actions and interactions which are embedded in the underlying complex social context of relationships and exchanges."*

According to Meyer and Rowan (ibid: 240), policy reforms therefore operate as 'institutionalized products, services, techniques, policies and programs which public organizations often adopt ceremoniously'. This suggests that public organizations reflect the cultures, structures and outcomes of the wider system in which they are situated. Operationally, public organizations do not function haphazardly but follow clearly laid down blueprints which link to the policies and goals of the wider economy.

In public organizations, public health workers are the primary elements who interact and engage in activities and processes aimed at achieving organizationally set goals. However, it is also understood that they are not only pursuing the goals of the organization they work for; they are members of households and other institutions by virtue of their networks and ties, and hence may be equally committed to meeting

[3] Selznick (1948: 25) sees formal organizations as a "structural expression of rational (policy reform) action".

personal, household and social needs. In addition, the public organization does not exist in a vacuum but is part of a system or environment with laid down institutions. Therefore, to understand the web of processes, relationships and interactions associated with organizational functions, the systems approach is considered the most appropriate (Ackoff, 1971; Checkland, 1999). The key focus is therefore to understand public health sector organizational processes and functions, interactions and relationships and the embedded constructs, which shape work practices.

2.4 Organizational Change

According to Holbeche (2006), change is inevitable in an organization. Change in an organization is the way to stay competitive and grow and thus how change happen remain a dominant theme of management (both in private and public organization) (Heller, 1998). As an organisational change tool, policy reform can impact positively on an organization by reorganizing how work is done and the incentives available to workers to enable them to perform better (Berman, 1995; Berman and Bossert, 2000).This study is premised on this understanding of policy reform as a change process that may have different levels of impact on the workers, organizational structures, incentive systems and service delivery outcomes (Berman, 1995; Biscoe, 2000; Holbeche, 2006).

The organizational management literature suggests different change typologies depending on the level of impact on the organization, the processes, its workers and outcomes (Walzlawick *et al,* 1974; Bartunek and Moch, 1987). In this connection too, the success of a change process in an organization largely depends on how change is managed (Kotter, 1996). As Kotter (1996) notes, subsequent to change initiation, it is important to know how change managers (organizational managers) and change implementers (frontline workers) respond. Other studies (Lorenzi and Riley, 2000; Nevin and Grace, 2000; Rowden, 2001) suggest the need to understand how organizational workers perceive and learn from their experiences in a change process, since this perception may shape their mind-set and attitudes to work and commitment to service provision. How to manage change, particularly in a complex service organization like the public health sector (Kernick, 2004; Pettigrew, 1990),

remains a key challenge. Lorenzi and Riley (2000: 121) state that change can be resisted based on whether it is perceived as a threat, challenge or opportunity:

> *''It is easy to change the things that nobody cares about. It becomes difficult when you start to change the things that people do care about or when they start to care about the things that you are changing.''*

Equally, they argue that change could contribute to the success of an organization particularly where there is ''trust, good communication, involvement and participation and simplicity of content and process in addition to perceived favourable outcomes'' (ibid: 118). The understanding of institutional policy reform is grounded in the logic that reform is an on-going process and depends on the day-by-day organizational practices, behaviour, and action of primary organizational actors (Orlikowski, 1996; Pettigrew, 1990; Van de Ven and Huber, 1990). Other studies (e.g. Feldman, 2000; Becker, 2004; 2005) highlight that workers, by their day-to-day work practices and routines make change to happen. Furthermore, as March (1981b: 564) notes, organizational change happens because workers are 'intelligently attentive to shifts in their job context and can alter their behaviour based on how well they feel motivated'.

Despite the relevance of policy reform as a change process, it is important to reiterate, based on the aforementioned studies, that change is a complex activity. As noted, the focus of this research is on developing insights into the emerging patterns, structures, processes and relationships arising from the implementation of policy reform as a change process. Since a change process generally seeks to bring about improvement in organizational performance, it is necessary to discuss the concept of performance.

2.5 Performance

In recent years, the performance of public organizations has attracted significant attention in developed (Boyne *et al*, 2006a; Andrews *et al*, 2006) and developing countries (Kruk and Freedman, 2008). Organizational performance is seen as a key benchmark that differentiates organizations, managers and workers (Ichniowski *et al*, 1997; Folan and Browne, 2005). Yet, while the performance of public service organizations has been in the spotlight in recent times, performance remains a

subjective concept (Boyne *et al*, 2006a; 2006b). Furthermore, understanding of what performance is and how to measure it remains controversial and inconclusive (Van Thiel and Leeuw, 2002; Boyne *et al*, 2006a, Andrews *et al*, 2006).

The literature links performance with strategic planning, operational control (Neely *et al*, 1995; Kaplan and Norton, 2001), work processes (Feldman, 2000; Pentland and Rueter, 1994) and the behaviour of workers (Franco *et al*, 2002), with the focus about how to transform dysfunctional public health organizational structures and processes and to make workers achieve set goals. However, there is a contradiction as to what public health performance is because of the multiplicity of interests involved (Boyne *et al*, 2003; Boyne *et al*, 2006a). In an attempt to understand the concept, this review considers a number of different perspectives. First, performance is related to hospital operational effectiveness. Adair *et al* (2006:98), for example, describe performance as a measure of "how well an organization or workers carry out its functions in relation to set goals". Thus, performance is related to the setting and/or realization of set goals or targets.

Second, from an economic perspective, performance is explained in terms of cost-benefit calculations (Williamson, 2000; Boyne, 2002). In particular, the economic efficiency definition of performance relates to how well organizational operations maximise available resources in delivering services. Closely related to the economic perspective is the political or institutional logic. As noted by Meyer and Zucker (1989: 111) public sector performance is related to "how existing power, politics and interests operate within a system to achieve maximum recognition and impact". This definition underscores the importance of power and legitimacy, interest and goals as critical elements that drive the demand for performance.

From a market perspective, public sector performance is associated with the neo-liberal discourse of competition and individual choice. Simons and Ingram (2004) note that performance is related to how well organizations compete to achieve set organizational goals within changing ideology of work. In addition, from a service management perspective, performance is related to how and to what extent services are delivered to satisfy customer needs (Gronroos, 1994). On this account, performance can thus be seen as a means of improving wellbeing of clients (Gronroos, 2001).

In the context of this study, the concept of performance is linked to how well hospital organizations achieve set targets. This in turn is strongly related to the strategic business planning and management logic in which performance is measured along set targets as a way of establishing a scorecard for comparison (Kaplan and Norton, 1996). This business management perspective has been a driver of performance issues within the public sector and focuses on service delivery processes such as customer orientation, including relationship management, responsiveness, timeliness, and waiting and consultation times.

Finally, performance by public sector organizations has become part of the language of democracy and good governance (Forbes and Lynn, 2006; Hughes, 2006). Thus, a public health organization can be said to perform well if it is working in line with the tenets of accountability and transparency of public service operations. Politically, the language of accountability and transparency in public service delivery has become associated with democracy and good governance (Lynn *et al*, 2000; World Bank, 2004a). All the same, it has exerted (and continues to) much influence within the wider political subsystem over the perspectives of public service performance. Drawing from the theory of bureaucracy (Selznick, 1943; Carnis, 2009), public organizations and public bureaucrats are expected to be responsible for doing what they are assigned to do – that is serving the best interests of the public. Of importance to the discussion on performance as an aspect of organizational governance, therefore, is to what extent (if at all), and how a public health facility provides services to the people (World Bank, 2004a). While public policy seeks to align interests and emphasises how well public facilities should operate to provide those facilities and services people need, the realization of policy objectives relies heavily on how organizational workers do their work day-to-day (Feldman, 2000). Thus, the functional operations of public organizations may differ from logical prescriptions of policy. The complex peculiarity of organizational outcomes (performance) seems to result from the inherent characteristics of roles and interests, including the work characteristics of public workers. For example, Lipsky (1980: 40) shows that public workers (addressed as street level bureaucrats) do their jobs under conflicting and ambiguous goals arising from differing legislative interests.

Overall, performance as presented by the policy reform seems to have been driven by the political ambition to reposition and re-invent government and public

organizations (Osborne and Gaebler, 1992) and to create value from 'tax-payers' money (Osborne and Hutchinson, 2004) and meet the needs of the majority, especially the poor (World Bank, 2004a). This suggests that issues of public sector performance are linked to wider development issues such as poverty, inequality and deprivation (Bloom *et al*, 2004; DfID, 2004; WHO, 2007).

2.5.1 Performance Targets

Recently, the focus of reform as a means of improving public service performance has resulted in the outlining of targets as standards for measuring performance in public hospitals (Bevan and Hood, 2006a/b; Kruk and Freedman, 2008; Propper *et al*, 2008a/b). The reviewed policy documents suggest that governments opted to set national performance targets as a way of assuring corporate standards. In the past, it was often said that public workers across developing countries public sector contexts were "lazy", often not knowing what was expected from them (Delfgaauw and Dur, 2008). Thus, one of the core concepts of the reform is that setting targets will create uniformity of behaviour and of standards to measure performance.

The "performance target culture" is a private business- and market-based management philosophy which originated in the industrial sector (Kaplan and Norton, 1996; Neely, 1999). The literature suggests that it has been an emerging trend in and characteristic of new public sector management, enshrined in the public health systems of many other countries (e.g. UK, USA, New Zealand, Australia, South Africa) (Hood, 1991; Pollitt and Bouckaert, 2004; Bevan and Hood, 2006a/b). Specifically, the use of targets as a policy instrument for improving service delivery systems is common, particularly in the context of developed countries' health systems (Marshall *et al*, 2002; Mannion *et al*, 2005: Propper *et al*, 2008b). Although the use of targets has emerged more recently in the context of developing countries, their effectiveness remains unclear and indeed may be context specific (e.g. Maritz *et al*, 2010; Kruk and Freedman, 2008). At the same time, government's interest in performance targets within the on-going policy reform process remains unprecedented. For example, based on evidence from policy documents (see Thompson, 2004; NEEDS, 2004), the Nigerian government hardly knows what public service providers do or that the service providers often pursue their own

interests – a concept rooted in principal-agent theory (Jensen and Meckling, 1976; Eisenhardt, 1989a). Performance targets therefore serve as a strategic tool used by government to align service providers to nationally-set government interests and goals. However, it is important to point out that the operation of performance targets suggests an extension of the culture of regulation and control, a way of "telling the workers what to do" (Hood *et al*, 1999; Power, 2000; James, 2000; 2003).

Operationally, the presentation of targets appears to have been based on the assumption that workers will see them as a "taken for granted rule" and therefore obey rationally (DiMaggio and Powell, 1983). Nevertheless, drawing from past organizational studies (e.g. Lipsky, 1980; Greenwood and Hinnings, 1996; Scott, 2001; Greenwood *et al*, 2002), there is consideration that the link between target and performance may not occur automatically because workers as professionals often operate with significant amounts of discretion and may or may not follow the targets. In line with the view of other past organizational studies (e.g. Smith, 1995; Smith and Goddard, 2002), a key issue is what are the incentives for meeting targets and how management of performance target operate in practice. This remains one of the central concerns of this study.

2.5.2 Measurement of Organizational Performance

In many developing countries, there is evidence that the quality and performance of healthcare services have remained unsatisfactory (WHO, 2000; FMOH, 2004; Rowe *et al*, 2005; Mills *et al*, 2006). Yet, the measurement of performance remains contentious, complex and difficult (Andrew *et al*, 2006; Brewer, 2006). Much of what is known today about public health performance is drawn from the service management approach (Morris and Pond, 2007; Gronroos, 1994), with most of what has been researched about performance based on customer-based assessment of hospital operations (Parasumaman *et al*, 1993; Zeithaml *et al*, 1994; Groenewegen *et al*, 2005). While recognizing that the customer approach may have served to show how service users perceive organizational outcomes, it is nevertheless important to note that it remains inadequate as it fails to account for the process component and how workers perceive their work and the outcomes. The literature (e.g. Al-Qutob and Nasir, 2008; Sudhahar and Selvam, 2008) demonstrates that providers'

(workers') own assessment of performance has hardly been examined (Wadhwa *et al*, 1999; Lee *et al*, 2000). Since workers are the primary actors in service delivery, it is important their perspectives as they relate to issues of performance on the supply side.

The relevant organizational literature demonstrates that the processes of delivering quality care remain complex and linked to broader issues of work practices, skills, attitudes (motivation, commitment and satisfaction) and organizational policies and procedures (Gerhart, 2005; WHO, 2006; Katou and Budhwar, 2007). In recent years, measuring performance has come to spotlight as a means of identifying how well organizations perform and also improve relevance to the people (Boyne *et al*, 2006a). In doing this, the use of customer satisfaction has often been used (Wadhwa, 2002; Sofaer and Firminger, 2005). Yet, there are challenges to data validity of consumer reports particularly across developing countries (Agyepong *et al*, 2004; Andaleeb, 2001). In general, healthcare quality and performance encompass the total features and characteristics of a product or service that bears the ability to satisfy a given need.

There is the potential, therefore, to argue that we cannot fully understand performance without integrating the views of workers, and the processes involved in achieving performance. Yet, the former are hardly considered even though the actions and interactions of health workers and their managers improve or retard performance. It is logical, therefore, to engage them in mapping out how and to what extent policy reform may have influenced organizational performance. In practice, although health workers and their managers are often bombarded with pressure from government to perform, and in fact often blamed for poor performance, they may have particular insights about what optimum performance is and how it can be achieved. Thus, focusing on the views of the workers will provide a believable assessment of performance.

The literature also reports performance measurement as a subjective implicit incentive (Baker, 1992; Baker *et al*, 1994; Gibbs *et al*, 2004). It is presumed that when workers know that information about how they do their work is being collected and that they will be rewarded by doing well (or having a good performance assessment), they will be motivated to do better. However, despite the

existing theoretical prediction and supposition of the possible link between performance measurement and worker motivation (Baker, 1992; Baker *et al*, 1994), empirical evidence remains scarce (Gibbs *et al*, 2004; Hayes and Schaefer, 2000). Theoretically, the logic of performance measurement is situated within the context of the debate on agency theory (Jensen and Meckling, 1976; Baker, 1992). It serves as a means of generating information about workers (agents) and at the same time generates information used to reward best performers. The overall aim is that it serves as a means of aligning workers' actions to the organizational objective. There is, however, ambiguity about how and to what extent performance measurement influences worker behavior, motivation and performance in practice (Gibb *et al*, 2009; Baker *et al*, 1988).

Finally, while the introduction of performance targets acts as a means of aligning workers' interests to those of government, the attachment of rewards to achieved targets acts as an incentive to motivate workers to work in line with the targets. The literature of organizational control (Ouchi, 1980; Power, 2000) also suggests that the introduction of an overseeing agency serves as a disciplinary and controlling measure. Workers may respond differently based on whether they perceive the change either as an incentive or as a regulatory or controlling measure (Gibb *et al*, 2009).

2.6 Incentive Systems (Compensation/reward)

As noted, changing the incentive (compensation/reward) structure is a major objective of the public sector reform. The public compensation/reward system is crucial as a human resource management tool (Becker and Gerhart, 1996; Baker and Huselid, 2006) with implications for worker motivation and performance (Lawler, 2000; Armstrong and Brown, 2006; Armstrong, 2007). The literature highlights a potential link between incentive systems and poor performance of public health systems in developing countries (Franco *et al*, 2002; WHO, 2006; Dielemann and Harnmeije, 2006; McCoy *et al*, 2008). Thus, one of the primary aims of reform is to put the "incentive right" to improve public workers' motivation (WHO, 2006; Drager *et al*, 2006).

The WHO (2000: 61) defines incentives as:

> *"All rewards and punishments that are provided to service providers as a consequence of their work in the public health organization"*

Armstrong (2007:3) notes that incentive/reward systems consist of "strategies, policies and processes in place through which the contributions of people to organizations are recognized by both financial and non-financial means". The WHO Report (2006: xvi) highlights that "incentives seek to enhance effective management of public health organizations and contribute to improving the performance and provision of quality of services". While organizations must have good incentive structures, the literature shows that the effectiveness of an incentive system is based on a core philosophy of procedural and distributional fairness and its appropriateness and linkage to efforts (Lind and Tyler, 1988; Greenberg, 1990).

According to Armstrong (2002: 4), incentive systems consist of salaries, allowances, fringe benefits, and pensions and non-financial recognition (praise, achievement, promotion, responsibility and personal growth). In practice, an incentive could be a reward for effort already carried out as in performance incentives, salaries and pensions; a punishment for not doing what is expected; a form of regulation; and a means of reinforcing behaviour. An incentive contributes to shaping and directing health worker actions, attitudes, behaviour and motivation, pushing them to do better. In addition, as a regulatory mechanism common within the principal-agent relationship, it seeks to reduce the ambiguity of roles and to direct activity towards the achievement of corporate goals, often representing the vested interests of the principal.

One of the reasons why the concept is intuitively appealing is that it encompasses a whole array of aspects of human behaviour and interactions, and cultural and institutional elements of a given context (Bernard, 1938; Simon, 1985). A frequently cited characterization is that it is a tool of institutional change, which sets out what is to be done and the associated rewards and punishment. Yet the divergence in the literature on incentive systems demonstrates the different views and predictions about human behaviour. The broadest approach to incentive systems as an element of policy reform is that they present a new workplace practice consisting of formalized work rules and standardization of procedures as a means of regulating

workers (North, 1990). The generalized idea of incentives as a driver of the institutionalization process is that they provide a formalized structure and relationship between the government and the service providers on the one hand, and between the provider and the service users on the other.

The theoretical foundation of incentives as highlighted by the literature suggests that it is underpinned by assumptions about organizations and human action and behaviour (Gibbons, 1998; Ratto *et al*, 2002; Saltman, 2002; Lewin, 2003; Besley and Ghatak, 2005; Miller, 2005). In particular, many of the past studies on the structure of organizational incentives appear to follow the formal analysis of principal-agent models (Jensen and Meckling, 1976; Eisenhardt, 1989a; Laffont and Martimort, 2002). The explicit prediction of this model is that public organizations consist of two parties who operate in the form of a contract. The first is the government as owners (principal) who provide resources and set out what should be done and how, including expectations about the actions required. With the government expected to serve the public interest but unable to do all those things directly, it thus employs health workers (agents) (the second element of the contract), who provide both the labour and skills.

Technically, there is a subsisting agency problem with this, arising from the fact that the actions and choices of the workers in doing what is expected are often unobservable by government (Holmstrom and Milgrom, 1991; Baker, 1992; Lambert *et al*, 1993). Therefore, the national government designs an incentive structure as a means of optimizing performance. Given that public workers are often construed as being lazy and rarely behaving as directed because of self-seeking motives (Delfgaauw and Dur, 2008), incentives therefore serve as human "constraints" that direct, motivate or enforce compliance to corporate goals.

The literature on incentive systems also sits within the theory of the firm or the 'happy-productive worker' thesis, which argues that incentives make workers happy and happy workers produce more (Ledford, 1998; Wright and Staw, 1999). Thus, organizational incentives act as bait to attract or motivate workers to behave in a rational manner relevant to the organization. Meanwhile, such systems can either be economically- or behaviourally-oriented (Murphy and Alexander, 2000).

The logic of incentive systems that good incentives equal better performance is not conclusive without empirical backing as there may be some variation that is not accounted for by intrinsic financial rewards or that goes beyond economic behaviour. Equally, although the behaviour of workers' groups in relation to incentives has been analysed in the labour relations literature (Nelson, 1991; Brito *et al*, 2000), the relationship between organizational incentive systems and public workers' behaviour and performance is still poorly understood in Nigeria (Ademolekun, 2002; Ajila and Abiola, 2004) because of the seemingly unexplored influence of the broader social system and organizational environment. Thus, existing incentive-related research, though important, is inadequate as it fails to provide an in-depth understanding of the particular situation of Nigeria's public sector.

More recently, there has been a vigorous debate regarding hospital incentives to health workers in developing country health systems, particularly in Africa (McCoy *et al*, 2008; Witter *et al*, 2007a; Mathauer and Imhoff, 2006; Drager *et al*, 2006). Yet, while policy initiatives on health worker incentives have been rife as part of the wider health reform agenda, very little is known about their underlying structures and practicalities, and especially how and to what extent (if at all) existing incentives may have impacted on hospital workers' performance. The literature suggests that while there may be various factors that could influence how workers perceive an incentive system, of greatest importance is the concept of fairness (equity) in terms of distribution and procedure. The literature of organizational theory, for example on the logic of organizational justice (McFarlin and Sweeney, 1992; Greenberg, 1996) claims that perceptions of fairness and trust could influence how workers perceive an incentive system.

Overall, work practices and pay remain central features of public service work, providing background characteristics about worker incentive systems. The critical role of work practices stems from the way these shape day-to-day experiences, while pay are supposed to have a direct impact on the welfare of the workers and their reciprocal attitude at work. The reviewed policy documents demonstrate that the government believes that reforming the incentive system will contribute to changing the way organizations and workers operate. As part of the initiative, it is claimed that changing pay and pensions, and introducing business models for performance measurement with appropriate targets will motivate workers to do better. It is also

construed by the policy reform that when workers know that information about how they do their work is collected or measured, they will again be motivated to perform better. In general, incentive systems are assumed to serve as a tool for unlocking the productive potential of health workers and enhancing the responsiveness, timeliness and fairness of service delivery (WHO, 2006). It is important to point out also that incentives operate as an expression of strong leadership and the management capability of government to make change happen.

Based on the review so far, it is understandable that the primary purpose of policy is to influence organizations through the introduction of purposeful incentives. It also suggests that how well workers are motivated will go some way to influencing their willingness to engage in organizational activities related to public health service delivery and thus their capacity to perform. At the same time, it is important to note that it is not enough to assume that incentives will always motivate workers as prescribed.

The theoretical foundation of incentives (e.g. pay) draws insights from a diverse range of theories. First, neoclassical labour market theory conceptualizes that under perfect competition pay is a function of supply and demand variables (Borjas, 1996; Booth, 1995). Second, efficiency wage theory (Akerlof and Yellen, 1990; Ehrenberg and Smith, 1994) indicates that an organization may pay above market value in recognition of a worker's level of effort, supposing that a higher incentive (e.g. higher pay) means higher performance or productivity. From the principal-agent literature (e.g. Laffont and Martimort, 2002), pay is a tool used to align interest and improve performance of agents. Other organizational studies (e.g. Gibbons, 1998; Saltman, 2002; Besley and Ghatak, 2005) point out that incentive is applied to influence human action and behaviour.

There seems to be a consensus that public sector incentive systems are complex (Dixit, 2002; Le Grand, 2003; Prendergast, 2007). Although it is widely theorized that a relationship exists between incentives, behaviour, and performance of workers (Ledford, 1998; Wright and Staw, 1999; Kuvaas, 2006), in practice the linkages are not always so straightforward because of multiplicity of interest and roles. More recently, there has been a vigorous debate regarding putting incentives right for public health workers across developing countries as a means of improving their

motivation and performance (McCoy *et al*, 2008; Mathauer and Imhoff, 2006; Drager *et al*, 2006).

2.7 Public Health Worker Motivation

Defined as the "individual worker's willingness to exert and maintain an effort towards the realization of hospital organizational goals" (Franco *et al*, 2002: 1255), motivation, is critical in influencing health workers' performance. They go on to declare that motivation is a "complex transactional process between the individual worker and his/her interactions with hospital organizational structures and the social system as part of the work environment" (ibid). Many other studies have identified public health workers' motivation as crucial to the realization of organizational goals (Hongoro and Normand, 2006; WHO, 2006; Perry and Hondeghen, 2008). In Nigeria currently, low motivation due to inadequate incentives (Raufu, 2002; Stllwell *et al*, 2004; and Oshiomhole, 2006) has been identified as the key challenge to public service performance. However, accompanying this have been other important factors that have impacted on motivation, including events in the wider context outside the workplace such as what others earn in other countries and sectors (Froehlich *et al*, 2001; Gore and Pratten, 2003), and a breakdown of trust between government and workers (Gilson, 2003 and Gilson *et al*, 2005; Mollering, 2006).

Another important determinant is how workers perceive organizational processes including the policy processes (Weiner, 1992). This includes how they make sense of the organization or of events within it (including policy changes) (Weick, 2001). As noted earlier, the issue of trust as well as existing power dynamics within the organisational structure could play a decisive role in shaping workers' perceptions. The literature also demonstrates that health worker motivation is equally related to agency – that is, how well available work practices and incentives influence their capacity to engage in an autonomous action or act (Le Grand, 2003: 2). Interestingly, while there remains a lack of empirical evidence to support these assumptions, particularly within the context of developing country healthcare systems, some significant new research has been conducted in recent years. For example, Lindelow and Serneels (2006) in their qualitative research on the performance of public health workers in Ethiopia revealed that workers responded to changes in the public

hospital organizations where they worked. The authors argued that this is contrary to the traditional assumption that public health workers are passive. Indeed, their study suggests that they are economic actors with their own options and preferences (ibid: 2235). Meanwhile, Agyepong *et al* (2004) in their study of Ghana's public health sector found that the workplace environment contributed considerably to worker motivation. In Mali, Dieleman *et al* (2006) conducted exploratory qualitative research into the match between public health workers' motivation and performance management. Their study concluded that the key motivating factors of public health workers include recognition, responsibility and training. Other studies have looked at public hospitals in Jordan and Georgia (Franco *et al*, 2004); Tanzania (Manongi *et al*, 2006); Benin and Kenya, (Mathauer and Imhoff, 2006); and South Africa (Gilson *et al*, 2005). These past studies draw on context-specific information to explore aspects of worker motivation and emphasize that the motivation of health workers cannot be generalized.

While there has been a lot of interest in how to measure health worker motivation within developing country health systems, an understanding of the key determinates of motivation remains elusive (Franco *et al*, 2002; Hongoro and Normand, 2006). Indeed, there are indications that across poorly-resourced health systems, and those undergoing varying levels of transition and modernization, incentives to health workers as a driver of motivation are seen as inadequate. The need to address this, particularly as it relates to workers in public hospital organizations upon which the majority of the population depend for basic health services, has been highlighted by a number of researchers (Dolea and Adama, 2005; Dieleman *et al*, 2006 and Mangongi *et al*, 2006).

Given this, a key empirical challenge to researching health worker motivation and performance remains how to measure such motivation, especially in a public hospital undergoing restructuring. Earlier work by Kanfer (1999) and Franco *et al* (2002) on this issue suggests that there are no hard and fast rules, except that it is context-specific and depends on the individual worker. They do recommend the need to appraise the 'will do' and 'can do' factors. The 'will do' factors relate to worker motivation and behaviour, which are further linked to how the worker makes sense of existing institutions, structures and processes within their hospital. The 'can do' factors, meanwhile, concern workers' personal capacities, their discretion

and experience of events and processes associated with change in their workplace. Franco *et al* (2002: 1260-61) also highlight the need to explore the wider social system and organizational culture. In general, this can be expected to provide informed knowledge about the workers' own characteristics and their interactions with the organizational structures and processes, and the wider environment.

2.8 Health Worker Behaviour

The literature demonstrates that by many standards, the behaviour of public health workers is often stereotyped as lazy (Klitgaard, 1997; Frank and Lewis, 2004; Delfgaauw and Dur, 2008). It also shows that good behaviour and work outlook among health workers are hugely important to correct poor organizational performance (Franco *et al*, 2002; WHO, 2006; Hongoro and Normand, 2006). The behaviour of health workers across developing countries is complex. For example, they have often been criticized as asking for informal payments from service users (Lewis, 2007; Ensor, 2004). Gupta *el al* (2002) for example conceptualize such behaviour as open corruption and theft while others (e.g. Ferrinho *et al*, 2004b; McPake *et al*, 1999b) see it as a coping strategy, especially under systems of poor incentives. McPake *et al* (1999a) highlight that public health workers often engage in other jobs while in the service of a public hospital, thus putting pressure on government resources.

Other studies within sub-Saharan Africa (e.g. Ghana-Asenso-Okere *et al*, 1999; Uganda-McPake *et al*, 1999; and Nigeria-Uzochukwu and Onwujekwe, 2005) identify public health workers' behaviour as perverse in how they attend to customers and more specifically in their handling of hospital resources such as drugs. In Nigeria, as in other developing countries, high levels of absenteeism have been reported (Jike, 2003; Okafor, 2005). Overall, the literature (e.g. Lewin, 2003; Van Lerberghe *et al*, 2002; WHO, 2006) demonstrates that perverse behaviour among public workers is linked to inadequate incentives and low motivation.

The literature further demonstrates that health worker behaviour is contingent on how workers perceive or attribute their work and incentive experiences (Champoux, 2000). In other words, an individual worker makes sense of organisational

happenings and draws inferences based on his/her experiences to act in a particular way (Weiner, 1992; Kelley, 1973). The literature also highlights that behaviour is influenced by the level of discretion at work (Lipsky, 1980), knowledge (Drucker, 1995) and how well organizational processes interfere with their individual lives (Jaffee, 2001). Overall, it is important to note that the concept of public health worker behaviour is central to understanding their motivation and performance. There is a consensus that worker behaviour is linked to available incentives and their level of motivation. However, how this operates in practice remains complex.

2.9 Exploring the Linkages: Incentive, Motivation and Performance

Based on the above, this section draws together the suggested association between incentive systems, motivation and organizational performance with respect to the context of the policy reform. The central assumption is that while past studies regularly report a possibly crucial role for incentive systems in addressing issues of worker motivation and organizational performance, the linkage is rather complicated and often lacks empirical justification (Franco *et al*, 2002; Dixit, 2002; Wright, 2007).

As noted, the literature suggests a positive link between incentive systems and health worker motivation and performance (Franco *et al*, 2002; Hongoro and Normand, 2006; WHO, 2006). Reinforcing this logic, evidence from developing countries indicates that poor performance of public organizations is linked to inadequate incentives and low morale or motivation (WHO, 2006; Hongoro and Normand, 2006; McCoy *et al*, 2008). Thus, when workers are adequately motivated they are more likely to collaborate and improve organizational efficiency and performance. Although the evidence of the linkages is seemingly quite vast, in practice, there are indications that the linkages (particularly in a public sector setting) may not be as straightforward as suggested, certainly compared with private organizations (Dixit, 2002; Le Grand, 2003; Prendergast, 2007).

Several factors converge to influence public service motivation including the multiplicity of roles, expectations, interest and agency of public workers (Le Grand, 2003; Perry and Hondeghem, 2008). Thus, the operational practice of incentive

systems and their linkages with public worker motivation and performance most likely depend on context. As outlined by Franco *et al* (2002), research is needed particularly across developing country public health systems to map out, identify and enhance the constellation of specific contextual factors that influence public health worker motivation and performance especially in a changing policy regime.

This study therefore attempts to map out the issue from the perspectives of the workers themselves. It argues that while there is optimism that changing the incentive system will positively influence workers and hospital organizations, there is a need to further explore through empirical research the mechanism at work behind the observed link between incentive systems and worker motivation and performance. To do this, it investigates the on-going policy reform, which has introduced various forms of incentives and changes in work practices. From the perspective of financial incentives, the pay changes represent a direct incentive designed to influence motivation and performance. Meanwhile, changes in work practice represent a form of non-financial incentive because of their likely influence on work itself, autonomy, recognition, relationships and status. As noted by the reform it is expected that the introduction of performance measurement as a means of generating information about work is likely to impact on the behaviour and actions of workers (Baker, 1992; Baker *et al*, 1994).

Overall, the policy reform will likely present opportunities, constraints and challenges, all of which could influence workers differently depending on how an individual perceives the changes in work practices and incentive system. In order to adequately capture the diversity of the linkages outlined above, this study therefore adopts a holistic approach. First, it draws from wage efficiency theory which posits that paying workers more will motivate them to do better (Shapiro and Stieglitz, 1984). Second, the analysis will consider how pay compares based on the equity and sociological comparison literature (Blau, 1964; Akerlof and Yellen, 1990), equity theory (Adams, 1965), and the concept of organizational justice (Lind and Tyler, 1988; Cropanzano and Randall, 1993). These all broadly support such an analysis of incentive systems, motivation and performance.

Meanwhile, the team performance literature pinpoints the need to consider satisfaction as a relevant performance factor; thus, satisfied workers perform better (Vroom, 1964). However, despite the positive correlation between job satisfaction and organizational performance, our understanding of what and how to satisfy public workers remains insufficient. Maslow's (1954) Needs Theory predicts that any initiative that enhances the capacity of the worker to meet their needs leads to job satisfaction. Other literature posits that job satisfaction remains an individual construct, dependent on having a positive work environment, good work relationships, feelings of autonomy and discretion in the work one does, a sense of trust and perceived involvement, and participation in organizational decision-making processes (Franco *et al*, 2002; Herzberg *et al*, 1959).

While overall, therefore, it is possible that adequate incentives and well-motivated health workers will improve organizational performance (Franco *et al*, 2002; WHO, 2006; Hongoro and Normand, 2006); it cannot be assumed that this will always be reflected in practice. This is not enough to suggest that there is no link at all between incentives, motivation and performance. Rather, what is argued here is that the link may not be linear, especially in a public sector setting (Dixit, 2002; Le Grand, 2003; Prendergast, 2007; Wright, 2007), as often presented. This study thus adopts a process-approach to shed light on the relationship between efforts, perception of equity, reward and satisfaction, which are critical to motivation and performance.

2.10 Procedural Justice

Equity theory as it relates to this study suggests that health workers are motivated by the perception of equity (Adams, 1965). This is because workers are predicted to be in a continual and never-ending state of social comparison with referent others. This social comparison logic is based on perceived inputs and outcomes (Adams, 1965). The inputs of an individual worker as a social exchange concept represent the perceived individual qualities and characteristics such as age, status, seniority, length of service, qualification, efforts and skill. The outputs relate to privileges, rewards, authority and duties. Whenever an individual perceives that inputs exceed output, a sense of inequity and de-motivation sets in.

Meanwhile, Blau's (1964) social exchange logic demonstrates that workers are always comparing themselves with others. In other word, workers are equity sensitive. Thus, the equity assumption is based on the prediction that health workers develop beliefs about what they do and in comparison with colleagues infer how fairly or unfairly they are treated or remunerated for the same or similar efforts. When for example remuneration is perceived as fair, motivation is sustained; but where there is a sense of unfairness, motivation could be disrupted. This understanding also implies that health workers could compare with referent others either within or between organizations.

The arguments of equity theory are developed by the theory of organizational justice (Lind and Tyler, 1988; Cropanzano and Randall, 1993), which incorporates notions of procedural, distributive and interactive justice. Procedural justice (Greenberg, 1990), the focus in this study, relates to individual workers showing concern with the procedures used in allocating resources or pay. The organizational justice concept and drive for fairness in the workplace remain key issues in the structure of an incentive system (Greenberg, 1987; Greenberg and Cropanzano, 2001), and inter-functional relationship researchers (e.g. Dewsnap and Jobber, 2002) not only reinforce this point, but also underline the importance of ideal pay decisions (Folger and Konovsky, 1989; Lind and Tyler, 1988). According to these researchers, if reward decisions are poorly managed, it could ignite an atmosphere that jeopardises the goal of integration, an outcome which leads to negative organisational performance.

While the concept of equity has led to beliefs that it plays an important role in mapping out how workers perceive their incentive system, how this influences health worker motivation and performance remains unclear. Moreover, while it is supposed that equity enhances motivation and commitment of efforts towards improving performance, the practice of the relationship remains complicated.

2.10 Summary

This chapter has reviewed the relevant literature in order to define the theoretical foundations for the framework of the study, presented in the next chapter. It has

highlighted that the operations of public organizations are complex and intricate (Kernick, 2004). Thus, developing an understanding of how the reform of policy and institutions influences organizations, work structures and processes in public health settings is challenging. The evidence above supports the use of a holistic and system or process approach to exploring the issues. This serves two purposes: 1) it captures the web of processes, practices and procedures operating in a socially-embedded context and system (Capra, 1982: 2) it provides a means of engaging with the workers in their day-to-day activities (Guba and Lincoln, 1994; Klein and Myers, 1999).

The contextual literature argues that a health organization, like any service organization, is flexible, adaptable, and constantly undergoing fundamental change in the way work is done to meet changing demands. Apart from being the target population of the reform policy, the health workers are also on the frontline and remain the primary policy implementers and main organizational actors involved in work processes and procedural activities. Most importantly, their motivation and behaviour are crucial to the realization of healthcare system reforms (Franco *et al*, 2002; WHO, 2006; Hongoro and Normand, 2006). The current policy reform in Nigeria, unlike past reforms, seems to appreciate this as the policy focuses on reforming work practices, pay and pensions. Consequently, in addition to motivation and behaviour, this chapter has reviewed the literature on the core issues of incentives, performance and wage equity-based procedural justice theory. This provides an essential basis to the holistic focus of this study, as the reviewed literature demonstrates that the objective, rationale and dimensions of the policy reform remain complex. Since the enactment and initiation of the policy reform follows a logical approach with increasing emphasis on changing institutions (i.e. rules or procedures of doing things) as a way of changing how organizations operate to provide better quality services, the approach followed here fits the target of bringing about positive change in a public organization – in this case, Nigeria's healthcare system.

In the next Chapter, the study methodological approach is explained.

3 Research Approach and Methodology

3.1 Introduction

Chapter 2 detailed the theoretical and conceptual foundations that underpin this study. This chapter details the research approach and methods appropriate for achieving this objective, specifically to answer the three research questions relating to health service delivery and pay reforms, and organisational change:

1. What changes did the health reform introduce with respect to work practices and pay systems?

2. How do frontline health providers perceive the change process as it relates to their day-to-day work practices?

3. How the different categories of workers in the hospital perceive the reforms have influenced their motivation to perform their jobs?

In order to answer these questions the thesis adopted a case study approach focusing on a single case study hospital, the Federal Medical Centre Umuahia (FMCU) in Abia State.

Immediately following this brief introduction, this chapter provide details of the research methodology beginning with the research approach, research themes, questions and information sources, data collection methods. Then the research process is detailed, including the selection of informants from within the case study hospital, and SERVICOM, as well as others involved in the policy process; finally, data analysis and interpretation are described. The chapter ends with comments on methodological challenges.

3.2 The Research Approach (Actor-Oriented and Case Study Approach)

This study uses an actor-oriented approach to the analysis of organisational change, specifically to capture the perceptions and behavioural responses of different actors directly involved in the change processes. An actor-oriented approach emphasises the central significance of the human agency, and the way internal and external factors and relationships among actors shape, and are shaped by, organisational change (Long and Van der Ploeg, 1989; Long, 2001). Long (2001) also emphasises that an actor-oriented approach locates individual actors, in this case hospital workers and managers, in their specific life world in which they manage or cope with their everyday affairs within the constraints brought about by policy interventions. The actor-oriented approach to analysis fits within the present study's epistemological stance which supposes that: "social reality resides with the workers and can be understood by interaction and dialogue" (Orlikowski and Baroudi, 1991: 14) and "social reality is based on how workers envision, define and interpret the policy and organisational change processes under which they work" (Newman, 1997: 69). Furthermore, the approach provides the researcher with an opportunity to gain an 'insider's view' of hospital dynamics, and how different categories of health workers do their work in real life or natural settings (Hodgson, 2001: 90).

The use of a single case for this particular study is appropriate given its actor-oriented approach to the understanding of organisational change, focusing on different actors all working within a specific hospital setting. The use of a single case is also relevant given that no previous studies such as this one have been undertaken in the health sector in Nigeria. There are, therefore, no data of this kind on work processes undergoing organisational change. As a single case study, this research does not seek to generalise, but rather to provide insight into an issue that can subsequently be investigated over a wider population. Finally, a single case study is also most suitable for addressing the research questions presented above, in that it allows the development of deeper insights into the unique phenomenon of interest (Stake, 2000; Hartley, 2004); it provides an insider's view of what is happening in an organization (Saunders *et al*, 2007; Atkinson and Hammersley, 1994), and it offers the opportunity to explore rich empirical descriptions of organizational processes, interactions, human action and behaviour in real

organisational setting (Yin, 2003; Eissenhardt and Graebner, 2007). Details of the case hospital used in this study are presented in Chapter 4 (Section 4.4).

3.3 Research themes, questions and participants

Table 3.1 below summarizes the research themes, research questions and related information sources/ methods, and informants.

Table 3.1 Research themes, questions and data sources

Research theme	Sub-themes and variables examined	Research questions	Data collection methods and informants
Policy analysis	**Implementation framework** **Who is to do what, how, in order to achieve what?**	**1. *What changes did the health reform introduce with respect to work practices and pay systems?* What drove the reforms?** **What was the content of reforms?** **What was the process of the policy implementation process?**	**Policy document reviews** **Semi-structured interviews with 12 key informants - policy-makers, top-level administrators and policy consultants** **Semi-structured and in-depth interviews with 16 operational managers & 6 executive managers** **In-depth interviews with 40 doctors and 45 nurses** **Economic analysis of pay awards** **Observation and field diary**
Changes in work practices	**Client-driven services; target culture and performance measurement; external audit agency**	**2. *How do frontline health providers perceive the change process as it relates to their day-to-day work practices?*** **What actual changes occurred in work practices at FMCU? What were the perceptions of policy changes by FMCU actors?**	
Pay reforms and pay processes	**Performance-related-pay; pay levels and pay gaps between worker categories; fringe benefits and allowances; payment processes**	**How do workers perceive the performance-related-pay?** **How do workers value different elements of the pay reforms?**	
Improved service delivery	**Worker motivation and job satisfaction** **Professional norms of good service**	**3. *How the different categories of workers in the hospital perceive the reforms have influenced their motivation to perform their jobs?***	

Table 3.2 below provides the justification for the selection of different categories of workers within the FMCU. It details what informants know, and where they sit in the organisation as a whole. The primary participants in this study are health workers, doctors and nurses, involved in healthcare service delivery in the case hospital. In the remainder of the thesis, they are largely referred to as frontline workers or simply workers. However, these participants were selected from different parts of the hospital hierarchy in order to capture different perspectives on the change process: hospital executives and operational managers as key organizational informants; and frontline doctors and nurses.

Table 3.2 Categorisation of organizational key informants involved in the study and justification

Hospital executives (HEM)	Hospital operational managers (HOM)	Workers' union representatives	Frontline service providers -doctors (HWD) and nurses (HWN)
1. Organisational gatekeepers **2. Very close to government** **3. Perceived as change**	**1. Knowledgeable about hospital operations** **2. Make and facilitate**	**1. Possess group reality and views** **2. Knowledgeable about government policy**	**1. Possess understanding of day-by-day work operations** **2. Knowledge about health practice** **3. Actions can influence policy and**

strategists **4. Very knowledgeable about government plans including policy, policy context, etc**	**operational decisions at ward level** **3. Know the workers very well** **4. Perceived as change managers** **5. Understand workers' behaviour and work life**	**3. Possess professional knowledge** **4. Actions can influence how doctors and nurses perceive their work** **5. Knowledgeable about workforce representation, negotiation processes and government policy**	**service delivery outcomes** **4. Change implementers** **5. Often presented as the problem as well as solution to quality improvement because of their direct involvement in service delivery** **6. Their behaviour, attitude, motivation, performance is very vital to care and provide 'real' picture and reality of public organization operations as they are in practice.**

Overall, there were 123 participants/ informants and these are detailed in Table 3.3. Table 3.3 is divided in two parts, with hospital staff located in the top half of the table and non-hospital and non-medical staff in the bottom part of the table. The hospital executive and operational managers were either male doctors or female nurses. The majority of the frontline doctors were also men, and the frontline nurses were mainly women. While I attempted to ensure that all departments were included, both doctors and nurses move across the three clinical departments and wards within the hospital. The General Outpatient Department is the entry point to the hospital, thus serving as the first point of call for patients. Details of the General Outpatient Department are given in Chapter 4 (see Figure 4.3).

Table 3.3 Distribution of research participants according to category and gender

Category of research participant	**% total participants**	**Number and gender**		**Total**
		Male	**Female**	
Hospital executives	**5**	**4**	**2**	**6**
Hospital managers	**13**	**12**	**4**	**16**
Frontline Doctors	**32**	**33**	**7**	**40**
Frontline Nurses	**37**	**6**	**39**	**45**
Policy Officers (Abuja based)	**3**	**2**	**2**	**4**
SERVICOM (5 FMCU based; 2 Abuja based)	**6**	**5**	**2**	**7**
Federal Ministry of Health (FMOH) officials (Abuja based)	**3**	**1**	**3**	**4**
Policy consultant (International)	**1**	**-**	**1**	**1**
Total	**100%**	**63 (51%)**	**60 (49%)**	**123**

3.4 Data Collection Methods

A qualitative research design was considered appropriate since it provides a means of exploring worker perceptions and experiences (Yin, 1994). It is also particularly suitable for exploring organisation change processes (Pettigrew, 1990; Healy and Perry, 2000; Patton, 2002), and for addressing 'how' and 'why' research questions.

Three key methods of data collection were used: policy documentary analysis, semi-structured interviews, and observation of events within FMCU. The policy level data sources consisted of key policy documents and interviews with policy actors. These documents included ministry circulars, memos and government White Papers including the wider NEEDS policy document, the Service Delivery White Paper, and pay documents from National Salaries and Income Commission based in Abuja. The documentary review took place in two stages. At the first preliminary stage, they provided the foundation that shaped the initial exploration of policy events, and at the second stage, they served to support the evidence collected from the interviews.

Details of the semi-structured and in-depth interviews and the observation process are given in the next section.

3.5 The Research Process

The research process at the FMCU began with formal meetings held with hospital officials (hospital executives and managers) to receive formal consent for the research, and with the administration to seek to access official staff lists. Following receipt of approval, hospital departments were visited and this stage was followed by a meeting with heads of departments to clarify the research objectives and respond to any questions and concerns they had. Subsequently, 200 questionnaires were distributed through these departmental heads. The questionnaires asked for demographic data (gender, age, position and length of service) and presented the study, also asking who was willing to participate in individual interviews. Eighty-two percent of these questionnaires (165) were returned. Seventy percent were completed fully and 120 respondents indicated a willingness to engage in further interviews. There is indication that others refused because of time constraints. In the end, 107 (53% of the 200) actually participated fully in the research. These consisted of forty-five frontline nurses and forty doctors, plus sixteen operational managers and six executives (see Table 3.3 above). Following these initial processes, interaction with frontline staff started with a group discussion of the key issues outlined in a preliminary questions list to be used for individual interviews. Each worker received the copy of the preliminary questions relating to a wide range of

issues about the hospital facility, changes in working conditions and pay brought about by the public sector reforms of service delivery, and pay systems.

While semi-structured interviews provided answers to specific issues and even served to discover emerging issues, they did not allow for more in-depth exploration of particular issues. Therefore, the in-depth interview method provided detailed accounts of issues discussed within and between different actors and worker categories. It also serves as a means of following up on other points that had emerged, and or clarifying and validating evidence. These in-depth interviews also allowed the interviewee more time to explain in their own words how they see their work and the changes forced on them. Repeat interviews allowed further checking of details, clarification of issues, and ensured that respondents understood what they were being asked. They were also useful in allowing the researcher to confirm his understanding of the responses to questions (see *Appendix 1B* for number of interviews according to type).

During the data collection process, the researcher made several visits to the hospital departments to make observations. These included visits to the staff room, wards and the General Outpatient Department. The observations served as a clue to salient issues that were raised in the interviews. Some of these issues emerged as rumour or gossip, and even seemed to sit (as it were) underneath the hospital, but all the issues signalled points to be covered in interviews. As part of the observation activities, the researcher also attended seminars and monthly meetings of workers within the hospital.

3.6 Data Analysis and Interpretation

As noted in Chapter 1 (Section 1.3), for its policy analysis this study draws from the conceptualisation of Walt and Gilson (1994), which is to assess policy context, policy content and the policy implementation process (see Chapters 4 and 5).

The whole process of analysis of the interview information used is summarized in Figure 3.1 below. Data analysis involved firstly, the systematic preparation of data. The approach to data preparation used in this study was in line with the investigation

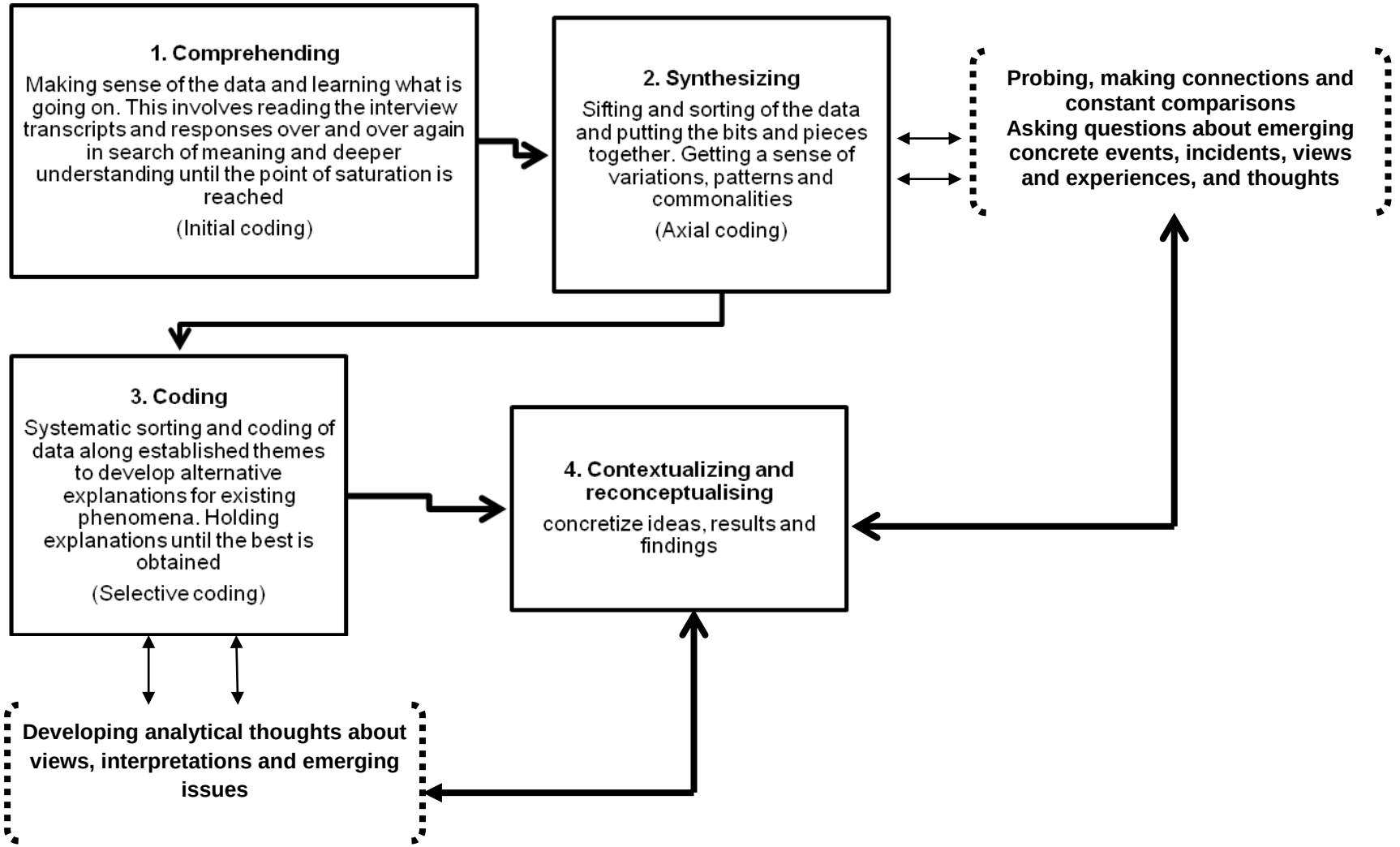
and involved coding to allow the simultaneous arrangement of the dataset, and pinpointing of the salient feature of the themes within the data. Using the same categories as in Table 3.4, in my preliminary coding (i.e. open coding), similar expressions and word frequencies were grouped together, themes were identified and later grouped into categories. Axial coding focused on making connections between themes and grouping them into categories (such as establishing patterns of behavioural responses to the target culture), Finally, having completed the first two steps, based on a review of the whole data set, established patterns or groupings were validated (selective coding). The coding exercise was aided by the use of NVivo software (Gibbs, 2002; Richards, 2005).

Table 3.4 Coding techniques used for analysis (Strauss and Corbin, 1998)

Type	Description of activities
Open	**Discovery of concepts from worker interviews in order to conceptualize issues as they emerge. Involves a line by line, paragraph by paragraph review of interview transcripts. Grouping of similar phenomena, events, happenings and objects under common headings. Categorization of data along similar issues. Very time consuming.**
Axial	**Relating categories into sub-categories and linking them up into different dimensions. Involves the reassembling of the data to represent specific issues or events, which are defined as relevant by the workers. Attempts to address specific questions about events as it relates to when, where, why, who, how and what. This provides more specific and greater explanatory power to the phenomena in question. The focus is on tracking actual words and expressions used by the worker, the meanings ascribed to them and how workers in their own words conceptualize their views and experiences. The focus is on the data and the conditions, actions and interactions and the consequences of the actions as explained or interpreted by the workers. Also about linking-up issues as they re-emerge from analysis.**
Selective	**Involves fine-tuning and refining of the themes towards concretizing evidence. The selective coding and analysis develop central categorizations and attempt to explain these using varied sources of evidence to build watertight evidence to guide conclusions.**

The analysis and interpretation was about searching for sets of meanings, metaphors (to give meaning as to why someone received an award for example), representations, narratives or statements that advance a particular point of view about a specific issue, theme or event. The results of the analysis are presented in the thesis using the respondents' own voices and employing verbatim translation.

Figure 3.1: The analysis and interpretation procedure (Adapted from Mason, 2002; Silverman, 2001; Geertz, 1973)



The analysis continued throughout the data collection process and began with reading and exploring the interview transcripts and notes to comprehend the data and the meaning respondents attributed to their experiences as expressed by their perceptions. It then sought to synthesize this by searching for recurrent or emerging themes before probing further (with follow-up exploratory interviews) to gain more insights into these emerging issues. As a more concrete understanding of the data developed, the coding and categorisation of these emerging themes were carried out.

The end of the analysis occurred when a point of saturation was reached. As Strauss and Corbin (1998: 212) argue, in qualitative analysis this occurs when: a) no new or relevant data seem to be emerging in respect to a given category or theme; b) the theme or category is well-developed in terms of its properties and dimensions demonstrating variation; and c) the relationship among the categories or themes is well-established and validated.

3.7 Ethical Considerations

Following approval by the Research Office of the University of East Anglia, the researcher sought and obtained approval from the FMCU executives (the organizational gatekeepers) to conduct the present research in the case study hospital.

The participation of respondents was voluntary, and based on informed consent. Prospective participants were also informed of their right to withdraw at any time should they wish. Furthermore, to protect the integrity and identity of participants, interviewees were assured of their anonymity- respondents were allocated individual codes - and that data would not be made available to third parties. All data were saved in secure computer files to which only the researcher had access.

Operationalising the research strategy and design involved close contact and interaction with the lives and views of respondents. In this connection, ethical considerations, particularly the need to build trust and the unequivocal commitment to respect the rights and values of the interviewees, were essential throughout. The ethical focus thus sought to ensure that "*research participants of the study are not made worse off (or harmed) by their participation in the research*" (Mason, 2002: 201). During the interview process, interviewees were reminded that the study was purely for academic purposes, with no links to any government. This was necessary

because, during the preliminary interviews, some workers questioned the identity and aim of the researcher, with some even suspecting he was an agent of the government. For the same reason, respondents were asked for their approval for the recording of their responses.

3.8 Methodological Challenges

During the exploratory conversations in FMCU, the researcher was somewhat surprised by the above-mentioned 'suspicion' expressed by some of the prospective respondents. One or two openly asked whether the research was for the government or an international organization, for example the UK's Department for International Development (DfID) or for the World Bank (WB). As was later discovered, this was because both organisations had previously visited the hospital with regard to the issue of the government's reform.

The workers also tended to treat me as a 'stranger' or 'outsider' in their 'own professional field'. Although I did not claim to be a health professional, one of them queried this saying, *"Tell me why you are here, are you a doctor or nurse? You economists claim a lot"*. Initially this unexpected question led to some discouragement on the part of the researcher and the workers were initially unwilling to talk to me because they were sceptical about whether the organisation had given me approval to do this research. It is important to note that I had spent most of my life living in the same city. This created specific opportunities in terms of knowing how to interact with the research subjects personally. Two doctors who know me personally (as we attended the same university) provided useful information and guide that shaped my initial approach to the organisation.

To get along with the workers a subtle approach was adopted, with myself assuming the role of 'student', willing to learn from the wisdom of the 'experts'. In addition, by expressing sympathy with their views, the workers were then willing to talk. I also used general questions to initiate discussions, such as:

> *How do you see your jobs and profession with respect to the reform government has introduced? Do you think that government considers your opinion in policymaking?*

The initial informal conversations (some one-to-one; others in twos, threes or fours) held at coffee time in the staffroom were very useful in teasing out interesting issues. I also used the time to make social contacts and to collect contact numbers. Overall, the issues that emerged during this exploratory exercise were very useful and contributed considerably in reshaping the focus of my research questions.

On the third day, I submitted a formal letter of intent, with a brief personal profile, my research objectives and focus, including the kind of data required. During this time, I continued with my informal conversations, developing my views about the emerging issues and reframing my questions. The following week, I received a letter calling me to interview with the hospital's three-man ethical committee. This was unexpected because I thought the ethical clearance from the University would have sufficed. I revised my ethical form and, satisfied with this, the ethical committee gave permission for the research, and authorised the staff to support my research by making the required information available. On receiving the approval letter, one of the organizational 'gatekeepers' introduced me to the heads of department, and the Chief Medical Director of the hospital. I was particularly pleased by the introductions given by the 'organizational gatekeeper':

> *This is our visitor from the United Kingdom. As usual, show him your hospitality. The management has approved that he does some research here, so give him your maximum cooperation and provide any information within your capacity to assist his research"* (Top level Manager HEM2)

This introduction was a privilege and opened doors for me. I conducted three rounds of interviews with the organizational gatekeeper. Thereafter, the hospital allocated me a temporary office located in the Research and Training Unit and an officer to attend to my immediate needs for specific information. I was given a visitor's named hospital badge. This badge served as a kind of licence and permit, or 'certificate of pass' giving me access to all departments in the hospital. This partially made me a privileged 'insider' and a member of the organization and community but, in terms of organizational personality, I found myself still deficient in knowing how the hospital and workers functioned.

After this, in most situations, and on entering a ward, it was common to hear one or two workers saying, "This is the person who has come to do research here". My identity was less 'suspicious' and many were very willing to talk. Overall, the initial

feeling of being an 'outsider' diminished and, in time, the workers showed me understanding and respect. Some were very willing, directing me to other colleagues who they said were "better placed to provide the information you are asking for".

However, I still felt that the way the research intent was publicized created a slight challenge for me. For example, I found it hard to deal with some of the occasional comments from the workers, such as *"We hear that you live abroad. What have you brought to us?"; "How is the United Kingdom?"; "I want to travel abroad. I hear that life is better there";* and *"You must be loaded (rich) to study abroad"*. These questions and comments constantly reminded me of the stereotypical personality often attributed to those living abroad. On the one hand, it presented a level of respect for me while, on the other, it was clearly inviting demands of me. For example, asking what I had brought has both ethical and cultural implications. Ethically, the respondents were indirectly asking for reciprocity for their participation. Culturally, it is expected that travellers or visitors offer some appreciation to those at home on arrival. At the end of the fieldwork, I did offer a packet of sweets to each of the ten wards in the hospital. Another challenge was the difficulty and delay in accessing the top-level workers/ managers because of their busy schedules.

The next chapter (Chapter 4) presents a detailed account of the reforms with respect to the context in which they appeared, and their content. The chapter also includes a description of the case study hospital organisation, where the reforms that are the focus of the study are being implemented.

4 Policy Analysis: Context and Content

4.1 Introduction

This thesis is about public sector service reforms that are at the centre of public debate in many countries. The aim of the thesis is to increase the understanding of these processes of policy reform in the public health sector in Nigeria. Beginning in this chapter on policy analysis, information is presented which aims to answer the first research question, that is: What changes did the health reform introduce with respect to work practices and pay systems?

As already noted in Chapter 3, the policy analysis approach being used in this thesis begins with an analysis of the context within which the policy emerged, followed by an analysis of the policy content. In terms of policy context, since public sector reform in Nigeria is part of what is referred to as New Public sector Management (NPM), any analysis of context in Nigeria must include some reference to initiatives undertaken somewhere else in the world. In terms of the policy content, this refers to the service delivery reforms introduced in Nigeria between 2000 and 2007, and to pay reforms introduced around the same time.

Immediately following this brief introduction, the reforms are outlined and an analysis of what drove the reforms is provided. This is followed by an analysis of the content of the reforms, and includes the setting-up of a service compliance agency referred to as SERVICOM. The links between the service delivery reforms and the pay reforms are also detailed. The chapter ends with a description of the case study hospital, the Federal Medical Centre Umuahia (FMCU) in Abia State.

4.2 Reforming Nigeria's Public Health Sector

While the thesis is focused on the public health sector reforms, pay reforms introduced at the same time form part of the whole reform strategy. The health sector reform constitutes part of the wider public sector reforms and reflects similar concerns in other public service sectors.

The government of Nigeria, under the Peoples' Democratic Party, and during the President Obasanjo-led government administration (1999-2007), initiated a health sector reform as part of the wider public sector reform. The vision of the health sector reform touches every aspect of the healthcare system, involving the adoption of changes in work practices and procedures by the introduction of a target culture as well as performance measurement and performance-related pay. Overall, the service delivery reform involves a shift in the culture of public service delivery, from one driven by the provision of excellent medical care and led largely by the clinical professions, to a demand-led system of service delivery within which the public become clients purchasing services to meet their needs and interests. As a demand-led process, the emphasis is on providing information to customers, and receiving feedback from customers on their satisfaction or otherwise with services received.

The pay reform consists of changes in actual levels of pay, reductions in the differences between pay levels of doctors and nurses, monetisation of fringe benefits in kind, and changes in individual pay awards given in recognition of good service and referred to as performance-related pay. The interest of this thesis relates largely to the performance related pay elements of the pay reform since this is directly linked with the service delivery reforms already discussed.

As with other public sector reforms, the health sector reform included the establishment of a performance audit agency known as SERVICOM. The role of SERVICOM is to facilitate the implementation of the health sector reform, firstly by promoting compliance with proposed changes from public health sector workers. Secondly, it works to ensure the engagement of clients purchasing public services in the process of organisational change.

This chapter sets the scene for the other chapters of the thesis. It details the context and content of the two reforms that are the focus of the research: health service delivery and civil service pay especially as it relates to performance-related pay.

4.2.1 Reform Context: What drove the reforms?

The health service reforms in Nigeria were driven by both external and internal factors. Beginning with the external drivers, it is widely argued in Nigeria that they were able to influence the reform process at the time they did because of internal changes in the politics and governance that were occurring at the same time. These internal changes were part of what is referred to in Nigeria as the democratisation process. Prior to these changes, Nigeria had spent years under military rule, a situation often reported as not amenable to reform ideas (Utomi *et al*, 2007; Soludo, 2006; Okonjo-Iwuala, 2005). Even though the need for reform had been presented in that period, there is suggestion that the military administration seem to have lacked the political will to support and encforce significant changes. The 1999 election which brought in the Obasanjo-led Peoples Democratic Party provided some considerable impetus for reform of public sector services. Thus, the sudden change in political context made reform more feasible, especially in terms of changing how government does its business, cooperating with others in response to pressures on the state from various quarters to improve services. The mainstream government opinion expressed by the President did recognise, however, that the reform would involve learning from other contexts.

> *The enormity of what is required to realise a 'New Nigeria' in which citizens will have access to quality services indicate that they cannot do it alone but require help from experts and reform in line with global events. We are going to learn from other countries [referring to UK], and collaborate in order to improve our public service delivery system which has become a symbol of inefficiency and corruption* (Obasanjo, 2003).

As noted by one of the key supporters of the reform, Okonjo-Iwuala, the impetus for the reform came in part from interaction with global policy happenings such the poverty reduction strategy programmes. According to Okonjo-Iwuala (2005), Nigeria needed to be integrated into the global happenings, particularly within the

conceptualisation of good governance with its emphasis on improving public sector management.

The repeated views emerging from policy texts (e.g. BPSR, 2004) demonstrate that the democratic processes seems to have served as a window of opportunity for external development interaction, and as a means of negotiating policy transfer and learning. In general, there is suggestion that the public sector reform is part and parcel of wider modernization processes presented to developing countries by international development experts as a 'one cap fits all' ideology of change (World Bank, 1996) that includes changing the role of the state (World Bank, 1997). The big picture also indicates that the reform is imbued with the ideology of new public sector management (NPM) (Dunleavy and Hood, 1994; Pollitt and Bouckaehrt, 2004).

The formulation of the reforms in Nigeria, therefore, received great external support that included technical advice and funding from the UK through the Department for International Development (DfID) and the World Bank. As part of its development assistance programme in the area of public health service delivery, DfID has played a leading role in shaping and addressing issues of health staffing and management and service quality (DfID, 2009: 20). For example, between 2002 and 2008, it provided £148 million under its Change Agent Programme (CAP) and Partnership support for transforming the Nigerian Health System (PATHS2) service delivery. Additionally, between 2004 and 2009, it provided another £30 million for health commodities and equipment procurement projects, including the provision of drugs. Between 2009 and 2010, it also earmarked another £120 million to be spent on health issues (ibid). More generally, DfID's development partnership with the Nigerian government has prioritized health service support and the transformation and strengthening of the healthcare system, focusing especially on accountability to both government and the people, and therefore on changing the responsiveness of service providers (DfID, 2004; 2009).

Continuing with the support from and influence of DfID, in January 2004, a key milestone was reached in reforming work practices with respect to service delivery with the formation of a Public Service Delivery Team headed by Dr Wendy Thompson (adviser to the British Prime Minister on Public Service Reform), and

supported by consultants from the UK and South Africa. Given that the reform process received adequate funding from the British government, the UK NHS may have been seen as a model. Thus, it was evident that the UK government played a leading role in advising Nigeria on service delivery reform. Perhaps, in line with this understanding, a team of consultants was contracted to conduct a "diagnostic audit" of public service delivery in Nigeria (drawing on the British experience of public service reform). The team was headed by the then Special Adviser on UK public service reform (under the leadership of Tony Blair) in the Cabinet office, with three specific terms of reference:

i. To examine the existing institutional environment for public service delivery

ii. To reflect on people's (customers') lives and experiences of public service delivery

iii. To draw-up a road map for a Service Delivery Initiative (SDI)

The extract from the policy document demonstrates that the consultants conducted in-depth analysis of official documents and other literature on service delivery, interviewed ministers and government officials at strategic and operational levels, conducted independent market research with service users (customers), and public service delivery staff using focus groups discussions and interviews, and undertook specific case studies on service delivery outlets.

There are reports among official policy-makers that people (specifically public service stakeholders including workers) were consulted in designing the reform. How and to what extent their views were actually incorporated into the report remains unclear and is considered in Chapter 6. Meanwhile, within the wider public service reform, some concerns have been expressed about the technical feasibility of reform based on learning from abroad (James and Lodge, 2003; Dolowitz and Marsh, 2000), given that the British setting is quite different from that of Nigeria. Thus, while the Nigerian government has pushed hard in its efforts to make a difference in public service delivery, it could be argued that it is trying to learn within a rather limited framework and context.

Nevertheless, In February 2004, following the diagnostic research, the consultants produced what has been an influential report. This report was adopted as a

government White Paper entitled *"Public Service Delivery in Nigeria: A Roadmap"*. The general conclusions were as follows:

> *"That public service in Nigeria is not serving the people well, mainly, they are inaccessible, poor quality and service providers are indifferent to customers' needs. Despite their policy ambitions, ministers lack the levers to ensure delivery happens 'on the ground'; there is no established procedure for telling who is doing what and how. Central public service delivery departments have little information with which to monitor staff performance. Support services are not designed to support frontline services, and are a major impediment to improving staff performance. Staff are poorly motivated and there is lack of adequate incentives to attract the motivation needed to improve services.*" (White Paper on Service Delivery, 2004)

The World Bank also played an active role in the formulation (design), promotion, and implementation of the wider public sector reforms, especially in the areas of governance, and pay (World Bank, 2004b; 2005b). In terms of governance, its focus has been to improve government accountability, through the introduction of due process, and documentation. The implementation of the wider public sector reform called NEEDS, reflects the World Bank's development strategy (World Bank/IMF 2000; 2004). The importance of this strategy in the case of Nigeria might, in part, be explained by the presence at the top levels of government of two World Bank-trained Nigerians Dr.Okonjo-Iwuala and Professor Charles Soludo, who participated in the planning of the reform. As already noted, the discussions about pay reforms emerged out of a series of internal (national) review committees and subcommittees which began in 2000 and are discussed below as part of the analysis of internal reform drivers. Certainly the World Bank along with other donors were in agreement that health reforms could only work if the workforce was motivated, and this motivation was seen to be almost exclusively (if not entirely) linked with pay.

In terms of internal factors that have driven the health sector reforms, it is widely claimed that the context of the current reform in Nigeria is embedded within Nigeria's existing social, economic and political circumstances. The internal drivers for reform include conditions in public administration and management, changes in politics and governance mainly through a democratisation process, citizen pressure from below and poverty, including the health status of the population

The perceived administrative failure of public sector organisation and management was already evident in the early 1980s and was linked to the structural adjustment

reforms that were initiated between 1986 and 1988 under the recommendation of the World Bank. Although the 1990s saw the implementation of public administration and management reforms in the health sector, poor public infrastructure furthered a decline in the quality of services delivered and led to the call for the current public sector reform in general (Utomi *et al*. 2007; World Bank, 2006b), and health sector reform in particular (FMOH, 2004a).

In terms of internal factors driving the health reform, there are a number of internal conditions that set the scene. Nigeria's public health service has been described as operationally inefficient with a poorly motivated workforce due to inadequate incentives, while workers' behaviour has been characterized as perverse and unresponsive (WHO, 2000; Hargreaves, 2002; DfID, 2009). At the same time, despite being one of the world's ten major oil exporters, more than half the population remains poor and suffers from ill health (NBS, 2006; 2007; WHO, 2007; DfID, 2009). Nigeria has experienced disappointing health outcomes over the last four decades, with minimal improvements in general health, wellbeing and living standards (NBS, 2006). National and international reports demonstrate that Nigeria's health outcomes are below international standards and among the worst in the world (WHO, 2007; DfID, 2009; UNDP, 2009). The public health service suffers from underfunding and inefficient governance and management (World Bank, 2005d), and "critical health workforce shortage" (WHO, 2006: 25). While the available data remain contentious, it is estimated that 660,000 Nigerian children die every year of preventable conditions. Furthermore, Nigeria has some of the worst social development indicators, with one in five children dying under the age of five while approximately, 6% of the population are HIV positive (DfID, 2009). The country also suffers from 10% of the total recorded maternal deaths globally, even though it has only 2% of the world's population. Meanwhile, as of 2007, life expectancy was forty-seven, unchanged since 2000 (UNDP, 2009). In the context of inadequate health services, it is predicted that Nigeria will be confronted by immense challenges in accelerating growth, reducing poverty and meeting the Millennium Development Goals (MDGs).

Analysis of the Human Development Index (HDI) which measures social wellbeing indicates that Nigeria's score remains lower than other countries with a lower GDP. For example, despite a GDP per capita of US$1900, Nigeria's HDI is less than 0.52,

while Kenya's, with a GDP per capital of less than US$1600, is 0.54 (World Bank, 2008; UNDP, 2009). Moreover, Nigeria's HDI rating has hardly improved since the index was first introduced in 1990. Thus, from 1990-2007, Nigeria's HDI has shown only a small improvement, increasing by a mere 0.91 annually from 0.438 in 1990 to 0.511 in 2007. This compares poorly with other countries in the sub-Saharan region, where less resource-rich countries have increased progressively over the same period (UNDP, 2009).

Another important internal driver of the reform is the apparent demand by citizens for better services. The notion of democracy (good government), as already noted tended to support the need to satisfy citizens' expectations of public services as a mark of good governance. During the democratisation process, which started in May 1999, there emerged a relatively high level of sustained citizen pressure and pro-governance institutions that increased pressure for change. Stakeholder seminars and workshops organised by different citizen support groups such as the Committee for the Defence of Human Rights (CDHR), the Civil Liberty Organization (CLO), and the National Democratic Coalition (NADECO) held immediately prior to the 1999 elections increased pressure from below on government to implement proactive and responsive change that would improve service delivery and the wellbeing of the public. Better services may have been seen as a political tool in strengthening public support for the ruling People's Democratic Party.

Parallel to the above was another important push coming from labour and professional organisations including the Nigeria Labour Congress (NLC), Nigerian Medical Association (NMA) and the Nigerian Nurses and Midwives Association (NNMA). These professional organisations, in the context of rising economic frustration, increased the pressure for more efficient and effective service delivery and saw improvements in salaries and general conditions of service as a viable option for achieving these goals. Professional unions, including NMA and NNMA, instigated a series of strikes and demonstrations throughout the country.

In response to all this pressure, and in order to maintain its position as the party in power, the new government committed itself to reforming the public service. At the same time, there emerged a strong perception among the political class that reforms

which target improving services delivery are critical element to sustaining the nascent democracy (Utomi *et al*, 2007; Okafor, 2005).

Against this backdrop, the government repeatedly demonstrated through public speeches and addresses its desire to initiate and implement reforms. Public debate was encouraged through a series of seminars with prominent Nigerians - a number of whom were employees of the World Bank at the time - speaking in support of reforms that were expected to change work ethics and organisational culture. For example, Soludo and Okonjo-Iwuala -both World Bank staff at the time – were recommended by the Bank to take top positions: Soludo as head of Central Bank and Okonjo-Iwuala as Special Advisor on reforms and economic matters, later Minister of Finance in the Obasanjo's second term administration. In general, the reform was in keeping with good governance prescriptions and considered as a means of strengthening transparency and accountability in government activities to improve user satisfaction.

At the same time, and in line with the views of Okonjo-Iwuala (2005), the political class in Nigeria understood the need for Nigeria to be integrated into the global conceptualisations of good governance with its emphasis on improving public management. Therefore, in line with the global concept, the health sector reform centres around "restructuring the way government and hospital organizations operate by making them stronger, better and more efficient in delivering essential services to the people" (NEEDS, 2004: xi). It also seeks t:

> (…) *create a public service that would be competent, professional, public-spirited and customer-oriented, capable of responding speedily to the needs of customers and exhibiting the core public service values of fairness, transparency and integrity, and one that is well remunerated, competitive and innovative* (BPSR, 2006; NEEDS, 2004).

The reform differs from previous development plans in three important ways: first, it is perceived as a people's plan (often described as home-grown); second, it provides a means of coordinating the actions and work practices of government; and finally, it is perceived as feasible in that it has a means of recognising and rewarding performance. So, while internal drivers can readily be identified, in general it is evident that the public health sector reform is part and parcel of wider modernisation processes which tend to popularise neoliberal ideology across developing countries

(World Bank, 1996), and include changing the role of the state (World Bank, 1997). As noted earlier, the big picture indicates that the reform is imbued with the ideology of the new public sector management (Dunleavy and Hood, 1994; Pollitt and Bouckaert, 2004). The reforms became part of the 1999 political manifesto of the Obasanjo-led People's Democratic Government. While this was justified as having societal benefits, as already described here, it was also clearly perceived as part of the agenda for good governance or government that meets the service needs of the citizens.

Another issue was what happened to the call for the option on pay reform supported by the workers and the workers' unions. The discussions about pay reform arose from a series of pay review committees and subcommittees which began in 2000. Although the details of the deliberations of the pay review committees remain unclear, there is suggection that the realisation of the reform objectives required a motivated workforce. The reasoning behind the pay reform stems from the view that the realisation of the service delivery reform was dependent on putting the incentives right (NEEDS, 2004). Therefore, from a practical standpoint, the pay review committees established by the government between 2000 and 2003 were commissioned to review the existing public sector pay structure as a means of encouraging individual worker motivation and compliance to the changes needed.

The Obasanjo-led administration announced a substantial increase in salaries of public servants in 2000 and in the same year, the minimum wage increased significantly. This was followed by other changes. In 2003, fringe benefits of government workers were monetised. Salaries were further increased in 2004 but, at the same time, a new contributory and privately managed pension system was introduced. By 2007, all civil service pay, including the monetised benefits was consolidated and taxed. What actually happened is that in 2004 the Nigerian Government initiated a comprehensive public sector reform called the Nigerian Economic Empowerment and Development Strategy (NEEDS). Clearly, there is mention within policy documents of a link between public service reform and pay reforms. According to the policy statement:

The focus of the public sector reform is about changing the way the government does its work. It seeks to restructure the government to make it stronger, better skilled,

and more efficient at delivering essential services. The reform seeks to transform the government from a haven of inefficiency to an institution that spurs development and serves the people well. As an instrument of change, the reform NEEDS provide overall direction of change, and supposes that achieving more efficiency require reform in pay to provide adequate remuneration and motivation of workers to enable them change their work practices (NEEDS, 2004: xi)

Within this reform, one focus was on improving public service delivery, and one of the first sectors to be addressed was the health sector. The key elements of the health sector reform consisted of changes in work practice, and the introduction of strategic incentives, i.e. performance-related pay, as a way of encouraging workers to change their work practices in order to deliver improved services.

4.3 The Content of the Health Sector Reform

This section presents the main thrust of the reform, consisting of reforming work practice (Section 4.3.1) and reforming pay (Section 4.3.2).

4.3.1 Service Delivery Reform

The content of the health reform is summarised in the White Paper on Service Roadmap published in 2004. The document includes the Customer or Social Charter, performance targets, and performance measurement for workers based on national standard with rewards for good performance. The document also detailed the establishment of a reform implementation agency (SERVICOM).

i. Customer or Social Charter

The Customer Charter is a pledge entered into by government and its workers to provide efficient and effective quality service that is fair, timely, responsive and responsible to patients. As outlined in the Charter, every customer is entitled to expect and receive open, accessible, and quality information; have access to better services; and be involved in decision-making processes that shape healthcare delivery. In addition, customers are entitled to receive proper explanations for poor services through an appropriate redress system. The overview of the Charter highlights four principles. First, it is consistent with government policy intentions incorporating a market-led approach to care. This implies a shift in the conceptualisation of service users from ‘patients’ to ‘customers or clinets’. Second,

there is a commitment to greater customer voice in decision-making processes. Third, there is a commitment to promote sound principles and procedures in the conduct of government business: increased accountability, transparency, and professionalism in the way customers are received and their healthcare needs meet.

Finally, the Charter commits to providing customers information that will increase their awareness of the services available, at which service unit, and so on.

ii. Performance targets and measurements

The most notable element of the service delivery reform with respect to public hospital organisations is the introduction of a culture of performance targets. The specific performance targets as outlined in the policy document related to healthcare consist of the following elements that, together, might be referred to as quality and quantity of service:

- Timeliness (waiting time and promptness of attention)
- Information to customers (leaflets and self-directed signs)
- Worker behaviour and attitude (e.g. absenteeism)
- Fairness (i.e. in terms of access to care)
- Responsiveness (i.e. reception, customer friendliness and courtesy)
- Patient/customer experience (i.e. level of satisfaction of customers)
- Accountability and due process (e.g. complaint and payment procedure) (SERVICOM, 2004; 2006)

These targets are supposed to serve as the standards for measuring hospital performance as well as for measuring individual worker performance. The performance measurement process is expected to provide information about the activities of service providers in order to guide the government regarding what works and how, and what does not work and why.

iii. Performance implementation and measurement agency

The task of SERVICOM is to ensure organisational change that result in a shift in the culture of public service delivery from one driven by the provision of excellent medical care, led largely by those in the clinical professions, to a demand-led system with the public as customers or clients who want services to meet their needs and interests. In order to do this, SERVICOM on the one hand facilitates the provision of information that guides customer choice, identification and access to available services and, on the other, works with hospital managers to assess worker performance based on national standards (see Appendix 3). In this way, SERVICOM acts as a kind of middleman mediating the interaction between the hospital organisation, the workers, and the customers. More details on SERVICOM operations are provided in Chapter 5.

4.3.2 Reforming Pay Systems

Given the understanding that health worker motivation was clearly a problem for public health delivery, the second aspect of the reform, i.e. pay reform, was specifically targeted to generate incentives in order to motivate workers to achieve changes in work practice. The reform of pay systems includes performance-related-pay; monetization of fringe benefits, and changes in pension systems. The interest of this thesis in pay reforms relates largely to the performance-related-pay (PRP) element of the health reforms that is, the link between pay and promotion based on good performance. The Nigerian Government implemented PRP to motivate workers to change their work practice. However, it is possible to conclude from policy documents on pay that the government initiated the pay reform to address the reported inadequacy (low pay) of public workers' pay. For example, the President noted that:

> *The gap between public sector and private sector wages has often been given as one of the reasons for inefficiency in the public sector. It is argued that public sector workers deserve adequate compensation commensurate with their labour, in order to bring about efficiency. This government will engage in meaningful reform to address this and to improve the living conditions of public workers and their immediate families* (President Obasanjo, 2004)

Nevertheless, with respect to the health reform discussed above, it is acknowledged that the PRP element of pay reforms was an attempt to link rewards to the realisation of targets. The philosophy is underpinned by the supposition that getting the incentives right is a way of motivating workers to change their work patterns in order to realise government national targets i.e. PRP will foster good performance. As claimed in the policy document, linking pay to performance assessed by reference to standard criteria ensures consistency in performance assessment, thus guaranteeing remuneration that is fair and deserving across different levels and tasks performed. This goes much further than simply talking about PRP. It reflects the thinking behind arguments for 'fair wages'.

Although PRP is especially relevant to this thesis, the value of paying attention to the other elements of the pay reforms is indicated in a number of documents (Pay Reform Act, 2000; 2004). In order to attract, retain, and motivate skilled professionals in the Nigerian public service, a pay rise was considered essential. Nevertheless, while it might be agreed that pay is essential to motivate workers to improved service delivery, the issue of poor pay administration has historically meant that public servants might receive pay in arrears, or regularly receive their pay late. Under these circumstances, it is reasonable to suggest that the whole pay package and the payment process (routinely paid to a prescribed schedule) should be the focus of attention if workers are to be motivated to change their work practice.

Consequently, public workers' minimum wage increased to N5500 in 2000 (The Minimum Wage Act, 2000). Following further agitation by the workers, the general view was that given the prevailing cost of living, the approved minimum wage was inadequate. Thus in 2001, it was increased to N7500 and, in 2009, to N11500 (The Minimum Wage Act, 2009). Details of the pay trends in basic salaries (a function of changes in minimum wage), are presented in Chapter 8. Also, changes were made in pay administration: all salaries were paid through designated banks, and the payroll office in each health facility was to prepare their pay schedules before the middle of the month and submitted to the central administration in Abuja.

The importance to government of the monetisation of fringe benefits and allowances in the reform is that it was expected to facilitate sound budgeting and revenue generation through pay as you earn tax once the pay package was consolidated.

However, it is possible that this monetisation is also important for thinking about motivation to work, and this is considered in Chapter 8.

Finally, another element of the pay reform was in terms of changes in the pension system, since prior to the changes, pensions in Nigeria were based on final salary, they were non-contributory and managed publicly. As part of the effort of government to ensure that workers have peace of mind about their future and do their jobs with maximum commitment, the government introduced a contributory privately-managed pension system. Public workers were to contribute 7.5% of their basic salary supplemented by a government contribution of another 7.5% into a public worker individual pension account. Again, however, it is argued that motivation to perform, change practices and so on may not only be about pay, but also about what is considered to be fair pay, or how payments are made. This thesis did not look at the pension reform because despite its importance, preliminary results suggest that it has no direct link with the service delivery reform.

4.3.3 Link between the two reforms

In general, the reform is about changing health workers' behaviour. Although there are several ways of doing this, the health sector reform considers just two approaches: the first about changing work practices, and the second about reforming the pay system to generate incentives for individual health workers to encourage such changes. The general perspective of the underlying principles of the health sector reform is that, for reform to be effective, it must operate in such a way to facilitate proactive work practice and at the same time attract the willingness and effort of the health workers. In an interview held with a senior government official from the Federal Ministry of Health, there is indication that the reform is about changing the way people do government jobs.

> *To actualise the intentions of the government, this reform is comprehensive in approach. It is not only about changing how people do government work; it is also about providing guidance based on societal interest and in line with political agenda. Government is interested in measuring performance and rewarding their efforts to enhance people doing well* (Government Official1)

Other officials from the office of the Bureau of Public Sector Reform noted how the reform components represent attempts to address the two performance challenges

related to inefficient work practice and inadequate incentive or pay. The views of the key government informants correlate texts drawn from policy documents that:

> *While government has set out new rules to guide how work should be done, the realisation of the intentions cannot be achieved if the workers are not motivated. This reform is all-encompassing and will address the two challenges of confusing work practice and inadequate motivation to follow rules* (NEEDS, 2004)

> *Without improving the pay of public workers, government's ability to attract, retain and motivate civil servants to achieve the set targets is unlikely to be possible* (The Pay Reform Act, 2004)

Commenting on how the current reform represents a fundamental shift in the organisation and management of the health sector, a key informant who compare the current health reform with the 1980s and 1990s reforms clearly stated that unlike past reforms, this current reform adopts a comprehensive approach. Another key informant from the national planning office in Abuja strongly highlights the relationship between the two reform elements, which have as their core changing workers' behaviour.

> *I think that this government has come to recognise that it is not just enough to set targets or measure targets, civil servants need to be motivated to achieve the targets. We know ourselves, if there is no "meat" on the table a lot of civil servants will not do as directed. People who do well need to be encouraged to do better* (Government official 2)

Another point of clarification about the linkages in the reform relate to the operational nature of the reform elements which operate more like a 'carrot and stick' mechanism. As outlined by a top-level manager at the case hospital, this is expected to steer individual competitiveness and the innovative capacity of public workers to achieving government policy plans:

> *When people are recognised and rewarded for doing well, there is possibility that others will follow. So, rewarding performance is expected to encourage a healthy competition towards achieving government policy goals* (Top-level Manager HEM2)

Many of the government officials who were interviewed shared the view expressed by HEM2. In general, they argue that the pattern of evolution of individual reward and recognition was symptomatic of the wider trend in public service culture, which before the reform, was seen as ineffective and not encouraging individual talents. During the interviews, lack of recognition of individual efforts was presented as a

constraint to individual commitment. It was also reported during interviews with top-level government officials that public workers in Nigeria will rarely "go extra the mile" in their commitment to following directives unless there is evidence that their efforts will be fairly rewarded. While this seems to represent an overstatement, the emphasis is that rewarding individual efforts has a link to following rules or new work practices.

Overall, there is consensus among all the government officials which demonstrates that the making of the reforms followed a seemingly formal policy-making process. Nevertheless, it is supposed that the realisation of the reform objective in work practice is dependent on the incentives to workers being adequate, and how well workers themselves are willing to commit their efforts to changing their behaviour. While the reform linkages appear to operate as a strategic human resource management practice, how they operate in practice, especially in public organisations, needs to be understood.

The next section describes the case study hospital that is the focus of the remainder of the thesis, the Federal Medical Centre Umuahia (FMCU). Chapter 5 continues with the policy analysis started in this chapter by looking at the actual implementation process within one specific hospital context.

4.4 The Federal Medical Centre of Umuahia (FMCU)

There are three levels of government-funded health care in Nigeria, namely tertiary or apex, secondary and primary health care. At the apex are the Federal Medical Centres (FMC) and teaching hospitals that are located in the state capitals. This level of hospital is operated by the Federal Government, and all the twenty-two Federal Medical Centres are comparable in terms of work force and infrastructure. In their provision of tertiary and comprehensive care, FMCs operate within the framework of the law: they are expected to provide good quality, affordable, specialized/tertiary level hospital care to the population, and to ultimately reduce the burden of diseases within their communities through provision of preventive, curative and rehabilitative services. Apart from providing the highest level of care, tertiary hospitals serve as the point of initial policy introduction. Federal tertiary hospitals are funded through

the federal budgetary allocation and administered through the Federal Ministry of Health (FMOH). As such, they provide the highest level of care in the State, compared to lower-level secondary and primary health care facilities. These lower-level facilities are the general hospitals, managed by the state management board and, at the local level, the primary health care services, mainly providing inexpensive and basic care services, as well as making referrals to either the general or tertiary hospital organisations. They are currently reported to offer inadequate medical support, and the majority of the population therefore rely on the Federal Medical Centres (FMOH, 2004).

This study focuses on a Federal Medical Centre located in Umuahia (FMCU), the capital of the state of Abia in south-eastern Nigeria. There are similar Federal Medical Centres (FMCs) in each of the surrounding states of Anambra, Enugu and Ebonyi.

The vision that informed the establishment of FMCU is in line with the constitutional requirement of the equitable (in terms of the states) presence of the Federal Government in providing tertiary healthcare. The FMCU serves a population of over four million, has a 280-bed capacity and over 3000 employees. It started as a mission hospital in 1975 under the name Queen Elizabeth Hospital. On May 4th 1976, it became a regional hospital in the newly created East Central State and acquired its position as a Federal institution on 5th May 1992.

Despite the similarities between the organisation of all the FMCs in Nigeria, each operate with their own location-specific challenges due to geography, political exigencies, poverty levels, and possibly the level of health of the population to be served. In terms of the policy reforms considered necessary for these tertiary-level organisations, the FMCU shares the same performance problems as other FMCs. The FMCU provides departmentalized/specialized services in areas covering but not limited to, Internal Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Laboratory Medicine, Radiology, Dentistry, E.N.T, Ophthalmology and so on. This specialized array of services covers five departments: administrative and information, therapeutic, clinical and diagnostic, support services and General Out-Patients Unit. Policy document indicates that the main areas of focus in performance management is the General Out-Patient department and the administration and information

department (SERVICOM Book, 2006), and this is highlighted in Figure 4.1 below. The services at these two departments are linked to the other departments.

In general, the services at FMCU are expected to be of high quality to meet the expectations of all customers, irrespective of where they come from. The services are also expected to be prompt and timely, efficient and affordable, and delivered in an environment conducive for tertiary health services, by a responsible and responsive, productive, courteous and highly professional personnel. The FMCU, in line with the provision of the current health sector reforms, is expected to:

i. Provide clear and concise general information about the hospital to its patients/visitors/relatives, including monitoring and publishing arrangements.

ii. Promote Rights and Duties of users and providers of health care services.

iii. Provide machinery and procedures for redressing patients' grievances and complaints.

iv. Improve access to quality health care.

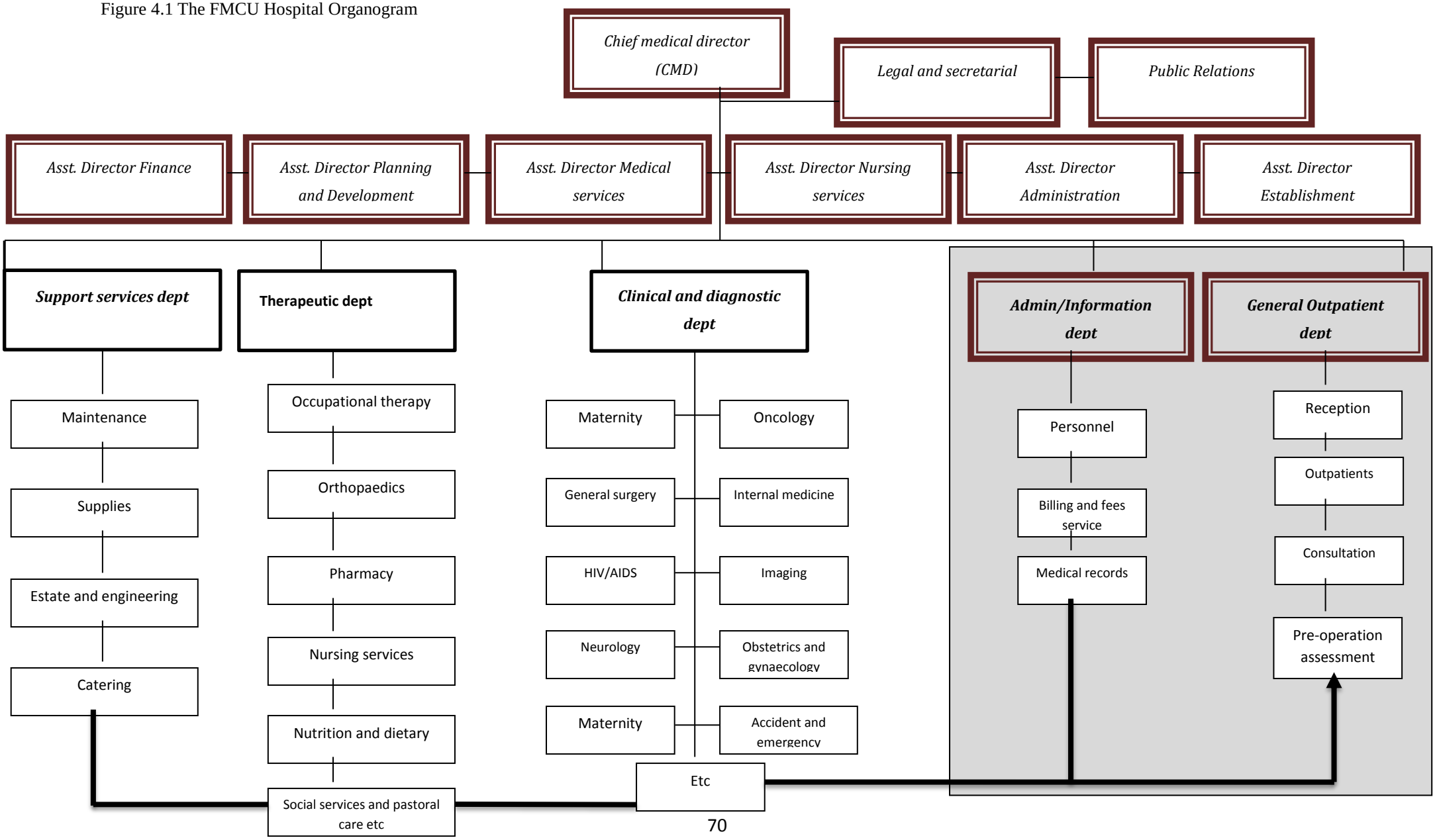
v. Provide 24 hours emergency care.

vi. Ensure that all equipment in the hospital is maintained efficiently in proper working conditions.

vii. Make provision for those with special needs (FMOH, 2004)

The organizational structure of Federal Medical Centre Umuahia (FMCU) (an example of a FMC in Nigeria) is detailed in Figure 4.1 below.

Figure 4.1 The FMCU Hospital Organogram



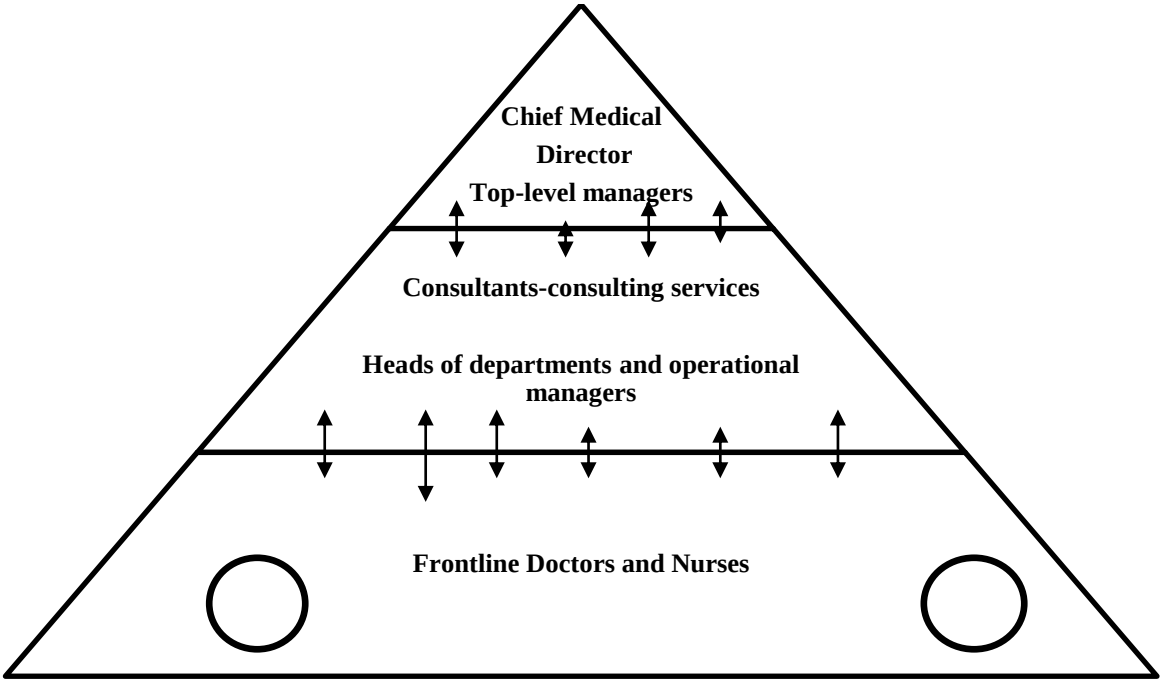
The General Outpatients Department serves each of the other departments, and is the first point of call for all patients. The clinical staff (doctors and nurses) at FMCU forms 21% of the 3000 employees. FMCU is staffed with a variety of health care workers organised in hierarchy. This study focuses specifically on clinical staff who are directly involved in service provision. Figure 4.2 below shows the chain of authority of the clinical staff in relation to top-level executives and senior consultants, middle-level managers, and the lowest level workers.

Since it is not possible to read off the actual way in which the FMCU hospital works from the official organogram (see Figure 4.1), Figure 4.2 and Figure 4.3 below detail the operational processes and interactions which shape how a hospital functions as an 'organism' rather than a discrete unit. It particularly focuses on the events within the General Out-Patients Departments (GOPD) where the majority of activities of the reform process occur.

Figure 4.2 below demonstrates the interaction and hierarchy existing among hospital workers particularly the executives or top-level managers, the consultants, head of departments or operational managers and the frontline doctors and nurses. As noted in Chapter 2, a hospital organisation operates as a living organism within a system. Hospital activities are not about discrete events but sequences within a web of interactions between the different categories of workers. Thus, understanding how the policy process operates within FMCU is about how workers operate as groups of actors and how they manoeuvre, negotiate and relate with one another to provide services in a real life context.

As noted, the focus of analysis in this study remains the understanding of policy process within a case hospital context. Therefore, it is argued that talking to these different categories of hospital workers will provide an insight into how such an agency works. This is underpinned by the understanding that organisational change reflects what actually happens within an organization, and not the prescriptions of what needs to be done.

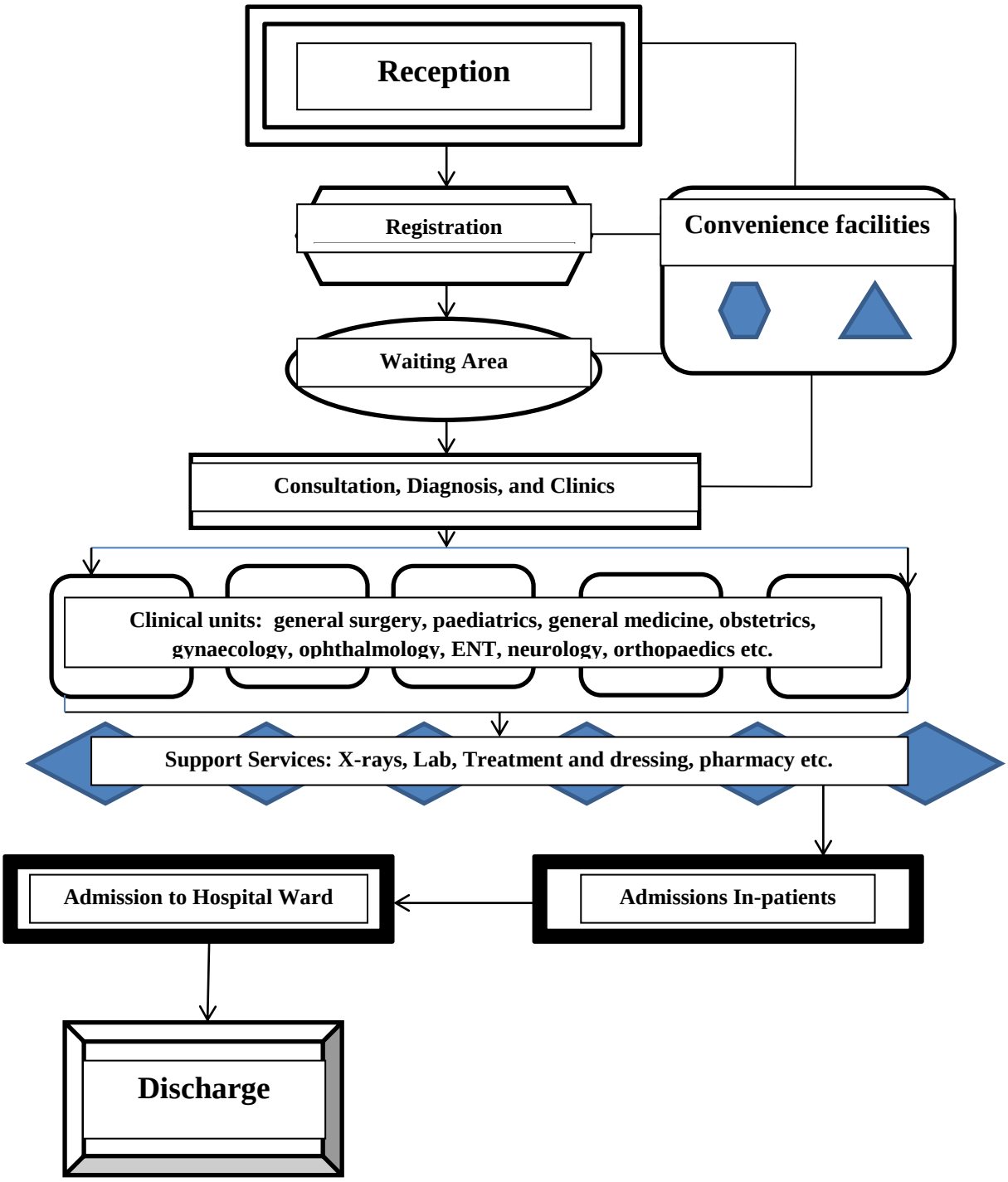
Figure 4.2 Operational hierarchy and interactions between different categories of health workers



A Chief Medical Director acts as the overall Chief Executive and is assisted by six Assistant Executives. The hospital executives represent the public face to the government, whereas the heads of department and operational managers see to the organisation and management of hospital activities including managing the change brought about by the reform. The operational managers are mainly senior and principal officers who have significant years of experience.

In between the heads of departments and the executive officers are the chief and senior consultants who occupy varied clinical or professional posts by virtue of their knowledge and years of experience. Most of them have been either assistant directors or head of departments in various capacities. Thus, they possess relevant managerial and clinical experience. At the lowest level are the junior officers. Professionally, the clinical staff varies in their specialty, status, position or hierarchy, personal characteristics, length of service or years of experience, age and gender. Consequently, it is expected that the change would mean different things to different categories of clinical workers.

Figure 4.3 Operational layout of the FMCU General Out-Patients Department (GOPD)



The GOPD is an integral part of the FMCU, collaborating clinically, administratively and physically with the inpatient department or wards in the diagnosis and treatment of patients. In FMCU, as in other Federal Medical Centres (FMCs), a key characteristic of the GOPD is overcrowding as it receives patients

and provide clinical diagnosis and other operating facilities like pharmacy and dispensary, health education programmes, and an emergency department (Accident and Emergency). The FMCU's GOPD also consists of a reception and waiting area, waiting rooms, registration and outpatient medical records, clinics, toilet facilities, pharmacy, and injection and dressing room. The GOPD has a separate access, and ensure that patient flow moves easily from enquiry to registration, and from waiting to examination room for diagnosis. The GOPD is also linked to the inpatient departments and all other diagnostic facilities such as x-ray, pathology laboratory and support services, including patients' liaison office and snack bar. Overall, the GOPD is the visible face of the FMCU hospital.

The core of previously mentioned SERVICOM's activities operates within the FMCU's GOPD, given that it is the hub of the hospital's day-to-day operations, and serves as the door to the patients and their attendants. As part of the changes in hospital opening times and hours, the FMCU's GOPD, which operated a 9am to 2pm Monday to Friday service prior to the reforms changed to offeriong 9am to 4pm Monday to Saturday service. Overall, since the GOPD offers a comprehensive range of services arranged into different clinical specialties, as well as administrative links and functions with other units or departments in FMCU, a key operational challenge to FMCU's GOPD, like any other FMC, is excessive delay at the registration counters and at the clinics.

In FMCU, workers see themselves as team players, or interdependent. This suggests that the functioning of the hospital also requires a good relationship within and between worker categories, and between management and frontline workers. This organisational dynamics and cohesion is vital, and enhances the smoothness of day-to-day decision-making processes. As teams, there is suggestion that workers have a level of freedom and autonomy of function, and as front line workers, a better idea of how the hospital should provide healthcare services on the ground.

Like any other public sector organization, the hospital has an established mechanism of staff structure, with bureaucratic control vested with superior over subordinate staff. Different staff categories belong to a range of different unions (e.g. Nigerian Medical Association for doctors, and Nigerian Nurses and Midwives Association for nurses). It is likely that union orientation could affect the way their members

perceive their position relative to others, and to the reforms. The staff organisation and orientation is characterised by differences in line of authority and power, levels of workers and differences in priorities and interest, status, expectations and negotiation ability within and between people within the organization. This is extremely vulnerable to differences, particularly in the way the reform will be perceived. This equally makes sense in terms of human behaviour, which supposes that people (e.g. organization and workers) respond differently to change. In order to capture the differences in lines of authority, workers of different levels were enlisted in the research, as detailed in Chapter 3.

During the interviews held at FMCU, a small number of respondents indicated that 'things are different now' expressing possible change in the work culture. Given that the current reform attempts to modernise the way public organisations operate, especially as this relates to organisation and management, the suggestion is that the operating environment of FMCU has witnessed significant change. Prior to the reform, for example, hospital workers reported to their line managers (who are also health professionals) and did their work based on their perceived professional knowledge. With the introduction of SERVICOM, which operates as a watchdog inspection agency with a set hierarchical structure, things have changed which might influence the way FMCU conducts its affairs. It is of note that the exact characteristics and distribution of power and authority between the agency and hospital managers are not fully spelt out. Nonetheless, there is a new form of accountability demand from one based on professional or expert norms to one based on SERVICOM's administrative or hierarchical structure. SERVICOM appears to have sprung from the government's view that it wants to enforce compliance; as implementation machinery, it is very likely to influence the way FMCU operates in order to deliver its services.

4.5 Discussion and Conclusions

The purpose of this chapter was to outline the contexts and contents of the health sector reforms in Nigeria. In attempting to improve the performance of the public health service delivery system, the government of Nigeria implemented fundamental changes aimed at transforming the way in which hospital workers do their work. The reforms, which focus on effective management and leadership of public organisations, first puts emphasis on strengthening new work practices aimed to create best practice/procedure, then on setting targets and performance measurements based on targets. This is supposed to provide a result-oriented focus as well as contribute to achieving a demand-driven focus, to health care delivery. There is also demand for effective communication and a feedback process set out to enhance culture of accountability. As part of this, the government established a performance audit agency (SERVICOM) to steer effective implementation and to secure compliance to customer-led service delivery.

Within the deliberate effort to change work practice and, in particular, to encourage health workers to change their behaviour, the second reform element revolves around getting the incentive right. The pay reform places emphasis on individual reward and recognition as a means of generating incentive to enable and encourage public workers to change their behaviour and work practices. Despite the fact that the principle of linking rewards to individual efforts and performance is presented as having potential in realising the reforms' objectives, the practice remains new in the Nigerian public service context. It is important to note that rewarding individual performance is also supposed to create healthy competition as well as enhance accountability of individual health worker actions towards achieving the set targets. What is particularly important is the fact that the underpinning philosophy of the above reforms has progressively been driven by claims of having the interest of the "people" (i.e. service users or clients) as a paramount concern of government. In realising this intention, there is an understanding that the government appears to recognise the critical role of the workers, and particularly that motivating public workers to change their behaviour towards the new work practices is a critical factor in improving healthcare. This sits within the wider context of debate about reforming public services especially as it relates to developing countries where

inadequate incentives have been outlined as critical performance challenges (Rowe *et al*, 2005; Hongoro and Normand, 2006; WHO, 2006; McCoy *et al*, 2008).

The use of pay (i.e. reward or recognition) policy to support changing work practices in healthcare organisations remains an emerging trend in public health sector management. Since pay is a subject guaranteed to attract the attention of most, if not all, workers in an organisation, how the interplay of reward and recognition, and changes in work practice/procedures will attract the necessary efforts and willingness from health workers to achieve the established reform objectives remains an issue of interest. It is important to recognise that, the reforms also largely promote a business strategy of rational planning, goal setting and measuring performance (i.e. efforts and outputs) (Kaplan and Norton, 2001; Neely, 1999). In addition, the rewarding and recognition of individual effort and performance is highlighted as a market ideal (Propper *et al*, 2004) that is supposed to stimulate competition among health workers.

There is recognition that changing health workers' behaviour by altering the existing structure, procedure and process remains a key element of the reforms. This is based on the firm belief that health workers are major critical success elements in the realisation of government policy objectives. The interest of this thesis, therefore, is linked to uncovering the implementation structure and process of reforms operate in practice, and how health workers interpret them. The analysis shows that the introduction of SERVICOM remains a fundamental aspect, particularly in terms of helping to enforce the implementation of the reforms. Put in a wider context, this clearly represents a changing trend in the role of government and expressive evidence of a transfer of responsibility to a government agency to regulate activities. Operationally, it represents an element of power and authority exercised by government over public workers (Power, 2000; Hood *et al*, 1999).

Moreover, drawing from the principal agent literature, the evolving supervision and auditing arrangements equally exemplify a contractual relationship in which government as principal treats the workers as agents (with SERVICOM as regulators) and expects the workers to comply and do as directed (Baker *et al*, 1994; Holmstrom and Milgrom, 1991). In this sense, the Nigerian government seems to be using the

reforms to set boundaries for healthcare workers, to direct what they think should be done and to retain ownership of hospital organisations. What is of interest to this study is how these conceptualisations regarding hospital organisation and management play out in practice.

Overall, this chapter has presented the health sector reform that underpins the analysis carried out in this study. From all indications, the reform is presented as desirable, necessary and unavoidable. There is optimism that the reform will act as a catalyst for realising fundamental transformation of public health service work procedures and, in particular, contribute to generating incentives for health workers to change their behaviour and practices. The analysis shows that the reform contents revolve around changing the existing structure, procedure and process in order to transform the way hospital workers do their work. The reforms offer a clear illustration of business and market strategy based on strategic performance management and a demand-driven approach to hospital organisation. The underlying assumption about the reforms demonstrate a shift in hospital practice from one controlled by the clinical professionals to one driven by a paternalistic view, with set procedures about how work should be done as well as mechanisms to check for compliance. Another element of the reforms relates to rewarding individual performance, seeking to reinforce compliance and, most importantly, to attract the efforts and willingness of workers to change their work practice.

While the reforms remain a sweeping effort put together by the government to transform the public service delivery system, the implications of the process have not been thought through. Nevertheless, the consensus view emanating from policy documents and interviews with government officials demonstrates that the reform is the government's planned decisions about what should be done and how. What is important to the analysis is a developing understanding of how the policy intentions operate within the web of interrelated organisation processes and culture wherein the reform is orchestrated. It is also important to map out how the reform is communicated, the available incentives, sanctions, and rewards/recognitions that are in place to enforce compliance and eliminate non-compliance. Clearly, there is no doubt that the reform represents a mechanism for change with strong political will, power, interest and influence from the government. At the same time, it is

recognised that although the reform is presented as necessary and contained as a local action in response to societal needs, it nevertheless sits within the context of wider global reform agenda.

With respect to how the reforms came about, although the above presentation did not intend to provide a complete analysis of how this happened, it did however show wide latitude of high-powered committee deliberations and recommendations which informed government decisions about the reforms. Regardless of committee recommendations, it seems clear that the reforms were part of the political agenda outlined by the interest of the ruling party under the Obasanjo-led administration. Despite committee recommendations to the Presidency, there is indication that decisions about reforms often happen behind closed doors, and involve overruling high-powered ministerial deliberations.

Even if only internal drivers are considered in the policy development process, it is not straightforward. As evident from the interviews with key government informants, the idea for the reforms emerged from a variety of sources such as the public, the media, politicians, development policy experts and public workers. Nevertheless, the overriding choice of which changes to implement and in which direction remained the sole responsibility of the government. The ideas about the reforms thereafter followed formal procedure and discussions involving high-level ministerial meetings, select senate committees and subcommittees. Specific case studies with specific terms of reference were conducted. A draft report was produced, and then subjected to intense public consultation and debate. A White Paper was then published and adopted as the working document for the reforms. The description offered here of how the reform came about does not show the extent of involvement of the workers in the policy-making process. It did, however, point to how policy making follows a series of opinions or arguments about the scale, responsibilities, roles and level of government, and committees. Public involvement in the policy-making process remains ambiguous and the thesis returns to this in Chapter 6. What is evident is that the policy-making process involved different levels of deliberations and operated as part of the democratic process. The understanding as revealed in the policy documents is an overriding claim that there was series of committee and consultants reports, presentations, case study references and simulations presented in different

levels of governments, and including involvement of workers to justify the rationale for change.

The next chapter (Chapter 5) presents the structure and process of the reforms' implementation. It is important to point out that, though the government's view is that the reform will operate and be implemented as planned, including the supposition that workers will take the reform for granted and follow the rules. The view of this study differs and expects that the process is very unlikely to be straightforward. This is driven by the fact that health workers as frontline service providers and primary actors in healthcare practice possess considerable discretion (Lipsky, 1980) and agency, and their actions are mostly embedded within the existing work and professional culture and practice (Long, 2001; Giddens, 1984; Meyer and Rowan, 1977). Thus, it is expected that human action and behaviour to the reforms will be diverse and may contradict linear expectations. The health workers could comply as directed or not, defect or even ignore policy instructions. What is important is to develop a deep understanding of how the reform operates in practice especially within the case hospital organisation described earlier.

5 Policy Analysis: Policy Processes

5.1 Introduction

Chapter 4 detailed the context and content of the recent health sector reforms in Nigeria, and their drivers. It also examined government expectations for initiating the reform. Then it described the Federal Medical Centre Umuahia (FMCU), the specific organisational context within which this study was undertaken. This chapter examines the health and pay reforms as introduced in the FMCU, seeking answers to the second research question, which is how health providers perceive the change process as it relates to their day-to-day work practices.

The chapter details the operational changes arising from the implementation of the reforms, and clearly identifies the concerns of the hospital workers about these changes. These concerns focus substantially on the work of SERVICOM, the implementation agency responsible for enforcing compliance with the reforms, and outline the formal relationship between the agency, the clinical departments, and the hospital's clinical staff, the tools it uses to measure performance, and the penalties imposed for poor performance at the hospital level. As indicated in Chapter 4, these tools and measures were laid down by the Federal Government and are not peculiar to SERVICOM at FMCU. They are, nevertheless, central to New Public sector Management (NPM) and what it appears to offer the Nigerian Government in its reform programme; that is, routine procedures with quantifiable and measureable outcomes. Evidence presented in this chapter demonstrates that the introduction of an audit or watchdog agency (SERVICOM) represents one of the biggest changes in hospital procedures and clearly demonstrates how the government wants to go about improving healthcare services in Nigeria.

To find out the operational practice of the changes, interviews were conducted with national and local staff of the inspection agency, top- and middle-level hospital managers as key organisation informants. Prior to these interviews, policy documents related to the structure, implementation of the reforms had been reviewed, and interviews had taken place with government policy-makers, as detailed in Chapter 4.

5.2 The Structure of Reform Implementation

In 2004, the government of Nigeria, as part of its comprehensive reform programme, set up an agency, addressed as SERVICOM, under the Reform Implementation Act 2004 ("the Act"). The role of SERVICOM is to support and lead in the implementation of the reforms nationally. SERVICOM works to an agreed national protocol, providing a similar service to all public service delivery departments or ministries.

SERVICOM is linked with the FMCU through two offices. The first is the Abuja office, which is the SERVICOM headquarters, and the second is the FMCU local office, present in all Federal Medical Centres. The staff structure of SERVICOM consists of civil service administrators who are non-health professionals, appointed by government. According to a SERVICOM policy document, at the heart of the decision to establish a specific agency to implement the current policy reforms is the view that previous policy failure can be traced to the lack of both regulatory processes and political will:

> *The goal of this administration is to make sure that government's goals and targets are achieved to the letter. SERVICOM will provide a timely assessment to show how organizations are achieving the goals. From the Service Delivery Diagnostic Report we received the lack of ability of public organizations to provide information about what they do will be over as SERVICOM will address the information gap, and help government and our planning office to plan better in the future. Also, service providers will behave well and follow civil service rules* (SERVICOM, 2004)

One national SERVICOM official based in Abuja details the activities or tasks of the agency as being to 'measure', monitor', 'regulate' and 'publish performance reports' and advise on who is to be rewarded for excellence based on the performance reports:

> *Government want us to measure, monitor and regulate how service providers operate to ensure that quality standards are met. This will also check abuses of office and ensure that customers are treated with respect, fairly and timely. SERVICOM will also provide information on performance to guide future policy and even help hospital managers and their workers to know the areas they have done well and identify areas that require improvement. By regulating how public organizations and their workers operate along the lines of government priorities, government seek to enhance probity and accountability in government offices* (SERVICOM Staff Abuja)

Part of the framework for the public sector reforms revolves around the Customer or Social Charter (see Chapter 4). Ideologically, this presents a market-based strategy which conceptualises service users (patients) as 'customers' who are entitled to expect and receive high quality healthcare services befitting their need. The logic as expressed in a Bureau of Public Sector Reform (BPSR) document suggests that SERVICOM is:

> *Commissioned to deliver a result-oriented and customer-driven, accountable services based on the logic of continuous improvement of public health care* (BPSR, 2006)

In addition, customers are expected to be treated with respect and dignity, and in a manner that is responsive, fair and timely as detailed in the Social Charter. The setting up of the Social Charter, therefore, might be viewed as an affirmative act in favour of all citizens who have not previously been in a position to benefit from health improvements. Quoting a SERVICOM text, there is a supposition that the Social Charter reflects the government's determination to create a service built on integrity, objectivity, accountability, openness, honesty and patriotism in public service delivery (SERVICOM Book, 2006). The Social Charter was unanimously adopted by the President, the Vice President, Ministers and Secretary of the government of the Federal Republic of Nigeria, Head of Service of the Federation, Permanent Secretaries and civil servants, and promises to be responsive, fair and accountable in fulfilling its duty to serve the people.

Interviews and discussions with national SERVICOM staff suggest that SERVICOM represents a top-down hierarchical structure linking government (its policy), the hospitals, and the people or customers. This was spelt out by one SERVICOM staff member as follows:

> *We are here to implement what government has set out. Our work is driven by the drive to make sure that customers are satisfied with the services they receive. We work to provide performance reports to government. This is also a feedback to hospital managers. Customers also come to us when they want to complain about the services they receive. We work to make sure that hospital organizations reduce waiting time at the outpatient department as a way of improving services. This is part of the performance improvement which this policy seeks to achieve* (SERVICOM staff Abuja)

All this makes it clear that the introduction of SERVICOM is an important step in the process of making each part of the health care delivery system accountable to a centralised and standardised unit of service delivery. The specific activities of SERVICOM are wide-ranging, and include providing a scorecard against which organisations and workers can be assessed against others in terms of set performance measures or targets; information management on hospital operations; and customer satisfaction (SERVICOM, 2006).

The SERVICOM office at FMCU operates as a Ministerial Department Agency (MDA), which implements the policy reform. The activity of SERVICOM, including within FMCU, is all-embracing and covers a wide gamut of activities. Overall, the key responsibilities of SERVICOM with respect to patients are to:

a) Protect patients and promote continuous improvement in the quality of healthcare they receive;
b) Promote mechanism that safeguards the right and dignity of patients;
c) Ensure that patients have fair and timely access to healthcare services;
d) Ensure that the hospital and workers provide information in the form of leaflets and self-directed signs to guide customer identification of available services and to make choice;
e) Facilitate a consultative process that regularly brief customers their rights and provides up-to-date information to workers regarding government expectations (SERVICOM, 2004; 2006).

At FMCU, SERVICOM makes sure that people who use services (i.e. customers) get better health care services, making sure that these services meet the new standards and rules outlined by the reforms about quality, health and safety of customers.

The SERVICOM unit at FMCU runs a service window (office) that ensures that customers are satisfied with public services. The office provides information leaflet-broadly titled "Ask SERVICOM"-which contains specific information regarding SERVICOM and customers' rights, indicating that:

> *Government is here to serve you. It is your constitutional right to expect service from government. It is equally your constitutional right to complain when service delivery fails. All citizens are customers of the government. All citizens have the right to complain when government fail. You can register*

> *your question by visiting the SERVICOM office, telephone, by writing, or by email* (SERVICOM, 2004)

More generally, it is hoped that customers will be encouraged to contribute towards improving government service delivery, meaning that the responsibility for change depends on both workers and their clients.

From every indication, an interview with a policy officer suggests that the SERVICOM model was based on the experiences of other countries such as the UK. The operation of SERVICOM, therefore, seems to replicate similar agencies in other countries (e.g. OfCom and Ofsted in the UK). This may have been adapted to the specific Nigerian setting as part of the policy transfer and learning process perharps presented as a form of modernisation agenda (Dolowitz and Marsh, 2002; Lodge, 2003).

5.3 Performance measures within FMCU

Fundamentally, performance measurement is expected to accomplish a variety of important objectives, which include motivating better performance and encouraging individuals to change their behaviour in line with what has been considered by government as ideal. The government argued that one aspect of best practice that could achieve this is by setting performance measures, referred to as targets or standards. Performance measurement by targets appear to be based on the understanding that every organisational worker has to conform, be rewarded for doing as directed, or face sanctions. In this context, the establishment of a performance measurement agency is to facilitate this agenda of 'comply or be punished'.

As noted in Chapter 4, this seems to be imbued with the ideology of New Public sector Management (NPM), which represents a new way of thinking about how to organise and manage public workers. The healthcare performance improvement measures (i.e. that are expected to facilitate improvement in healthcare performance) for all Federal Medical Centres, such as FMCU, address key aspects of worker behaviour (welcoming patients as valued clients, treating patients equitably, providing prompt service and so on) all of which are designed to satisfy clients and

include action to ensure conformity with these service delivery norms (complaints procedures on the one hand, and PRP and public recognition of good service procedures on the other).

Once developed, these performance measures were communicated first through the Federal Ministries (e.g. Federal Ministry of Health), and subsequently to the heads of each Federal Medical Centre through the SERVICOM ministerial department agency office. As specified by the reform implementation act, all ministerial departments are expected to pursue the realisation of the performance measures.

With respect to how the performance measures were rolled out, especially at FCMU, interview results show that it was not different from the procedure of policy dissemination through official and hierarchical channels of communication. For example, one FMCU hospital executive noted that the government circulated memos to all ministerial departments, including FMCU, indicating the following intention:

> *The government has announced changes in hospital management. We were told that these changes are most likely to affect how we do our work as well as to improve our motivation to do government work. There was a significant increase in salaries, changes in pay process and increased accountability as work is now to be inspected by an agency to be established by government* (Top-level Manager HEM2)

As indicated in the policy document, the performance measures specifying the changes expected in the healthcare system were first announced at a ministerial meeting of Chief Executives and top-level officers of the Federal Ministry of Health (FMOH). During the interviews held at FMCU, one hospital executive stated that they received memos and circulars from the FMOH, National Planning Commission, and SERVICOM office, communicating the government's intentions regarding the performance measures. It was also reported among other executives and operational managers that there was series of media broadcasts, including radio, television and newspapers promoting the reform, outlining what the government was about to do and the expected results. At the FMCU, it was also reported by managers that SERVICOM also conducted sensitisation and awareness seminars as part of the mechanism to popularise the reform, and the performance measures in particular.

One of the most important functions of SERVICOM has to do with performance appraisals based on the prescribed national performance measures. This is an altogether new development for clinical staff and one of the most obvious signs of change. Although one of the hospital line managers indicated that while frontline staff were previously appraised for promotion purposes, this was never based on set targets. Rather it was based on a manager's subjective assessment of staff performance, and the years of experience of the different staff members. Under the new measures, two sources of information are used for staff assessment: SERVICOM observations and inspections, and client reports.

As evident in the agency's operational manual and illustrated in the policy documents, SERVICOM's performance assessment mainly covers activities at the General Out-Patients Department (GOPD). There are two kinds of supervision carried out by SERVICOM at FMCU: regular/routine supervision and unannounced supervision. The aim of the regular/routine supervision is to reinforce the reform objective of measuring how workers are doing their work. With regard to inspections, the unannounced inspection is not usually regular. It is carried out by National SERVICOM staff from Abuja and is mainly used to check out or follow up issues. The announced inspection is often followed by an unannounced inspection (undercover inspection) in which national agency staff could visit a hospital to see things for themselves. A SERVICOM staff member at FMCU concurred with this, stating that:

> *We often have our colleague from the national office come for inspection. We ourselves did not even know about their visit. For example, we have had sometimes a visit during which a head of department was demoted because of indecent behaviour* (SERVICOM staff FMCU)

The above incident was confirmed by a hospital operational manager, who said that:

> *I do not really think that the head of department was as bad as they reported, but the incident was very serious although many feel it was unfair. In any case, the report that the head of department embarrassed a national staff member thinking that he was a patient shows how some workers may be treating patients* (Operational Manager HOM11)

Although the inspection procedure may not be thorough or robust, there are indications that it is perceived as a driver of change. A local SERVICOM staff member at FMCU noted that:

> *What people should know is that we did not manufacture the performance indicators. All our assessment is based on the laid out performance evaluation form. We score workers, units and the hospital based on what we watch and in line with the requirement specified in the evaluation form* (SERVICOM staff FMCU)

Ideally, routine supervision is conducted by the FMCU SERVICOM staff only. In this case, everyone knows that SERVICOM is around in a ward or GOPD. During a routine inspection, SERVICOM staff discuss with service users what the reform gave them reason to expect from the hospital. The focus is to make sure that customers get better health care services, so it is the job of SERVICOM to regularly check and ensure that services provided meet the national targets. They also verify whether the hospital and its workers provide service users with the necessary information leaflets and self-directed signs to guide them.

As part of its routine activities, SERVICOM conducts a quarterly seminar where customers are invited and reminded of what they should expect from a public hospital. Customers are encouraged to be involved in decisions about the care they receive. They are also encouraged to make complaints, contacting the SERVICOM office either by phone, email or letter, or by visiting the office and making a verbal report. As evident in the interview texts, customers are encouraged to do the following:

> *Tell us what you think. You can help us decide if your hospital (i.e. FMCU) gives good and safe care. Please tell us about things they are good at, as well as things they need to do better. Telephone or email us, we treat your views confidentially. Tell us also any worker who you think has done well and any experience that you feel was inappropriate. It is your right. You can also contact a SERVICOM staff or your local group to make your complaint* (SERVICOM staff FMCU)

The presence of SERVICOM at FMCU means that things are different from before. A SERVICOM staff member noted that:

> *In our regular inspection at the wards and GOPD, we look at the services or care customers get. We do encourage customers to share their experiences by providing feedback to us. We also do check using the evaluation form from Abuja how FMCU workers are meeting the standard. We also check the reception area to see how customers are received and facilities provided while they are waiting for their treatment. We also inspect the facilities to make sure that the hospital is clean and safe or free from infection. We are supposed to*

> *do many things, but now, we are not able to cover everything because of inadequate staff* (SERVICOM staff FMCU)

As reported by many other FMCU SERVICOM staff, it is expected that customers be involved in decisions regarding the care they receive. The SERVICOM staff claimed that during the inspections and interviews with customers, customers are asked how well they think their privacy, dignity and independence were respected, or whether before they received any examinations, care, treatment or support the worker asked them for their views or if they agree to whatever the event was. During the interviews with SERVICOM staff at FMCU, a number of focus issues were raised. These relate to how well customers feel that their service needs have been met, their perception of the cleanliness of the hospital, and so on. A SERVICOM staff member also said that their work includes handling of non-compliance.

> *We can do many things if a worker does not meet the performance measures or standard. We can query the worker and the line manager. Those involved will be summoned in a SERVICOM court. Depending on the outcome, they could be asked to report to Abuja. The end of each case will either be a warning, suspension of salary, recommendation for transfer or in extreme dismissal* (SERVICOM staff FMCU)

Improving access to health care services is widely documented as an important objective of the health sector. As outlined by the recent reforms, smooth information flow in public hospital organisations is considered a critical strategy to improving access to services. Thus, SERVICOM at FMCU, as in other FMCs, operate to facilitate information flow, first to guide customers to identify and access services they need. A key SERVICOM staff member at Abuja commented:

> *Having adequate and rich information about the activities of the hospital is will contribute to improving hospital performance. Available information on hospital activities is perceived to be critical because it is expected to facilitates easy identification of available services; enhances customer access and choice to services and reveals to government what works and how* (SERVICOM staff Abuja)

The general view about the drive for improved information flow seems to suggest that the government wants to know what is happening in the hospital and ensure that customers have information to facilitate choice and access to available services. Improving information is also considered a means of enhancing the mechanisation of hospital activities. A local SERVICOM staff member reiterated this:

> *We make sure that hospital organisation provide customer with varied information about their activities. The information must be provided in the form of posters, leaflets, signs and directions. The leaflets must be written in three Nigerian languages (Igbo, Hausa and Yoruba). The information leaflets or signs provide direction and instruction customers on how to identify, access and pay for services and demand for receipt afterward, make complaints if they felt dissatisfied with the services they receive. The self-directed signs facilitate hospital organisation* (SERVICOM staff FMCU)

Most important in the work of SERVICOM with FMCU is the enforcement and management of the information system. As reported by SERVICOM staff, the idea behind improved management of the hospital service's information system is to facilitate customer awareness of available services, enhance choice, and improve access to services, and promote operational efficiency by reducing crowding around the hospital. As part of the information system management, SERVICOM carries out documentary evidence related to workers' attitudes and behaviour regarding work. For example, one member of the SERVICOM staff explained that one of the changes in work practice is in terms of attitudes to work (i.e. attendance, absence or lateness).

> *As spell out in the reform, public workers are expected to report to duty at assigned time and place and to remain on duty during scheduled work hours. We provide appropriate documentation about worker attitude to work. Workers who report to work 10 minutes but less than 1 hour after start of scheduled work. When a worker is late more than 1 hour after start of a scheduled work shift, s/he is considered absence to work. We keep attendance registers at the gate, which workers are supposed to sign, and we keep movement register at the ward to track worker movement within the hospital* (SERVICOM staff FMCU)

Another change in work practice relates to providing information to service users. A SERVICOM staff member commented on this, saying:

> *We monitor hospital activities to make sure that workers and their managers provide detailed leaflets to first inform customers what to expect from the hospital, changes to ways of accessing healthcare services, which services are available and from where. The information format has to be self-explanatory with self-directed signs to guide customers around the hospital* (SERVICOM staff FMCU)

At FMCU, SERVICOM staff claimed that their activities also involve the observation of individual worker's punctuality to work, as well as work-related

behaviour such as responsiveness to customers, cleanliness of wards and reception areas. A local SERVICOM staff member noted:

> *We observe individual worker performance by checking their attendance and punctuality. At the hospital gate, workers are expected to sign in and out. Yes, things are different now because days are gone when workers hardly come to work and expect to be paid. Customers are encouraged to report any unacceptable behaviour displayed by workers. Customer complaints are followed up with appropriate queries. Customers also report good behaviour and such is further investigated. A worker with outstanding behaviour is recommended for awards while those with bad behaviour could be sanctioned e.g. by recommending a suspension of their salaries. While good behaviour could also earn a worker instant promotion, queries could retard promotion to the next level (*SERVICOM Staff FMCU)

Another noted:

> *We visit wards and units to find out if the hospital provided self-directed direction signs and posters, information on leaflets about available services and time they can be accessed, how much that need to be paid and at which service window, opening times and how payment should be made. We also look at the infrastructures at the general outpatient department for example. Next, we would look at the reception area to find out if customers are provided with chair and water etc. as they wait for services, we monitor that patients are treated on first come first served basis. We do so many things and observe so many things, we observe and ok that work is done properly to meet customer satisfaction* (SERVICOM Staff FMCU)

Further evidence provided by another SERVICOM staff member demonstrates that the information mechanism also relates to payment of fees for services. This agency staff member said:

> *"As part of the effort to make sure that hospital workers comply with the due process with regard to fee payment, collection and documentation, we make sure that all payments are well documented. During our interaction with customers, we instruct them not to pay any fee to the doctors or nurses. And we also instruct them to demand receipt for all payment made and to report any payment that is not receipted to our office"* (SERVICOM staff FMCU)

5.4 Reform implementation processes in FMCU

5.4.1 Rewarding Performance

Managing people (both workers and customers) is a vital part of the activities of SERVICOM within FMCU. As evident in the policy document, this is supposed to enhance improvement in the reward system, and in the management of staff innovativeness (talents) to enhance overall productivity, organisational culture (i.e. the way work is done at FMCU) and general public service work ethics. Therefore, as part of the second element of the changes, SERVICOM is also interested in worker incentive management by identifying performance differences among workers rewarding and providing sanctions for compliance and non-compliance respectively to enhance motivation and discipline among workers at FMCU. This is drawn from the supposition that a vital root to improving performance is rewarding individual effort and performance through the introduction of performance-related pay mechanisms. Evidence from interviews demonstrates that a merit system emphasises a core facet of individual effort and competition, and links worker commitment, promotion and performance to reward.

A SERVICOM staff member commented the following:

> *Government has introduced a merit system to create a competitive public service. We identify, recommend and reward good performers. Sometimes, we recommend them for salary increase or promotion, display their photograph at the reception areas and wards, and issue a certificate of merit. This is a positive reinforcement for better performance improvement. We also recommend workers with inappropriate work-related behaviour to different types of punishments. This includes verbal and written warnings, queries, suspension of salaries, requesting them to report to Abuja for further interrogation and demotion depending on the nature of behaviour* (SERVICOM staff FMCU).

The above statement indicates that SERVICOM activities facilitate a 'carrot and stick' incentive mechanism supposed to enforce compliance to government policy plans, enhance worker motivation and productivity. When asked about the process of identifying good performers, the view of a local SERVICOM staff member at FMCU suggests that the process is relative:

> *Customers are encouraged to recommend any staff who they feel deliver quality and responsive service. In addition, managers recommend workers and workers recommend colleague but do not recommend themselves. We*

> *follow up recommendations and make final selection in consultation with management. We maintain confidentiality of actions and in the final process of choosing good performers* (SERVICOM staff FMCU)

This statement does not give clear detail of the process, but it suggests a significant level of subjectivity based mainly on what customers say and SERVICOM's own assessment. This seems to intimate that the process of performance measurement culture might be problematic and open to abuse. Besides, the claims among the health workers that SERVICOM staff are not well trained to exercise such judgements provide further evidence. A local SERVICOM staff member noted the following:

> *A worker is classified as a good performer if s/he is well motivated and committed to government work, responsive to attending to customers, follow the rule and targets, has good testimony from customers and colleagues, punctual and do not absent from work, facilitate customer rights and respect...the list is many* (SERVICOM staff FMCU)

Another staff member identified a good performing ward or organisation as being complicated because:

> *We look for a lot of things outlined in the evaluation form. This include issues related to management and personnel (e.g. organisation of work and including clear line of accountability, workers wear named badge), complaint and redress system (e.g. customers have access to complaint process and receive information about how to make a complaint, number of complaints and how they were treated), premises and facilities (cleanliness and receptiveness of the reception areas, safety of the hospital, information and signs to guide identification and accessing services and ward/hospital responsiveness to customer needs...so many things* (SERVICOM staff FMCU)

The operationalization of the above changes within FMCU is reported as part of the idea of naming (i.e. identification and rewarding of good worker) and shaming bad workers (i.e. sanctions to be imposed on defaulting workers), a central element of the performance measurement protocol. As outlined by a senior SERVICOM staff member at FMCU:

> *Government put the merit system in place as a transparent and fair way of motivating the workers and a way of creating a public service work environment that will make individual health workers respond to opportunities, work in line with set targets, work to the best of their abilities and maximise their talents, act as their own source of discipline, take responsibility for improving healthcare services, and take pride in their achievement* (SERVICOM staff FMCU)

As a means of recognising excellence in public services, personnel management by merit is a means of recognition and appreciation of the extra efforts of individual workers, and a source of gaining promotion and enhanced status.

SERVICOM solicits nominations for outstanding workers status from frontline staff (but workers do not nominate themselves), customers and managers. Following such a nomination, supplementary information about the individual is sought from the operating managers and management. The outcome of such a collaborative consultation results in a recommendation to Abuja and to the hospital management promotion committee. The climax of the process is an open recognition during the monthly award ceremony which is held with hospital stakeholders (i.e. customers, workers, and the public) in attendance. The photograph of the winning worker is placed in strategic locations (e.g. GOPD, wards and administrative offices) within the hospital. Following this, a certificate of merit is issued. It is important to note that, although the instant cash award is not large (10% of the individual worker's salary), the worker could also receive household items (e.g. fridges, electronics and cooking utensils). More important, workers who win these awards also receive recommendations that they have the potential to be promoted. In general, the responses demonstrate that, as part of the change, SERVICOM is implementing the reform which links pay to performance and emphasises individual worker recognition as an important incentive mechanism that is supposed to stimulate healthy competition among workers. Although the operation of performance-related pay, as outlined by the policy document remains elementary, it is supposed that its operation will likely give workers something to think about.

Conversely, SERVICOM also imposes sanctions for non-compliance. SERVICOM operates a special complaints unit which deals with grievances from customers about perceived unsatisfactory service experiences within FMCU. Apart from the identification of good performers, another SERVICOM staff member remarked that they do issue sanctions to enforce compliance and punish bad behaviour:

> *Our work is not only about identifying good performers, we also work to deter people from engaging in acts that are considered derogatory or that undermine customer satisfaction. As a result, we tell customers to report to our office any feeling of dissatisfaction. Furthermore, we follow-up all complaints and depending on the nature of the offence, we could be issued*

> *queries, suspend salary or even terminate appointments. Sometimes a worker or manager could be asked to report to Abuja for further interrogation* (SERVICOM Staff FMCU)

Based on the interview statements, and as outlined in the SERVICOM documents (SERVICOM, 2006; 2008), the following are the sanctions that can be imposed on a public worker observed to have performed poorly:

- Query (written request for explanation), sometimes requesting the worker to come to Abuja for the case during the deliberation period;
- A written warning;
- Delayed payment for upward of 3-6 months;
- Demotion;
- A combination of the above

Commenting on the potential impact of the process referred to as naming and shaming, a local staff member stated:

> *So far, what people should know is that the policy i.e. measuring performance is a national initiative. It is a good policy and we have been receiving good testimonies from customers. However, to be frank, monitoring a Nigerian is challenging; a lot of people always think you are not doing a good job or that you are biased. To be frank, we have been witnessing significant improvement in hospital organisation because of the on-going hospital inspection. The priority of government is to make hospital organisation and workers focus on improving customer access to quality services* (SERVICOM staff FMCU)

It is important to note that the issue of naming and shaming is new, but could have varied implications. A key concern is not only about the claimed transparency of the process, but also about how the process could drive change, behaviour and changing relationships between, and within, worker categories. Ideologically, the process prompts a culture of competition and self-interested individual behaviour. Whenever reports are received about a worker or unit, the SERVICOM office at FMCU issues a query to the respective line manager, who then questions the individual worker concerned. SERVICOM expects the line manager to report back within twenty-four hours. All cases are examined by the SERVICOM complaints unit (called the SERVICOM court), and further enquiries may be made if found necessary. In some circumstances, both the line manager and the individual worker may be summoned to report for further questioning, either in the FMCU SERVICOM office or at the headquarters at Abuja.

At the end of the case, and depending on the severity of the issue involved, a worker or manager, could be dismissed or demoted. The salary of the affected worker could also be delayed, or the worker could be transferred to another unit. During the interviews, a SERVICOM staff said that there has been no evidence of dismissal yet, but the other sanctions have been effectively used on different occasions. Clearly, the activities of SERVICOM in the way it handles non-compliance suggest a management-by-threat mechanism. It is important to note that SERVICOM also assesses hospital performance in comparison with other hospitals. The overall hospital performance is compared against the national and specific key targets, and this is drawn from the aggregate of SERVICOM's assessment of individual worker performance. Based on the performance measured, SERVICOM comes up with an aggregate score ranking ranging from zero to four. The overall assessment of FMCU and other FMCs is made public on the SERVICOM website, servenigeria.com. Interestingly, however, there is indication that the assessment reported remain useless.

The above analysis demonstrates that, although SERVICOM has in principle been given the power to sack any worker that fails to comply with the new work procedures, in practice, there is no indication that SERVICOM has the capacity to actually do this because of possible legal constraints involved. What is evident, however, is the fact that SERVICOM does administer other sanctions, and this demonstrates that they are somewhat powerful and, thus, very likely to influence work behaviour. In general, SERVICOM's activities (i.e. as they relate to performance-related rewards) suppose increased awareness and emphasis on results, competitiveness and customer satisfaction as the key determinants of productivity, especially in healthcare service delivery.

5.4.2 Enforcing due process and accountability

The idea of due process as outlined by the reform process is twofold. The first is about strengthening the mechanism for improving operational effectiveness such as reducing waiting time and improving equity of access by making sure that patients are treated on a first-come-first-served basis. The second relate to the introduction of a centralised mechanism for payment and collection of user fees.

A SERVICOM staff member commented that:

> *In this hospital we monitor due process now. We go ward to ward and particularly at the general outpatient unit, our staff are positioned to make sure that patients are treated as they come. Everybody has equal right and there is no more room for patients receiving treatment based on who they do which makes the operation process unfair. In this hospital, we also monitor payment and collection procedure for user fees. We inform customers were to pay for services. There is now a centralised point for all payments and we tell customers to demand receipt for all payments made and to report any payment that is not receipted* (SERVICOM staff FMCU).

Cross-examination of the concept of due process demonstrates existing dichotomy between SERVICOM's view and the professional view of the workers. For instance, the study interviews suggest that following targets and the first-come-first-served rule, as well as the centralisation of fee payment and receipting within the hospital organisation collection points, are all examples of due process expressed by SERVICOM staff. As noted by one member of the SERVICOM staff, there is a supposition that training has been provided to SERVICOM staff to monitor these variables, how well the training has been done in this light remains another issue. Nevertheless, the initiative of due process as outlined in FMCU remains promising. Commenting on the overall outcome of SERVICOM activities, a national staff member stated:

> *From what we are seeing, things are different now. Our record shows that there has been an improvement in timeliness as people now access services quickly. Because of the information provided, patients identify and access services easily, people no longer cluster in one place just to ask for direction from a nurse or doctor. There is no more room for favouritism. However, based on our recent published performance report, a lot of hospital organisations need to improve. Government is looking at revisiting the sanction mechanism to make it a bit tighter and to improve the performance rewards to attract better performance in the future. In general, things are no longer the same* (SERVICOM staff Abuja)

Despite the claimed success, the presence of SERVICOM at FMCU could mean a great deal to the operational relationship, particularly since they are making judgements about how health workers do their work and even issuing out sanctions to those they consider to have performed poorly. At the same time, their activities in terms of linking performance to rewards remain a nuanced development in the hospital management and incentive system. Nevertheless, given that the complaints and disciplinary procedure remains discrete and anonymous, and lacks an objective means of verifying the results, it is difficult to say precisely how health workers will perceive the change.

5.4.3 SERVICOM data Collection and Collation process at FMCU

In general, to operationalize the above activities, SERVICOM uses a combination of methods to collect data from different sources. This includes customer satisfaction interviews and surveys, interviews with health workers, SERVICOM observations, research into organizational activities and then analysis. First, SERVICOM organizes hospital-based workshops and seminars for management and service provider and a stakeholder forum for members of the public (customers) in and around the vicinity of the hospital. The purpose is to ensure that hospital stakeholders understand the existing national performance targets and target expectations. These also serve to inform customers what they should expect, their rights, the complaints and redress procedures and other information related to access to government services.

Second, SERVICOM conducts entry and exit customer interviews and surveys. The purpose is to assess customer service expectations and evaluate their service experiences respectively. For the exit interviews, customers provide feedback on their service experiences based on the performance measures, and can either rank their service experience as good, efficient, very efficient, satisfactory or inadequate.
Another important focus of SERVICOM's assessment is the assessment of customer satisfaction level with the way the hospital workers respond to their needs, the reception they were given, and the attitude or responsiveness of the doctors and nurses towards them, or to other customers. Furthermore, SERVICOM conducts radio and television phone-ins to enable customers to air their views, positive and

negative, about the services provided by government hospital organizations. Further feedback is provided in face-to-face meetings or by phone, mail or email. This method identifies the value customers place on the service outcomes of hospital organizations and measures their experiences and satisfaction levels. The use of such surveys to assess the worth and performance of public organizations seeks to generate a quantifiable estimate of satisfaction, based on the general assumption that customers will provide reliable information about their level of satisfaction. There are however some studies that suggest that patient satisfaction is very unreliable indicator of quality of clinical care (Propper *et al*, 2008; Bevan and Hood, 2006a/b).

Finally, SERVICOM gathers raw data from the hospital organization through meetings and interviews with executive and operational managers and frontline service providers, evaluation of existing operational reports including attendance registers and health records, and an inspection of the working environment and workers' behaviour and attitudes to work. The above views suggest that SERVICOM's performance appear to focus on non-clinical outcomes. The arguments that emerged from interviews with frontline workers and managers suggest that SERVICOM lacks the cognitive ability to assess clinical effectiveness.

Commenting on the data collation process, a member of SERVICOM's hospital-based staff stated:

> *We explain to the workers what government expects from them and how their performance is measured. Then we collect the data using the form format sent to us from Abuja (head office), we total the scores and then our officer takes it to Abuja for final computation* (SERVICOM staff FMCU)

The result of the examination of how performance data were analysed indicates that it followed a weighting appraisal system involving ranking and aggregation to develop a composite performance score. The interviews with SERVICOM staff and analysis of the policy documents show that this activity involves data-ranking, aggregation and adding-up processes. The claim by a senior SERVICOM staff member that the "field staff are doing their work well" seems spurious, since there is no objective evidence to support it. As evident in the interviews, SERVICOM's activities appeared to be plagued by a lack of any triangulation mechanism. This was

an inherent problem in the performance report. One of the senior officers for example claimed that they are doing their "best" to collect reliable information:

> *We are doing our best. We make sure that our field staffs attend seminars where they learn about how to relate to customers and attend to their complaints* (SERVICOM staff FMCU)

This statement, however, is rather based on trust rather than on objective evidence and there is no indication that all is well, as captured by another member of staff:

> *While it is important to verify the data we collect, so far we are not doing it due to inadequate staff and equipment to perform this task* (SERVICOM staff FMCU)

As noted by one SERVICOM staff member, the overall performance from the evaluation modalities is scored and summed up for SERVICOM compliance.

5.4.4 How did SERVICOM relate to the hospital managers?

Prior to the introduction of SERVICOM, the hospital management was under the control of executive and operational managers. As noted previously, the presence of SERVICOM tends to suggest a shift in hospital management. An executive manager summed up the development in the following words:

> *Things are different now; things are no longer the same since government introduced SERVICOM. Government want us to report to SERVICOM on how we serve customers* (Top-level Manager HEM2)

In recognition of the fact that a shift in power mirrors changing perceptions about public administration, an operational manager alluded to the new management structure, stating that:

> *"They" (government) are using "them" (SERVICOM) to direct "us" (hospital managers) how to manage the hospital* (Operational Manager HOM9)

Many operational managers complained that SERVICOM operated as a top-down management structure with differing values and culture, which is thus not providing constructive feedback to guide clinical practice. Moreover, the perception by frontline workers of SERVICOM as a regulatory and controlling agency has impacted negatively on their motivation. Apart from the hinted role-conflict experience, frontline workers and hospital managers were gravely concerned that

they are often queried by SERVICOM about the way they do their job. One manager said: *"We have often been queried by SERVICOM. This is an embarrassment to our profession"* (Operational Manager HOM8). This view, which was also, echoed by six other managers, and many frontline workers, points to the understanding that SERVICOM is seen as a threat to hospital workers. One manager noted that, before SERVICOM was introduced, they carried out informal performance appraisals for promotion. Assessing the evidence indicates that this relied entirely on the subjective assessments of line managers and not on any standards. Thus, the introduction of SERVICOM in this regard represents a significant shift in performance management procedures, with formalised standards for performance management. As will be seen in next chapter, this study also considered the way in which workers and their managers view SERVICOM. Without going into detail here, it is worth noting that there was considerable distrust about the activities of SERVICOM.

5.5 Discussion and Conclusions

This chapter has presented the reforms implementation structure and processes within the case hospital organisation. The analysis shows that the implementation focused on bringing about change in organisational culture and work attitude and behaviour and responsiveness to customer needs. Clearly, the process revolves around changing existing formal and informal ways of doing things, with emphasis on information and feedback processes to facilitate effective control and accountability. The role of SERVICOM as a performance inspection agency is supposed to help enhance compliance, and alignment of workers' interest and efforts, in order to realise government policy plans. In pursuing the overall policy objective, the government highlighted its commitment to improving the incentive system by enhancing individual recognition and rewards for doing as directed. Evidently, the use of merit or performance rewards for health workers showing improvement in overall effectiveness remains a strategic human resource management approach, set out to manage individual behaviour, motivation and performance. However, the appropriateness, validity and importance of rewarding performance in a public sector setting warrant empirical investigation. It is important to recognise that this involves a shift in concept about public service work culture as

it relates to promotion; i.e. from promotion based on seniority and status to one based on individual performance.

Indeed, this represents a widely recognised approach in the new public sector management (Christensen and Laegreid; 2002; Pollitt and Bouckaert, 2004; Newman, 2005). The operation represents an amalgamate of neo-liberal business principles into public service management which, for example, presupposes a language of 'customers' (i.e. service users as active and sovereign whose priority is first) which replaces the traditional view of service users as 'patients' (i.e. as passive recipients of government facilities who have no voice). In the first instance, the approach supports the emerging view of 'business culture' in public sector management (Newman, 2005: 45); secondly, it emphasises the claim that patients' involvement as a form of power relations is key to achieving quality care.

Another important issue, as evident in the implementation process, is the introduction of the language of 'measurement', 'monitoring', and 'audit' and 'regulation' into public health sector management. Conceptually, this seems to reflect a business strategy and an official ideology driven by politics, power, and institutions (Freidson, 2001; Scott, 2001; Greenwood *et al*, 2002; Saltman, 2002). While this remains novel in the political economy of health sector management in Nigeria, it correlates past studies (e.g. Friedson, 2001; Davies, 2004) which demonstrate that the approach is a deliberate attempt to put a grip on professional power in an attempt to govern, or have control over, public organisations. To some extent, the premise of the implementation process seems to pre-suppose a mechanical sequence of events, and that hospital workers will follow the rules on a taken-for-granted basis. Nevertheless, to understand the functional aspect of the implementation process within the case hospital, it is important to recognise that the hospital organisation operates as a system involving notable agency and discretion of health workers. Therefore, while it remains believable that the interaction of the reform structures underpinning the implementation process will affect the discretion and agency of the workers, the nature and pattern of the effects remain uncertain.

The analysis in this chapter demonstrates that SERVICOM operations within FMCU could have several notable implications for hospital operations, management and

organisation. There is a clear evident indication of a shift in power relations arising from new forms of leadership and management based on information systems rooted in feedback and accountability demands, rather than bureaucratic hierarchy. This development is not different from events in other country contexts (e.g. the UK health service before the current coalition government) (Blackler, 2006; Bevan and Hood, 2006b), where health and education (Newman, 2001; Steer *et al*, 2007) were targets and regulation was the fad in public service management. There is no doubt that the implementation structure and process in place is supposed to provide corporate direction (indication of strategic leadership and political will) towards the realization of the Nigerian vision and mission of a 'New public service', as well as provide and guarantee quality service performance in a timely, fair, honest, effective and transparent manner. Within the domain of organisational (or individual worker) effectiveness the relationship between good planning, organisation and management (e.g. by setting national targets and regulation including inspection of how work is done and performance measurement) and performance remains inconclusive.

Nevertheless, within the broader conceptualisation of the reform which includes emphases on target and measurement, there is a widely held view that strict inspection will deliver. The analysis seems to suggest that the conceptualisation appears narrow. This is because the conceptualisation of SERVICOM activities suppose a linear and objective procedure of hospital activities (e.g. as in industrial production), focusing more on results than on the actual conduct of process of healthcare work.

While the establishment of SERVICOM remains a fundamental change, there are concerns about the procedural and distributional transparency of its activities. Overall, it is important to recognise that SERVICOM operates in a challenging context. For instance, in a work environment such as the Nigerian public sector, there are many comments suggesting that 'accountability' in public service activities is confusing and untidy, particularly because of inadequate data. It is, therefore, not known how, and to what extent, SERVICOM will be responsible, consistent or thorough in its activities. Furthermore, the competence of SERVICOM as non-health professionals, particular in observing what health professionals do, could remain uncertain in their assessment. Most important, is the fact that there seems to be lack

of clarity about the prescribed performance measures with reference to geographical preciseness, and this is suggestive of the suspicion that exist about the capacity of SERVICOM to deliver. Hence, while the implementation structure and implementation process remain promising, the operation seems to lack methodological rigour and leaves the question of how well relying on customer satisfaction will deliver quality care open to debate. It is interesting to note that SERVICOM's profiling, reporting, rewarding and sanctioning of performance remain a nuanced approach to change. Further empirical analysis is needed to explore the influence on work, relationships, human behaviour and performance in a public sector context. The implications of these changes, especially as they relate to work practice, role, position, and status of health workers, and social structure and work culture within the hospital are explored in Chapters 6 and 7.

This chapter has presented the reform implementation structure and process. The analysis has demonstrated the relevance of leadership and management of professionals as a way of making them more effective and efficient. In fact, it would appear, at least from the perspective of government that changing work practices and putting in place the right incentive with adequate control and regulation of individual activities, are outlined at enforcing compliance. Operationally, the reforms revolve around the interplay of changing structures and processes in shaping the agency or discretion of workers. There is no doubt that these changes could have significant implications on how workers do their work. There are grounds to believe that SERVICOM (as an audit agency) remains a fundamental change to government intentions and the way it wants to go about improving services. In fact, the emphasis on targets and performance management and a system of management through information protocol remain clear. Having looked at what is actually happening at the hospital level as outlined in this chapter, it is expected that the operations will very likely impact significantly on the workers. The analysis however, demonstrates that there is no clarity about the practicality of measuring the targets. It is important to point out that the fact that the targets were drawn up in Abuja, and SERVICOM oversaw their implementation, suggests that the reform and its implementation are enforced on the workers.

While it is supposed that SERVICOM will adequately monitor what health workers do, it is not very clear whether SERVICOM has the capacity to implement the reforms as prescribed. There is no doubt that the way the reforms are implemented so that the use of audit agencies appears prominent is imbued as part of the new public sector management (Power, 2000; Hood *et al*, 1999). The analysis demonstrates that given that SERVICOM staff are appointed by the central government, there is no guarantee that their activities will be totally independent or incorruptible, or free from political interference.

The analysis also demonstrates a clear shift in power from medical professionals to the administrative managers and clients. This ambitious plan is expected to contribute to overhauling the public service delivery services system. The evident change in work culture remains prescriptive, with emphasis on rules and procedures which suppose that workers are expected to do as directed, rather than doing their work based on their own professional orientation. The analysis also suggest that, compared to hospital organisation and management before the reform, "things have changed" and the presence of SERVICOM seems to represent a form of power used as a coercive strategy to change management. At the same time, despite the pervasiveness and perceived critical importance of setting rules, measuring and rewarding compliance, the analysis indicates that, so far, the implementation process tends to lack substantive clarity. Even SERVICOM agency appreciated the fact that there are potential challenges. However, there is no denying the fact that the recommendation and operation of SERVICOM remains persuasive and promising, and a critical factor to its success or failure will depend somewhat on a wide range of actions and reactions from the health workers, as they are the reform policy targets and are engaged in day-to-day healthcare decision-making processes and practice.

The following chapters 6 and 7 provide insights into the results regarding how health workers perceive the reform process (Chapter 6), and the effects on their work and performance (Chapter 7).

6 Health Workers' Perception of the Reform Process

6.1 Introduction

This chapter analyses how health providers perceive the reform process from its design to its implementation. The chapter directly answers the research question: how do frontline health providers perceive the change process and its effects as it relates to their day-to-day work practices? In doing that, the analysis and discussion of findings is undertaken simultaneously.

This chapter is divided into two main parts. Part 1 presents the different perceptions about the reform. It focuses specifically on how frontline workers and their managers perceive the changes that have actually occurred in their day-to-day work and in the terms of their employment. Part 1 consists of three main sections which follow a distinction in all the texts. This distinction is that, at times, hospital workers spoke of their perceived understanding of the reform development, mainly regarding its design; their perception of the implementation process; and their perception of the logic and operation of the reform contents which workers expressed as benefits (advantages) and costs (disadvantages).

Part 2 examines how health providers perceive the *effects* of the changes with respect to their work, hospital and practice. This part presents empirical evidence of the perceived effects, and consists of four principal themes, namely: (i) incentive, behaviour and motivation; (ii) workload, efficiency and balance of duties (between clinical and administrative); (iii) quality and quantity performance variables; and (iv) managers' and workers' resistance, that is non-compliance with the policy.

The analysis conceptualises the reform process as involving interaction and relationship between actors, interweaved with varied evidence of implicit and explicit features of *power relations* and *trust* constructs. For the first part, there is demonstrable evidence of a power struggle between professional health workers and their autonomy, and non-clinical or bureaucratic managers, especially with respect to the reform design and implementation. Similarly, for the second part, *trust* emerges

as another important theme of the content of the reform, particularly, with respect to the perceived effectiveness of the performance targets, performance measurement and implementation of performance-related incentives.

This analysis sheds light on the need to develop a more effective mechanism for developing an in-depth understanding of the reform process which brings out the inherent complexity often associated with policy-making and implementation process. Most importantly, the notions of power and trust contribute to highlighting how the psychological aspect of individual workers particularly their professional culture, attitude, beliefs, and perceptions has been shaped because of a shifting conceptualisation of power and trust in the implementation of the reform.

The issues presented in this chapter are of particular interest to research into policy process. Given the importance of these themes (power relations and trust) in understanding the reform process, it is important to provide a concise conceptualisation of these themes in relation to the analysis in this study. First, power is a complex construct construed as a relational and perceptual concept associated with negotiation processes, both in policy and discursive terms, as a result of the inherent contestation among different policy actors. Often, an actor who has power could have access to information or resources, and could influence the reform choices and the overall policy process in their interest. On the other hand, a shift in power from one actor to another could mean loss of control and influence, as well as loss of the capacity to negotiate and influence the reform and the organisational process.

The analysis in this chapter concerns how differential power relations among policy actors, i.e. reformers, implementers or SERVICOM, managers, workers (doctors and nurses) and patients, negotiate their agency within the policy process. In his discourse on power as a relational construct, Luke (1974) outlines the claim that the main rationale of power is that it suggests how one actor has ‘power over’ the other, and how power revolves around three dimensional elements. The main power questions surrounding Luke’s categorisation relate, first, to power as a concrete and observable behaviour among actors, which could lead to a potential conflict of interest among actors. The second question relates to power as a pattern of exploitation or control, and finally to power as an ideology. In the second aspect, A

has power over B because A influences and determines the activities of B. The view of Luke, which is supported by other related literature (e.g. Cleg, 1989; Knight, 1992), suggests that power relations serve as a mediating mechanism between human expectations and behaviour in organisational relationships and, depending on its asymmetric nature, a power arena could create a potential for conflict among actors. It also suggests that the circus of power influences actors' position and status, access to and ability to use available resources, engagement and participation in decision-making. In line with this, Knight (1992) expresses the idea that the exercise of 'power over' someone or some group is a mechanism for controlling one's space, resources, and choices (Knight, 1992: 41). This conceptualisation of power offers a number of pertinent features of the policy-making process. It allows for a wide range of views about how different actors, with different interests and positions influence the policy choice, tools and instruments. In addition, it embodies the principle of politics, i.e. the way by which government achieves its objectives, which could include or exclude [an] actor (s) based on perceived legitimacy, often judged by the dominant actors or interest.

With respect to how the workers to which this study refers perceive the policy development, the results suggest how the operating dynamics of power relations, intertwined within the reform, shape the power circle of the reformers, implementers or SERVICOM, managers, workers (i.e. doctors and nurses) and patients. It suggests how subjective perception of asymmetric power relations results in a shift in how individuals evaluate or re-evaluate their position/status, and their voice in the policy process, and which the workers believe poses a restriction to their professional discretion. Bloomfield *et al* (1998) found that power relations in this regard "set procedures and command based on what is considered as 'correct or best' practice, and often is driven by dominant interest or political judgement" (Bloomfield *et al*, 1998:5).

As noted by Cleg (1989: 236), the above ideas of patient empowerment and frontline worker disempowerment occur within the 'circuit of power', which lead to gains or losses of power in organisational relationships. This has also been demonstrated by past studies (Chambers, 1997; Keeley and Scoones, 2003; Sabatier, 2007) which found that empowerment and disempowerment show the extent of inclusion and exclusion in the policy process. In line with Foucault (1980), the interest of this

research with respect to the discourse of power within the reform process focuses more on *how power operates* within a given system (Foucault, 1980:145).

In addition to power, and especially with respect to the relationship and operation of the reform contents, i.e. performance targets, performance measurement and performance incentives, 'trust' was another important theme. Numerous researchers from various disciplines seem to agree that trust [and distrust] is widely acknowledged as an important construct and enabler in human actions and interpersonal relationships within an organisation (Hosmer, 1995; Kramer, 1999; Dirks and Ferrin, 2001). As highlighted by Kramer (1999: 569), trust has an important benefit for organisations and their members in terms of maintaining a healthy working environment. This is particularly important in healthcare settings because health workers largely depend on each other; thus a good trusting relationship between workers and managers, and between worker and patients, is crucial to corporate effectiveness. Without going into the complexity in the definition and dynamics of trust, research suggests that trust is often understood as a belief, behaviour, attitude, confidence, expectancy and an interpersonal variable between organisational actors engaged in a given relationship, and can easily be created, and broken (Fox, 1974; Dunn, 1988; Luhmann, 1991). The implied views of these researchers suggest that trust as a dynamic construct is person-, or situation/context-, specific. It follows from this premise that trust, as described by Hosmer (1995), is the reliance by an actor on the part of another actor, that is to say that A trusting B suggests that A expects B to have the capacity to perform to the best interests of A, and will do so in a fair and morally correct manner (Hosmer, 1995: 383).

In relation to the analysis in this study, Meyer *et al* (1995) identify three trust-related issues, namely: perceived ability or capacity, benevolence and integrity/fairness. For instance, capacity refers to the perceived capability of SERVICOM to perform or undertake a given task; benevolence is the extent to which one worker acts in the interest of another and it connotes a positive attitude and commitment to one another. Finally, integrity relates to the perception that a worker or manager will

adhere to a set of principles that is considered professionally worthy and fair. Based on the view of Bachmann (2001), the consensus is that workers' subjective perception of trust could be based on their personal experiences (*personal trust*), the functioning and reliability of the reform process within the public sector system and underlying social structures (*system trust*) and trust between different categories of workers within the organisation e.g. between workers and their colleagues, and workers and managers (*institutional or organisational trust*).

In general, this chapter applies the constructions of power relations and trust in the analysis of the way workers view the reform process, including the dynamics of interactions and relationships. Throughout this thesis, distinctions of power are also evident with respect to how different actors express their views (e.g. bureaucratic/administrative and professional views), and the way different actors construe their views (e.g. as in the use of "them" and "us" mentality). This was found to be most appropriate given the relational nature of the policy process, and the discourse and bargaining process often engaged in by different actors, which shape both their understanding of the policy reform and its effects. This provides micro-level empirical evidence drawn from the policy recipients, who are the primary policy target group and are involved in healthcare service delivery.

It should be pointed out, however, that there are, inevitably, ways in which health workers' psychological attitudes and perceptions about the reform and its effects overlap. For instance, commenting that the reform has introduced new power relations in hospital operations, and that they experience a sense of being under control and a loss of professional discretion, have ideas in common. After studying the texts at length, this study presents an interesting difference, and it is therefore useful to divide the analysis in this way. Nonetheless, this study also recognises the difficulty in disentangling the extent to which it is possible to separate workers views of the reform process and its effects.

A number of specific and important findings emerge. Overall, there was a measure of agreement between these different worker categories with some differences of opinion between top-level executives and the rest. Firstly, with respect to the policy design, all the respondents except the top-level managers expressed their view that they had been, and were being "left out" in the design of the new policies and

fabrication of the performance measures. Secondly, with respect to the reform implementation, the frontline workers and their managers perceived the activities of the implementation agency as bossy and autocratic, and thus often questioning their professional integrity. In addition, making workers work under structurally imposed targets suggests to them that they are no longer in control of their professional work. Thirdly, there was a widespread indication of perceived unfairness arising from how workers perceive the performance measurement process, and the distribution of individual performance awards. Finally, results presented in this chapter also suggest that hospital staff had a lot of fear and anxiety about the changing nature of their work and they perceived the reform process as threatening to their job security and professional practice. This chapter also indicates that the workers do suggest positive perceptions towards the reform. For example, workers perceived the reform as good in that it has helped them to know what is expected of them. Moreover, there is an indication that the reform has contributed towards improving operational efficiency in terms of reducing waiting times, improving the speed of operations, and increasing the number of patients seen on a daily basis.

6.2 Health Workers' Perceptions of the Policy Reform Process-Its Design and Implementation

This section consists of two parts. Section 6.2.1 examines the reform development or design process, while Section 6.2.2 presents an analysis of workers' views of the reform implementation structure.

6.2.1 Reform Design

As noted earlier, the creation of the reform involved many actors and processes. As health workers attempt to make sense of their non-involvement in the policy design, they presented their own understanding of how they feel they should be engaged in decision-making processes affecting their work.

The following extracts from the interviews held with one nurse and one doctor give indications of the way in which hospital staff perceived the design having taken place.

> *Foreign consultants put together the policy for government. They did not involve us; don't mind what they are saying. When we attended the seminar, nobody asked questions because some of us did not know what they were talking about. Besides, nobody wanted to be anti-government since government has already made up its mind to implement the policy. At the end, they provided us with biscuits and water. I have been in this service for 28 years, forget it, government has never involved our views in policy making in this country* (Female nurse HWN19)

> *There were so many public speaking events such as seminars and workshops, about the reform. They told us that the reform was patterned on the experience of other countries like UK, even our neighbours like South Africa have adopted similar reforms, and that it is working. What really happened was that government used the events to tell us what they have decided to do. I do not think that it was for us to contribute* (Male doctor HWD12)

A senior nurse voiced that:

> *There has never been a time where government in this country has involved us whenever they are making policy. They do it alone; we only receive circulars informing us what we are to do* (Nurse HWN4)

The claim of being 'left out' by the frontline doctors and nurses in the reform design process, especially in the planning of the performance measures was supported by ten of the sixteen operational managers interviewed. Furthermore, the view of the doctors' union representatives reaffirm this sense of alienation and reveal that, despite the official claim that there has been reasonable consultation with and participation of the stakeholders, including the health workers, the government instead used foreign consultants and experts to drive the reform design.

> *Government remains frantic about the reform. It is government policy not ours. While the idea to reform how we do our work seems profound, it has not been tested. They just told us that it is working elsewhere like UK and South Africa. The foothold of our argument then and even now has been that buying a cap because it fits another person could result in devastating experiences. This was exactly our experience with the structural adjustment programmes of the 1980s and the 1990s. During the seminars, we submitted a communiqué to government. However, none of our perspectives was integrated into the reform. It is ridiculous to say that we were involved* (Doctors' Union representative)

However, one operational manager provides a rather different perspective on the reform and on the reaction of his colleagues to the reform:

> *Really, it is difficult to say, but at the time government was talking about this reform there were many other things in the news such as a plan to reduce the civil service. People were being very careful; nobody wanted to be a* scapegoat *or to suffer for criticising government. Besides the consultants as we were told are experts in the reforms* (Male Operational Manager HOM9)

All the six top-level managers interviewed, together with half (eight out of the sixteen) of the operational managers suggested a sense of policy ownership. One top-level manager, for example, said that:

> *We welcome the whole reform process and we are optimistic that it is just what our country and health system need. This policy has come to stay and our commitment is that we all are involved and should be involved to make our services better* (Top-Level Manager HEM3)

One operational manager adds support to the above comment:

> *Yes, 'they' told 'us' and we see the whole process as our national commitment to changing the public sector. What we found embarrassing is the way government has singlehandedly decided for us how we should do our jobs* (Top-Level Manager HOM7)

A comment by one doctor (supported by many others) suggests that the workers were reasonably aware that the nature of the information exchange, consultation, and engagement in the reform process did not suggest any 'true' form of active participation:

> *They told us the reform is good and that it has worked in other countries. They talked to us, we listen to them, but they did not give us opportunity to speak our minds and they did not consider our situations* (Doctor HWD10)

Overall, while half of the operational managers consented to the reform and even recognised it as a national objective, the main issue that run through the interview is that they did not seem to welcome the way the reform process was handled. Moreover, the union representatives who spoke on behalf of their profession particularly dislike their lack of participation. During the interviews, it became clear that, top-level executives, and even some operational managers, seem to have had more information about the reform process. Nevertheless, they may not have felt that they were in a position, as government ambassadors at the organisation level, to question the proposed policy.

Interestingly, all the workers believed there was an overwhelming variety of media publicity sponsored by government as well as organised seminars and workshops which they were mandated to attend. The emerging view of the workers contradicts government claims that the policy arena provided opportunities for public debate and cross-fertilisation of ideas between different actors. The general view of the frontline workers suggest that these so-called consultation fora were laden with technical ideas and preoccupied with political interests, and therefore served as a strategy used by government to get across their message and intentions about the reform. Further analysis of interview texts, however, suggests that top-level FMCU hospital managers were supportive of the policy process, and in fact acted more as the "public face" of government, speaking in defence of the reform and being more optimistic about the delivery of the expected reform outcomes than others.

The construction of the experiences and the reported interaction between the frontline workers, including the operational managers, and the speaker during the workshops and seminars suggests that there may have been an unequal balance of power between the policy experts and other speakers and themselves. The frontline workers believed that the policy arena was monopolised by government bureaucrats and their contracted policy consultants [policy experts] who now and then told them the reform was the best thing that could ever happen because it had worked in other countries. The reform design process gives an indication of unequal power relations rather than an open forum, for policy dialogue. Most of the workers perceive that it was a 'classroom' which gave the contracted policy consultants or experts an opportunity to popularise the policy idea.

The results of this study suggest that workers believed that they were excluded from the decision-making processes, especially with regard to identification and definition of the policy choice, goals and strategy. From the analysis findings, besides the concern of lack of participation, another key issue is the belief that the reform was inconsistent with their expectations that change should be based on clinical practice. A core emergent concern arising from analysis conducted is that the workers claim that the government monopolised the policy-making process. They argued that government snubbed their union representatives. While workers strongly argued their claims, making generalisation based on this is problematic. This 'problematic' conclusion adds support to the literature already flagged in Chapter 4: harmonising

the views of different actors in a policy process is arguably challenging. Nevertheless, research evidence drawn from other cases (Haas, 1992; Hall, 1997; Hill and Hupe, 2002) does confirm government dominance, and the use of policy experts in designing policy recipes. Evidence of lack of participation of policy recipients in policy processes especially across developing countries policy contexts, has been well outlined in policy process literature (Keeley and Scoones, 2003; Sabatier, 2007).

The results regarding workers' exclusion from the policy process also correlate with findings of Taylor (2003), which particularly shed light on how 'claimed' public participation in government policy activities is inherently marred by asymmetric power relations. A similar criticism of 'fake' public participation in government policy-making processes has been reported in the policy context of other developing countries. For example, Williams *et al* (2006), in their study of policy-making in South Africa, demonstrated clearly that "interactive and in-depth policy discussions have often been sacrificed for fast and easily organised presentations bureaucratically arranged using policy experts who flood the policy dialogue with technocratic information" (Williams *et al*, 2006: 17). The same authors found that such arrangements allow little opportunity for meaningful dialogue and contribution to the pre-set policy intention. The results on government's influences in policy-making also correlate with Foucault (1982) in his discourse on governmentality. Foucault is of the view that governments often adopt a 'paternalistic approach' to policy-making, which emphasises that governments know what is right and good for the public interest. In so doing, governments deliberately monopolise the policy arena, setting out a rational and strategic procedure in an attempt to govern 'others' and make them comply with their political interests (Foucault, 1982: 220). Similarly, Hood (1998) recognises this logic as a strategic configuration of power apparatus and an "art" which modern states use to exert influence.

The point, in sum, is that evidence of power relations in the policy process creates a platform of unequal access to policy information and dialogue. Clearly, differential power among actors within the policy process is an elitist ideology which has often been the root of frequent conflict and contestation among actors with those with lesser power often alienated by dominant interest and ideas (Keeley and Scoones, 2003). This study observed that while it seems reasonable that health workers should

be involved in policy design, how to achieve this in practice may not be a straightforward process.

6.2.2 Implementation Structure-SERVICOM agency

This section presents and discusses health workers' perceptions of the implementation agency and its appropriateness in facilitating good working environment. There was a consensus among the operational managers indicating that SERVICOM operates as a form of "power over" the existing status quo. The sense here is that hospital operational managers could be feeling loss of status and control over the hospital they manage.

The view of a female operational manager, which also found support from many other managers, suggests that: "SERVICOM is perceived as a power window used by government to regulate how managers manage and how frontline workers do government work" (Operational Manager HOM7). The discourse of 'power' was also widely acknowledged by frontline workers who also perceived it as a form of political interference and hegemony over their profession. Many frontline workers reported that SERVICOM operates as a disciplinary instrument put in place to ensure that workers and their managers comply with government directives.

The frontline workers perceived SERVICOM as a questionable agency. Hospital staff expressed concern that SERVICOM is made up of non-health professionals, and thus, lacks clinical capacity regarding how a hospital operates. There was consensus among hospital staff in expressing significant discontentment because the government is using 'them' (SERVICOM) to direct how 'they' (health workers) do their work. In general, the results demonstrate that the majority of the workers, including operational managers, were rather peeved by this arrangement, as evident in the following quotes:

> *SERVICOM query both frontline workers and even us manager. The other time a line manager was replaced because of reported case of sluggishness towards customers. We have also had cases were a manager and staff were summoned to Abuja for further interrogation concerning a case that was treated locally but the local SERVICOM office claimed that it was not well treated* (Operational Manager HOM9)

> *'They' (government) are using 'them' (SERVICOM) to tell 'us' (health workers) what to do as if we no longer know our jobs* (Doctor HWD8)

> *Everybody knows that SERVICOM is watching. You cannot ignore 'them' because they can recommend people for award, others have been recommended for sanctions including delay of salaries, and others have received query and warning. I just think that there is too much politics influencing our jobs. Although they do not know everything we do, yet, they are still using what they think to challenge the way we do our work* (Doctor HWD12)

The above statements from different categories of hospital workers reveal that SERVICOM is perceived by hospital staff as an administrative control mechanism and has, thus, created a new form of power relations. The view among the health workers was that SERVICOM operates as a mechanism that seeks to [dis]organise their professional knowledge and profession. The workers see their profession as having come under severe control, consequently, being far less autonomous. Many other frontline workers, as reflected by HWD12 for example, offered their views which, overall, suggest that they see the way government is using SERVICOM to oversee their work as a form of control. This study's results indicate that there is a clear sense of uneasiness among the frontline hospital workers and their operational managers. The hospital workers in general expressed fear of having their professional power and agency weakened, which influences their decision about how to provide healthcare services. The results suggest that the perceived dislocation of the professional power of the frontline workers has often resulted in tension and dichotomy, as expressed by the construct of the "they", "them" and "us" culture. One of the senior consultants said:

> *I think it has not been easy for both professional and administrative views to coexist regarding how healthcare should be provided. While there could be common ground, healthcare remains a professional issue. The state of affairs as we have seen suggest a general lack of openness. I do not think that SERVICOM is open enough to appreciate our professional views. They are just following government orders. Frankly, it is hard work to pursue government rules and sometimes contradict our professional ethics* (Doctor HWD3)

Continuing, the same informant said SERVICOM has less capacity to direct how healthcare should be organised because 'they' (SERVICOM) are not professional health workers.

Another manager, highlighting the language of regulation, control and sanction noted that:

> *I think that SERVICOM's objective i.e. making sure that customers receive timely, fair, and quality services in an honest, effective and transparent manner is a good one, but the way they are going about it raises doubt on our competence to manage. For example, we have an incident in which a head of unit was removed because of SERVICOM inspection. It happened that a health worker was queried following a customer complaint. As usual, SERVICOM sent in a memo and requested that the matter be investigated. After interview with the worker, the manager felt that the case lacked clinical evidence and so was dismissed. But SERVICOM staff was not satisfied, both the manager and the health worker was summoned to Abuja for further interrogation. Although at the end the worker's salary was suspended for a month and the manager received a written warning, the way it was handled suggest expression of power in practice. They are challenging our capacity to manage our workers and patients* (Operational Manager HOM8)

Concurring with the above incident, a hospital executive commented:

> *I do think that the relationship between managers and SERVICOM need to be improved. The expression of some managers has been that SERVICOM as non-health professionals are assuming superiority over how customers should be treated. There is no protection for managers and even health workers at the frontline, any identified mistake you could be out. The other time, we heard in the news and in our meeting of how the government removed two executives of a federal hospital organisations because SERVICOM reported that the hospital performance was shameful. Everybody is feeling the pressure but I feel the intention of government is not to undermine us but sometimes, situations emerge that appear anti-productive* (Top-level Manager HEM3)

Another doctor commented on the audit function of SERVICOM as lacking power in observing what they do:

> *I just think that we are been watched as if we no longer know our jobs. Government is indirectly claiming to be telling us what to do. I do not think that asking SERVICOM to watch us will make us do better, after all SERVICOM may not see everything we do since they are not doctors and nurses* (Female Doctor HWD21)

In general, doctors and nurses interviewed were of the view that SERVICOM lacks the professional capacity to 'observe and measure' what they do. One operational manager (a doctor) said:

> *Our work has come under severe criticism due to too many rules and regulations coming from the top. As we have been experiencing, sometimes the activities of SERVICOM are not in congruence with our professional ideas.*

> *For example, SERVICOM staff just feels we are resisting change when we try to bring out what an action means clinically. There is too much talk about targets and customers (rather than patients) as if we are in the market place. Nobody is suggesting concern about clinical quality which has always been our concern. Government is wasting too much money on SERVICOM while we do not have the facilities we need to do our work* (Male Operational Manager HOM9)

In addition, a union representative said:

> *We have made it clear to government that our Medical Council branch based here at FMCU hospital does not subscribe to the use of non-professionals with minimal or no knowledge of medical affairs to measure and monitor our work. This is unprofessional. Despite the numerous complaints we have made to government nothing has changed. SERVICOM operates as a teacher, telling us how to do our job and this is raising a lot of discontentment among our professional colleagues. SERVICOM is not about clinical quality and procedure because their staffs do not understand this aspect of our work. They are just filling registers based on the mandate given to them by government* (Doctors' Union representative)

The results suggest the operation of SERVICOM is perceived as a source of demotivation. Clinicians believed that SERVICOM operates as a form of 'control' which has introduced a rigid work mechanism, and a restriction to their professional autonomy. One doctor said:

> *They are telling us what to do as if we no longer know our jobs and this is frustrating. I do not think we are progressing. Yes, they imposed on us the targets. Targets are not everything. We just will want to do our jobs as clinical staff and not pushed here and there as factory workers. The target is too rigid, some of us no longer do private practice as we want* (Doctor HWD7)

The above statement, which was welcomed by the majority of the other doctors, in particular paint a picture that the operations of SERVICOM have restricted their freedom. The doctors complained that they are overmonitored; therefore, their freedom to engage in private practice has been infringed upon. Although this appears to be a negative perception of the reform, it still stands out as a success story or achievement of the reform. This is because one of the major performance challenges of many developing countries' health delivery systems is the criticism that public health workers (especially doctors) use government time and resources working in their private hospitals rather than focusing on the public hospital organisations (see McPake *et al*, 1999; Ferrinho *et al*, 2004a/b). These past studies found that public health workers, in particular doctors, are often accused of showing up for a few hours only in the state hospital where they are fully employed, and

spending most of their time in their private clinics. It is also often rumoured that doctors do divert patients from government hospitals to their private practices. This negative perception of the reform with respect to infringement on the freedom of the clinicians is akin to the perceived effects highlighted in in Chapter 7 (Section 7.2.5.2), in which workers complained that the reform has affected their ability to exercise their socio-cultural duties to their friends and family members in that they are no longer in a position to influence their family's and friends' access to government services.

In general, the results suggest that different people have a difference sense of what is right and wrong, in relation to what they feel is the explicit and implicit professional and social culture. Indicated earlier, clinicians seem to perceive their professional culture or freedom to do what they seem right as a divine right. Hence, reducing their opportunities to do private practice, or attend to their friends and family members, is perceived as an infringement on this culture. Thus, the results suggest that the operation of the reform seems to have generated a shift in cultural orientation with respect to professional and social relations. This indeed seems to be in line with the aim of the reform, which is about changing the way the government functions or how public workers do their work.

The above texts point to existing tension between SERVICOM staff and hospital workers. This resonates in the regular expression of the 'they', 'them' and 'us' mind-set. All the workers expressed the view that using administrative managers, described by one of the doctors as 'outsiders', to 'tell workers what to do and to monitor how we do it' is not appropriate.

Following on from the views expressed above, ten out of the sixteen operational managers interviewed noted how the operation of SERVICOM has led to shifts in the balance of power, changing roles, and a sense of alienation and dissatisfaction. One of them for example said:

> *Often it seems that we are no longer in charge, if it is not SERVICOM that is pressuring you, it will be customers that will be reporting you to SERVICOM. It is also deeply evidenced by one of the SERVICOM leaflets that 'customers should Ask SERVICOM if they are not satisfied with services' as if SERVICOM will treat them* (Operational Manager HOM6)

Another manager was of the view that their work has come under pressure because of how SERVICOM operates as a new form of power structure:

> *"We are always under pressure from SERVICOM to provide information, address complaints and improve service. Yet, SERVICOM has no say about the inadequate hospital facilities in this hospital. Yes, providing this information represents an improvement in hospital leadership, but, the approach is too bureaucratic. We spend too much time redressing query and filling out the paperwork"* (Operational Manager HOM3)

Another concern regarding the way hospital staff perceived SERVICOM relates to the consensus among the hospital staff that SERVICOM lacks the capacity and cognitive ability to effectively measure their performance. Several reasons were linked to this. First, hospital staff claimed that their work is indivisible and difficult to observe or measure, and is not as discrete and measurable as presented by SERVICOM. The second is related to the fact that SERVICOM workers are not health professionals, and thus lack the training and cognition to know and/or observe what the workers do. The background of SERVICOM workers has been highlighted earlier, in Section 5.2. Finally, there was a unanimous view among the frontline workers in particular that SERVICOM relies on the use of customer statements and complaints, and national targets operating as a generalised best practice, to gauge individual workers' performance. The perception of the hospital workers suggests that this represents reductionist assessment, which is subjective and lacks adequate coverage of clinical matters.

Another related issue that shaped the way hospital staff perceived SERVICOM has to do with the operational methodology used by SERVICOM for performance data collection and analysis. As outlined above, it remained largely subjective and cannot be said to be robust. More so, despite much discourse about performance data collection and measures, there was a lack of hard data to support the claims made by SERVICOM. However, whether SERVICOM is making the right decision about worker or hospital performance is one thing, the fact that their presence signals the evolution of an audit mechanism is perhaps the most important issue in terms of likely implications for human behaviour and change. The indication that the observation and scoring process involves using the present SERVICOM evaluation form and is based on the discretion of SERVICOM staff indicates a potential source of serious error. During the research, there was no objective evidence that such

errors as claimed by frontline workers have occurred. Nevertheless, there were consistent rumours and suppositions among frontline workers, and even a few managers, that given the way SERVICOM staff operate and the fact that details of their data analysis is not easily available, indicates potential problems. For instance, SERVICOM staff at FMCU relied on the national evaluation forms in their research and observation procedures. The use of this universal form implies first a generalisation of activities across all public hospital organisations, and second that the scoring process relies on box ticking activities and the subjective assessment of the assessor. A sample of the SERVICOM evaluation form is provided in *Appendix 2*. Overall, workers seem to perceive the activities of SERVICOM as far from perfect, and inappropriate, because they fail to capture a holistic view of their work.

Most importantly, hospital staff regularly complained about SERVICOM's leadership style, stating that they are too officious, bossy and top-down. The perceptions of the workers did suggest that although they recognised that some form of audit was necessary in their work, they did not consider the way the government was going about it as appropriate. The results suggest that the use of SERVICOM to implement the reform represent, yet, another medium of power through regulation and control. The subject of the regulation and control of healthcare professionals has emerged in recent times as a universally aesthetic feature of health policy agenda designed with a view to modernising public service (Hood *et al*, 1998; Power, 2004). While this represents an evolving shift in the role of the state in managing public organisations, it seems, in turn, to be leading to a new pattern of human interactions which health workers believe do not necessarily conform to their operating practice, or is considered appropriate. The focus of control and regulation, as evident in this study, reflects the trajectory of the new public sector management characteristics of modern democracies pushed forward as a way of encouraging the modernisation of developing economies.

The main question relating to the perception of the use of SERVICOM relates again to the recurring dichotomy between non-clinical and clinical ideas as expressed consistently by the workers with the language of "them" and "us", inherently suggesting a form of power struggle in organisational relationship. Most overtly, the presence of SERVICOM has a direct power consequence on the workers and their

managers. For example, there were steady complaints from the workers and operational managers that they are losing their professional power and autonomy, their identity and self-worth.

As evident in Section 6.2.1, the workers clearly did not welcome the use of non-clinical administrative managers in the development, as well as the implementation of the reform. Two-out-of-every three frontline workers interviewed see the arrangement as inappropriate because it operates as a form of control. In particular, three-in-five managers interviewed described the presence of SERVICOM over their work as repressing and unsuitable to their management practice. The managers alleged that the said shift of management power to SERVICOM triggered a sense of subordination, and threat to their professional capacity to manage. The workers believe that the use of SERVICOM is too mechanistic and technocratic for their professional work culture. However, though the literature prescribes potential benefits of regulations and control for public organisations and workers in terms of contributing to aligning interest to set goals (Latham, 2004; Latham and Locke, 2006) and providing information (Symon, 1993, Heinrich, 1999), the effectiveness of the operation of this goal-directed initiative in particular, as perceived by the workers, remains particularly limited.

Section 6.2 has offered a useful analysis of workers' view of the reform design and implementation process. The ambiguities in the use of the language of "them" and "us" suggest a clear dichotomy in ideas and class struggle between clinical workers and non-clinical managers. It also suggests that workers refer to the reform as not being their idea or simply that it is "government policy" which has been "borrowed" or driven by expert advice. The workers believe that a lack of participation in the reform process tends to widen the gap between policy-makers and policy recipients which may have contributed to a perceived ineffectiveness of the reform. The concern of the workers, which found expression in much of the texts correlates with the assertion highlighted by other policy researchers particularly across many developing countries' policy contexts (Keeley and Scoones, 2003; Sabatier, 2007).

The workers raised concerns about the way government used non-clinical managers to set and implement performance measures which clearly signal a shift of power in hospital organisation. There is an indication that the ideology of public health sector

regulation originates from developed countries, and reflects the domineering evidence of modernisation ideology, seen as a form of governance arrangement, and characteristic of the new public sector management (Hood, 1991; Power, 2000), which is supposed to facilitate compliance to the reform's goals. Nevertheless, the reform has been seen as undermining the professional autonomy of the workers because, as noted by past studies (Luke, 1974; Ouchi, 1980; Power, 2004**),** the operation of SERVICOM suggests a form of control structures with evident elements of 'power over' health organisations and its workers. Although it is understood that regulating how workers do their work will check their operational agency and discretion, and help to align interests to government corporate interest, the idea of control, as noted by Barley and Kunda (1992), reflects the dominance of a positivist and rational thought in business management discourse which is based on a widespread functionalist approach to change and apply institutionalised procedures, measures and targets. The result, as outlined by the workers' views, is that this has contributed to a sense of powerlessness in healthcare professional culture and clearly demonstrates the main reason for the discontentment expressed by the workers.

While the rationale for regulation remains rife in policy debates, its operational relevance seem inconclusive. What emerges strongly from the workers' views is that their subjective perception of asymmetric power relations in the policy process creates a sense of subordination, powerlessness, and disenfranchisement. The results correlate with sociological schools of thought (Meyer and Rowan, 1977; DiMaggio and Powell, 1983; DiMaggio, 1988; Scott, 1992; Long, 2001), which suggest that perceived control could weaken workers' agency and position and their capacity to negotiate their interest within the reform process and social context of their work.

6.2.3 Power to Patients

Concerning the issues of power relations discussed above in Section 6.2.2 another theme that emerged from the reform elements relates to how the reform has given power to patients. Power to patients has emerged in recent times as a doctrine operating as a supposed way of holding frontline workers to account and enhancing their capacity to provide improved services (Blakeman *et al*, 2006; Fox *et al*, 2005; Filmer *et al*, 2002).

The underpinning rationale as captured in the current reform is that it will enable patients to query, or seeks redress for, perceived poor performance through the Grievance and Complaint redress system. As reported by the managers, power to patients is one of the core elements of the Social Charter. Six out of sixteen managers interviewed suggested that it has had positive effects, especially in providing feedback and driving customer focused care. The following extract from the interviews with these operational manager interviews (HOM2 and HOM6) notes this:

> *The introduction of a complaint procedure means that we now get feedback from patients. Before the reform, this hardly occurred. Patients now provide us reports of how they feel. This is treated officially and any worker found wanting is reprimanded* (Operational Manager HOM16)

> *Before the reform, public workers were often accused of not suggesting a sense of respect to patients. They treated patients as they liked and had no respect for their rights and dignity. Now things have changed. We are here to serve the patients as our customers. They are the reason why we are here. If you misbehave in front of customers, they can report you and it can earn the worker a query and damage reputations* (Operational Manager HOM2)

These comments suggest that giving power to patients has enhanced the value of patients' voice, and this is regarded as important because it is seen to be the driver of improved performance. However, as is evident from the opposing thoughts detailed below (see the comments of Nurse HWN19 and Doctor HWD11 in the next page), patients' voices can easily be viewed as problematic where they are interpreted as questioning professional conduct.

The frontline workers in particular argued that giving power to patients is detrimental to healthcare practice. Half of the frontline doctors and nurses involved in the present study perceive that this reversal of power – power to patient - has

resulted in increased verbal abuse on their person. Nurses, who seem to report more on the construct of an increase in verbal abuse, possibly because they interact more with patients, asserted that they are reluctant to report their experiences because their operational managers and SERVICOM staff hardly listen to them.

> *The first time I was verbally abused by a patient my manager did not do anything; I was only told that SERVICOM would take the matter up. Sometimes you feel you are not safe because patients can talk to you anyhow. I think that we have lost our professional status. We are blamed, reported and queried for every little thing that goes wrong* (Nurse HWN19)

> *"Sometimes you feel very sad to just sit and allow yourself to be insulted by a patient. The last time a male colleague tried to defend himself he was almost immediately suspended from work for one week, and given a query even though everybody knows that the patient was wrong."* (Doctor HWD11)

Five of the sixteen managers confirmed this increase in verbal abuse on workers especially nurses in the outpatient department. One of the managers said:

> *I think that the customers often go too far and even insult our staff. There is a need for more awareness of how customers can politely make complaints. When a worker feels verbally insulted they are de-motivated. We have had more verbal abuse on the nurses than doctors, particularly at the General Out-patient Department* (Operational Manager HOM7)

The doctors and nurses claimed that patient power interfered with clinical decision-making. The perceived negative outcomes of 'power to patient' are very clear from these summaries. Both doctors and nurses claimed to have suffered different kinds of sanctions such as a query, suspension and even demotion as a result of complaints from patients. About a third of the managers expressed negative feelings and complained that the redress process resulting from the patients' complaints is a threat to their jobs. For example, one operational manager narrated an incident in which a ward manager was demoted following a patient's report to SERVICOM. His report simply states:

> *One of our heads of unit was demoted two steps after a report made by a customer to Abuja* (Operational Manager HOM11)

The view of HOM11 was echoed by a top-level manager (Male HEM2), who commented that, even in other federal hospitals, patient's power has been significantly threatening:

> *Two top-level managers of a federal hospital in Nigeria were removed all because of statements of dissatisfaction were received from customers* (Male HEM2)

These reports suggest that patient's power has been affecting *all* workers irrespective of their status, and in fact, is seen as challenging to the traditional understanding of healthcare knowledge as reserved for clinicians only. Interesting discussions drawn from Section 6.2.2 indicate that, theoretically, SERVICOM was about empowering the patients. As highlighted above, health workers perceived this empowerment as defective and inappropriate to their practice. In addition, the understanding that patients could report poor performance, or a frontline worker in particular, to SERVICOM for disciplinary action suggests that, for the workers, there is another form of asymmetric power relations, control and regulation in their work, hospital and profession. The views of the workers, as demonstrated by majority frontline workers and managers interviewed indicate that they did not see the arrangement as good, arguing that it is undermining their authority and operational discretion.

The results of this study, nevertheless, did not seem to suggest that workers prefer to be left alone to do as they like, but what has emerged is that the whistle-blowing job of patients seems to introduce a new work culture that questions the sovereignty of medical knowledge. Drawing lessons from medical sociology, it can be deduced that power to patients relate to the argument that patients should not be treated as 'passive' but should be seen as elements who can actively influence medical decisions. This correlates with relatively to old literature (Parsons, 1951; Illich, 1975), which could be seen to a have link with global health policy in the 1990s and now, in the 21st century. Illich (1975), a strong supporter of patient empowerment, argues that integrating the "sick role" of patients is relevant to understanding a patient's illness and perspective about their health and social contexts (p.5). The view of the workers, on the contrary, suggests that involving patients in deciding healthcare is an oversimplification of the clinician-patient relationship, and a challenge to the fundamental ethos of their professional knowledge with respect to the content, values, context and outcome of their clinical decisions. Critiques to power to patients, which support the views of the frontline workers, demonstrate that it poses a threat to these workers. For example, Johnston (1999); Blakeman *et al*

(2006), and Fox *et al*, (2005) point to the understanding that power to patient is problematic because it interfere with clinical decision-making process.

According to WHO (2002), strengthening patient (citizen) power policies and action is expected to enhance quality and accessibility to healthcare services. The World Bank (2004) outlined that amplifying patients' voices in healthcare delivery decisions provides some hope to improving performance because of the supposed role in providing information that links together performance, rewards and sanctions. The patient rights approach to service delivery has also been advocated in other developing countries such as Ghana, Uganda, Brazil and South Africa. Despite the fact that the issue of patient power and rights in service delivery in health and education has, in recent years, been rife, and increasingly seen as an important component of international development and specifically social or health policy (Filmer *et al*, 2000), there are no clear parameters regarding the practice. For example, Gauri (2003) found that the operation of patient power remains vague, impractical, or self-defeating because of imperfect structural rigidities in many developing countries that make assurance of patient power problematic. The conclusion based on the above results suggests that, in spite of the ambitious potentials of patient power, there is no certainty that it is a quick fix for healthcare delivery performance challenges in Nigeria. The views of frontline workers and their operational managers suggest that it contradicts their professional knowledge and decisions and leads to tensions, thus, its effectiveness remains inconclusive and open to debate.

In general, all workers except the top-level managers believed that they are losing their status and professional identity in decision-making processes that shape their work. Giddens (1991: 53) highlighted in his discourse that self-identify is a reflexive construction of agents (i.e. workers) based on their perceived position, space, control of, and access to, resources. While the issue of reform effects on motivation will be discussed in detail in Chapter 7, the results point out here that workers' views and construction about their professional identity, arising from the perception of being under control and regulation, suggest a feeling of [de]motivation. It is, however, important to emphasise that one positive perception of the reform design and implementation structure is that it provided the mechanisms for aligning interest and motive for compliance. This has had a positive effect in terms of holding workers to

account and ensuring that they follow the rules and, in particular, provide information to their clients.

The results as presented in this section have provided evidence which suggests how workers' narrative and conceptualisation of power relationships contribute to providing a nuanced account of their endemic psychological attitude, behaviour and perception of the reform. The results indicate that workers believe that the operation of SERVICOM exerts control over their healthcare practice. Of course, workers cannot effectively practice without a form of control, but the results of this study point to the suggestion that the perceived lack of participation and control of professional activities by non-clinical, bureaucratic managers weakens the effectiveness of health providers. It is hoped that these results will serve as a focal point that could drive a rethink and debate by examining issues raised about the policy design and implementation.

This section has offered some useful insights on workers' perceptions and responses to the reform process, with particular focus on the reform design and implementation structure. It draws from the first theme that emerges in the analysis (i.e. power relations). The next section (Section 6.3) focuses on the operation of the reform contents and especially draws from the construct of trust as the second important theme.

6.3 The Reform Contents and Relationship among Organisational Actors

Section 6.2 presented an account of how different categories of health workers perceive the reform with respect to its design and implementation. The section related to how 'elitist power relations' (Lukes, 2005; Sutton, 1999) associated with the reform design and implementation excluded the workers from active involvement and decision-making processes that shaped the reform. This section provides a more detailed and micro-level analysis of the reform process. Specifically, it analyses and discusses doctors', nurses', and managers' views of the operation of the reform elements such as performance targets, performance measurement, and performance-related-pay incentives. It also examines interactions

and relationships between policy implementers (i.e. SERVICOM) and hospital workers. The approach is discursive in that attempts are repeatedly made to place the texts and issues within the context in which the workers articulate their views.

Unlike Section 6.2, which focuses mainly on the theme of power relations, this section draws from the concept of trust which emerges as the second important theme. As noted in Section 6.1, trust relates to the reliance of one actor (*trustor*) on the part of another actor (*trustee*) that the trustee will act on the best interests of the trustor (Hosmer, 1995). Drawing from past studies, (e.g. Meyer *et al*, 2002; Meyer and Allen, 1997; Meyer *et al*, 1995), trust influences, and very likely, enhances an individual's perception of commitment, fairness and behaviour within the organisation where they work. There are different dimension of trust that emerge. This relates to the trust workers have among themselves and their managers, and the trust they and their managers have in the reformers and the implementers (i.e. SERVICOM). Kramer (1999) found that trust in organisations and social interactions increases the likelihood of achieving shared goals, and is, thus, very important in achieving organisational or reform effectiveness.

This section consists of three main subsections. Section 6.3.1 examines how the workers perceive the operation of the reform elements. The workers' views are expressed in terms of benefits (advantages) and costs (disadvantages). Section 6.3.2 presents an analysis of workers' views of the associated interpersonal relationship and interactions inherent in the operation of the reform elements. Section 6.3.3 presents the discussions and conclusions.

6.3.1 The Content of the Reform

This section presents the analysis of the reform content focusing on performance target culture (Section 6.3.1.1); performance measurement, including its associated elements such as performance ranking and public disclosure of performance reports (Section 6.3.1.2); performance-related-pay (PRP) (Section 6.3.1.3); and Section 6.3.1.4 presents the discussions and conclusions.

6.3.1.1 Performance Target Culture

Extensive literature, particularly from business accounting management, has been concerned with setting performance targets or measures to facilitate the measurement and monitoring of activities and behaviour of workers and organisational activities (Kaplan and Norton, 1992; Neely, 1999). There is, however, little evidence to demonstrate the practice in public health settings especially in a developing country context like Nigeria.

During the interviews held with regard to this study, it was understood that the introduction of performance is perceived by the frontline workers and their managers to present both benefits and costs of targets, to themselves, to their profession and to the hospital, these benefits and costs are referred to below as advantages and disadvantages.

Advantages

All the hospital personnel including hospital top-level managers, operational managers, and clinical staff interviewed talked about a range of advantages arising from the operation of the targets. Four main themes emerged and are presented in Table 6.1 below, using extracts from individual interviews to exemplify the themes.

Table 6.1 Advantages of performance targets (PT)

Strategic management and leadership tool	*Where there is no vision, there is no direction. PT is good because they provide us with a vision, direction and mission which guide us to knowing and doing what government want* (Male Operational Manager HOM3)
Align workers' interest to government corporate objective	*A target culture has helped to know the demands placed on us and the expectations from our patients (now clients) and this help us to maximise benefits for patients* (Doctor HWD2
Provide focus on customers	*A lot has improved because of the waiting time target. For example the timeliness of access to healthcare services has improved* (Doctor HWD2) *All eyes are on the targets and how they can be achieved. This has helped us to see our work clearly and to make sure that workers are doing the right thing to service customers* (Female Operational Manager HOM4)
Yardstick for measuring performance	*Targets are touchstones used to measure our performance. Nowadays we use targets to assess workers for promotion purposes* (Male Operational Manager HOM3)

While these extracts demonstrate a general agreement on each of the themes, in practice, it was possible to distinguish the perspectives of each category of personnel. All the managers, including top-level, demonstrated in the interviews an appreciation of the strategic position of a target culture in the health reform. They were more likely, therefore, to talk about the role of targets in providing direction and vision than anything else. Operational staff, including the lower-level managers were especially interested in the value of targets for facilitating effective coordination of work practices. Operational managers spoke more about targets providing a yardstick against which worker performance and assessment could be measured, whereas, among the frontline doctors and nurses, half indicate that targets are regarded as signalling movement towards meeting government objectives. On the contrary, the interview results suggested that frontline doctors and nurses were less likely to mention the advantages.

Disadvantages

Frontline doctors and nurses, including operational managers were more ambivalent about the benefits of a target culture in spite of their ability to point to the advantages. Table 6.2 summarises the range of views of the disadvantages of performance targets to healthcare practice.

Table 6.2 Disadvantages of performance targets (PT)

Reductionist view of complex process procedure	*Our work is complex. At times when you are in the clinic room, you do not know what to expect because most of our patients do not have appointments before they come. Targets suggest that service provision is more straightforward. This is problematic for our work* (Doctor HWD21) *We are not factory workers. Our outputs are not generated automatically. There are a lot of processes and interactions involved in our work. In this new culture, we are pushed here and there to see customers and turn them out as fast as possible. Delivering care is not like fixing a car; it involves a series of processes and diagnosis. SERVICOM as the implementing agency is obviously only interested in outcomes* (Doctor HWD26)
Incomplete and inaccurate picture of hospital work process	*Government just selected the targets based on what they think we do and therefore many things we do are not covered. They talk about waiting time and nothing about facilities, clinical processes and quality* (Operational Manager HOM11) *PTs neglect important areas of work (e.g. quality and relationships) and there is paucity of data to measure even those outlined targets* (Doctor HWD1) *Our activities are wide-ranging but the targets do not cover all we do.*

> *We nurses no longer spend enough time interacting and engaging with patients. This is not good for a caring profession like nursing* (Nurse HWN28)

There is a general view amongst doctors and nurses that a target culture is deterministic and does not provide the 'whole or big picture' of what healthcare practice is. Thus, the recurring negative perception of the workers suggests that a target culture undermines 'holistic or comprehensive care'. Contrary to the indication that a target culture is about results, workers (e.g. Female Doctor HWD26) are of the view that targets treat their practice as if it were a *machine or factory operation* where causes and effects can be readily identified. In their view, health care practice is a complex process that involves identifying possible causes, often from unclear symptoms being experienced by people who are anxious about their health and who need to have confidence in the skills of the services providers but also need assurance of their caring interest i.e. the process components of health care. Another widely held reported disadvantage of performance targets is that it prioritises and standardises healthcare work: the conceptualisation of performance targets demonstrates a structurally-imposed rule and a mechanical approach to change which did not recognise the dynamic nature of healthcare work. Informants articulated this as a strong limitation entrenched in the target culture.

6.3.1.2 Performance Measurement

Performance measurement emerged as a key element of the performance management process (Adair *et al*, 2006; Epstein, 2009; Smith *et al*, 2009). The workers interviewed expressed differing views about the concept, process, appropriateness and relevance of this process to healthcare practice. A very experienced operational manager summed up the objective of performance measurement thus:

> *This government introduced a mechanism for measuring performance and ensuring that workers and the hospital organisation comply with the national targets. By measuring performance, government wants to provide information to guide its operations and to facilitate timely and fair access to quality health care services* (Operational Manager HOM5)

Advantages

All respondents recognised the value of the information and communication feedback provided by performance measurement in that this information enhances accountability and, therefore, provides a means of recognising good and bad performance. The frontline workers, as well as their operational managers, suggested that performance information facilitates individual promotion in addition to providing a means of addressing grievances and complaints from patients (clients or customers) as summarised in Table 6.3 below.

Table 6.3 Advantages of performance measurement (PM)

Recognises good and bad performers and facilitates good management	*Through PM, management can see what is working and what is not working. The process helps us to identify future leaders or managers. It also enhances our capacity to effectively manage the hospital because it help us to direct workers toward the achievement of government corporate objective* (Male top-level Manager HEM6)
Provides information	*Because of PM, we are now providing information to customers such as leaflets, self-directed signs to facilitate identification, access to and choice of services. It assists patient understanding of what we do and how to access our services*(Operational Manager HOM6)
Enhances operational accountability	*Since this PM started, workers, managers and the hospital organisation as a whole are competing to perform well because everybody knows that they are being watched. So the public service is no longer a place where you do as you like. People have to suggest results for the money they earn* (Operational Manager HOM4) *They (government) are using them (SERVICOM) to monitor our work. People are now conscious of that they do and say* (Male doctor HWD8)
Facilitate assessment for individual promotion	*Things have changed. If you do well, you are rewarded or shamed or even shown the door. In fact promotion is no longer only based on seniority and length of services. People now earn promotion by results that are visible to everyone* (Operational Manager HOM8) *One of my colleagues was promoted two steps because the PM report identified her as a good worker. A lot of people are working hard to be promoted. This merit award is also creating an incentive to guide managers' decisions about promotion of staff working under them* (Nurse HWN18)
Addresses complaints and grievances	*Because of PM, customers can now make complaints about the services they receive, and even make recommendations on how services can be improved. All cases are treated promptly and bad behaviour is punished by query, written warning, and even demotion or suspension of salary* (Operational Manager HOM2)

For managers at all levels, PM reports provide a gauge that suggests how, and to what extent, they have achieved their targets. The claim that the process facilitates

information and communication between workers and patients indicates an improvement in operational efficiency. One operational manager noted:

> *Before the reform, people were always crowded at the Outpatient Unit but since information has been provided, patients follow the signs to points where they will receive attention* (Operational Manager HOM7)

One nurse (HWN4) stated that because of performance measurement, *"We are now providing information to customers to guide their access to and choice of services".* Other frontline doctors and nurses consistently reported that information to customers has improved. While workers consider this important, yet, they equally think that information to customers needs to be well guided and relevant to customer needs. All the six top-level managers interviewed confirmed this and noted that providing information is in line with the Social Charter more informed customers mean enhanced timely, fair and honest services. The responses reported here suggest that the operation of PM has introduced changes in the reward system with rewards being attached to individuals and in theory reflecting individual efforts and performance. On the subject of rewards, details of the perceptions of the informants about performance related pay are presented in Section 6.7.

Disadvantages of performance measurement

As evident in the reported texts presented earlier, views were also expressed as to why performance measurement is detrimental to healthcare practice. These views are categorised and presented in three themes in Table 6.4 below.

Table 6.4 Disadvantages of performance measurement **(PM)**

Undermines professional autonomy and discretion	*We no longer do this work as we know it. "They" (government) set the targets and use "them" (SERVICOM) to enforce it on us* (Doctor HWD19) *Patients now take us for granted. This is because they feel that the policy has empowered them to query what we do* (Nurse HWN29)
Costly and time-consuming	*Government has been spending a lot on SERVICOM. We believe that this money would have been more effectively used in improving our facilities and providing better drugs and medical supplies. Besides, the PM process is too administrative and is time consuming* (Union representative)
Reduces time with patients	*There are a lot of deadlines to our work. Yet we are now wasting appreciable time – sometimes when I calculate it is just like we spend 30-40% of our time - filling forms and these forms are very boring. I do not think we are doing well in reaching out to, and discussing with patients in the wards because there is inadequate time to spend with patients. Everything has to be done very fast nowadays* (Nurse HWN14)

> *Our staff members do not have enough time to consult with patients and engage them in a meaningful dialogue to fully dig out and know their problems* (Operational Manager HOM1)

The interviews suggest that the costs or disadvantages of performance measurement were widespread, especially among frontline doctors and nurses. Among the common concerns about the reform is that performance measurement operates as a 'control and regulatory' measure and undermines professional autonomy and decision-making processes in healthcare.

As already noted, the primary goal of performance measurement is to improve health service delivery. Worker ranking and public disclosure of individual performance information is described in the reform as a 'naming and shaming' process. During the interviews, the respondents articulated the advantages and disadvantages of this process. The results suggest that performance ranking, as noted by ten out of sixteen managers interviewed said it encourages individual initiative and talents. For example, one of the operational managers said:

> *What this reform has done is that it categorises workers into good and bad performers, and this provides a means of identifying workers that merit reward and even promotion. This is a smart idea compared to how we recommended workers for promotion before the reform. This was based on the personal recommendation of managers and was often fraught with the human factor and even bias. It is no longer enough reason to say that a worker should be promoted based on length of service and seniority. The worker performance status has to be evident* (Operational Manager HOM9)

One of the top-level managers also said:

> *The system as outlined by government is providing a straightforward comparison of workers. This is encouraging workers not to be lazy but to work hard* (Top-level Manager HEM5)

The responses demonstrate that operational managers view naming and shaming as a critical human resource management strategy for talent management. It signals to managers and management how workers are doing, and serves as an information feedback loop to guide managers in making promotion decisions. One senior doctor spoke in support of naming and shaming and noted: *'I think that the process is not too bad because it communicates our performance back to us'* (Doctor HWD9).

The results of analysis also show that the naming and shaming process were related to public disclosure of performance reports and ranking. More doctors than nurses referred to this practice as exposing their profession to public view, which is one of the objectives of the health sector reform. The way managers spoke about the public disclosure of performance reports reinforces the earlier claim that performance measurement generally has had a positive contribution towards enhancing accountability and transparency. The following statements of a top-level manager and an operational manager are evidence of this:

> *The publication of performance information has been important in many ways. It provides us with a report card of our work where we have done well and where we need improvement. We are learning from our performance reports - we want to identify our shortcomings and to maximise our results* (Top-level Manager HEM2)

> *Our stakeholders (government and customers) want to know how we are performing. This is also an indication of how well we are using government resources and optimising government objectives. For our workers, the public disclosure of those who did well is a means of telling everybody what they do and encouraging better performance* (Operational Manager HOM2)

A third of the frontline workers interviewed spoke about the process as encouraging individual efforts, and facilitate the provision of information to patients.

> *I think that disclosing information about our work has made workers to be more careful of what they do. People no longer hang their dirty washing in public. Everybody is working hard, and being careful in the way they do their work, particularly in relating to patients or clients* (Nurse HWN21)

> *It is not only about information regarding who has performed well. Public reporting of information means that we are now expected, and we are providing, information to guide patients* (Doctor HWD5)

The frontline doctors and nurses and their managers also spoke extensively about some operational effects of the reform elements discussed above. These are discussed in Section 6.3.2 and Section 6.4.

6.3.1.3 Performance-Related Pay (PRP)

The wider literature on performance-related pay (PRP) suggests that it is an emerging issue particularly presented to service organisations as a way of enhancing the motivation and effectiveness of frontline workers (Richardson, 1999; Lazear,

2000; Chamberlin *et al*, 2002). During the interviews, both workers and their managers expressed their views on the advantages and disadvantages of PRP with respect to healthcare practice: PRP is regarded as the climax of the performance measurement, ranking, and disclosure process.

Advantages of PRP

During the interviews, respondents, and particularly the managers, expressed a consistent view regarding PRP as an incentive system based on merit (Table 6.5).

Table 6.5 Advantages of performance-related pay (PRP)

Incentive based on individual merit	*Before the reform, people were hardly encouraged to go the extra mile in their work because there was no extra reward for doing this. This government has introduced this performance- related pay to compensate for hard work. Days are gone when few are doing the work and many are sitting on the fence and still receiving their salaries. Performance-related pay motivates people to perform better. In addition to this financial incentive/ reward, they are also compensated by improved status and promotion. It has introduced a culture of meritocracy* (Top-level Manager HEM6) *In the public service, pay, status and promotion is very important to every worker. The performance-related-pay (i.e. PRP) is making workers more responsive. It gives one a peace of mind to work hard since good performance is rewarded, and there is drive among workers to perform. Workers are paying attention to doing what they think will earn them an award* (Doctor HWD2)
Strategic incentive for effective human resource management	*PRP is purposeful because it focuses on improving performance. For us managers, it is not only about identifying outstanding performers and rewarding them, it is also about identifying future managers* (Operational Manager HOM2) *It has introduced an incentive system based on performance to replace long experience and status as criteria for promotion* (Operational Manager HOM6)
Organisation aims/goals become the priority of the workers	*PRP encourages individual focus on the goals of the organisation. As we focus on wining an award, it means also that one is committed to achieving the targets. This also means that one is more productive and more efficient* (Operational Manager HOM11)

Hospital managers (HOM2 and HOM6) perceive PRP as a strategic management approach set out to encourage individual innovativeness. Frontline workers also perceive PRP as an incentive. For example, one of the nurses reported:

> *When you think about the PRP in terms of the immediate monetary reward attached, it is not a big deal. What is making people talk is the fact that when you win an award, you could get instant promotion. Promotion matters*

because in the end, your salary, your position, and your status will change (Nurse HWN27)

The operational evidence of the relationship between PRP and health worker motivation is presented in Section 6.4. Here, the individual worker and manager reports indicate concerns about PRP and suggest that it has resulted in practice which is detrimental to good health care. The details of these disadvantages are presented below in Table 6.6.

Disadvantages of PRP

Table 6.6 Disadvantages of Performance Related Pay (PRP)

Undermines 'traditional' public service ethos	*I came into this job because I wanted to serve, but from what I am seeing, somebody can be cherry-picked for coming early to work for example, and be given double promotion over others. This is not good. While you are there serving and doing your best, others who may be lucky to be seen, or who blow their trumpet will be promoted. When you are not recognised, commitment to serve is nonsense since we are told that this will not be rewarded. I feel really bad about this* (Nurse HWN13)
Strengthens individualism which undermines cooperation and teamwork	*In this work, we need each other. Doctors need nurses. But this reform is bringing in an individual focus. People hardly help each other especially if it does not contribute to their immediate gain* (Doctor HWD9) *I think that PRP is encouraging individual effort and thus undermining teamwork. Those who did not win an award often become envious and jealous, and this reduces their willingness to cooperate with colleagues and even makes them see us managers as their enemies* (Operational Manager HOM5)

The responses here firstly suggest a possible link between the operation of PRP and individual worker performance. The way the workers spoke about PRP suggests a disagreement about whether differential pay for performance should be for individual workers or for groups of workers. Two thirds of the frontline doctors and nurses interviewed advocate group rewards arguing that healthcare work is rarely due to the effort of a single worker, but depends upon all workers. This, therefore, strengthens the argument that it is inappropriate to single out one worker for reward and leave out the others. The other third of the workers who were rather more in support of individual rewards said that if rewards are based on group effort, there is a possibility of 'free rider effect' in which some workers may slack off while others do the work, and yet all reap the benefits.

Overall, the results suggest that a number of thoughtful oppositions to PRP were presented by the workers and they were very articulate in their argument against the initiative. While the issues remain inconclusive and complicated, in some cases assumptions underlying the stated disadvantages of PRP relate to the perceived implications such an initiative has brought into healthcare work practice. The results suggest that the majority of those who spoke against the initiatives claim that they have worked hard, and were disappointed because their names have not been recommended for award. This frustration raises questions about the procedural and distributional mechanism of PRP.

6.3.2 Interpersonal relationships and trust among organisational actors

It is widely recognised that 'good' relationships and trust are essential for efficient delivery of healthcare services (Gilson, 2003; Gilson *et al*, 2005; Gerekick and Fagin, 2005). The focus of interest is on relationships between the reform implementers (i.e. SERVICOM) and health workers, worker and worker or manager, and worker and patients. This section presents an account of how workers perceive the operation of the reform elements based on analysis and discussion that relates to issues of trust as the second important theme of analysis, as noted in Section 6.1.

Despite the growing conceptualisation of policy as a change process, the true operations with respect to interactions and relationship among organisational actors remain largely unknown. The main trust-related issue surrounding the perception of the workers about the operation of the reform contents has to do, first, with their view of the lack of reliability and confidence in the capacity and honesty of the performance measurement process and distribution of performance-related incentives. When talking about SERVICOM, as noted in Section 6.2.2, hospital workers express doubt about performance measurement and the extent to which it could be said to be honest. Although it was difficult to find specific examples of dishonesty or corruption, it was widely acknowledged by the frontline hospital staff (doctors, nurses and managers) that the performance measurement operation is far from perfect. One operational manager was of the view that concern for trustworthiness and honesty is a systemic issue:

> *There are so many rumours that government institutions are not easily trusted. Sometimes they are viewed as being under external influence, or it is argued that they watch but cannot see, or that they see but cannot understand, or that they understand but are corrupt. Overall, our institutions are not always reliable* (Male Operational Manager HOM1)

Commenting on the lack of trust in the performance reports for example, a senior doctor said:

> *I do not think the reports say much about the clinical quality of our work. For me the best thing about healthcare practice is for a report to tell us whether the clinical procedures have been improved to enhance quality care. They [SERVICOM] just computed their reports based on what the customers told them. These data are not available for verification. It is bad that the benchmarking is not about our healthcare process and procedure* (Doctor HWD3)

The results suggest that there are believable rumours that the operation of the reform elements lacks procedural transparency. Commenting on the issue, two operational managers provided supplementary information to these claims and asserted:

> *It is hard to make workers believe that the rating judgement which classify 'good' and 'bad' worker is sound and unbiased. Yet, the fact that the judgement determines who gets rewarded and who does not means a lot. I realised that whenever a worker feels that a colleague has been judged to have performed better, and has as a result received an award, a feeling of being cheated sets in. The workers see the manager as wicked and corrupt* (Operational Manager HOM16)

> *We also find it difficult to accept that the performance assessment is as simple as presented. As a manager, I think that the fundamental problem is in the development of good standards based on our clinical experience. Many people do not trust that the performance measures truly represent our work. There is problem of developing yardstick that will capture what "we" think make up a good worker and not what "they" think* (Female Operational Manager HOM10)

One senior (experienced) doctor express the view that the process of measuring performance cannot be trusted because it is a "secret". This doctor explained how government activities are often categorised as secret, in many ways precipitating doubt and rumours of dishonesty. This senior doctor said:

> *The central issue is that our work is not as segregated as presented. It is difficult to separate one activity from another. You cannot measure the efforts of the nurse in the ward or the doctor in the consulting room. They do so many things which are not in the targets and which outsiders do not know. I think that it is just inappropriate to treat us as if we are industrial workers. Clearly, it would have been good to do so if data is available* (Doctor HWD3)

Five other doctors said that, if given the opportunity, they would have liked to query the process. This is because, as one of the doctors stated, *the reform assessment and ranking is not representative of our efforts; I cannot trust it* (Doctor HWD39). Overall, the issue of lack of trust in the process was widely supported by frontline doctors and nurses. During the analysis, there was a growing sense that performance target culture is a selective process which does not provide a 'big picture' of their work. Related to this is the acceptance that performance targets did not take account of the practical aspect of their work, especially as it relates to clinical procedures, standards and practice. The results raise significant questions about how to develop performance measures, including how to measure the performance of individual workers in order to develop a long-lasting and effective measurement that will enhance healthcare delivery. It significantly suggests that the performance measurement initiative did not realistically reflect the reality of healthcare work. It also indicates that the measured effectiveness of all the workers is not exact; thus, the process is seen by the workers as unreliable. The results did not in any way say that the principle is bad, but largely demonstrated an existing gap between the prescription of policy and the functioning.

The results also suggest that the validity of performance measurement is an issue that is open to debate. This is widely highlighted in literature (Propper *et al*, 2008a/b; Bevan and Hood, 2006a/b; Andrew *et al*, 2006). For example, Andrew *et al* (2006) found that performance measurement issues are often controversial because of its subjective nature. With respect to validity, this study's analysis draws from Potter and Wetherrel (1987) to gain more insight into the interpretations of the workers. Potter and Wetherrel (1987) provide four useful and concise summaries of the ways in which validity of interpretation could be considered in the context of the present analysis. The first refers to the extent to which the performance measurement process is believed by the workers to be suitable to their practice. The second relates to the extent to which the performance measurement process is believed to have engaged their views and captured what it seeks to do, and in particular what the workers do. This also relates to the third idea, which is about the perception of comprehensiveness of the performance measurement process in

revealing or providing believable evidence about the 'big picture' of what the workers actually do in their work.

Finally, there is another interpretation of validity which has to do with the extent to which it can be said that the reform has solved problems or created new problems of its own. There is consensus among the workers that performance measurement and its elements cannot be trusted because there is no convincing evidence to demonstrate that it has actually solved the problem of improving healthcare service delivery. This is primarily because of the belief among frontline workers that it fails to provide accounts for clinical issues, skill development, and infrastructural improvement which the frontline workers construe as critical factors to their success. The results suggest that issues about the operation of the reform elements have certainly raised questions about how bureaucratic ideas attempt to shape the actions of clinical workers and work practice, which could be interesting to pursue.

In general, and considering the above, the results did not provide convincing evidence to demonstrate that the workers trust that the performance measurement process and its associated elements provide a valid assessment of healthcare work practice. The results suggest that the way in which the workers outlined their lack of trust in the validity of the performance measurement and the believed difficulty in measuring the performance of healthcare workers, present a powerful message to policy-makers. The results also indicate that the clinicians perceived the process to be inaccurate, and inconsistent with the circumstances of their work practice. Although operational managers were somewhat reserved and reluctant to accept the issues of distrust and validity ten out of the sixteen managers who commented said that the process was not perfect, suggesting room for improvement. The results imply that central to the issue of trust is the relationship between hospital workers, and external policy implementers (i.e. SERVICOM) of the reform.

Overall, the above results suggest that erosion of trust associated with the reform process seem to have had a negative impact on the performance of the health workers in the hospital. The results suggest that mistrust strengthens individualism, which undermines team spirit and professional ethics of community service. The results correlate with the view of other studies (Spence *et al,* 2001; Gilson, 2003;

Van de Walle and Bouckaert, 2003; and Gilson *et al*, 2005; Rowe and Calnan, 2006) and conclude that perceived mistrust in organisational relationships very likely has implications for the effectiveness and performance of the hospital. Akindele *et al* (2005), providing a macro assessment of the political economy of Nigeria, found that breakdown of trust results in increased transaction cost. This has also been reported by Collier (2008), and Gore and Pratton (2003), who found that increased transaction cost creates room for hidden actions and rent-seeking behaviour in public transactions. The negative implications of mistrust have also been reported in other context, as being destructive to public and social transactions (Greif, 2000; O'Neil, 2002). Other studies, such as Lindenberg (2000), Putnam (2000) and Haque (2001), found that mistrust in service-oriented organisations contribute to the breakdown of altruistic behaviour, which is a valued ethic of public service. This implies that mistrust could have potential negative implications for the performance of the hospital.

In terms of the similarities and diffrences in how different categories of workers responded tio the reform, managers were more positive about PM than frontline workers. Among the frontline workers, doctors were less positive than nurses. Also, male workers (doctor or nurse or among the managers) were more vocal in their views than female workers.

6.4 Workers' Resistance and Non-Compliance with the Reform

This section presents an account of workers' and managers' resistance and non-compliance with the policy. During the interviews, all the top-level managers expressed significant support for the reform, and were very optimistic about the policy changes, describing them as desirable and appropriate. One of them characterised workers who attempt to resist the policy changes as old-fashioned and not having foresight.

> *You see, whenever a good thing is about to happen, many who want to remain they way they are will always drag their feet and sometimes speak about it. This government has showed its preparedness to bring about this reform and we are optimistic that it will bring about lasting solution to the way people do*

> *government and particularly address the problem of poor performance in the public service* (Top-level Manager HEM3).

From every indication, the top-level managers seem to have more information about government interests and showed a more positive attitude towards the policy changes than the operational managers and frontline doctors and nurses. Besides, during the interviews, many doctors and nurses referred to them (top-level managers or executives) as part of government.

Meanwhile, although the operational managers and frontline doctors and nurses did express support for change; largely, they treated the way government went about it with scepticism. There was a great deal of emphasis among the frontline doctors and nurses, and their union representatives in particular, that the reform contradicts their practice and professional culture, or the way they do things in the hospital to provide services. One of the doctors echoed that saying:

> *We did tell government through the communiqué our union sent in that the proposed change element contradict how we operate and what we think should be done to improve services, yet, they imposed it on us. We knew it was not going to be easy with us once the reform was implemented and we never felt that the way the outlined the reform will ever benefit our work, patient and hospital. They and their contracted consultants were very chauvinistic about the reform and did claim that they were right. That was why we went on strike to defend our views* (Doctor HWD9)

Evidences from interview with frontline nurses support the above statement and suggest that they did not support the practice of the reform on the argument that it contradicts their professional practice.

As noted in Section 6.2 and Section 6.3, the other reason behind inadequate support for the reform by frontline doctors and nurses was the claim of exclusion in the development of the reform especially with respect to the creation of the performance measures and implementation process. During interviews with the doctors' and nurses' union representatives, there was an indication of resistance to the policy changes. For example, the union did mobilise their members to embark on strike action on two occasions to express their discontentment. A member of the doctors' union representative said:

> *We did express our annoyance. Our union members voted and embarked on a sit-down strike but government went on with the reform. We have had two rounds of strike. What government did was to go ahead with the reform and*

> *even refused to pay our salary for the month we went on strike* (Doctors' Union representative)

The nurses' union representative also acknowledged their active resistance to the reform. Apart from the fear of the unknown, another reason given for expressions of resistance to the policy changes was the general feeling of being "left out" during the design of the performance measures used to direct and assess performance. Possibly even more important was the sense that the targets were being imposed by "outsiders" (both international and national consultants in addition to government bureaucrats). According to the union representative of the nurses:

> *Politicians set targets based on what they claimed to know but in fact using consultants from abroad. They are not involving us and yet everyone is blaming us. You cannot use the same targets for all federal hospitals and hospitals are not the same as many other government bodies. Even patients suffer from different diseases requiring different care. We think that the whole process is a mismatch to our practice. These were part of the reasons we went on strike to protest against the reform* (Nurses' Union representative)

Unlike doctors, who went on strike on two occasions, the nurses said they only went on strike once. The implication is that through the strikes, doctors and nurses openly resisted and questioned the rationale of the reform, particularly expressing their lack of support for the way the government went about the reform. One of the nurses said:

> *I must confess, I feel somewhat demoralized when we realised that the reform was just about effort by government to take over our work and hand us over to non-clinicians or administrators. That is why some of us openly supported and voted for the strike. During our union meeting, everybody was pissed off about the whole arrangement. Yes, despite the strike they still implemented the reform* (Nurse HWN 10)

A doctor also reiterated this sentiment saying:

> *A number of things concern us…I mean the way government decided not to involve us, they excommunicated us from negotiation the changes in the way we do out work, and about our pay. There are many assumptions made by the politicians and the reformers. Well I just do not buy into the idea that was why we embarked on strike. There is no doubt they did not listen to us, yet we made our views clear. In fact, the whole reform is wrapped up in politics, and politicians hardly listen to professionals. They just do not know what we are talking about, because they are not part of us* (Doctor HWD7)

The above statements constitute a form of resistance, a gentle and invisible fight of ideology and mind-set between clinicians and non-clinicians or politicians. During

the interviews, apart from the visible forms of active resistance reported above, there were also elements of passive resistance, though these were more difficult to detect. However, the analysis shows that other forms of lack of support run through the texts and relate to workers' expressions made manifest in the tone of their voice, body language, and in the way they often use rumours and gossip to say negative things about the reform. As noted in Section 6.2, the fact that workers regularly address the reform as 'government policy' and the expression of the 'them' and 'us' mind-set provides indications of passive resistance. While the reform as a change process remains inevitable, the clinicians argue that the operation of the reform was not in the best interests of the patients, clinicians and the public hospitals.

The operational managers reinforced the views of the doctors and nurses, and acknowledged that fear of the unknown also contributed to the strike action. One senior manager said:

> *Apart from the understanding that the reform proposal was top-down, people were disoriented about reform and were always making reference to similar reforms implemented under the structural adjustment programme in the 1980s impacted negatively on public service work culture, incentive and our welfare. I just think that many people were afraid and then we did not even have enough information about what the reform seeks to do* (Operational Manager HOM6)

Another manager was of the view that the reform process seem too radical and structural, and was being introduced too quickly.

The results show that while change is inevitable, the fear of the unknown and uncertainty about the operation and outcome of change were primary reasons behind the expression of resistance to the reform. As noted by Cumming and Worley (2005) change involves moving from the known to the unknown, and because the future is always uncertain and may adversely affect people's competence, worth and coping abilities, resistance is inevitable. So, readiness to accept the change and to make workers comply will depend on how well they are carried along or how they understand the change with respect to their work and wellbeing. As noted by Armenakis *et al* (1993), readiness to accept change or resistance influences the effectiveness of realising the change goals. The results show that frontline doctors and nurses, and including their managers and union, resisted the reform because of perceived inconsistencies with existing work culture and healthcare practice. This

result correlates with the work of Kotter (1996), which found that people resist change because of fear and believe that it contradicts the way they do things in their organisations. The claims that frontline workers and their managers, seem not to have had a clear vision and understanding of the reform reiterates the implication of their exclusion in the development of the reform. Kotter (1996) also found how inadequate communication of change proposal across different categories of organisational actors results in resistance, and could even undermine or block the effectiveness of organisational change.

The results gleaned from additional interviews with managers and frontline doctors and nurses suggest that despite the fact that they did not give their full support to the reform and even resisted it, they had no option but to comply since they have no other jobs and remain government employees. A quote from one of the frontline doctors is suggestive of this:

> *Traditionally, we are like a married woman in a house, you just have to follow your husband or you go back to your parents. The reform is government policy, and we are government employees. Besides, individuals are winning awards or receiving sanctions (e.g.as a result of a query) based on an assessment of how well they comply with the targets. People are making efforts whether they like the policy or not, to behave well. The problem is that following the rule is not everything* (Doctor HWD20)

A senior manager said:

> *Government has said that there is no going back to the reform. People were afraid of losing their jobs, even during the strike, the fact that after the first strike people were not paid their salary for embarking on strike against government plan was enough warning not to avoid the reform. Besides government at that time was also talking about downsizing the public workforce and even privatising other public sectors as it has done in telecommunications and power sector as part of cost-saving measures* (Operational Manager HOM10)

During the interviews, it was evident that all workers acknowledged the need for change, they seem uninformed about the policy development process, arguing that they were not involved. They also complained that the development process was not properly communicated to them, and they did not express their thoughts, professional meaning and decisions about the reform, thus leading to either information distortion or misinterpretation of the vision and goals of the change as

presented by the policy reformers. These issues of non-involvement are well outlined in Section 6.2.

Another main source of resistance deals with experiences which leaves a pessimistic image of reform, and in which many treat the reform with scepticism. The evidence of a reactive mind-set, and inclination that the reform will not provide an add-on positive effect to clinical practice and professional improvement of the workers posed an inevitable obstacle and provided reasons for expressed resistance. The workers did express pessimistic views about the reform and argued that it is not consistent with their professional values, and they fear that it challenges the status quo embedded in their professional practice and work routines. The results of this study correlate with past studies (e.g. Goldstein and Burke, 1991; Kruger, 1996; Klein and Sorra, 1996), which found that fear that proposed change initiatives will pose challenges to existing status quo provide evidence that support the reasons why organisational actors resist change, which consequently undermine the realisation of change objectives.

Further analysis shows that doctors, who are mainly male, showed more expressions of resistance towards the reform than nurses, who are mainly female. Even male managers were more forceful in their expressions of lack of support than their female counterparts. One doctor provided useful information relating to why doctors seem to be more concerned and said, *"Yes, we should be more affected by the reform because the demands associated with the reform do restrict or reduce the chances of doing private practice"* (Doctor HDW30). It is, however, important to point out that inadequate forcefulness in the way nurses express their views comparative to their doctor colleagues did not in any way suggest that their voice about the reform has no weight. Although this study did not uncover the reasons, further information provided by three doctors and five nurses demonstrated that this seems to relate to wider narratives regarding gender differences, professional identity- in which doctors for example seem to command more power than nurses, and culture -in which women are construed as less aggressive than men. This seems to demonstrate another important form of power structure in the hospital.

In addition, with respect to differences in culture and tradition, it would have been out of place to see a female nurse speaking more forcefully than a male nurses or

doctor who may have been her husband working in the same hospital. During the interviews, and particularly with respect to an interview with a senior doctor conducted at his home and also with another senior female nurse working in the same hospital who happens to be the wife of the doctor, it was observed that though the nurse voiced her views, she was rather subtle in her expressions. The tone of voice and body language of the nurse did suggest that she was not feeling open to speaking out in the presence of her husband. These issues are complicated and need further research, but the results show that there was a greater resistance to government reform amongst doctors compared to nurses. While the results seem patchy and perhaps highly inaccurate, there is an established dominant narrative that men are more vocal in public space than women (Rose, 1999; Garber, 2000; Ranade, 2007).

Although the reform was construed by the government as a considerable structural change set out to transform the way workers do their work, there were still signs of resistance, and non-compliance. The results identified four issues found to receive attention in this regard: (i) clinicians understood the reform as a top-down and imposed plan over their jobs and hospital organisation, thus creating tensions and dilemmas; (ii) hospital workers felt threatened about their professional identity and positions; (iii) hospital workers did not see the reform elements as compatible with both the purpose of healthcare and the daily clinical decisions and work culture; (iv) many are sceptical about the reform process arguing that it was imported from abroad, and express conflict between their own professional views and those of policy reformers. Overall, the clinicians treated the reform with scepticism and claimed that its design and implementation did not actually capture what they think is the best practical way to bring about change in their work.

In line with the earlier work of Luke (1974) and Foucault (1980) states that expressions of power and power relations seem to shape workers' perceptions of, and resistance to, the reform. Jermier *et al* (1994) also found that expression of resistance to change represents a reactive process in which workers express discontentment because they did not want change to be imposed on them. The central message that drove worker resistance relates to perceived ambivalence, tension and dilemmas associated with the reform, which then was not properly understood or communicated. Drawing from sociological literature such as

DiMaggio and Powell, 1983; Meyer and Rowan, 1977, the expression of resistance is a consequence of policy reform operating as a prevailing and rationalised conducts, and a form of formalised structure which challenges the existing status quo of the workers. Townley (2002) found that change introduces competing rationalities which shift health workers' understanding of their organisation, work and professional practice. There is a strong belief among frontline workers and managers that the reform process is inconsistent and not a useful way of transforming their professional culture especially as it relates to how they do their work and their clinical practice.

Section 6.4 has provided an understanding of the issues surrounding managers' and workers' responses to the reform in terms of implicit and explicit expressions of resistance and non-compliance with the policy. The responses reveal that, despite the parliamentary support for the reform, frontline doctors and nurses explicitly or implicitly treated the reform with huge suspicion. The understanding that the public health workers did express their own rationality about the reform by engaging in strike action and even spoke about the reform as 'government policy' suggest an explicit and implicit form of non-compliance. Given that as public employees, government has an overriding legitimacy with respect to them. However, during the interviews frontline doctors and nurses did show obvious wry attitudes to the reform especially in the way they communicate their clinical ideas and the non-clinical perspectives of the reformers and implementers.

The issue of worker resistance to change is not new. Yet when reviewed in the context of this study, there is an indication that the underlying argument surrounding worker resistance provides an arena that could shape further discourse and debate especially as it relates to how the perceived differences in interest and power asymmetry which run through the texts encourages resistance or non-compliance with policy.

The results show how professional identify and differentiation in work culture influence individual perception of inclusion and exclusion in policy debate, relative position, and asymmetric relations in social power structure, and perhaps negotiating and coping mechanisms during change. The results have implications for public policy and suggest that, no matter how well policy may have been considered, it can

still be resisted. Therefore, there is a need to anticipate resistance to any change efforts, prepare for it, and make special plans to assess and deal with the resistance. This conclusion leads to the suggestion that how workers perceive change in the context of their individual position is a significant issue that reformers, implementers and managers should be aware of. While these issues remain interesting, this study did not explore them in detail. Nevertheless, the results add valuable insights that can contribute to our knowledge of understanding change and change management, especially in an organisation with differentiated work categorisations such as a service organisation or public hospital.

The next chapter presents part two of the empirical data. It examines and discusses how health providers perceive the *effects* of the changes with respect to healthcare work, hospitals and practice. It presents empirical evidence and understanding of the perceived effects and consists of two principal themes, namely: (i) workload, efficiency and balance of duties (between clinical and administrative); and (ii) quality and quantity performance variables.

7 The Effects of the Reform on Health Workers

7.1 Introduction

While Chapters 5 detailed the way in which the policy reform was implemented in the case hospital organisation, FMCU, and Chapter 6 provided an account of how different categories of health workers perceive and respond to the reform process. The present chapter addresses part of the third research question of this thesis: how are different categories of workers in the hospital perceived the effects of the change processes? It is argued in this thesis that since the health reforms relate directly to the behaviour or work practices of health workers, the way in which these workers experience the reforms in a specific work context is especially important for understanding policy processes. Although this chapter is also based on the perceptions of the workers, and sometimes overlap with issues presented in Chapter 6, specifically, this chapter examines how health providers perceive the *effects* of the changes with respect to their health work, hospital and practice. It presents empirical evidence and understanding of the perceived effects, and consists of two principal themes, namely: (i) workload, efficiency and balance of duties (between clinical and administrative); (ii) quality and quantity performance variables.

The results are briefly summarised as follows: First, despite the perceived theoretical importance of performance measurement and performance related pay incentives, the outcome is not always clear and did not seem to have provided a robust incentive to attract 'good' behaviour and motivation of the frontline workers. The operation of the reform incentive element is believed to have created division, tension and dysfunctional behaviour among frontline workers. For example, cherry-picking a worker for reward introduces a winner and loser mentality, which encourages some and discourages the majority who are not rewarded. This also resulted in ineffective work behaviour such as jealousies, envy and blame culture, as well as lack of openness and cooperation among colleagues.

Second, while the reform is supposed to provide strong incentives for workers to pursue organisational goals, there is no convincing evidence in this study to suggest that it has achieved this objective, and, thus it does not seem to have provided any solutions to the problem of how to motivate frontline workers. The results also conclude that rewarding workers based on their previous performance creates adverse incentive and individualistic behaviour, and this is potentially destructive to developing and maintaining healthy working relationships. In fact, this study suggests that the incentive system did not provide convincing evidence to the workers about why their colleagues receive awards and they do not, or what they can do in objective terms to be given an award. In addition, the results indicate that the imprecise and segregated nature of healthcare work did not guarantee fair assessment and allocation of individual rewards. Consequently, this provided little incentive to the workers to change their behaviour as they feel that they are very unlikely to be rewarded if they work hard because of inherent evaluation problems. As noted, the feelings of unfairness and lack of trust in the reform incentive arrangement was not able to motivate the workers to change their behaviour and perform better.

Finally, although there are positive efficiency gains such as improved timeliness in access to healthcare services, and increase in the number of people that are treated in quantitative terms, there is no convincing evidence to suggest that the reform has actually improved the capacity of health workers to provide quality healthcare services.

7.2 Effects of Changes in Work Practice

Based on the claims made by the informants, the results suggest that the changes in work practice with respect to the operation of performance measurement has had significant positive (e.g. attitude to work and absenteeism) and negative effects on the health workers (e.g. blame culture, envy, jealousy, and opportunistic behaviour among workers).

7.2.1 Health workers' attitude to work

Health workers' attitude to work across developing countries including Nigeria is often described as sluggish and lazy (Delfgaauw and Dur, 2008; Dieleman and Harnmeijer, 2006). The results of the present study suggest that the reform has had positive effects on health workers' attitude to work. All the six top-level managers said that many things have changed in terms of health workers' attitudes to government work. One top-level manager said: *"The days are gone when public health workers could be found loafing around and leaving the patients unattended"* (Top-level Manager HEM4). Half of the operational managers were of the view that there has been modest improvement in health worker behaviour. This was particularly related to the claim that frontline workers no longer engage in corrupt practices, such as charging informal or unapproved fees:

> *Since this reform started, all loopholes that facilitate workers collecting or asking for informal charges have been blocked. The workers know that they are under watch, and that a customer can report them which could affect their jobs or promotion. Nowadays, all fees are paid, receipted, and collected at a central point. Patients are told to report any payment that is not receipted. Our workers are also responding to the new directive which is part of the due process instituted by the reform* (Operational Manager HOM5)

Although the frontline doctors and nurses supported the positive behaviourial effects mentioned above, this does not in any way suggest that 'bad behaviour' has been wiped out completely. Another manager, referring to the advantages of performance measurement (detailed in Section 6.3.1.2), said there has been some improvement in worker accountability. Another operational manager said:

> *Before the reform, we had cases in which drugs and supplies would just disappear from the store. This has not happened since the reform. Our workers have repented. I can say that government workers are now born again. This is what the social charter is about. People have to be accountable. Before the reform, bad behaviour was often not exposed, but now, bad*

behaviour is exposed and sanctioned, so the reform is making workers follow the rule (Operational Manager HOM7)

All the six executive managers interviewed corroborated the claim that accountability among health workers has improved.

7.2.2 Absenteeism

The results of this study suggest that another significant positive effect of the reform relates to absenteeism at work. For the top-level and operational managers high levels of absenteeism among workers were an operational and performance challenge. The evidence of reduced absenteeism was echoed by all categories of hospital workers, as is clear from the texts below:

Every day our workers are now at their duty post on time and remain until close of work. I think that the monitoring operation of SERVICOM is yielding good results (Top-Level Manager HEM4)

We used to have so many workers reporting sick to work and yet you now find them in their business. Sometimes a worker would tell you he/she is on a break and from there they would go home. Since this policy started, things have changed. Workers are expected to sign in and out. There are no longer unregulated breaks. Even when a worker reports sick, he/she has to follow due process; they have to provide a medical certificate. Absenteeism has reduced significantly (Operational Manager HOM4)

The doctors and nurses also acknowledged that the reported improved performance was due in part to a reduction in absenteeism. One doctor (HWD31) and one nurse (HWN27) reported respectively:

It is now a serious offence to be late to work or to leave before close of work. Sometimes it is very challenging to keep to this because some of us now live very far away from this hospital since housing benefits were monetized under the reform. We no longer live in government quarters as it used to be before the reform. Sometimes the managers understand, sometimes they do not. Moreover, sometimes you just ask a colleague to cover (Doctor HWD31)

Before this reform started, we had been having many problems handing over because the nurse that was supposed to take over arrived late. Since this reform started, I have never in my shift experienced this problem. This means that the problem such as starting clinics late which is often associated with lateness, has been removed (Nurse HWN27)

The fact that the reform is operating as a disciplinary and control mechanism seem to have paid off. Another nurse said:

> *Nowadays, everybody is aware of the implications of being reported for not following targets or satisfying customers. We are more careful to avoid being caught. However, sometimes it is obvious that some of the claims about our work are unfounded, yet, we have been made to follow the customer charter and to see everybody equally. We have also seen a lot of customers lodging complaints over what they feel are unfair or unacceptable. Sometimes, you just feel that we are being witch-hunted just so that someone can be blamed for something* (Male Nurse HWN20)

An operational manager also reiterated that:

> *Everyone is under watch, both managers and frontline workers. They (SERVICOM) act as if the hospital is just like a factory. Making everybody follow the rules is good but our work is not about rules, particularly if those rules have no clinical relevance. If you fail to follow their directive though, you could be punished or sanctioned. There is no sacred cow to this. People feel that their job is at risk* (Operational Manager HOM7)

Another doctor stated that:

> *You see, nobody likes a query in the public service because it could delay your promotion. SERVICOM is just issuing queries here and there. I have received two because I came late three times in a week. I live very far away and even though I leave my house by 6am to start work by 9am, sometimes I get here 30 minutes to 1 hour late because of traffic and sometimes fuel crisis* (Doctor HWD4)

The view of HWD4, which correlates that of others, suggests on the one hand, workers feel stressed and unhappy about the reform's demands on them. On the other, they supposed that the reform has been effective in improving timeliness, thus addressing worker inefficiency. Therefore, as pointed out by HWD4, the fact that workers arrive late to work suggests a genuine reason for them to be sanctioned. The result suggests a degree of ambivalence in health workers' attitude to the issue of reducing absenteeism and improved efficiency. Nevertheless, by implication, the results might suggest that the reform has been effective. However, the pooled views of the workers suggest that the results should be interpreted with caution. This is because the "signing in and out" mechanism, which SERVICOM uses to judge absenteeism, is in no way perfect. The candid view of one nurse that: *"sometimes workers ask their colleague to cover for them"* (HWN13) highlights a potential difficulty in measuring and observing what the workers do. This result, which correlates with past studies particularly the principal agent studies (such as Jensen and Meckling, 1976; Baker *et al*, 1994; 1998), supposes how potential hidden action

of health care workers, arising from asymmetric information between agents and principal or policy implementers (i.e. SERVICOM) create doubt about the potential practice of performance measurement in a professional organisation. The implication of the results is that a common practice could be that workers might be using their agency to engage in cheating or dysfunctional behaviour and work attitude even though SERVICOM claims to be monitoring and observing them.

7.2.3 Blame culture, envy, jealousy and conflict at work

Examining the views of the health workers, many frontline doctors and nurses seem to argue that performance related pay initiatives, in particular, are incongruent with healthcare work because they have encouraged competitive pressure, which creates an unhealthy working relationship and rivalry among workers. Specifically, workers resent one another, and are unhappy that despite their efforts, they feel disappointed that they do not get recommendation for rewards.

Speaking about their concerns, and as highlighted in Section 6.3.2.1 frontline workers did not seem to trust the reform process to encourage friendly competition and, as noted in Section 6.3.2.2, the subjective perception of unfairness in the process added to the perception of blame culture, envy and jealousy.

One doctor said:

> *I am not praising myself, but God knows that I work hard. Yet, the other colleague was given an award and promotion for coming early to work. There is no difference between those who are professionally sound and those who are strategically competing to win awards without concern for our overall commitment to this work* (Doctor HWD15)

One nurse had this to say:

> *"We are all public servants; we are here to serve and even to serve together and not to strive among ourselves. I am not happy about it because it has introduced competition as if we are in the market place."* (Nurse HWN21)

An operational manager acknowledged that unfriendly competition breeds envy and jealousy at work, and has often resulted in significant quarrelling, backbiting, and an overall lack of trust in the system:

> *There are people who have gained in the system, while majority are losers. The problem is that that people do not like to see their colleagues who everybody sees as 'good' to be rewarded. Our problem is that there is high-level distrust in the system. As managers, we do not see everything that happens in the ward, sometimes, the workers may know better. Therefore, because people hardly accept the feedback they receive, I think that is the main reason for envy. The problem is that this system is creating a lot of rivalry which it was not intended to do. I do understand the fears of the workers. I believe that anywhere there is scepticism and feeling of unfairness, envy, and resentment is bound to be there. We are doing our best* (Operational Manager HOM8)

A senior nurse also commented:

> *Everybody is under pressure to perform. There is too much tension and fear nowadays. There is a lot of finger pointing here and there. This is not the public service I know. People spend more time looking for whom to blame. Work is no more about commitment and devotion. There is too much competition and strive among workers* (Nurse HWN1)

Another nurse also commented:

> *Although I am not moved by the reward, I am here because I want to serve, but the way they are presenting the process is derogatory. During the award ceremony, unless you win an award, you are indirectly blamed and perceived as ineffective. This is not good; there are some who have done more that those who were given an award* (Nurse HWN5)

Another doctor said the following:

> *If you are not selected, there is nothing you can do. You just have to move on. Naming one worker as good and another (the majority) as bad performers is creating envy and jealousy in this place. Since I was given an award, a lot of people just look at me with suspicion and are envious of me* (Doctor HWD24)

Further examination of the respondents' comments suggest that seven out of sixteen managers interviewed noted that public disclosure of results and photo displays of outstanding workers have indeed affected relations amongst colleagues. This is because it creates a winner and loser mentality with the losers often displaying signs of envy. There is significant evidence suggesting that ineffective work behaviour including blame culture, envy and jealousy, has implications for individual workers' performance. The results might also suggest that, in the above conditions, the workers did not think that their motivation and overall performance had improved. These results correlate with Bies and Trip (2005); Cohen-Charash and Mueller (2007); and Smith and Kim (2007), who found that envy and jealousy amongst individual workers undermine performance.

Overall, the results suggest that the reform might have resulted in unhealthy relationships among workers. The results also indicate that the operation of competition in work relationships has had negative effects on behaviour and quality of outcome. This supports the findings of Propper *et al* (2008a; 2004); Besley and Ghatak (2005); and Gaynor (2004), who found that despite the clamour for increased competition in hospital organisations, there is no convincing evidence to suggest that competition in hospital operations has the potential to improve individual workers' performance in terms of the quality of services they provide.

7.2.4 Workload, efficiency and balance of duties (between clinical and administrative)

The analysis of the present study reflects an indication that the operation of the reform is perceived to have affected workers' workload and efficiency, and shifted the balance of duties between clinical and administrative workers. While it seems that the claim of workload is common in healthcare practice (Kawada and Ooya, 2005; Surani *et al*, 2007), the perceived increase in workload was widely reported among doctors and nurses and their managers.

One nurse for example said:

> *This week I have done 3 long shifts even though I am supposed to be on shift duty off. My managers refused to deal with the problem because there is nobody to cover. We are only 3 nurses in this ward attending to 25 patients, and now we are reduced to two because the other nurse called in sick. She too did 3 long shifts last week* (Female Nurse HWN27)

A doctor who reported experiencing an increase in workload also said:

> *Look, I now see between 60-80 patients every day. Before the reform, I saw between 30-35 patients. Yet they expect me to be effective. Sometimes I do not take my break. Sometimes I feel very tired. There is too much paperwork* (Male doctor HWD15)

Doctors and nurses also reported that they have been under tremendous pressure to meet targets and complete necessary paperwork, and this means a disruption and diversion of their professional work patterns and consumes an inordinate amount of time. Overall, the majority of the frontline workers and managers said they are de-

motivated at work because increasing workloads lead to increased stress, tiredness and burnout, and this is telling on the health of workers. The following are comments from an operational manager and a senior consultant:

> *It is not only that pressure could lead a worker to make mistakes, but also that the health of workers is not safe. For example, because of increased workloads, some of our workers after long hours report sick. Last month, one of our staff was rushed to an emergency unit because of accumulated stress arising from the intensity of work* (Operational Manager HOM3)

> *Stress is a silent killer. It is even more worrying among junior workers who lack experience. We have been having more sick calls. It is understandable because we are understaffed and some of the staff do more covers than they should* (Male Senior Doctor HWD1)

One doctor (junior) suggests that the reform has often resulted in a mismatch of roles as some of them do work they are not trained for, and sometimes they do not receive adequate support from their seniors. This is because their seniors report that they are busy. This doctor said:

> *Many of us are left to do what we may not yet have adequate experience to do. Even when you contact your supervisor or senior for support, they are busy. You just do as much as you can until they come, yet the patient will be asking all kinds of questions* (Doctor HWD37)

Interviews with the managers supported the above claims that increase in workloads, shifting roles, and work patterns may have resulted to junior workers taking on roles they lack clinical competence. Commenting that this could result to serious medical problems for patients (customers), one junior doctor said:

> *Look, the problem is that some of us do not yet have experience, yet we are often posted to cover because there is not enough staff. Yet, you do this extra work and have nothing to suggest for it. Sometimes, you just refer the patient to come another day, or to attend a private hospital because you do not want to make mistakes* (Male Doctor HWD30)

While the workers asserted that the reform has contributed to inadequate staff, there is inadequate evidence to suggest that staff shortages are mainly caused by the reform. The statement made by HWD37, supported by five other junior workers and even three senior staff and two managers suggests that not receiving adequate support and mentoring because of increased workloads on senior workers reduces the junior staff's ability to provide good service, and limits the development of clinical skills through on-the-job training. The majority of frontline staff declared

they would rather learn and do their best to adjust. When asked about their coping strategies, one doctor stated:

> "*I have made up my mind not to overwork myself since I am not paid for it, yet some people are picked and rewarded for their willingness to overwork as if another is not doing work here. I will rather do private work with my extra time, and be paid for it.*" (Doctor HWD12)

The statement made by HWD12, which was repeated by a number of other doctors, suggests that increasing workloads can be unproductive in hospital environments where there are already staff shortages. Providing further information, one of the managers said that, *"We do not have options, we are short staffed and we are now subjected to do a lot of things, sometimes junior workers do cover clinics. We just have to move on"* (Operational Manager HOM4). Another senior manager, however, pointed out that the way they are functioning in the context of the reform is not professional and highlighted how increased pressure and workload may have resulted in avoidable incidents and accidents at work.

> *Everybody is under pressure. This is not the public service I knew 30 years ago. Look, we cannot guarantee that all the workers are working perfectly especially the junior ones who may not have much experience. People are bound to make mistakes and error when under pressure. In this profession, error is not good because we are dealing with people's health* (Operational Manager HOM9)

Although healthcare work is conventionally labour intensive, overall the results suggest there has been an increased workload experienced by all the hospital personnel. For example, there is indication of increase in number of hours worked arising from the extension of opening hours and days for consultation (the specific details of the changes were highlighted in Chapter 4, Section 4.4 (p. 74). This is coupled with increase in speed of operation and the widely reported increase in work done compared to before the introduction of the reform. Operational managers also acknowledge increased pressure, workload, and administrative paperwork. Both doctors and nurses, as well as their managers, consistently reported that the government's target of ensuring a 24-hour service in tertiary hospitals has meant longer shifts (the term used for nurse duty hours) and or longer call duties (the terms used for doctors' duty hours). Ten out of sixteen operational managers said that frontline doctors and nurses now do more 'long day duties' than previously, particularly because of the need to cover the longer opening days and times

introduced by the reform. Thus, they claimed that time-off between shift/call duties had reduced drastically.

The health care managers also confirm that the new form of power and command in hospital management means that they are under fire to perform better. The following quotes from two managers are indicative of this:

> *This government has outlined that it will no longer condone irresponsibility and has put in place a mechanism to identify bad behaviour and work attitudes. This government will sanction or even remove any worker who is found wanting* (Male top-level manager HEM2)

> *The reform has put enormous demand on us and our workers. Anyone who reports late to work is sanctioned, and can even have his or her salary withheld. We also have had cases in which workers are queried because customers reported them to SERVICOM. Making workers do their work is part of the effort put in place to address inefficiency in service provision. What we have been observing is that workers have not been finding it easy to adjust to the new rules and regulations, and are even afraid of being sacked or demoted* (Operational Manager HOM10)

The results also point to evidence of conflict of roles between clinicians and policy implementers. A manager and a nurse narrated how power asymmetry (detailed in Section 6.2) leads to conflict in their work operations. The nurse said:

> *They are telling us that we cannot make decisions for ourselves. I felt bad receiving a query the other time from SERVICOM because they said a customer had complained that I did not follow the queue and it was rumoured that I used my position to help my sister. It was very worrying because my salary was stopped until the case was settled. My report on the incident was not initially accepted by SERVICOM but after a series of investigations and interrogations, it was clear that the patient was not my relation. This is very discouraging; we no longer do our work as we know it* (Nurse HWN22)

The operational manager made this comment:

> *Although nobody will want to condone poor performance e.g. lateness to work, what we are seeing that annoys workers is that sometimes SERVICOM staff appear to exceed their limit of authority. There was a situation for example in which a line manager investigated a query and then dropped the matter. Thereafter he was arraigned before a SERVICOM disciplinary hearing at Abuja for not instituting appropriate disciplinary action against the worker involved* (Operational Manager HOM4)

The results suggest that increases in workload, pressure and stress associated with the reform may have had negative implications for the workers and the way they do their work. On the other hand, the increase in workload could be seen as an

improvement in operational efficiency and effectiveness. Nevertheless, as evident in the interviews, frontline workers claimed that reform has had a detrimental effect on their work by contributing to an increased clinical and administrative workload. There is suggestion that the increased workload seems to have had implications on frontline workers' performance capacity to deliver quality services. More details are outlined in Section 7.2.5 below.

7.2.5 Quality and Quantity Performance

This final part of the analysis of the effects of the reform consists of two sections. The first relates to quantity (Section 7.2.5.1), and the second relates to quality performance (Section 7.2.5.2), as both remains an issue in health care delivery (Gronroos, 2001; Donabedian, 2005). However, while it may be that quantity performance is somewhat straightforward, assessing quality performance is challenging.

7.2.5.1 Quantity of Care

During the interviews, and as noted earlier, all categories of health workers reported that their work activities (workloads) increased after the reform was implemented. The managers in particular noted that, because of the increase in the numbers of patients seen on any one day, frontline staff no longer have to start each day's work with a backlog of untreated cases from the day before, as was the case previously. One of the managers characterises the changes acknowledged by others:

> *Workers now see patients very quickly. People no longer wait ages before they see a doctor. Because the time a patient waits before receiving attention has reduced, more people now have access to healthcare and on time too. We no longer have unattended overflows of patients to next day clinics, as it were before the reform* (Operational Manager HOM8)

Despite the negative effects hinted earlier, frontline doctors and nurses did acknowledge that quantity of output has increased:

> *Patients are no longer delayed and we are seeing many people daily since the reform started. There is no more waste of time and delays during consultation* (Doctor HWD31)

> *Now we see that there is improvement in the number of people that come and go in this hospital. We no longer delay patients before they are discharged from the ward. However, I do not think that rushing patients in and out is good to patients' health* (Nurse HWN15)

These results suggest that, since frontline workers now attend to more patients daily than before the reform, this can be seen as an improvement in efficiency in the use of resources, and especially time. However, frontline doctors and nurses, and their managers, reported that despite the achievement in terms of quantity, all is not well because they did not think that quality had improved. In fact, the results suggest an existing tension between quantity and quality performance, and this indication correlates with past studies. For example, Peabody *et al*, (2006) and Silimper *et al*, (2002) found that, across health system contexts in developing countries, quality rather than quantity matters mosts especially because it influences patient health and safety more than quantity elements.

7.2.5.2 Quality of Care

Quality of healthcare is an important issue in all setting where healthcare is provided, and across developing countries, perceptions of declining healthcare quality have been a concern to health policy (Akin *et al*, 1995; Andaleeb, 2001; Rowe *et al*, 2005; Al-Qutob and Nasir, 2008). Even in developed countries, recent studies (e.g. Atkinson *et al*, 2010; Raleigh and Foot, 2010) indicate realisation that healthcare quality is at the heart of the global healthcare policy agenda. Major, and widely discussed, elements of healthcare quality often vary between individual, organisation and context. However, it may, not be surprising that the quality domain which emerged from this study, and is discussed therein, is particularly related to the reform context and goals, though somewhat similar to other contexts (Arah *et al*, 2006; Audet *et al*, 2005; Donabedian, 2005; Derose *et al*, 2002). Of importance is the fact that it draws from in-depth interaction and discussion with the professional views of those involved in healthcare delivery. The elements which are discussed here include equity of access to care, staff responsiveness and patient-centeredness, time spent with patients by service providers, providers' interpersonal interaction with patients, and timeliness or waiting time.

Equity of access to healthcare services

Access to healthcare services is a valued quality attribute in healthcare delivery (Goddard and Smith, 2001; Donabedian, 2005). During the interviews, managers and frontline workers recognised that good access to healthcare services makes people feel better. All the workers were of the view that the reform had had a significant positive effect on their ability to deliver quality healthcare, particularly in terms of improving 'customer' access to healthcare. Everyone interviewed said that access to services has improved. One manager said that, in line with the reform protocol, frontline workers now treat patients based on a *first-come-first-served basis*. However, a doctor said that this has created a concern regarding family bias, concern which means that they are no longer able to use their position to help their family, friends or those they know:

> *It is no longer fashionable that a patient should receive express attention because his/her brother is a doctor or sister is a nurse in this hospital. People have to wait for their turn. My people seem not to understand that things have changed. The other day our chief visited this hospital and they just ran to me. I asked them to sit and wait for their turn. This was hard to say but it finally turned out that the Chief went back home and confronted my father that I was insensitive and could not care and that I am not a good ambassador. It is difficult to tell people that things have changed; they will not understand* (Doctor HWD11)

The above statement, which ten of the forty doctors and fifteen of the forty-five frontline nurses interviewed mentioned, suggests that few workers were concerned that the reform had restricted their social and family commitments.

On the part of the managers, the reform is doing well in this regard, and commented that the idea of *first-come-first-served basis* is in line with the "Social Charter", which is about ensuring fairness of access as a means of enhancing patients' respect and dignity.

> *Before the reform, patients often used their connections to manoeuvre their way through, and/or workers hardly treated patients as they come. Since the reform started, our workers have been doing well in attending to patients as they come. There is a queue and patients are treated on a first-come-first-served basis* (Operational Manager HOM8)

All the doctors and nurses interviewed asserted that they are now treating patients fairly as a way of enhancing patient access to healthcare services. Nevertheless,

frontline doctors and nurses also argued that this practice has a cost to it. The workers believed that the reform processs introduced a rigid system which restricts their professional discretion in determining who should be given care based on triage assessment. This may have serious negative effects on the health and safety of patients. For example, as one senior doctor explained:

> *The other time a patient was waiting for her turn, and because the doctor on duty was following the targets and could not give her immediate care she slumped and fainted. All effort to resuscitate her failed. It is difficult to blame the doctors and nurses on duty because they were following the rule* (Doctor HWD3)

This reflects the fact that although equity of access is a key element of healthcare service utilisation, there is recognition among frontline health workers that a rigid work culture may not be best for all because it does not consider the particular needs of specific clients. The frontline workers also argued that having equal access to services does not guarantee gaining access to, or utilisation of, quality services, or appropriateness of access in terms of meeting individual patient's needs.

With respect to healthcare service coverage, one senior doctor was of the view that sometimes, following rules did not give room to provide comprehensive or holistic care:

> *The government targets do not cover everything that we do. When we focus on the targets, we neglect other things that although they are important they are not part of the targets. For example, we are focusing on seeing patients very quickly, but nothing is said about clinical procedure and clinical quality. SERVICOM does not talk about this* (Doctor HWD9)

Twenty-seven of the forty-five nurses interviewed mentioned that many basic clinical rules are not often followed. One senior nurse said:

> *This is not what we as nurses were trained to do. We should be allowed to do our work as we know it. In addition, every aspect of our work should be a focus of any reform because all aspects are important. Whether it is about washing your hands before you enter the wards or treating a patient on time, or following the set clinical procedures or providing bandages, they are all important and should not be neglected* (Nurse HWN2)

Other frontline doctors and managers supported the view that the target culture operates simply as a prioritisation process that excludes adequate allowance for comprehensive care. The analysis of the interviews clearly indicate that doctors and nurses, as well as their managers, were unhappy because the policy changes restrict

their discretional knowledge in doing what they think is professionally correct. The perceptions of the workers, however, suggest significant ambivalence. For example, the workers also recognised that some of their colleagues had abused this discretion in the past to favour their family and friends. A constant theme running through the interview texts is that narrowing healthcare practice because of the prioritisation of what needs to be done seems to have reduced the coverage of healthcare services being delivered at this hospital.

Staff responsiveness and patient-centeredness

The literature acknowledges that improving provider responsiveness to patients is also a healthcare quality performance attribute (Gronroos, 1998; Andaleeb, 2001). During the interviews, both top-level and operational managers spoke about improvement in physical facilities in the reception area as a mark of responsiveness to patients needs.

An operational manager said:

> *I think we now have a good reception area where patients can wait until they are attended to. We have now provided enough chairs, a television and proper signposting to guide customers. We now focus on customers; we receive them well, and we make sure they are satisfied with the services they receive. We provide good information to patients in the form of leaflets and signs to guide them well* (Operational Manager HOM3)

Although five out of sixteen operational managers interviewed, and all the top-level managers, claimed that the hospital is now patient-centred, frontline doctors and nurses presented an opposing view. These doctors and nurses express discontent that the reform has reduced their time for face-to-face interaction and consultation with patients. One doctor said:

> *Yes, we are seeing many people since the reform started. However, everybody knows that seeing people just like that is not a statement that all is well or that we have solved all their problems. We do not have time with patients* (Doctor HWD28)

A nurse said:

> *The problem with this reform is that we hardly know patients as we used to … The way we do nursing has changed. This is not the nursing I know; where we were trained, we had to take time to care for patients and to ensure that they had access to quality services. Things have changed. Government asks us to*

> *provide self-directed information for patients to sort themselves out. Sometimes, we do not talk to them, we just ask them to follow the signs on the wall* (Nurse HWN40)

During the interviews, two out of every three frontline workers and seven of the sixteen operational managers interviewed complained about reduced time for care and hinted that inadequate time for care was undermining the quality of direct patient care. The nurses, in particular, were very unhappy about this.

Both frontline workers and their managers mentioned two reasons for the reduced time for customer care, and they were the increased workload resulting from the introduction of targets, and administrative paperwork. A senior doctor was very clear about the implications for his work:

> *We are focusing on targets and there is too much paperwork. We have lost focus on detailed clinical quality and procedures, so I do not think that the quality of care patients receives have increased. To provide quality service, you require adequate time for diagnosis and consultation* (Doctor HWD7)

Commenting on a similar claim of declining quality of care, a line manager (Operational Manager HOM9), commented on the aforementioned lack of time and work overload, and the fact that often, inexperienced staff have been assigned to do consultations. The manager who also expressed guilt noted that this practice undermines efficiency or effectiveness of service delivery. The manager provided a critical case to substantiate his claims:

> *We cannot say we are getting it right all the time. The other time we had a case of a woman who was rushed in and out of the clinic even though it was evident that her case was malignant and chronic. In fact, I was very uncomfortable because this woman's case would have been avoided if adequate time had been committed to her diagnosis. Besides, this woman was attended to by a house officer who is inexperienced because the chief was very busy. In fact, it is sad to say that she never recovered from the illness. What we have been saying is that there should be an element of professional sense regarding how we treat patients* (Operational Manager HOM9)

This concern about the time needed for patient diagnosis was also raised by nurses. One nurse in particular was concerned to explain the complexity of this task:

> *We no longer have ample time to interact with patients. When you do not interact with patients well it is very challenging and problematic because it is difficult to dig out and gather the relevant information about the patient which would shed light on their overall health condition. Sometimes you know what*

> *to do, but you lack adequate information from the patient's personal and clinical situation* (Nurse HWN10)

Responses also indicate possible links between inadequate patient-service provider interaction and hence less than adequate diagnosis, and medical accidents and errors. For instance, one nurse said:

> *We have to appreciate that we are not getting it all right, detailed diagnosis is required to produce good results* (Nurse HWN19).

Both doctors and nurses also complained that inadequate interaction time was undermining appropriate counselling with patients:

> *Nowadays, we are always in a hurry and we do not have enough time to attend to patients and counsel them effectively. Sometimes even after we have provided treatment, they need further counselling to ensure that they continue with the treatment* (Nurse HWN13).

> *There is no doubt that patients now have a lot of information. What is missing is that they may lack the ability to make use of the information given about their health. Health care is not just about the provision of drugs. We should be counselling people to reinforce our treatments. Do you know that some patients need counselling rather than drugs? I thing that rushing patients in and out is not good because they are missing good counselling and this affect the quality of the care we provide* (Doctor HWD3)

Strengthening these comments on the importance of good relationships and interaction with patients for overall quality performance, an operational manager said:

> *Our work is not only about having time to talk with patients, we need to listen and know them well. Also knowing the personal life situation of patients is very important. When there is no time, it is even difficult to make out patients' opinions and perceptions. I think what we are saying is that sometimes we do not give patients enough time to express themselves about their conditions and everyday habits* (Operational Manager HOM12)

A senior consultant provided an example of how inadequate interaction undermined quality performance and individualized care for a patient who was critically ill:

> *The overriding importance of individualized care is enormous. It is extremely desirable that workers treat patients based on their personal characteristics. People do not understand why workers ask them to wait. Patients just feel that spending time on one patient while others are waiting is unfair. The other day a patient slumped and died while waiting for his turn. Every effort to resuscitate him failed. This same patient was in the hospital the day before and it was later discovered that an inadequate diagnosis had made it difficult to discover the health condition of the patient. This is a shame and it suggests*

> *how the new work rule appears to have taken away our professional common sense* (Doctor HWD9)

It is clear from these reports that both frontline workers and their managers are experiencing the negative aspects of the new management system linked with the service delivery reforms, and that these negative aspects relate especially to the impact it is having on the quality of patient care. Although there is no guarantee that with more time for patient diagnosis and counselling, the quality of care would be improved, this suggests that health care delivery is more complex than is suggested by the performance measures being introduced. At the same time, the responses here make it clear that work practices, or behaviour, have changed in response to the new rules and incentives (or penalties) but, as everyone remarked, this change has potentially serious implications for health care.

Timeliness and waiting times

Waiting time and how to reduce it in Federal Medical Centres (FMCs) in Nigeria, especially at the general outpatients department (GOPD), is one of the central concerns of the reform. The term waiting time, as used in this study is the actual time a patient (customer) may have to wait for an appointment, as well as actually waiting in the hospital before s/he receives attention (Harrison and Appleby, 2005). Waiting time emerged as a key performance issue in the service delivery process as it is assumed to reflect worker efficiency in providing care. As noted by the policy view, reduction in patient waiting time is a major policy goal (SERVICOM book, 2006).

In support of this position, a top-level executive manager quoted from the policy document about the general concern of the reform regarding long waiting times. This executive noted that:

> *There are frequent complaints from patients who attend federal government hospitals that they spend too much time waiting to be attended to, and that services at the Outpatient Department are sluggish and did not follow procedure* (Top-level Manager HEM2)

Another executive manager highlighted that:

> *Before this change was introduced, visiting a public hospital was a frustrating experience. This is because patients are not sure if they will be attended to on time, or even at all. People used to make caricatures of public hospitals and*

> *say that anyone visiting should go with a sleeping mat because of delays. Now we have improved and we make sure that patients receive treatment as soon as possible and faster* (Top-level Manager HEM3)

Three managers (HOM7/HOM8/HOM16) claimed that, because of the reform (and the introduction of a waiting time target), the hospital no longer has patient overflows like before. One doctor reported:

> *We are now treating patients very fast and there are no more delays. We attend to more patients now than when the policy was not in place. Yes, we now see patients as soon as possible. People no longer wait for a long time before they are attended to* (Doctor HWD19)

In spite of this acknowledgement of the value of reduced waiting time, the question of whether, and to what extent, this is a good indicator of quality service provision was raised by a number of informants. Frontline workers commented that focusing on reducing waiting time could undermine the quality of services they can provide. A senior doctor expressed the view that these new targets are damaging the quality of diagnosis and assessment of patients' needs:

> *I think that the process is undermining the good assessment of cases. This is worrying particularly for junior staff that may not have the experience to facilitate their decisions within the short time they have to consult with patients. I do not see the process of rushing to treat patients as good for healthcare* (Doctor HWD1)

Other frontline staff shared this opinion. For example, one nurse noted:

> *I just feel the process is not good for quality care. I feel bad when I watch a patient discharged to create space for other patients in the ward because we want to meet the targets. I just think that some patients ought to stay a little more in the ward. We have been having so many readmissions into the wards because of early discharge and some of the patients come back with malignant cases of infection* (Nurse HWN13)

Another doctor was unhappy about the way their work had become like a 'microwave service' which rushes diagnosis and assessment to the detriment of the patients (Doctor HWD33). Commenting further, HWD33 alleged that accelerating consultation can result in incomplete diagnoses and assessments, and since not all workers may be capable of handling the pressure, accidents were possible. Other staff (e.g. DoctorHWD29 and Nurse HWN18) believed that though it was good to treat patients on time, this should be done based on professional evidence and clinical diagnosis rather than on mechanical rules, which might not be appropriate

for everyone. In addition, a manager complained how the performance measurement culture has resulted in early patient discharge as part of the effort to reduce waiting time:

> *We no longer keep patients long in the wards. This reform has enabled us to reduce length of stay of patients in the ward. This is sometimes not good but we are following the rule. The other time, we had a case of a patient being discharged too quickly and she was readmitted following re-infection at home* (Operational Manager HOM 4)

Therefore, the results suggest that the new approach to work practice has led to an improvement in operational efficiency in terms of reduced waiting time; nevertheless, there is no convincing evidence to suggest that this has in practice contributed to improving quality of healthcare services provided. From the detailed analysis, it would seem rational to think along the lines of the policy outline, that increasing speed and equality of access provides good orientation to healthcare work. The results of this study provide a rather contrary viewpoint. Largely, frontline workers and their managers believed that increasing speed and timeliness by reducing waiting time alone will not deliver quality care. These claims correlate with wider literature in other contexts (Bevan and Hood 2006a, Propper *et al*, 2008). The results suggest that the reform culture and orientation, as it relates to the aforementioned work practices, impedes effective consultation, adequate diagnosis, and counselling which, according to the frontline workers, are critical elements to realising improvement, in healthcare quality. Thus the results of this study suggest a contradiction with respect to quantity and quality performance, given that the drive for reducing waiting time is not recognised by different categories of health workers and their managers as having improved the quality of healthcare services provided.

7.3 Discussion and Conclusions

Chapters 6 and 7 have examined how different categories of workers in the case study hospital are affected by, and deal with, the reform processes with respect to changes in work practices. The findings suggest that the reform process has had significant implications for the delivery of health care services.

The results that emerged from the qualitative data suggest that the operation of performance measurement based on national standards is perceived as a controlling

mechanism over the workers. The conceptualisations which emerge of "they" (government) using "them" (SERVICOM) to monitor "us" (workers) or to tell "us" what to do, suggest changing power relations within the hospital organisation. In addition, the "they", "them" and "us" mentality seems to have produced a feeling of frustration and, as verbalised, a form of alienation and loss of control among the health workers. The implication is that workers reported a fall in their professional status due to the understanding that their profession has come under a structurally-imposed regime by an agency with no professional accreditation. The results suggest that regulation of healthcare activities in this way influences what health workers are passionate about doing, based on their professional perception of how healthcare should be provided. All the discussions with the health workers pointed to demotivation and an erosion of professional power, discretion and autonomy. Both clinical staff and operational managers acknowledged feeling demoralised by, and dissatisfied with, the arrangement of using SERVICOM to 'police' their work.

The managers reported that shifting power relations in hospital management has had a chilling effect on their authority to manage the hospital. This result is in line with the study findings by Blackler (2006), which reported that modernisation of the British NHS including the use of audit agencies, undermines hospital managers' capacity to do their work as health professionals, and creates significant frustration among them. There was consensus among the FMCU health workers that because of the reform, they are losing professional power and autonomy.

The above findings correspond with reports on other public service sectors in other countries, such as education in the United Kingdom where OFSTED, the school inspection agency, was reported to have demoralised classroom teachers (Steer *et al*, 2007; Shaw *et al*, 2003). The results from this case study hospital in Nigeria that performance inspection did not seem to improve health worker motivation and performance is consistent with the observations of Shaw *et al* (2003) that inspections of secondary school teachers fail to take account of teachers' achievements. Others studies from England and Finland have equally suggested that inspection in hospital did not improve motivation of frontline service providers (Webb, 1998).

Based on the interviews held with frontline staff and managers in the present study, there seem to have been a significant reduction in waiting time at FMCU. Given the

understanding that long waiting times were typical performance challenges in FMCs in Nigeria prior to the reform, accordinbg to past studies (e.g. Bamgboye and Jarallah, 1994; Ajayi, 2002), the results here suggest that there has been an improvement in operational efficiency. Other past studies (Chung *et al*, 1999; Jackson *et al*, 2001) have indicated that reduced waiting times enhances timeliness of access, and improves patient satisfaction (Dixon, 2004; Wilcox *et al*, 2007; Harrison and Appleby, 2005). However, there were inconclusive reports from FMCU that rushing to deliver care in an attempt to reduce waiting time could be dangerous to patients' health. Propper *et al* (2007) found that long waiting time has remained a political issue for several UK governments, and has informed the development of targets as a way of reducing waiting times. In correlation with Propper *et al* (2008a/b), and Bevan and Hood (2006a/b), and despite the popularity of reducing waiting time, there is no robust empirical evidence to suggest that this measure has actually improved healthcare quality in NHS hospitals in England. While the debate goes on, however, there is an understanding, as raised by the results of this study that the drive for efficiency gains in reduced waiting time leads to unintended consequences.

The evidence from this study also suggests that increasing speed in care operations did not give adequate room for interaction between patients and health care workers, and for counselling. The importance of this interaction has been discussed in other studies. Adler and Hammet, (1973) and Heeg *et al* (1997) suggest that adequate counselling has a therapeutic effect, often addressed as a 'placebo effect'[4] on patients health, particularly for the treatment of chronic illnesses requiring palliative rather than curative measures (e.g. cancer or HIV/AIDS). This relates to the therapeutic effect that a patient receives from a particular treatment which arise from adequate counselling from the provider, and from the the patient's expectations and preconceptions of what the drug is supposed to do, rather than from the drugs itself. There is also an indication that speeding up diagnostic activities in order to achieve the targets of reducing waiting time can hinder adequate information sharing between the providers and patients. While it was difficult to pin down any specific case where inadequate patient diagnostics had resulted in poor quality service, the

[4] According to Shapiro (1960, cited in Adler and Hammet, 1973), it is a psychological effect of medicine arising from interaction or medical procedures given with therapeutic intent, which are independent of or minimally related to the pharmacological effect of medication.

health workers at FMCU were very clear in their understanding that inadequate diagnosis predisposes workers to by-passing clinical procedures. Drawing from past studies (e.g. Burhans and Alligood, 2010; Suhonen *et al*, 2005), there is evidence to support the view that inadequate diagnosis can prompt workers (especially comparatively inexperienced workers) to commit "medical errors". Other studies (Simmons and Elias, 1994; Kazaoka *et al*, 2007; Brady *et al*, 2009) also shed more light on this matter, and in particular on the link between inadequate diagnosis and early patient death. Again, the results from this case study hospital strongly indicate that increased workloads are telling on the health and work-life balance of health workers and this, along with increased stress and pressure, could undermine patient health and safety (Aiken *et al*, 2001; Kelly, 2004; Leap and Berwick, 2005).

While the claim by the clinical workers at FMCU that rising workload/stress is hindering their effectiveness remains inconclusive, other studies (e.g. Aiken *et al*, 2002; Eriksen and Ursin, 2004; Svensen *et al*, 2007; De Cuyper and De Witte, 2007; De Cuyper *et al*, 2008) have provides evidence that an increased workload does lead to stress and reduces worker morale. Furthermore, junior clinical staff perceived their professional motivation to be low because a mounting workload for their seniors leads to them being less disposed to provide their junior colleagues with adequate support and mentoring. This is particularly noteworthy given the critical role of mentoring in enhancing indidividual workers' capacity to perform because of its role in skill development for junior clinical and frontline staff in particular (Buerhaus *et al*, 2005; Niedhammer et al 2003; Laudicina, 2001). All these authors point out that mentoring empowers the mentee, decreases job strain and increases job satisfaction; thus, there where there is inadequate mentoring, performance is likely to be poor.

Another striking finding from FMCU relates to how performance measurement has led to a growing individualism, breeding unhealthy competition, fragmentation in the workplace, tension, distrust among colleagues, and reduced teamwork and willingness to assist co-workers. The implication of this is a reduced culture of intrinsic motivation among health workers. Again, this is in line with past studies (e.g. Frey, 2000; Francois, 2000; Benabou and Tirole, 2003), which suggest that individual-based performance measurement and incentives erode or crowd-out intrinsic motivation.

The fact that teamwork is a critical success element for effective healthcare practice, there is an indication that lack of teamwork may have undermined individual performance. This result corroborates past studies (e.g. Rafferty *et al*, 2001; Sims, 2003; Dieleman and Harnmeijer, 2006), which point to an existing positive relationship between teamwork and staff effectiveness, and job satisfaction, particularly in service-based organisations such as those providing healthcare. Other studies have noted the importance of teamwork in securing collegial trust (Gilson *et al*, 2003; Gilson, 2005) and performance. Overall, the results of the present study shed light on how the perception of declining cooperation among frontline health workers creates a regressive work environment, and results in low morale, dissatisfaction, and poor performance.

Notwithstanding the fact that the overall implication of the above is difficult to assess, the findings are suggestive, and clearly suggest a correlation between lack of cooperation among workers and commitment to group action. Past studies have highlighted how lack of cooperation can result in frustration and non-compliance (Cropanzano and Randall, 1993: Folger and Konovsky, 1989), as well as poor performance (Dooms and Van Oijen, 2005). Futhermore, it can be argued that while the conceptualisation of performance measurement culture and individual reward system is a market ideology, the results suggest that the reform has improved some aspects of health worker performance, even though there are claims that quality has been sacrificed in some cases.

The findings on the effect of the policy changes on individual worker's behaviour and attitude to work were mixed. On the one hand, workers reported a relative improvement in their performance and attitude to work. This related to the reduction in 'bad behaviour' such as charging unapproved or informal fees, pilfering drugs and supplies, and /or sitting around and not working. In this study, while these vices were not visible, they were mentioned in interviews. Besides, past studies in Nigeria (e.g. Uzochukwu and Onwujekwe, 2004; 2005) have acknowledged that this behaviour is common in the public service setting. Across many developing countries' health system settings there are unconfirmed reports that frontline health workers often charge unapproved fees (Ensor, 2004), pilfer drugs and supplies (McPake *et al*, 1999; Ferrinho *et al*, 2002; 2004), or have a reputation for laziness (Delfgaauw and Dur, 2006).

With respect to health workers' work attitude, the results suggest an improvement in terms of a reduction in absenteeism. While past studies in Nigeria have reported absenteeism as a mark of poor performance (e.g. in Nigeria-Bamgboye and Jarallah, 1994; Ajayi, 2002), and from other developing country contexts (e.g. Chaudhury *et al*, 2004; Ensor and Witter, 2001; Ferrinho *et al*, 2002), providing evidence of attitudes towards absenteeism, and actual absenteeism, remains challenging because of the difficulty of observing this malpractice. The fact that the FMCU workers claimed that they sometimes ask their colleagues to 'cover them' suggests that tracking absenteeism is difficult. This corroborates past agency research (Baker *et al*, 1994; Goddard *et al*, 2000), which suggests that observing what individual workers actually do can be difficult. There is also evidence that the drive to achieve targets and receive individual recommendations seem to have predisposed health care workers to unfriendly competition and misbehaviour (e.g. misrepresentation of their efforts). This is also in line with findings from other studies (e.g. Bevan and Hood, 2006a; Mannion *et al*, 2005; Propper *et al*, 2008a/b).

The results also suggest that while patient power may have increased, this may have undermined the confidence of health workers. The health workers at FMCU, particularly those nurses and doctors working in the Out-patient and Accident and Emergency departments, found it difficult to cope with some of the verbal abuse they reported having received from patients. These findings, though difficult to triangulate, nevertheless correlate with other studies (e.g. Lin and Liu, 2005; Pejic, 2005; Kisa, 2008) which have highlighted that verbal abuse and intimidation of staff by patients is common in hospital settings.

Overall, the results do suggest that differences in interest and personality, professional life, and expectations, influence individual motivation. All this is supported by past studies from elsewhere (e.g. Jones *et al*, 2008; Oreg, 2006; Kavanaugh *et al*, 2006), which highlight the fact that individual mind-sets about life influence attitudes to work. Again, studies from China (e.g. Hu and Liu, 2004); England (e.g. Blackler, 2006); and Malawi (e.g. McAuliffe *et al*, 2009) suggest that levels of de-motivation and dissatisfaction tend to be influenced by individual worker characteristics.

In conclusion, the presentation in this chapter suggests that although motivation is an important component of health workers' work lives that can impact on their work performance, there is a perception that health workers seem to be de-motivated by the changes in work practice. Many workers did not perceive that their motivation and performance had increased as a result of the changed work processes introduced by the reforms, because of the way increasing workload and stress is undermining their capacity to function optimally. In relation to SERVICOM, the results reported in this chapter suggest how the audit system is creating an awareness of how administrative norms seem to override professional knowledge of healthcare practice. The frontline workers, and even their managers, see the process as generating a frustrating work environment which does not support progressive relationships. However, there is suggestion that health workers who are nurses appeared to be more motivated than their doctor counterparts. In addition, workers with relatively long public service records expressed more anxiety than their junior colleagues about their job security and status. The results suggest that the health workers made important claims based on their subjective perception of the effects of the reform. It is, however, important to point out that sometime the way the workers presented their claims often suggests an undeniable ambivalence. This also sheds light to how underlying work culture and contexts shape individual perceptions of change effects.

The next chapter presents further empirical data that also examines how health providers perceive the *effects* of the changes, but with respect mainly to their incentive, motivation and behaviour.

8 Incentive, Behaviour and Motivation of Health Workers

8.1 Introduction

The focus of this last data chapter is on pay incentives to health workers to change their work practice, behaviour, and to motivate them to perform better. It is important to reiterate that changing any organisation and workers' behaviour, and motivation in particular is not often as easy as predicted. As noted in Chapter 4 (Section 4.3.2), given the understanding that health workers' behaviour, and motivation was clearly a problem for public health delivery, the second aspect of the reform, i.e. pay reform was specifically targeted to generate incentives in order to motivate workers to achieve the desired changes in work practice. As noted in Chapter 4, the reform of pay systems includes performance-related-pay; pay rises, monetization of fringe benefits, and changes in pension systems. The interest of this thesis in pay reforms lies largely in the performance-related-pay (PRP) element of the health reforms. This is the aspect of the pay reform that relates directly to the service delivery reforms or changes in work practice; it provides the link between pay and promotion based on good performance.

Equally noted in Chapter 4, the Nigerian Government implemented PRP to motivate workers to change their work practice. However, it is possible to conclude from policy documents on pay that the government also initiated the pay reform to address the reported inadequacy (low pay) of public workers' pay. Nevertheless, with respect to the health reform which forms the focus of analysis in this study, the performance-related-pay element was acknowledged as an attempt to link rewards to the realisation of targets. The philosophy is underpinned by the supposition that 'getting the incentives right' is a way of motivating workers to change their work patterns in order to realise government national targets, i.e. PRP will foster good performance. As claimed in the policy document, linking pay to performance which is assessed by reference to standard criteria ensures consistency in performance assessment, thus ensuring remuneration that is fair and deserving across different levels and tasks performed. This goes much further than simply talking about PRP.

It reflects the thinking behind arguments for 'fair wages' across different worker categories and how this has contributed to changes in status.

Although PRP is especially relevant to this thesis, the value of paying attention to the other elements of the pay reforms is indicated in a number of documents (Pay Reform Act, 2000; 2004). In order to attract, retain, and motivate skilled professionals in the Nigerian public service, a pay increase was considered essential. Nevertheless, while it might be agreed that pay rises is a pre-requisite to improved service delivery, the issue of poor pay administration has historically meant that, in Nigeria, public servants might receive pay in arrears or regularly receive late pay. Under these circumstances, it is reasonable to suggest that the whole pay package and the payment process (routinely paid to a prescribed schedule) should equally be the focus of attention if workers are to be motivated to change work practice. As noted in Chapter 4, in general the reform is about changing health worker's behaviour. Although there are several ways of doing this, the health sector reform considers just two approaches, the first about changing work practice by measuring performance, and the second about reforming pay system to generate incentives for individual health workers to encourage changes in their behaviour and work practices. The general perspective of the underlying principles of the health sector reform is that for reform to be effective, it must operate in such a way to facilitate proactive work practice, and at the same time, attract the willingness and effort of the health workers. As noted in Chapter 4 (Section 4.3), policy documents and key informant interviews were used to verify the link between changes in work practice and pay reforms.

To understand PRP, it is important to set out the context within which it operates, particularly as it relates to the issues of pay and incentives for different categories of public workers. Firstly, the results indicate that different categories of health workers (doctors, nurse and managers) are obviously paid differently. Secondly, it is important to recognise that there has been a dramatic change in the pay of public health workers over the past three decades, with a marginal improvement in the pay of health workers. On the average, public health workers have been paid more promptly and timely than before, yet, there has been tremendous variation in the real value of pay.

Thirdly, because of the pay changes, public workers claimed to have lost all in-kind fringe benefits which they previously enjoyed. The in-kind fringe benefit has been monetised, harmonised (i.e. paid across the board), and consolidated into their basic pay, and taxed alongside this. Although there has been a recovery or a rise in pay (in norminal terms) compared to the 1990s, workers were very concerned and often compared their pay now with what they previously earned in the 1980s and 1990s, which seems to suggest that they are earning considerably less now. There is a general perception that public workers feel exposed to decline in real take-home pay due to rises in cost of living. This is coupled with the fact that they now have to worry about the loss of the in-kind benefits they enjoyed before the reform.

In the context described above, the performance-related pay (PRP) incentive is applied, and the focus of this chapter is PRP, which is the core incentive component of the reform. The operation of PRP sits within the wider context of the new public sector management debate and is about how to motivate public workers. The PRP incentive structure is concerned with linking rewards to individual performance. While there are questions about its effectiveness, there are indications from this study that the operation of PRP may have affected the motivation of the workers. The real contribution of this chapter is not simply looking at the reform incentive element; rather it puts it into context, with a view to understanding how, and to what extent, workers perceive the changes and how these changes motivate them within the public service sector.

The analysis in this chapter draws on two main data sources: public service pay data (1983-2007) from the national pay office, and workers' perceptions and interpretations of the changes in pay and status change. It begins by presenting the results from the analysis of the national pay data suggesting details of the pay trends in basic salaries (a function of changes in minimum wage). It then provides an account of how different worker categories see their pay changes, and how they see their relative pay, and changes in status. Finally, focusing on the performance-related pay incentive, it provides a specific analysis of effects of the performance-related pay on different categories of workers.

8.2 Pay Trends and Changes

The first theme that emerges from the pay data analysis, as shown in Figure 8.1a below, is that nominal pay increased for all categories of health workers. At the same time, the rising cost of living (see Figure 8.1b) has resulted in the erosion of real pay (See Figure 8.2) for all categories of workers.

Another theme about pay reform relates to relative pay. As noted by Katz and Murphy (1992) and Clark and Oswald (1996), relative pay is important. The results indicate that significant differences exist in real relative pay distribution *within* worker categories and levels. As can be seen in Figure 8.3, top-level doctors earned 2.22 times more than lower-level doctors before the reform (1983-1999), 2.34 times more that lower-level nurses during the early part of the reform (2000-2002), and 2.32 times more during the latter part of the reform (2003-2007). Conversely, as shown in Figure 8.4, top-level nurses earned 2.8 times more than lower-level nurses before the reform (1983-1999), 3.0 times more during the early part of the reform (2000-2002), and 2.9 times more during the latter part of the reform (2003-2007).

In addition, as evident from Figure 8.5 and Figure 8.6, significant differences in real relative pay exist between worker categories. For example, Figure 8.5 shows that the entry salary of doctors was 1.43 times more than the entry salary for nurses in 1983-1997, 1.7 times more in 1998-1999, 1.45 times more during the early part of the reform, and 1.42 more in 2003-2007. Similarly, as shown in Figure 8.6, the analysis suggests that the end salary of doctors is 1.11 times the end salary of nurses in 1983-1997, and 1.41 times in 1998-1999. This dropped to 1.12 times in the early part of the reform, and remained at 1.12 during the latter part of the reform. The results clearly suggest that pay inequality has been an issue. Of particular interest is the fact that, because of the reform, while inequality seems to have increased within categories (i.e. doctor to doctor, or nurse to nurse), there has been an equalisation of pay between categories (i.e. doctor to nurse). This is a significant achievement and tends to suggest that the reform has been successful in narrowing pay differentials between doctors and nurses.

Figure 8.1a: Trends and structure of nominal salaries for entry and end career for doctors and nurses

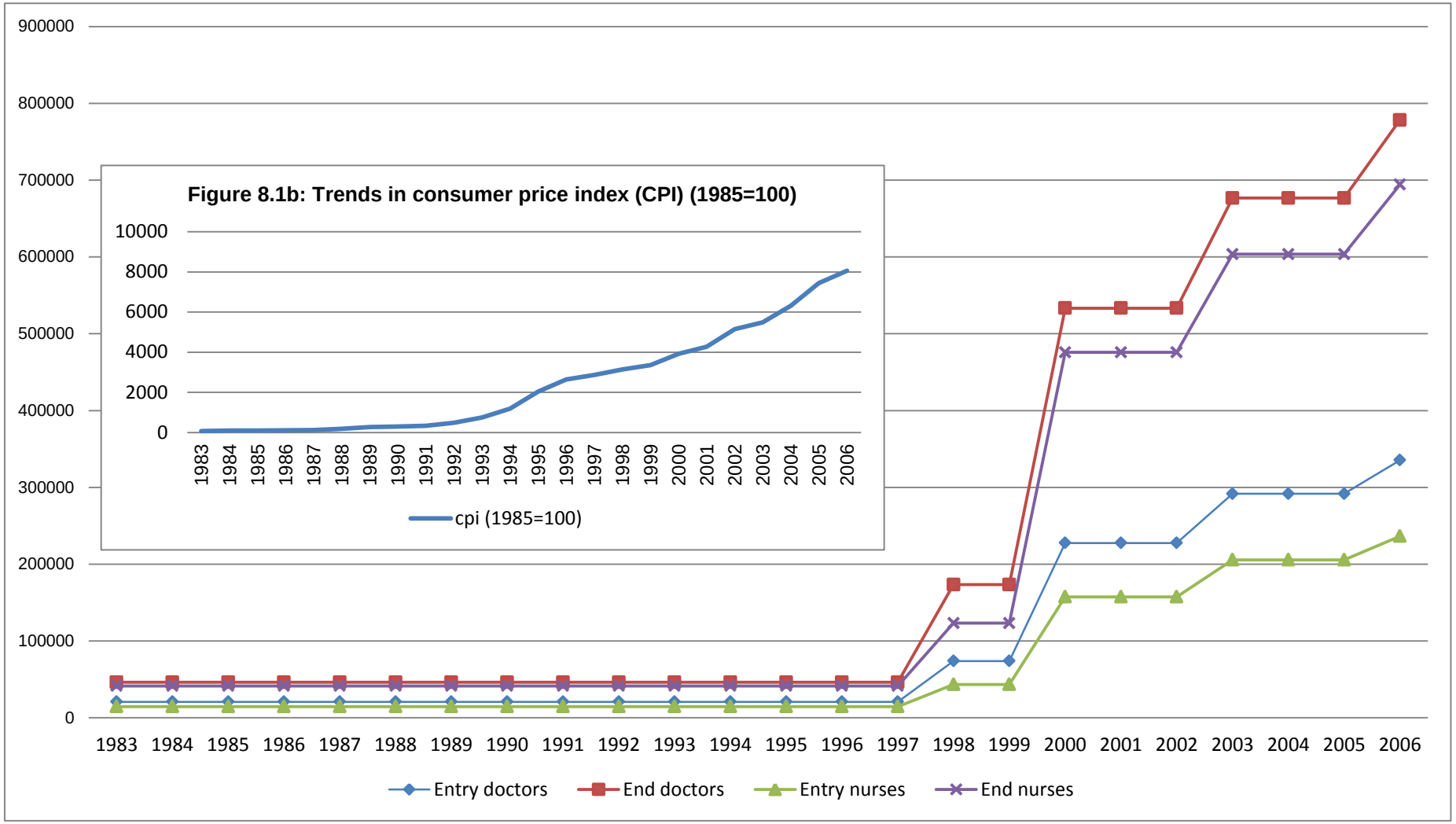


Figure 8.2 Trends in real entry and end salaries for doctors and nurses

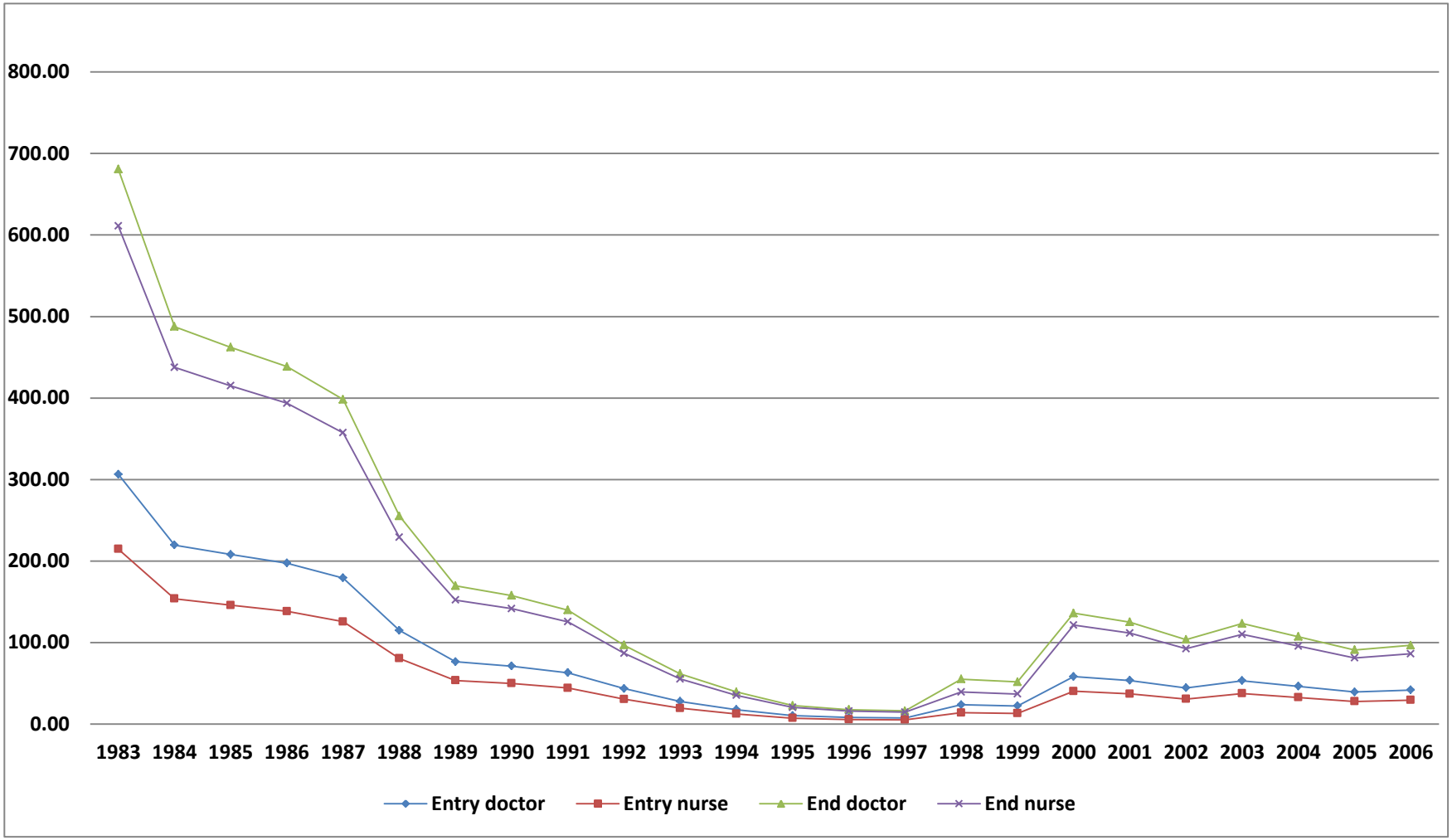


Figure 8.3 Relative salaries for doctors 1983-2007

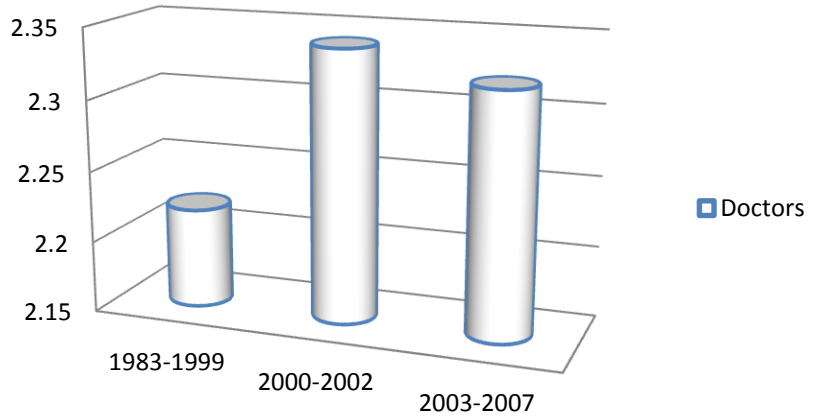


Figure 8.4 Relative salaries for nurses 1983-2007

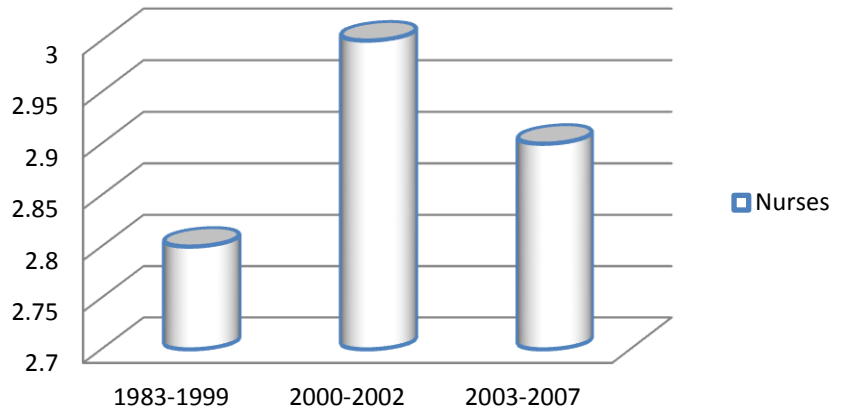


Figure 8.5 Relative entry salary of doctors vrs entry salary nurse

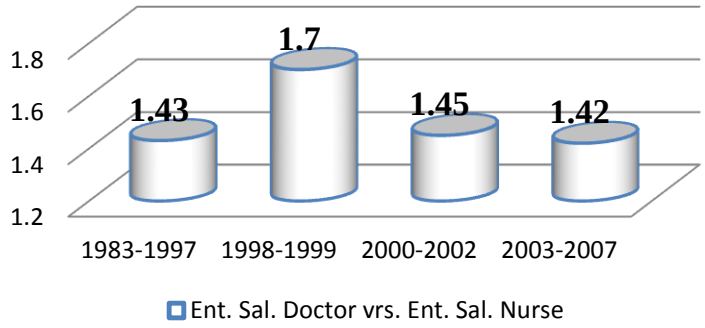
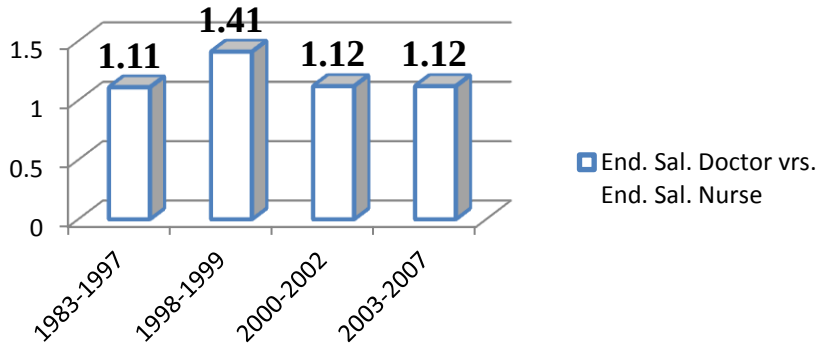


Figure 8.6 Relative end Salary of Doctor vrs. End salary of Nurse



The statistics presented above suggest that the real growth rate of doctors' and nurses' salaries for all levels has been negative since the 1980s and 1990s, but has risen sharply because of the reform. This indicates that there has been a recovery, although this does not yet appear to be sustained.

8.3 Fringe Benefits and Allowances

As indicated in Chapter 4, another distinctive characteristic of the pay changes is the monetisation and consolidation of fringe benefits and allowances. The importance to government of this aspect of the reform is that it is expected to facilitate sound budgeting and revenue generation through pay-as-you-earn (PAYE) tax once the pay package is consolidated. However, it is possible that the monetization of fringe benefits and allowances to workers is also important for thinking about motivation to work.

As noted, prior to the reform public workers enjoyed in-kind benefits and allowances which were tax free. The fringe benefits consisted of free housing, transport, utilities, furniture, call and shift duty allowances, and meals. These in-kind benefits were mainly for senior workers as a mark of recognition for their length of service, and status. Under the reform, all in-kind benefits and allowances were monetized, consolidated and subjected to PAYE tax together with the basic salary. Of importance is the fact that as part of the distributive and harmonising nature of the pay reform, the government decided to pay all workers the monetised fringe benefits. At the same time, the monetised individual fringe benefits attracted differential cash equivalent for top, mid and lower categories of both doctors and nurses, as indicated in Table 8.1 below.

Table 8.1Percentage composition of yearly benefits (in cash equivalent) as % of basic salaries

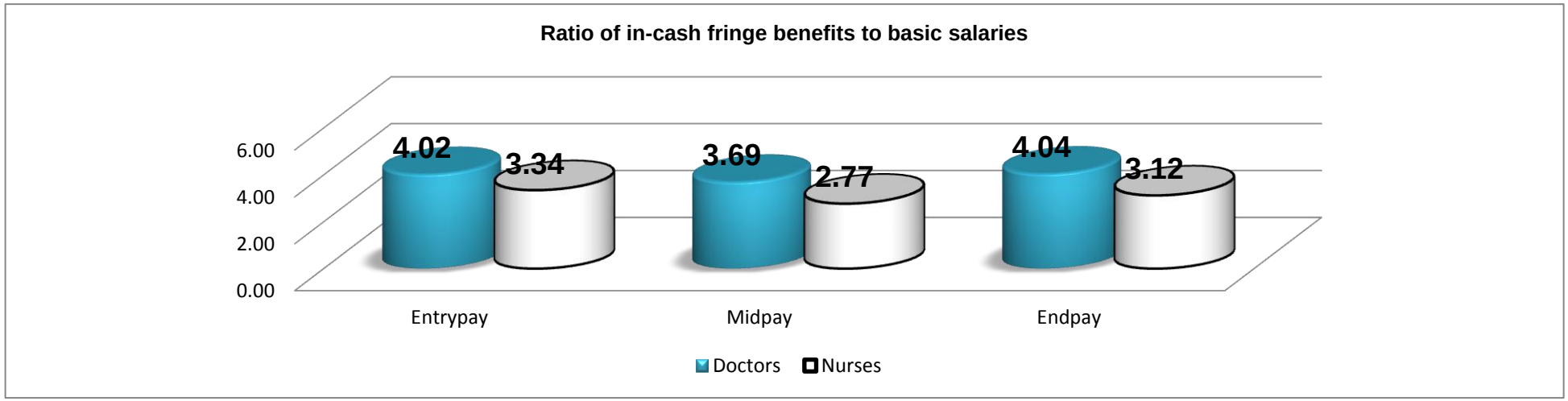
Worker level (doctors and nurses)	**Furniture**	**Utility**	**Housing**	**Transport**	**Meals**
top	**40%**	**20%**	**75%**	**29%**	**80%**
mid	**40%**	**20%**	**60%**	**29%**	**60%**
low	**40%**	**20%**	**60%**	**29%**	**40%**

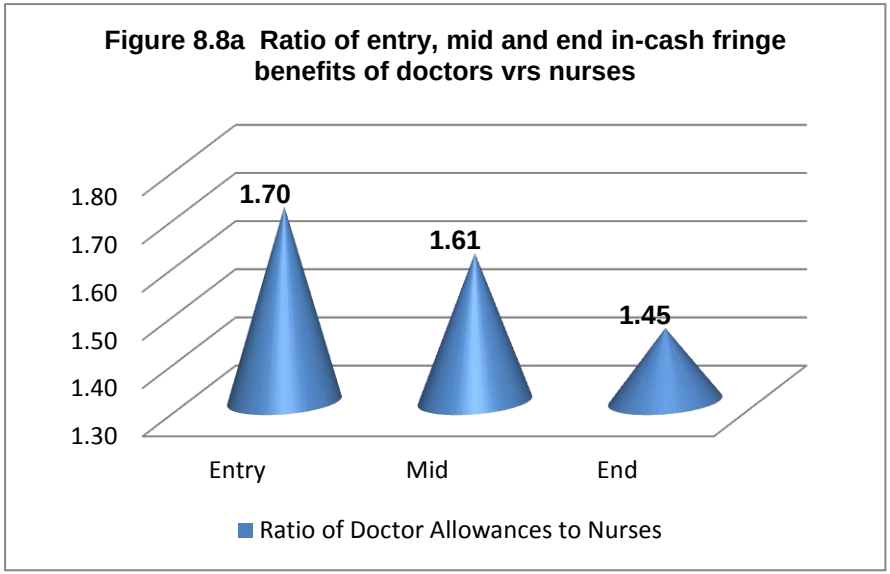
Source: National Income, Salaries and Wages Commission Circular, 2003

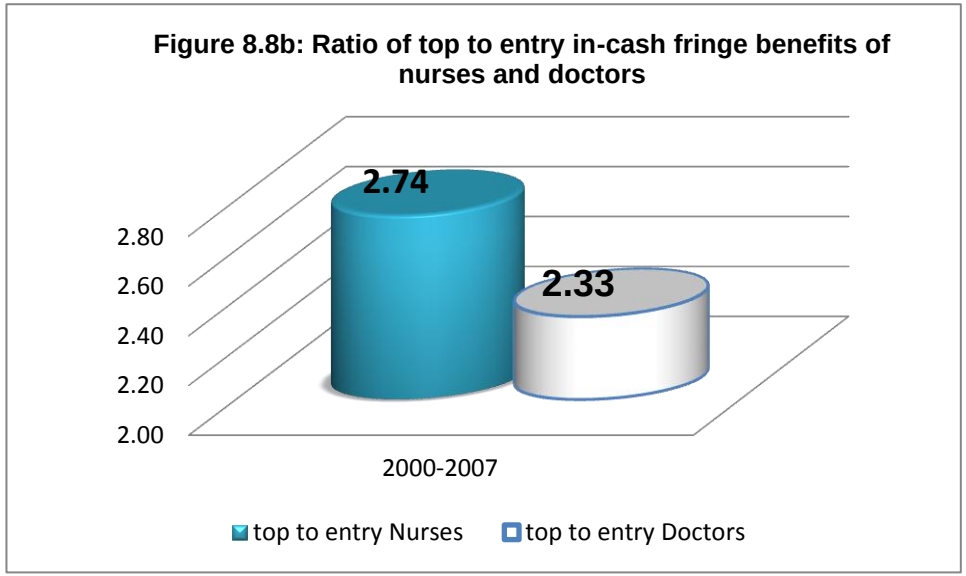
Doctors and nurses are also paid cash allowances for call duty (doctors) and shift duty (nurses). The pay data indicate that allowances are paid at the rate of 4% of the basic salary per unit call for doctors, and 1.7% of basic salary per unit shift duty for nurses. As evident from Figure 8.7 and Figure 8.8, fringe benefits and allowances constitute a significant portion of public health workers' total take-home-pay.

For example, as can be seen in Figure 8.7 below, doctors earn about 80% total pay or 4.0 times their basic salary as bonuses (benefits/allowances), while nurses earn about 77% or 3.0 times their basic salary as bonuses. Whereas top-level nurses earn 2.74 times more in bonuses than lower level nurses, top-level doctors earn 2.33 times more in bonuses than lower-level doctors. Therefore, the analysis of pay data suggests that benefits and allowances make up a significant proportion of health workers' total salaries. This is consistent with past studies (e.g. Lindauer and Nunberg, 1994), which report that bonuses and allowances in developing countries amount to between 35% and 100% of basic salaries.

Figure 8.7 Distribution of the ratio of in-cash fringe benefit to basic salaries between doctors and nurses







8.4 Health Workers' Perceptions of Pay Change

With respect to health workers' perception of the pay change, all the workers acknowledged the pay rises and said that their nominal take home pay has increased. One of the nurses said: *"The reform has increased our pay, everybody knows this"* (Nurse HWN15). However, it was widely acknowledged that the pay rise has been eroded by the rising costs of food and services.

> *Our pay is insufficient because prices of food and services in the market are too high. When we compare our pay now with our pay before, I just think that we have not gained anything, before prices were not as high as it is now* (Operational Manager HOM9)
>
> *Even though my pay has increased so much, I am always running out of money to pay bills and school fees. It is very difficult to make ends meet with our pay, prices are too high* (Nurse HWN4)
>
> *Government did not meet our expectation regarding what we think should be paid to us given our work and the prices of basic foods. Some of us are not meeting our needs; we are barely managing to survive, yes surviving is not living, but there is nothing we can do. Do you know that some workers 'eat without meat' in order to survive?* (Doctor HWD22)

Despite the recognition of the pay rise, both frontline doctors and nurses and their operational managers claimed that their salaries remained *"insufficient"* and they are not *"making ends meet"* implying that their salaries have been eroded by the rising cost of living. Although these views should not be taken at face value, as people will always say that their pay is not enough, the views of the workers correlate with the pay data presented in Figure 8.1a and Figure 8.1b.

Another change in pay relates to the pay process. All interviewees claimed that the pay reform had improved the pay process, specifically in terms of regularity and timeliness of pay. This is in line with the objective of the pay reform, as outlined in the pay document:

> *It has come to the notice of government that public workers for long hardly receive their salaries as and when due. On many occasions, unpaid salaries have been in arrears of 2-3months. This situation has been a source of worry to public workers; government has put in place measures to improve pay scheduling as a way of ensuring that salaries are paid on time* (NISWC, 2004)

The literature also reports this as a common feature of, and a major challenge to, pay systems in sub-Saharan Africa (McCoy *et al*, 2008). The interviews here revealed that, prior to the reform, workers were hardly ever paid on time or on a regular basis.

Table 8.2 reveals that almost all workers reported improvements in their pay process and satisfaction with the regularity of their pay.

Table 8.2 Health workers' opinions on changes in the pay process

% of workers satisfied or motivated by pay process and delivery mechanism	All Managers (operational and executive) (n=22)		Doctors (n=40)		Nurses (n=45)	
	Satisfied	Dissatisfied	Satisfied	Dissatisfied	Satisfied	Dissatisfied
Timeliness of pay	91% (20/22)	10% (2/22)	100% (40/40)	-	100% (45/45)	-
Regularity of pay	100% (22/22)	-	88% (35/40)	12% 95/40)	91% (41/45)	9% (4/45)
Pay information	100% (22/22)	-	100% (40/40)	-	100% (45/45)	-

Source: Field data, 2008/9

Declaring that the *"era of unpaid and delayed salary payment is over"*, one manager noted:

> *Before the reform, there were so many problems about our salaries. The first was that our salaries were very low and most importantly we hardly receive our salaries on time. Sometimes as was the case, government owed us salaries for up to 3 months. So before the salaries come, you have borrowed so much. Nowadays since this reform started, a good thing that has happened is that we now receive our salaries on time and there are no more arrears of unpaid salaries* (Operational Manager HOM3)

In general, this was a widely accepted view, as reflected in the following comments made by a doctor:

> *Everybody knows that this reform has done well as we now receive out pay promptly and regularly. At every first week of the month we are sure of our pay. Before the reform, sometimes when you go to the bank for your pay, the bank will tell you that the salary cheque has bounced. Nowadays we no longer experience this. Also, they provide information like payslips about our pay* (Doctor HWD7)

More specifically, some emphasised how the change had improved workers' welfare, even enhancing planning spending:

> *To say the truth, I no longer borrow because salaries are now paid on time. Receiving my salary on time has been helpful particularly in making plans* (Nurse HWN2)

> *Before, you hardly knew the deductions on your salary; you just go to bank and collect your salary. Now we receive our payslip and it tells us when the money has been paid into our account. Everything is now clear, if you discover a mistake you just take your payslip to payroll/account and they will correct it next month* (Doctor HWD21)

Meanwhile, a top-level executive, reiterating the mind-set of the government, said that the improvement in the pay process was part of the wider reform objective, which has sought to improve the government's overall budgeting and planning system:

> *The government has improved the pay process and budgetary procedures. All ministries are now expected to produce the pay schedule on time and send it to the Presidency for approval before the 3rd week to enable public workers gets their pay on time* (Top-level Manager HEM6*)*

Furthermore, all workers indicated that they now received pay-slips specifying how much they are paid, as well as the deductions made. The interview data suggest that workers saw the changes as important, because the majority claimed that they no longer borrowed because of non-payment of salaries. The results indicate that apart from the amount, value and relativity of pay, public workers attached considerable importance to timeliness and promptness of pay as a predictor of how well the issue of pay motivates them.

8.5 Health Workers' Perception of Relative Pay

During the interviews, two levels of comparison on relative pay were noticeable. The first relates to how pay compare *within* worker categories (e.g. doctor-to-doctor or nurse-to-nurse), and *between* worker categories (doctor vs. nurse). This is also looked at in terms of relative pay differentials for the highest-paid and lowest-paid workers. The second relates to how health workers perceive their pay relative to their colleagues in private hospitals.

Regarding the first, the results of the 'within category' analysis suggest concern that the reform has caused a divergence in pay distribution between the top-and lower-level doctors and nurses respectively. The trajectory of individual responses unequivocally suggests that doctors and nurses, particularly at the lower-level, reported that their top-level colleagues earned proportionately more. Although there

was no indication among the lower-level workers of a demand for equal pay, there were concerns that top-level workers earn disproportionately higher salaries, and this was construed as unfair. The workers' narratives about relative pay correlate with the pay data presented in Figure 8.3 and Figure 8.4. The rising tension over the relative pay differential of top managers and others is a concern in other health system contexts. For example, in the UK NHS it has been widely reported in the media that there is a significant pay disparity between top managers and other levels of public health worker. In a recent report entitled *"NHS pay disparity between top and lower workers exposed"* (*BBC News,* 2010), in 2008/9 top NHS managers received an average pay rise of nearly 7%, compared with less than 3% for general workers.

Regarding 'between category' salary differentials, the opinion among nurses was that *"Doctors earn more than nurses",* while doctors reported that *"We cannot earn the same salary as nurses because our work and skill is higher*". The issue of doctor-to-nurse pay differences triggered tension and the evidence suggests that it remains a source of contention. Twenty-seven of the forty doctors interviewed were of the view that they were comparatively better in terms of training, skill, expertise, and commit more effort to their work than nurses. One doctor said: "W*e are the pillars of hospital operations and nurses are supporting staff"* and so should be paid higher (Doctor HWD17), suggesting a presumption that doctors are superior to nurses. In this context, the claim that doctors should be paid more because they put in more effort is consistent with past studies (Akerlof and Yellen, 1990; Georgiadis, 2008), which advocates that fair pay means pay according to effort.

Meanwhile, an operational manager noted that relative pay differentials within categories create a sense of unfairness and tension:

> *There has been a lot of tension since the reform started. This has often resulted to strikes. Nurses complain that doctors earn more than they do, and junior workers said that senior workers earn more. I think that people are too engrossed in comparing this or that* (Doctor HWD19)

Meanwhile, listening to nurses on the issue of relative pay produced a different view. One nurse strongly argued that healthcare delivery is team work and did not see why

there should be discriminatory pay differentials between doctors and nurses.[5] Claiming that *"a nurse is treated as inferior to a doctor"*, she noted:

> *Government hardly listen to us as they do to doctors. They take our work as inferior. Nursing is a woman's work; even a house officer who started yesterday earns more than a nursing officer who has put in 15 years in service. This is unfair. We are in this job together and work together to better the life of patients* (Nurse HWN10)

A consensus among nurses emerged from the interviews and discussions that their profession is treated as *"inferior or second class"* in healthcare delivery. One of the nurses claimed that:

> *Anytime doctors go on strike, government give them better pay, but for us we are not as forceful as doctors. I think that is why they look down on us; even some doctors treat us as if we do not know anything, yet some of us because of our experience we provide advice to them. I think it is not good to think that we are less valuable or inferior to doctors. We are not saying that our pay should be equal, but at least it should be considerate and fair, we are all in this job together. Sometimes you just feel cheated and frustrated* (Nurse HWN2)

Furthermore, another, concurring with the "team concept" and the fact that their own length of service is not often considered, said:

> *It is painful that my son who has studied medicine who is now working in this hospital earns more than my salary despite my years of experience. This is not justifiable in any way. You see no doctor can work without a nurse from the theatre to the consulting and treatment room. Yet, we are treated as second class in health care* (Nurse HWN9)

The issue of disparity between doctors and nurses remains rife and this study did not see the need to go into more details about it. Suffice to say, and as revealed by five out of the six top-level executives interviewed, the pay disparity between doctors and nurses is not unique to Nigeria. Although one of the executives candidly acknowledged that pay disparity has been a problem, it was widely stated that what people earn in the public service is a function of training and profession. Citing a policy document, a manager said:

> *Pay in the public service is dependent on the principle of federal character, the point of entry of officer into the federal public service shall is based on the principles of experience, length of service, relevant qualification, training and*

[5] There are ample media reports that nurses and their professional unions have long been calling for pay parity with doctors (The Nigerian Guardian, 2000; Nigerian This Day, 2001; Nigerian Daily Trust, 2009)

> *examination where applicable* (Operational Manager HOM10 *citing* the Civil Service decree No 43, 1988)

The result that nurses feel demotivated by the relative pay differences compared to doctors has also been recognised by other recent studies. Cloutier and Vilhuber (2008), for example, found that feelings of disparity in pay often make nurses grumpy and frustrated. A senior nurse stated, however, that even though their pay differs, things are no longer as bad. This study indicates that relating pay differentials rather than pay is a key determinant of health worker motivation. It has also been reported that relative pay differential is a global issue (Freeman, 2007; Freeman and Oostendorp, 2001).

Another relative pay issue has to do with how public health workers perceive the pay changes, or what they earned, compared to their colleagues in private hospitals. Prior to the policy, and since the 1990s, health workers in private hospital organizations have earned more than their public sector peers (Ogunbekun *et al*, 1999; Alubo, 2001), a situation that, as noted by literature, has contributed to many public health workers leaving to join these private organizations. Within the framework of the pay reform, the government promised to make public sector work very competitive (NEEDS, 2004). Concerning how the salaries of public health workers compared with those in private hospitals, many interviewees felt that their pay had indeed overtaken that of their private sector colleagues. Indeed, many workers were particularly happy in this regard and noted that, before the reform, private hospitals paid better than public hospitals.

A senior manager drew attention to the positive effect this may have had on workforce management and increased worker retention.

> *Because our pay has overtaken the private sector pay, a lot of people now want to work in the public sector. Before our experience was workers leaving and joining the private sector. Before the reform, we were losing 2-3 staff a quarter to the private sector. The tide has turned in our favour and private workers now want to join the public service because of improved pay* (Senior Operational Manager HOM1)

The view of the above manager was mentioned by all the six top-level managers, and six out of sixten other operational managers. The results that public health workers now earn better pay than their colleagues in private sector organisations correlate with recent country-wide assessment in Nigeria (Barnes *et al*, 2008), which

found that, between 2005 and 2008, the salaries of public health workers overtook those in private hospitals. Despite this development, frontline workers were concerned that the pay rise is not commensurate with the increased workload they face. One manager stated:

> *Not everything we do is paid for. Sometimes, you just have to continue because our work is a humanitarian service. I think also that that is why we are called public servants. I see that so many people are complaining these days and even sometimes there are grudges when you ask people to serve* (Operational Manager HOM11)

Interestingly, the opinions of workers were inconsistent and often ambiguous. For example, while a third of doctors and nurses interviewed wanted to be paid for every job they do, the other two-thirds who claimed to be driven by intrinsic motivation, said that though not everything they do is paid for, there is need for fairness in pay. Meanwhile, for those driven by intrinsic motives, there is an indication that commitment and devotion to duty seem to have come under attack, or are being eroded:

> *Many people are not happy with the way things are going. We need to be encouraged to do more. I do feel happy doing extra towards saving lives. Helping people in need is why I chose to be a doctor. If we are looking to be paid for everything we do, patients will be abandoned to die. I do not like to see patients die while I can help. However, I discovered that sometimes some doctors are made to do work as if they are being punished. We need to be encouraged to do more. Sometimes, many colleagues comment that they need to be encouraged to do extra work* (Doctor HWD18)

> *"I am just doing this work because I want to, not because of the money, because the salary is not commensurate with our work. I have remained in this job, not necessarily because of money, but you feel bad because they are commercialising our work, yet, there are no facilitates. For example, we do not have functioning dialysis equipment. Sometimes we refer our patients to private hospitals that have facilities"* (Nurse HWN32)

It is important to underscore that the claim that pay is not commensurate with effort remains complex. While doctors, for example, said that they put in more effort than nurses, measuring individual effort in practice is complicated and contentious. The take-home message is that workers' own subjective perceptions of the link between efforts and rewards appear to stand out as a stronger motivator than the pay rise. While this seems to correlate with the existing literature on human capital theory (Ehrenberg and Smith, 1994; Armstrong, 2002), which found that individual morale

falls when one perceives that higher efforts are not adequately rewarded, it contradicts mainstream classical economic theory (Akerlof and Yellen, 1990; Elliot, 1991), which supposes that higher pay means an increase in motivation. Contrary to traditional stereotypes, which suppose that paying workers more will increase their motivation, the results of this study suggest that feelings of unfairness due to a disproportionate reward of pay for effort may have implications for public-spirited attitudes. This was found to be very consistent with past research (e.g. Frey and Oberholzer-Gee, 1997; Frey and Jegan, 2001), which highlighted how perceptions of unfairness in the distribution of performance-related financial incentives could result in declining intrinsic motivation. Previous studies, such as those on equity (Adams, 1965) and organizational justice (Lind and Tyler, 1988; Cropanzano and Randall, 1993), support this view.

The results also suggest that, in general, despite the acknowledgement of pay rises, health workers stated that they were not motivated, with the doctors seeming to be more discontented than the nurses. While their reasons remain inconsistent, a common theme was that the reform did not provide adequate incentives to make up for the changes in the work-balance of doctors. One of the doctors said that, as result of the rigid work process introduced by the reform, they no longer have adequate time to do private practice, through which they receive additional earning. The statement by this doctor, which was also mentioned by ten out forty other doctors interviewed, was clear:

> *Working in government hospitals gives doctors the opportunity to do private practice in their spare time. While I cannot say that this has stopped, there are a lot of checks about our work and sometimes increased workload mean a reduction of time for private work. Most of us meet up with earnings from private practice* (Doctor HWD11).

One of the nurses attested to the above statement and confirmed that: *"Doctors are better off because they can do their own work or work in a private hospital*" (Nurse HWN29). The study results suggest that, although both nurses and doctors indicated that their intrinsic motive for working in a government organisation seems to have been eroded, nurses seem to indicate less discontent than doctors.

One doctor noted that, compared with previous years, the motivations of those doing government work had changed:

> *Years back when we joined this service, there was a strong willingness to serve, but now, what we have been experiencing is that people are hardly serving with their whole heart. I do not think it pays any longer to commit one's devotion and commitment because status and position, and the associated benefits have been removed. There is lot of politics and infighting; I think that a lot of things have spoiled this work* (Doctor HWD24)

One operational manager clearly reported that apart from pay, public health workers are equally, or even more, motivated by intrinsic factors such as the decision to serve, status as a government worker, and a good working environment or work context:

> *For a public servant, pay is never enough. There are good times and there are bad times. Apart from pay, other things make you choose to be a public servant. Money is not everything. If anyone thinks that making money is all it takes to work then I do not think that public service is the best place. A lot of us value social status which working as a senior government official provide, and including the benefits in the society. I think that this is no more. We entered into this job 32 years ago because we wanted to serve, yet, I think that you cannot serve without earning a living. Although we are "public servants" I think that it is important that we have congenial working environment that will encourage public servants to serve well* (Operational Manager HOM4)

During the interviews, many frontline doctors and nurses, and even their managers asserted that the spirit of "public service" built on altruism appeared to have been eroded because of an increasing sense of individualism and unfairness perceived to be associated with the incentive structure, and loss of status in the public service generally. This is consistent with Le Grand (2003), who notes that public sector workers are also driven by self-interest and not simply by external incentives, as often supposed. The view given above highlights the complexity of public workers' motivations and is consistent with the literature (Dixit, 2002; Prendergast, 2007). The central message is that public workers are motivated by a variety of factors. Nevertheless, past studies suggest that across developing countries, for example in sub-Saharan public health systems, perceived inadequate pay stands out as one of the major motivational challenges (McCoy *et al*, 2008).

8.6 Health Workers' Perceptions of Status Change

The literature suggests that status in an organisation and society influences workers' perception of self-worth, self-concept (i.e. perceived personality) and motivation (Agrawal, 1977; Franco *et al*, 2002). Two aspect of the incentive system shaped

doctors', nurses, and their managers' perceptions of their status and position within the organisation and society. The first relates to the shift in the nature of fringe benefits; from in-kind, which are based on earned status and length of service, to harmonised cash-based fringe benefits, which are open to all. The second, which perhaps is most important because of the way it links the service delivery or changes in work practice reform and individual worker performance, relates to the introduction of performance related pay incentives, which operate as a merit reward-based on individual workers' performance and, at the same time, influence individual workers' promotion.

With respect to fringe benefits, the interview results suggest that workers valued in-kind fringe benefits because they enhanced their status within the organisation and society. This is also because, prior to the change, fringe benefits were a privilege reserved for senior workers, as recognition for long years of service and status. Senior workers said that they considered in-kind fringe benefits as a "legacy" from government, which improved their "status" in society.

> *When we joined this job, we were attracted by fringe benefits like official cars and good accommodation. Some of us did not go to private sector because such did not exist. Fringe benefits were not only a legacy of government work, it is what government gives to us to improve our status in society, having hope that one day you will be a boss with a government driver taking you here and there and to your village during Christmas. It was the dream of every public servant to progress in their job to become qualified to receive the fringe benefits* (Operational Manager HOM2)

Another worker pointed out how in-kind fringe benefits serve to compensate for inadequate pay compared to the private sector – particularly as it had been pre-reform:

> *Before this reform, in-kind fringe benefit was earned based on position and length of service. It distinguished public servants and it was a mark of respect. After this reform, government has monetized and harmonized the fringe benefits to make sure that all public servants enjoy this. I think this is good because we are all servants and it is just fair to give everybody* (Nurse HWN38)

Meanwhile, the harmonization of fringe benefits seems also to have impacted on the existing status quo in which "status", "class" or "position" no longer determine who receives such benefits. One senior worker said that it is not fair that, after she had

waited for so many years, her expectation of living in a government apartment and using an official government car had been dashed by the reform.

> *We are no longer treated with respect as it was 30 years ago. It has just reached my turn and government has removed official cars and no more living in government residential quarters. To be frank, not having these in-kind benefits is demoralising because some of us have waited for our turn* (Senior Nurse HWN6)

The general perception of senior workers is that public work no longer commands the high status it enjoyed thirty years ago, and senior workers are now treated as equals with respect to the payment of fringe benefits and allowances. Many other senior nurses and doctors, who feel that their expectation of enjoying in-kind fringe benefits has become unattainable, express discontent and argue that it is a breach of their contract of employment. One of the doctors recounted how they joined the public service not necessarily because of pay (because it has never been enough), but because of the extra benefits they recieved. A frontline senior doctor said:

> *When we joined this job, part of the agreement was that government will provide these in-kind benefits as additional attraction and incentive to work in the public service. This was good because it improved our image in the society. Things have changed our position in the society is no longer viable as a senior government worker. The truth is that when you think about the fact that you will not get the in-kind benefits, it will somehow affect your devotion* (Senior Doctor HWD2)

On the contrary, interviews with junior level workers suggest that they valued and supported the harmonization of fringe benefits. One junior worker said:

> *The fringe benefit is good, it is good to recognise everybody, and this is fair and supportive* (Junior Doctor HWD39).

All the junior workers interviews allude to what was mentioned by HWD39, and said clearly that providing fringe benefits is good on equity grounds.

The results as shown in Table 8.3 below indicate that overall workers were not satisfied with monetization initiatives because monetised cash benefits are not in line with the rising cost of living. While middle-level and all lower-level workers asserted their support for harmonization of fringe benefits, the majority of top-level workers felt it introduced an *"equalization effect"* which undermined their cherished *"status and position"*.

Table 8.3: Percentage of health workers reporting their level of satisfaction with changes in fringe benefits

% of health workers reporting level of satisfaction with changes in fringe benefits	Monetization		Harmonization		Consolidation	
	Satisfied	Unsatisfied	Satisfied	Unsatisfied	Satisfied	Unsatisfied
Top-level workers (n=20)	35% (7/20)	65% (13/20)	15% (3/20)	85% (17/20)	40% (8/20)	60% (12/20)
Middle level workers (n=41)	20% (8/41)	80% (33/41)	95% (39/41)	5% (2/41)	34% (14/410	66% (27/41)
Lower level worker (n=46)	11% (5/46)	89% (41/46)	100% (46/46)	-	20% (9/46)	80% (37/46)

Source: Field Data, 2008/9

Finally, in general, all workers across all categories were dissatisfied with the consolidation of fringe benefits. While the reason was not always stated clearly, the analysis suggests that by consolidating fringe benefit into salaries, government removed the "tax exemption" that was enjoyed on cash benefits. Thus, the workers argument is that the consolidated strategy is taxing the "cash benefits" so reducing their value further.

Further analysis suggests that senior consultants and others with relatively long lengths of service were unhappy and demotivated because promotion is now largely based on individual performance, rather than on seniority and length of service. One senior male nurse expressed this view in the following way:

> *I do not think that that linking rewards and even promotion to individual performance respects our deserved privilege as senior staff who have given many years to the service. I have been in this service for 28years yet the other day a worker who joined ten years ago was promoted last month to the same rank as myself because they said she has performed well. This is discouraging* (Senior Male Nurse HWN5)

Other senior doctors and nurses expressed similar discontent about the shift in the criteria that inform promotion decisions.

Conversely, junior frontline workers were rather favourable to the initiative arguing that it means that one will no longer wait for years without promotion. So, junior staff sees the link between individual performance, rewards and promotion as a means of getting accelerated promotion:

> *Before the reform you had to wait years before you could receive (if at all) promotion. What this reform implies is that your future is in your hands. You either wait for so many years or do what they say and get promoted. The problem I find with the new arrangement is that doing what they say to get promotion is not synonymous with improved quality performance because it is difficult to measure everything workers do* (Junior Male Doctor HWD33)

The results suggest that senior workers are more likely to be motivated if they believe that changes in incentive systems did not undermine their organisational self-esteem or status. Given the contrast to the junior and senior workers, these study's results are consistent with the understanding that relative status/position is a critical determinant of the motivation of public health workers, particularly senior workers. This result could be explained in line with the understanding that status and position in the public service is a link to other benefits outside pay. The issue about the complaint by the senior workers is not that they do not like to compete, but it was rather seen as derogatory that their length of service, which should form the basis for promotion and status within the organisation and even in society, has been eroded by the introduction of performance-related pay incentives. This seems to have created a sense of psychological deprivation and, thus, a source of demotivation for some and demotivation for others.

The study results suggest that older frontline workers seem unenthusiastic about the culture of harmonising fringe benefits and disregarding status and length of service in assessing who gets the benefits. According to them, this is inappropriate and unappealing because it contradict the traditional culture of the public service.

8.7 Effects of the Performance Related Pay on Health Workers

As highlighted in the introduction to this chapter, the interest of this thesis in pay reforms as an incentive relates largely to the performance-related-pay (PRP) element of the health reforms. This relates directly to the service delivery reforms or changes in work practice, thus providing the link between pay incentive and promotion based on good performance. This section, therefore, accounts for the results of the perceived effect of the changes in pay incentive, and relate more to pay to individual workers' incentive.

8.7.1 Individualism, teamwork and collegial behaviour

The literature asserts that effectiveness of healthcare practice depends on a large variety of factors, particularly teamwork and collegial behaviour among workers (Firth-Cozens, 2004; Gilson *et al*, 2005). Another perceived effect relates to how the operation of the incentive structure has introduced selfishness and individualism which, as suggested undermines individual commitment to one another, cooperation and teamwork. A nurse had this to say:

> *When you make people work as if they are in the marketplace, do not expect them to share their information, otherwise it will no longer be competition. How can you expect me to share information I know will make me a winner to another? This is the problem. This reform has created selfishness in our work, people hardly cooperate as before and this is not appropriate for healthcare. We work and achieve in teams. They are destroying teamwork in this practice* (Nurse HWN18)

Corroborating the above statement, another nurse with relatively longer years of experience than HWN18, said:

> *This reform has encouraged individual effort and rewards. So many people are just after the reward and can do anything to get it. In principle, everything is presented as good but in practice, the process is far from being good. There is a lot of finger pointing, people are no longer their brothers' keeper, and people are just concerned with themselves. Although I am not jealous of those workers presented with an award, no one really knows how they did it. A lot of rumours going around are about this issue and so many people have become selfish and even hoard information (Nurse* HWN13)

A female doctor also pointed out how the behaviour changes referred to above undermined the professional ethos of cooperation and teamwork:

> *When we are signed up to do this job as a 'public servant', we solemnly and sincerely swear that we will faithfully serve with high level devotion and commitment to duty, and to cooperate with one another to achieve the corporate goal of the public service which is to serve the public putting personal interest apart. Now this reform has introduced selfishness and personal pride. I think that a lot of people are no longer 'public servants', they have become servants to themselves while undermining the efforts of others. This is against professional norms and public sector ethos and this makes one rethink ones commitment* (Female Doctor HWD9)

The statement of HWD9 is very instructive, and was also referred to by others. Confirming the view of HWN18 and HWD9, a ward manager said:

> *In this work, we need each other. Doctors need nurses. However, this reform is bringing in an individual focus. People hardly help each other especially if it does not contribute to their immediate gain. I think that the reform has*

> *introduced winners and losers mentality rather than a win-win relationship, this is telling on teamwork. Those who did not win an award often become envious and jealous, and this reduces their willingness to cooperate with colleagues and even makes them see us managers as their enemies* (Operational Manager HOM5)

The extracts drawn from the interviews with HWN13 (see Table 6.3.6) suggests that the feeling of being *"left out"* in the performance incentive and reward list despite one's own perception of having worked hard or even harder than those rewarded, creates resentment and results in an unwillingness to keep and maintain altruistic behaviour. As captured in the word of one of the operational managers, *"Nowadays, people are just on their own and after reward, status and promotion. You hardly see people do things just in the name of good service"* (Male HOM9). At face value, this seems an overstatement; however, it is an indication of how reward can be linked to individual commitment.

Commenting on the relevance of teamwork to health care delivery, a senior nurse said that it is only by working together that quality nursing care can be realised:

> *Our work is team-based; no single nurse can make it. We need each other to build on what we do. When we don't work in teams, patients become vulnerable and could be abandoned. It would have been nice if the reward process valued team awards than individual awards. This naming and shaming process is unfair, creates unequal opportunities and in fact is divisive and threatens good nursing work* (Nurse HWN2)

The result suggests that more nurses than doctors spoke more about the link between the reform operation and the breakdown of team spirit and intrinsic behaviour.

One doctor said:

> *People are no longer concerned with doing the work as public servants. Everybody is on his/her own. There is lot of conflict and lack of trust among frontline worker and their managers. There are rumours that some managers and even SERVICOM is using the process to recommend their favourite for promotion* (Doctor HWD12)

The statement by HWD12, which represents the potential implication of lack of trust outlined in Section 6.3.2.1, suggests how the reform has resulted in conflict, and perhaps a reduction in intrinsic public service behaviour.

A nurse also said that:

> *I came into this job because I wanted to serve, but from what I am seeing, somebody can be cherry-picked for coming early to work for example, and be given double promotion over others. This is not good. While you are there serving and doing your best, others who may be lucky to be seen, or who blow their trumpet will be promoted. When you are not recognised, commitment to serve is nonsense since we are told that this will not be rewarded. I feel really bad about this* (Nurse HWN13)

Overall, the results suggest that the reform process breeds unfriendly competition, and reduced commitment and helping behaviour among workers. One nurse added that everybody is working for their own benefit, saying *"People hardly work as a team anymore"* (Nurse HWN28).

The results suggest that the operation of the performance-related pay incentive for frontline health workers creates a competitive spirit which has led to an 'every worker to him/herself' mentality, which is perceived to undermine the traditional professional ethos of teamwork and cooperation in healthcare practice. This has led to isolation and indifference, thus undermining the collective work ethics which are essential to good healthcare, and the frontline workers perceived this as demoralising. The results support existing findings that extrinsic incentives based on competitive performance arrangements have too narrow an understanding of what motivates frontline health workers, and there is no convincing evidence to demonstrate that competition enhances individual performance and quality healthcare (Gibbs *et al*, 2009; Propper, *et al*, 2008a).

8.7.2 Perceived unfairness in the operation of performance-related incentives

This study also highlights how the relationship in perceived fairness and unfairness of the procedure and process of performance measurement and distribution of performance related pay incentives operate as a motivational determinant. The importance of fairness in the distribution of performance-related rewards was highlighted, but there were ambiguities and inconsistencies in the conceptualisation of what amounts to being fair or unfair in the reform process. First, as it relates to the conceptualisation of the reform and the incentive system in particular, and as noted in Section 6.2, clinicians believed that excluding them from the decision-making processes that shaped their incentive is considered unfair. A senior doctor said:

> *We do not see the rationale for excluding us from the reform development. It is very unfair to use outsiders and non-clinicians to fabricate how we should do our work* (Doctor HWD1)

Commenting on the development of the performance measures, the frontline workers also claimed that they were not consulted about how performance should be defined or measured. One of the nurses said:

> *I perceive the conception of the reform process as discriminatory. We know our work; I do not know why they did not involve us. The process is biased and we cannot trust it because it is not in line with our clinical expectations* (Nurse HWN18)

Second, the frontline workers also made mention of unfairness with respect to the performance measurement process and individual reward. This was highlighted as important because of the link between performance measurement outcomes and allocation of performance-related incentives. The frontline workers commented that performance measurement that categorises who is to be given performance pay is a cherry-picking exercise which selects one as 'good' and naming the majority as 'bad' performers. They found this particularly unfair because their work practice is not in any way segregated. Both categories of workers (doctors and nurses), and their managers and union representatives, spoke against the sense of unfairness in the reform operations.

> *What we have told government is that our individual work is difficult to measure. We work in teams, so instead of rewarding individuals (which is divisive) it is better to reward and encourage teamwork. The process of just picking out one person from a group is unfair and does not acknowledge differences in local contexts, skill and experience* (Union representative)

> *It is difficult to believe that the performance measurement and performance related pay is valid and fair process. It is difficult to believe that a worker who everybody believed is not working hard is declared a winner* (Doctor HWD23)

> *Workers hardly see the process as fair and even look at us managers as the enemy of their progress* (Operational Manager HOM5)

In line with the above, the results also highlight that frontline health workers point clearly to a sense that the perceived selectivity of who is to be rewarded and who should not creates a 'winners and losers' mentality. In the above context, there were

rumours that the process is not honest, and frontline workers stated that operational managers, or even SERVICOM staff, use the evaluation and reward process to recommend their favourites for quick awards and promotion. The perception of bias and favouritism suggests that the categorisation of a worker as a 'good' performer is not the same thing as saying that they have actually performed. This is because of the supposition that the performance assessment carried out by SERVICOM may have been incorrect. There were also rumours among the frontline workers that the drive for performance-related awards may have created room for cheating. One of the doctors clearly noted:

> *Human beings are smart, people are desperately cunning. Though it may not be evident on the surface, people do a lot of things to make their way through, sometimes people sort out their way through their friends, social links, personality and politics. Those who do not get along with the system will only complain, but this complain has no impact. The truth is that nobody will tell you everything they do to better their lives. Sometimes, this is based on some form of 'you scratch my back and I will scratch yours'* (Doctor HWD6)

The above statement suggests that bias and favouritism, which is perceived as a systemic procedural failure may have clouded the good effects of the reform elements. Workers who had not already received good assessment or performance rewards did not accept that they had been adequately assessed, and this added to the poor relationships with their colleagues, their managers and with SERVICOM. Although the evidence was hard to pin down, there were rumours that award winners may be results of 'playing the system'. Equally, they may have used their connections or some competitive advantage over the colleagues. For example, related to the perceived difficulty in segregating individual performance, a senior frontline doctor indirectly accepted the imperfection of the system and asserted that lack of trust and perception of unfairness is a systemic issue in Nigeria:

> *It is hard to believe that everyone who has won an award achieved it through merit. People can do many things to get what they want. This is Nigeria where many things happen though networks. Although the rumours are there, so far, no one has been charged* (Doctor HWD3)

Another challenge to the procedure of performance measurement is that the workers perceive that it creates an unequal opportunity for all workers. Two nurses expressed their views:

> *I came into this job because I wanted to serve, but from what I am experiencing I fell that people who work hard are not seen. Others who may*

> *be lucky to be seen, or who blow their trumpet will be promoted. I feel really bad about this because the assessment is not accurate and is unfair* (Nurse HWN13)
> *We do not have the same ability and are not working in the same unit. Nobody from our unit (HIV/AIDS) has won an award. I just observe some units (e.g. Accident and Emergency, and General Outpatient units) are always favoured. I am focused in doing my work. Therefore, nobody will recommend me because I do not have a smiling face* (Nurse HWN19)

It is clear from the analysis that the way workers and their managers conceive of the fairness remains ambiguous. However, it is intresting to note that there are different interpretations of fairness, which produce different interpretations of reality and outcomes. Largely, health workers' articulation of their sense of fairness is clearly visible in the texts and, though subjective, remains an instructive result. The results of this study suggest that, despite the normative significance in the perceived diversity of fairness, it was, however, difficult to pin down exactly what constitutes shared values with respect to fairness.

The results also demonstrate that workers' subjective perception of unfairness of the reform operation and associated relationships impacted negatively on the work environment. The analysis of unfairness in organisational relationships has been reported on business work environments in a number of studies (Lind and Tyler, 1988; Cropanzano and Folger, 1991; Dooms and Oijen, 2005). In particular, Dooms and Oijen (2005) highlighted the fact that perceived procedural unfairness (i.e. unfairness linked to process) such as in individual workers' assessments, was one factor that endangered the possibility of realising corporate policies and objectives. Greenberg and Cropanzano (2001) also pointed to the fact that perceived distributional unfairness (i.e. unfairness linked to the distribution of incentives or rewards) can result in undesirable behaviour among organisation workers. To sum up, the results of this study suggest that an effective work environment plays a critical role in reform effectiveness, it encourages trust among organisation actors, and it creates an operational arena that boosts the perception of fairness among actors in the reform. Throughout the texts, and as outlined in Section 6.2.1 and Section 6.2.2, the sense of being "left out" in designing the performance incentives seem to have created a sense of alienation and professional demotivation among the health providers.

A senior male doctor said:

> *It is important to involve us in decisions about our work. However, this government never considered our views. I think this is not good. They just called a meeting and told us what they have decided to do during the seminars. Based on our experiences since the reform started, there is every reason to think that some of us were ill-informed about the way the reform was going to impact on our work* (Male HWD2)

A nurse was of the view that, *"When you involve people, they will cooperate, but this government has pushed the policy on us"* (Nurse HWN23). Overall, two-thirds of the frontline doctors and nurses and ward managers expressed their demotivation about the way government imposes change on them and even uses "outsiders" to plan and regulate their work.

8.8 Discussions and Conclusion

This chapter has examined the effects of how different worker categories perceive the reform pay incentives and their effects. Clearly, the issue of public worker incentives has been the centre of debates about motivation of health workers across developing countries health system contexts (Nigeria included) (McCoy *et al*, 2008; WHO, 2006; Hongoro and Normand, 2006; Stillwell *et al*, 2004). Generally speaking, the use of performance-related pay incentives based on ex post evaluation of individual workers' performance (Gibbs *et al*, 2004; Baker *et al*, 1994; Holmstrom and Milgrom, 1991) draws from the economic logic of human behaviour which presumes that workers are rational and self-interested, and will willingly commit to achieve a set organisational goals (i.e. targets), if information about their work is provided and that they are rewarded accordingly (Williamson, 1985; Neely *et al*, 1995; Otley, 1999). The results indicate that there is no convincing evidence to show that individual workers' morale has improved within the context of operation of performance-related incentives associated with the service delivery reform. There are several reasons for this. The first relates to the belief that the incentive process is discriminatory and introduce a selecting process which labels workers as losers or 'bad performers' and winners or 'good performers'. The results suggest that workers, especially the majority who are categorised as bad performers, feel that they have been disproportionately penalised and unfairly treated. This might have implications for worker motivation. This result correlates with relatively old empirical research

drawn from process theories of motivation (e.g. Adams, 1965), which found that perceived unfairness in social relationships erode morale.

Second, it was clear from the analysis that senior workers in particular reported that they are demoralised. This is because linking pay and promotion to individual performance contradicts their expectations of an easier ride for promotion. Although the supposition surrounding the reform incentive arrangement point to the traditional mainstream economic perception that public workers are motivated by extrinsic incentives (Frank and Lewis, 2004; Delfgaauw and Dur, 2008), the results of this study suggest that intangible factors, such as social status and position, provide more intrinsic motives and have a crucial influence on public health workers' motivation. This suggests that health workers appear to value non-financial incentives more highly as motivators than extrinsic incentives. The results correlate with past studies (Mathauer and Imhoff, 2006) which found that across many developing countries, particularly within the African region, public health workers are motivated more by non-financial factors. It also corroborates Franco *et al's* research (2002), which suggests that public health workers' motivation is not often simple, but relates to a number of factors associated to individual, social and organisational contexts.

The third reason has to do with the understanding that frontline workers did not see any strong link between their efforts, and the possibility of receiving the performance incentive as prescribed. The fact that, despite their efforts, they complained of not having received a reward and promotion suggests a perceived weak link between workers' efforts (i.e. achieving the reform targets) and receiving the reward and promotion. The frontline workers perceive the process as unfair and defective. The results correlate with Rainey *et al* (1986) and process theories of motivation (Vroom, 1964), which found that, where there is weak link between efforts, expectations and results, motivation wanes. As noted by past studies (e.g. Fishbein and Ajzen, 1975; Snyder and Stukas, 1999; Wigfield and Eccles, 2000), it is supposed that expectations serve as perceptual and interpretive filters that influence individual motivation and performance. The fact that some claimed that even though they has done well, they could not receive recommendations for an award, point to the fact that they consider the performance measurement process that underpins the selection of who is to be rewarded as inconsistent and subjective. The results suggest that inability to achieve ones' expectations tends to erode the intrinsic

motivation to cooperate or perform. Overall, there is a suggestion that the focus on extrinsic performance incentives which undermine the intangible benefits, such as status and position, appear to have had a deleterious effect on the intrinsic aspect of their job. This results correlate with Deci and Ryan (1985), Frey (2000), and Frey and Jegen (2001), who found that emphasis on extrinsic motivation erodes intrinsic motivation, which is the core driver of individual public workers' willingness to work, and their commitment and devotion to duty.

Meanwhile, frontline health workers held appreciably more negative views about performance-related pay because it was particularly noticeable that although they have claimed to have done well, and thus deserve rewards, they grumble and express discontent that their expectations were not realised. This denial appears to create psychological deprivation and demotivation. The workers press on to say that that the performance goals linked to performance incentives, and the selection and distribution process of the incentives, are somewhat unclear, and perhaps unachievable. The results corroborate literature on expectancy theory (Wigfield and Eccles, 2000; Lawler, 1971; Vroom, 1964), which stresses the importance of expectation as a predictor of individual motivation and behaviour. Also, Lawler and Suttle, (1973) found that worker expectation is related to their motivation and performance.

Another issue is connected to the view that performance-related incentives have encouraged dysfunctional behaviour, individualism, tension, infighting and grievances, which add up to create an unhealthy work environment. As noted earlier by other studies (Bevan and Hood, 2006a/b; Goddard *et al*, 2002; Marsden and French, 1994), there is believable evidence drawn from other studies that such situations not only lead to dysfunctional behaviour, low morale, and erosion of intrinsic motivation, but also to poor performance by individual workers. Another worrying effect acknowledged by the workers is the assertion that it is rather unfortunate that the incentive system undercut cooperation, and the spirit of teamwork and selfless service which forms the traditional ethos of public service work.

Finally, although the pay rise is not directly linked to the performance of workers, it is important to note that, workers showed surprisingly negative views in that they

still complained that they are not motivated, even though they earn more. This contradicts traditional economics which suppose that paying workers more will motivate them to do better. Rather, it supports the emerging understanding of the behavioural happiness research (Easterlin, 1995; 2001), which supposes that higher pay does not necessarily imply higher satisfaction. Easterlin (2001) found that more pay does not make a worker happy or motivated. In line with social comparison and equity research literature (Akerlof and Yellen, 1990; Adams, 1965), this study sheds light on how individual workers' subjective perceptions of changes in relative pay with respect to relevant others shape their motivation. In this context, it seems suggestive that the widespread complaint of inadequate pay across developing countries' health systems has also been reported (e.g. McCoy *et al*, 2008; WHO, 2006; Hongoro and Norman, 2006; Drager *et al*, 2006), and in this context, despite the huge pay rise, indicates that this may not mean that public health workers are not being paid enough, but that their pay compares poorly in relative terms, and compared to the cost of living. This clearly points to the complexity in the use of extrinsic incentives and public health sector motivation, which have been highlighted by past studies (Perry and Wise, 1990; Dixit, 2002; Prendergast, 2007).

In general, the overall study results indicate that there is no convincing evidence to suggest that performance-related incentives have improved the effectiveness of the individual workers within the case hospital organisation. The results suggest that the practice of rewarding performance was found to be defective and, thus, failed to provide adequate motivation to individual workers for several reasons. First, the workers found that despite the fact that they had worked hard, thus meriting the incentive, they were not recommended. Consequently, they did not feel that the performance measurement/assessment process and the distribution of the performance-related incentives were comprehensive in accounting for their efforts. They perceive the incentive process as unfair, imperfect, and inconsiderate.

Second, the perceived imperfect performance measurement process induces frontline workers to attempt to engage in self-interest seeking behaviour (in order to win awards) that make it appear they are doing well relative to their colleagues but in fact, is contrary to the goals of the reform. Because this opportunistic behaviour operates as a hidden action which the implementers are unable to observe or detect, it undermines the effectiveness of the reform. This conforms to the principal agent

literature (Jensen and Meckling, 1976; Baker *et al*, 1994), which demonstrates how asymmetrical information could make it difficult for SERVICOM to ascertain individual worker performance. This explicitly provides a compelling explanation and acknowledgement of the subjective nature of the individual workers' performance measurement process linked with the performance-related incentive system, and suggests how the distribution of performance incentives may not have been 'truly' based on perfect knowledge of 'good' and 'bad' performers. Besides, and as noted, there is an understanding that frontline workers may have neglected deep-seated clinical procedures which contribute to achieving and maintaining the clinical quality of their work, since they are not rewarded for following such procedures.

In the contexts of the above situations, and based on the perceived positive correlation between available incentives (Croxson *et al*, 2001; Laffont and Martimort, 2002; Mathauer and Imhoff, 2006), and individual health worker's motivation and performance (Kanfer, 1999; Franco *et al*, 2002; 2004; Manongi *et al*, 2006), there is no convincing evidence from this study to suggest that the incentive system has enhanced workers' capacity to perform better. A final message from this chapter is that frontline health workers overall are strongly driven by their professional ethos including status, recognition and constructive support from colleagues as intrinsic elements of their vocation, and adversely affected by financial incentive. The result confirms that non-financial incentives play a critical role in increasing the motivation of frontline health workers and supports findings from other studies (Franco *et al*, 2002; Dielemann *et al*, 2003; Mathauer and Imhoff, 2006).

A take-home message from this section is that there is marked relationship between individual health workers' subjective perceptions of fairness in the distribution of performance-related pay, which operates as an extrinsic incentive, and their intrinsic motivation (i.e. commitment and devotion to their vocation) and their desire to change their behaviour to perform better. It is, however, appreciated that the perception of fairness and unfairness was not straightforward, but rather ambiguous, and in some instances, inconsistent between different worker categories. Nevertheless, the study has shed light on how intrinsic elements of incentive shape health workers' motivation.

9 Conclusions

9.1 Introduction

The overall aim of this study was to understand policy reform processes and organisational change in the public health sector in Nigeria, with particular emphasis on exploring how health sector reform works by investigating how frontline health providers perceive of, and respond to, reform as an organisational change process.

The study addresses three distinct but closely related research questions about the reforms:

1. What changes did the health reform introduce with respect to work practices and pay systems?
2. How do frontline health providers perceive the change process as it relates to their day-to-day work practices?
3. How the different categories of workers in the hospital perceive the reforms have influenced their motivation to perform their jobs?

The study sheds light on public sector service reform processes that are at the centre of public debate in many countries. It focuses specifically on health sector reforms implemented in Nigeria between 2000 and 2007, and on changes introduced in Federal Medical Centres (FMCU) or tertiary hospitals. In Nigeria, these tertiary hospitals are key organisations responsible for the delivery of health care, and therefore are central to the reform process. The study is based on research undertaken in Nigeria in 2007 at the Federal Medical Centre, Abia State over a twelve-month period. Information was collected from a number of sources including policy documents, semi-structured interviews, and direct observation by the researcher.

To address the first research question: "What changes did the health reform introduce with respect to work practices and pay systems", the study engaged in a systematic review of the reforms with respect to policy context and content (Chapter 4). This was followed by an analysis of the policy process (Chapter 5) which

detailed how the reforms operate in practice within the research case study hospital- the Federal Medical Centre, Umuahia (FMCU) in the capital of Abia State in southeastern Nigeria. This analysis included detailing the role of the government reform implementation agency, SERVICOM. To address the second research question: "How do frontline health providers perceive the change process as it relates to their day-to-day work practices", detailed interviews with different categories of health workers, including managers and frontline staff, were conducted and reported on in Chapter 6. Addressing the last research question, "How are the different categories of workers in the hospital affected by the change process, and how do they deal with it", also involved the detailing of the experiences of different categories of health workers, and their senior and operational managers, within the case hospital. The analysis of these experiences is detailed in Chapters 7 and 8.

The study is mainly informed by two bodies of knowledge: New Public sector Management (NPM) and elements of organisational change theory that address the issue of worker motivation and behavioural change. This study has provided important insights into the understanding that, although the promotion of demand-driven public service delivery has apparently been enthusiastically adopted in many developing economies, including Nigeria, the operational realities are complex. It has been widely argued that the way in which this interest in changing public sector service delivery has been formulated in policy, and in its mode of implementation, has been highly prescriptive and top-down, and this has had implications for policy effectiveness and organisation outcomes. It is also argued that the socio-political context in which the reforms are being sought, the policy implementation process in a specific local environment, and the attitude of clinical workers working in that environment who are often the target of such reforms, all determine policy outcomes and need to be considered in both policy formulation, implementation, and in monitoring and evaluation procedures.

It is important to recognise that a key limitation of the study potentially lies in the fact that the data were collected from one case hospital organisation. Although the case hospital organisation consists of various other actors such as patients and other non-clinical staff, the focus of this study was predominantly health workers and their managers who are primarily involved in healthcare delivery.

Based on a more critical reflective discussion of the challenges and limits of the research design, robust triangulation of evidence was a major challenge. The thesis recognises that ambiguity and inconsistency permeated most aspects of the health workers' subjective narratives, and there is suspicion that workers will always complain and grumble whatever the circumstances. Nevertheless, the research process made attempts to seek out further information that would enhance explanations and or substantiate claims. Together, pondering over the robustness of the evidence, there is an indication that the analysis and discussions did not take the individual worker's narrative at face value. The lack of 'hard' or objective data limit the extent to which this research could make generalisations. Thus, the findings of this study need to be interpreted with caution, and viewed within the expressed experiences and accounts presented by the respondents, and within the specific context.

It is important to recognise that there are some issues that the research design simply cannot engage in, or resolve conclusively, yet, it still shed some light on them. In particular, based on the case study, it seems likely that the findings of this study could be beneficial and supportive for future understanding and conceptualisation of how reform works. The findings can optimistically provide the basis for future research and practical recommendations for public health management action which could complement or improve the effectiveness of reform and performance of public health workers in particular.

9.2 Framework for understanding the reform process

This study has shed light on public service delivery reform processes with an emphasis on how health professionals, in this research doctors and nurses responsible for delivery of healthcare in tertiary hospitals in Nigeria, perceive, and respond to, the effect of the reform on their work. These doctors and nurses are the target group for the realisation of the health and related salary reform objectives in Nigeria. Driven by the research aim of contributing to the understanding of policy change processes in the context of service delivery reforms, and the role of the various policy and organisation actors, this study adopted an actor-oriented approach to understanding policy reform (Long, 2001). The actor-oriented approach provides a more appropriate framework for dealing with how different organisational actors

interact in the context of change. It stretches further than the positivist view of reality, and is informed by the understanding that the subjective perception of primary actors are socially constructed and interpreted based on individual actor's interest, power and position. While this suffers a limitation in that it cannot be taken as objective, it provides a more realistic way of relating with the daily experiences, processes and interactions of the actors. Meanwhile, the analysis and interpretation of the reform process goes beyond the face value to include the dynamics of social contexts and work culture, which add flavour to developing in-depth view of how workers perceive and interpret the reform effects.

In line with issues that emerged during the research process, the framework of analysis recognises the dynamics of power and interest among actors (e.g. implementers and the clinicians, clinicians vs. clinicians, and clinicians and patients) especially at the organisational levels wherein the reform operates. Lukes (1974) points out that this involves an inherent element of power and interest of one agent over another agent (e.g. clinical workers). In practice, power relations reflect differences in ideas and perceptions about a given problem within the social, economic and political sphere of the reform. This relates directly to issues of control or regulation in order to restrict, it forges discipline or normalises one's action and discretion (Lukes, 1974; Foucault, 1980), it reconfigures existing interactions and agency among actors within a social relationship (Long, 2001; Giddens, 1984), or reshapes existing incentives, sanctions and operating culture (Lukes, 2005). Within the understanding of power relations is an underlying concept of relationship and interaction among actors (e.g. trust or distrust relations) (Holmes, 1995; Kramer, 1999; Dirks and Ferrin, 2001) which also contributes to shaping behaviour and maintaining a healthy working environment.

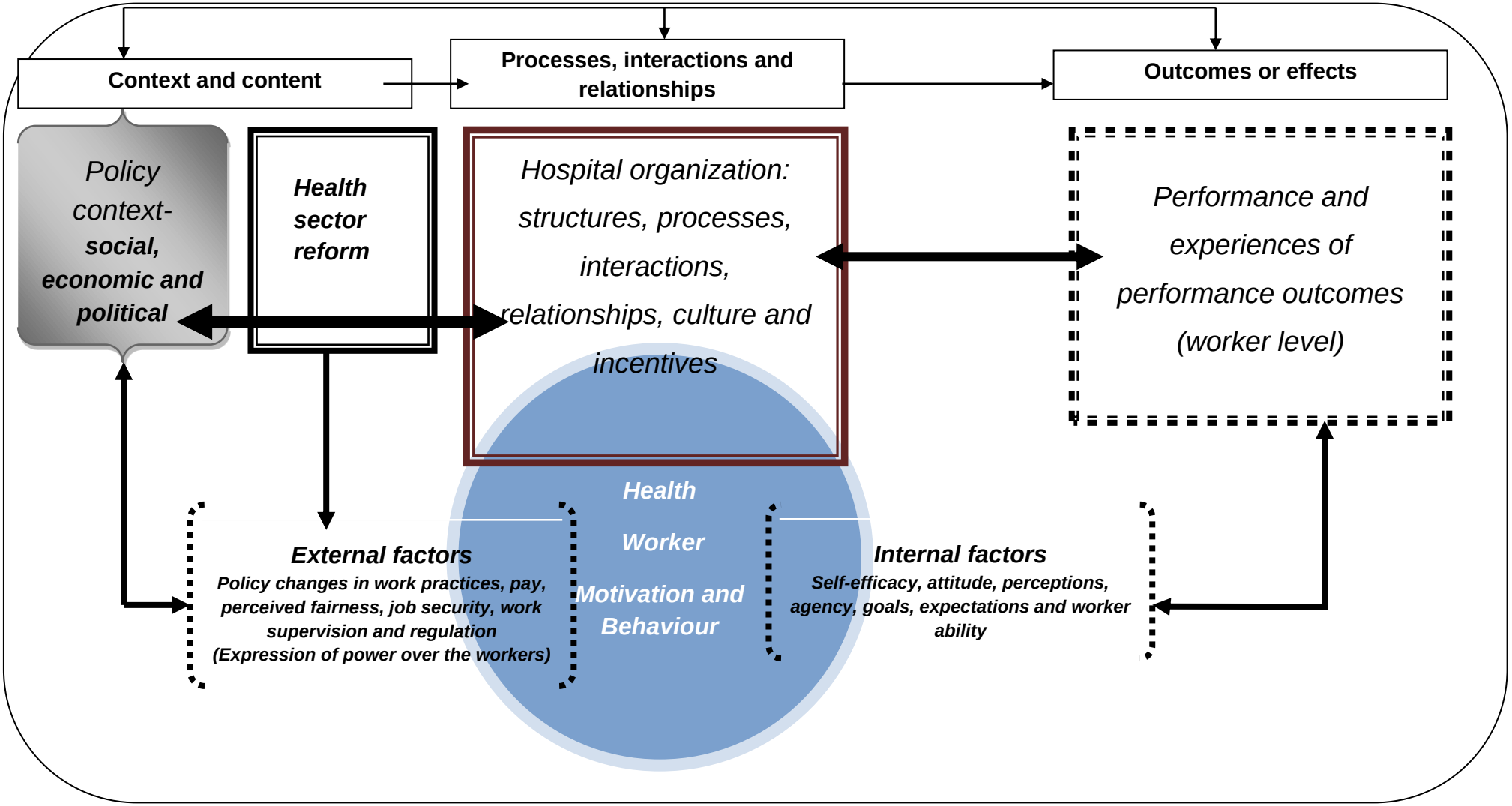
The framework of analysis draws largely from the understanding that change happens not simply because of prescription of what should be done but, most importantly, because of the day-to-day operational realities, and the varied negotiations, manoeuvres, relationships, and interactions engaged in by organisational actors who operate with a significant level of agency. Given the centrality of motivation for behavioural change in the realisation of the reform goals at the individual worker level, the framework points to the relevance of social context, professional culture, and norms in shaping individual workers' behaviour,

rather than simply formal rules or extrinsic incentives. This framework builds on the well-established sociological literature on organisational change (Meyer and Rowan, 1977; Giddens, 1984; DiMaggio, 1988), which emphasises the role of agency and autonomy of actors in shaping the motivation to act. While conventional policy analysis, which conceptualises reform as a logical and segregated activity (Grindle and Thomas, 1991; Sabatier, 2007), has largely overlooked this aspect of organisational life, the evidence that emerged from this study suggests the contrary, that reform, which operates as an organisational change process, is a complex process. By virtue of the dynamic nature of organisational processes and interaction, communication and interpretation of information about the reform within, and between- different actors is hardly straightforward and the outcomes are unpredictable.

In addition, with respect to how the reform is perceived by different actors, this study's framework emphasises how the diversity of interest, life experience, status and length of service of individual workers can influence how frontline workers perceive, and respond to, changes in their workplace.

In accordance with the above conceptualisation, Figure 9.1 summarises the framework of the present study in terms of how the reform came about, how it operated within the case study hospital in Nigeria, how the various actors working in the hospital engaged with and perceived the processes of change, and how the reform's effects were percieved.

Figure 9.1 Framework for the study of policy reform process and its effects



Overall, the framework used in this study was found to be appropriate for developing a detailed understanding of the dynamics of what happens once policy is developed and implemented, and especially of how policy recipients translate and respond to the policy and the processes of change being introduced. Beginning with the understanding that the reform sits within the context of changing social, political and economic situations in Nigeria, this study conceptualised the reform as a change process. This conceptualisation served as a means to analyse the views of multiple actors within a specific public health sector setting.

In this study, the understanding of policy reform processes transcend seeing policy reform as a linear and discrete event, which when implemented will automatically result in predicted outcomes. Rather, policy reform needs to be seen as a messy and complex process. This study's framework supports the idea that change happens not by prescription of what should be done, often driven by ascendency and interest, but through the actions, agency, relationship and processes engaged in by organisational actors on the ground where policy is orchestrated and implemented. This study is, therefore, of the view that understanding policy reform processes and effects needs to accommodate possible contradictions imbued within the existing culture, agency, norms and professional identity of health workers who are involved in the delivery of healthcare.

The framework begins with the understanding of the reform objectives, then moves from the content or instruments to understanding how the reform operates in practice by focusing on the actions of the target groups in response to the changes. It ends by demonstrating the links between implementation processes and actor responses to introduced changes, and predicted reform outcomes including the effects on frontline workers. The approach began with gathering data about the reforms (both the health and related pay reform), their content and context, and how the health reform in particular was initiated. The analysis of these data was used to develop an understanding of what changes were expected, and why, and which occurred with respect to work practices and incentives. Then, data about the actual implementation process, and including the actual actions of the different actors involved (including SERVICOM), were collected. These data provided a detailed picture of the reform process itself. Thereafter, data on hospital practice based on the perceptions of

different categories of health workers were gathered to address research questions 2 and 3.

Overall, the framework provided a comprehensive understanding of the actions of the actors involved in the reform process, and an in depth description of the different views of the actors that was used to develop an understanding of reform effectiveness at the organisation level. It is understood that the on-going policy reform process represents a sound strategy for changing how government service delivery agencies operate. Nevertheless, the connections between the reform process, human behaviour and performance, and outcomes, though predictable to some extent, remain uncertain especially when the full range of factors that influence behaviour and motivation are incorporated into the analysis.

The specific findings of this study are summarised below beginning with the reform context and content, and implementation process. This is followed by health workers' perceptions of the policy reform processes. Finally, the findings on the effects of the reform on health workers are presented.

9.3 The reform-context and content, and implementation process

The health reform that attracted my interest in this study involved, first, changes in hospital procedures (i.e., performance measurement practices) and more importantly, a shift in the culture of public service delivery from one driven by the provision of medical care led largely by the clinical professions, to a demand-led system within which the public become clients purchasing services that are expected to meet their needs and interests. These changes have involved the establishment of a performance audit agency, in this case called SERVICOM. The role of SERVICOM is to ensure worker compliance with the reform, and to guarantee quality assurance, both to the public, and government. With reference to the second element of the reforms related to changes in pay systems, the main interest of this thesis has been on the performance-related pay elements because it is this component of the pay reforms that is directly linked with the health service delivery reforms. Pay incentives given to individuals for "good behaviour" are used to motivate and encourage compliance with the changes in work practice deemed essential for achieving client-driven services.

Clearly, the reform is linked to the classical economic conceptualisation of human behaviour based on the scientific management approach to industrial organisation. The contemporary debate and discourse underpinning the reform which primarily focuses on changing the way government and public workers operate is largely linked to New Public Sector Management (NPM) theory (Brignall and Modell, 2000), within which change is driven by a market ideology of individual competition and rewards.

The health reform in Nigeria represents a new way of thinking about how to organise and manage public health sector services, and an important dimension of the reform relates to changing human behaviour. So, a major part of the policy reform involves discrete problem identification, for instance through the introduction of targets, performance measurement, and getting the incentives right for individual rewards to attract "good behaviour", reinforce further compliance, optimise the use of resources and improve the quality of care.

Based on the views of the professionals providing clinical services in the FMCU, there is suggestion that it is difficult to measure individual performance, and hospital activities are hardly isolated. Rather, as was pointed out by many informants, the provision of clinical services frequently depends on teamwork, possibly involving group action but also individuals providing parts of a sequenced set of services. Little support was given by any medical staff to the introduction of individual rewards, and no one pointed to evidence that they had improved healthcare delivery. At the same time, everyone agreed that the target of timely and transparent services for all clients had been achieved.

Clinical staff pointed to the benefits to them even of this change, meaning there were no long queues gathering over days with patients prepared to sleep in waiting areas in order to ensure that they were seen by a nurse or doctor. Nevertheless, this state of affairs – no carry-over of patients from one day to the next – had not been achieved without some costs. As detailed in Chapter 7, these costs included a sense of work overload, anxiety, stress, and tiredness, all of which has been noted by other researchers. Absent from the reform is any sense that there would be costs to be born, and for anyone to be in a position of saying that the changes had been successful, there must be monitoring of outcomes. We cannot say that these are unpredicted

outcomes because earlier research, admittedly in different contexts, had already pointed to some of these costs. Another cost relates to the way SERVICOM has wielded significant power over the health professionals, which has often led to fear of job loss, demotivation and a sense of losing control. The hospital managers found the bossy attitude of SERVICOM devastating and believed it has had negative effects on their capacity to manage, created role complexity, and eroded the professional agency, discretion and autonomy of health workers in general in doing their work as they, professionals, know how to.

In the view of the health professionals, although the emphasis of giving power to customers with which they can become involved in decision-making processes remains a viable option, the extent to which this may have actually resulted in improved care for customers remains contentious. It was mentioned that clinical staff felt demoralised that patients often abuse them, but perhaps what was worse for the clinical staff was the reporting by clients to SERVICOM on 'bad service'.

In particular, given the nature of healthcare practice, it seems inappropriate to believe that following the Social Charter will lead to better services for all customers, irrespective of their health condition. This study finds that this one-cap-fits-all ideology, which is a common feature of NPM recommendations, is problematic and has serious implications for individualised care. The broader picture is that the reform operates as a market ideology which supposes equal treatment as a way of encouraging customer rights and dignity. Indeed, it is fair to say that customers should be treated fairly; nevertheless, based on the views of the frontline workers, this study finds that following a rigid rule in order to achieve equality of access to services alone is not enough. The central argument raised by the frontline workers demonstrate that based on the unpredictable nature of customers' needs, it is inappropriate to assume that healthcare practice consists of rational decisions which can be predetermined in advance, meaning that customers' needs are regarded as homogenous with well-ordered, and pre-set or mechanical approaches to meeting those needs.

It has been demonstrated in this study that, not only expert knowledge, which is often drawn from outsiders' views of what is consider socially and politically desirable, but also the practical views of those involved in day-to-day practice at the

organisation level are important in designing effective change. While this study has not taken a fault-finder position on the reform, it has however suggested that the paternalistic view of government in policy design is rather parochial and seems to neglect the fundamental element of how change happens within professional organisations like public health services. The study's results suggest that government seems to have initiated and implemented the reform based on national interest, and on the premise that, at the very least, workers will follow set directives. Yet, there is no indication that the views of the workers were effectively engaged; thus, the knowledge and agency of the professionals seem to have been overlooked. The relevance of professional agency has been highlighted by past studies (Greenwood and Hinings, 1996; Giddens, 1994; Lipsky, 1980), and in line with the views of the workers, undermining the conventional professional values/norms/culture in place of bureaucratically set rules and targets did not seem to augur well in healthcare practice. There was huge distrust among the workers about the empirical and methodological reliability of a performance measurement culture in healthcare practice, particularly in Nigeria where information is inadequate. Besides, the findings of this study suggest that the way the reform is being implemented suggests to the workers that their profession has been polarised between, on the one hand, the bureaucratic implementation agency and workers/managers, between managers and workers, and finally among colleagues (who are under pressure and competition to achieve individual rewards). This finding is supported by the work of other researchers (e.g. Freidson, 2001), which demonstrates that the introduction of bureaucratic control, exposure to a market-related work process and management represents an attack on the structural practices and the professional ideology underpinning the healthcare profession, and leads to stratification of the health profession.

9.4 Health workers' perceptions of the reform process

While the reform is presented as necessary, hospital workers did not always express a favourable attitude towards the reform because they perceived that it was imposed on them. This study finds that hospital workers perceived the reform process in which SERVICOM is regulating their work as bossy and officious. According to this

view, health workers were not only concerned about the changing nature of their work content and characteristics; most important to them was the perception that they are losing control of the work they do. In addition, the perception that government is using SERVICOM as non-health professionals to tell health professionals what to do, and even measure how they do their work, raised feelings of discontentment.

The view of the frontline workers, as demonstrated in the results, suggests that there is little trust that SERVICOM has the capacity to know what they do, or be in a capacity to contribute constructively and meaningfully to improving how they should do their work. At the same time, while generating performance information represents, a cohesive measure put in place to hold workers to account and to provide evidence to guide further improvement, this study finds that while the performance measurement is supposed to generate information that will be useful in addressing a wide variety of problems and situations related to access and use of services, hospital staff perceived that the available performance information from SERVICOM is inconsistent and lacks clinical relevance. It is not entirely surprising then that, despite the proliferation of the reform idea about the role of SERVICOM, this study lacks convincing evidence to suggest that SERVICOM has contributed to improving clinical practice.

The whole point of the reform, which is about performance measurement by targets, was perceived by the majority of the health workers as inconsistent with the reality of health care practice. The concept posits a very simplistic idea. It assumes that healthcare practices operate as discrete and divisible activities which can be observed and measured quantitatively. Based on the perception of the workers, this study finds no evidence to demonstrate that emphasis on individual efforts and performance, and making individual workers to do their work faster in pursuance of efficiency gains with a set mechanism that separates implementation from doing as effective. The study finds that at the core of the reform process is the belief in quantitative measurement of individual efforts, but the fact that healthcare activities are scarcely measurable suggests that there may not have been any advance in improving healthcare service delivery.

Another consensus, which emerged among the frontline workers and their managers, relates to the fact that the performance measurement culture operates as means of monitoring and maintaining organisational control. The conceptualisation of the reform sits within the ideology of "business culture" (Kaplan and Norton, 1996; Neely, 1999), an approach borrowed from the private or industrial sector, in which control is presented as a means of improving efficiency and effectiveness in the public health sector.

Nevertheless, despite the rather broad and somewhat ambiguous specification of the role of administrative control, frontline workers felt that using an outsider agency (SERVICOM) to tell them what to do, or to measure how they do their work, signify stripping them of their authority, and thus threatening their medical professionalism and autonomy. As evident in this study, the use of SERVICOM as an audit agency largely supports broader tenets of new public sector reform (Hood *et al*, 1999; 1999; Power, 2000). This is also in line with principal-agent literature (e.g. Holmstrom and Milgrom, 1991; Besley, 2006), goal-setting literature (Locke and Latham, 2002; 2006) and clinical governance literature (Scally, 1998; Swage, 2004), which supposes that setting goals or targets for workers, and measuring how they achieve the goals provide incentive that will enhance operational efficiency.

This study finds that hospital workers did perceive the use of administrative managers to control how they do their work as inappropriate. There are several likely explanations to this. First, there were claims of existing tensions between hospital workers and SERVICOM, in that SERVICOM (i) does not have the requisite experience to do their work since they are not health professionals, (ii) is a little highhanded in their operations (iii) gives rise to controversy and doubt regarding the consistency and robustness of its assessments because of feelings that erros are likely (iv) and the attempt by government to improve service delivery using strategic control measures is perceived by workers as narrow, counterproductive and inconsistent with the operational realities of healthcare. Overall, the results suggest that the performance measurement process, including the published performance information by SERVICOM, is perceived as fragmented and poorly developed and has no relevance to clinical operations and decisions. The irrelevance of performance information has also been reported in other contexts (e.g. in the UK

National Health Service, see Checkland *et al*, 2007) which draw attention to methodological challenges in data collection as a key issue.

In general, this study finds that frontline workers, managers and union representatives expressed concern that the reform was imposed on them and thus operated as a top-down mechanism to change. This study also finds that the operation of performance measurement by targets as a prioritisation and formalisation of work practice is perceived as defective and inappropriate because it does not give a whole picture of healthcare practice. The hospital staff felt that performance measurement by targets focuses on results rather than process, is administratively oriented, and did not seem to capture the professional norms. Another issue related to SERVICOM's activities and the reform implementation process is the confrontation of identities between professional views and bureaucracy.

9.5 The Effects of the Reform on Health workers

Analysis related to research question 3, that is, how the different categories of workers in the hospital are affected by, and how they deal with, the change process demonstrated that the reform has had significant effects on health workers.

This study finds that frontline workers said that the use of an audit agency gave rise to feelings of dissatisfaction at work because of the sense of being under regulation and control by administrative managers who are non-health professionals. Furthermore, frontline workers' sense of shifting power relations, victimisation and alienation impacted negatively on their morale and job satisfaction. The findings are in line with past studies (Scott, 1982; 2002; Friedson, 2001), which demonstrated that perceptions of loss of control undermine worker morale and individual productivity. As noted, the use of the construct that "they" (government) are using "them" (SERVICOM) to tell "us" (health workers) what to do signifies a deepened expression of alienation, and professional victimisation of health workers.

9.5.1 Workload, stress, tiredness and burnout

This study offer evidence emphasising that the operation of the policy reform has increased daily workload with respect to: (i) increased pressure to achieve targets; (ii) increases in hours worked and number of customers attended to on a weekly

basis; (iii) increased administrative responsibility (paperwork); (iv) increased levels of anxiety, stress and burnout; and (v) increased reports of workplace assaults and abuse. These results corroborate past case studies across developing countries (Aiken *et al*, 2001; 2002a/b) and specifically within the African context (e.g. Ghana-Witter *et al*, 2007; Uganda-Burnham *et al*, 2004; Kajula *et al*, 2004; South Africa-Bhayat and Cleaton-Jones, 2003; Walker and Gilson, 2004), which suggest that organizational restructuring appears to create heavier workloads for frontline service providers.

This study offers evidence that highlights a significant relationship between workload, working relationships and the ability to deliver effective care. The workers reported cases of back pain, depression, insomnia and tiredness associated with increased workloads. This correlates with past studies (e.g. Akerstedt *et al*, 2002; Kawada and Ooya, 2005), which noted an association between increased workload, and the health and performance of health workers. In their study, Surani *et al* (2007) highlight how increased workloads interfere with health worker's sleep and rest time, resulting in increased fatigue and poor performance generally. Also, Lockley *et al* (2007) found that increased workloads among health providers resulted in sleep deprivation and under such conditions, and under such situations, workers were more likely to make imperfect clinical judgements, resulting in performance errors and accidents.

Another conclusion that can be drawn from this study is that the increased workload of senior clinical staff reduces the time available for them to provide support and mentoring to junior clinical staff. This reduction in mentoring seems to be critical for the professional development of clinical staff. Thus, the claimed link between inadequate management and clinical support and medical error and overall performance of clinical staff is well supported by wider management literature (Kotler *et al*, 2006; Parry and Song, 1993). This conclusion echoes the evidence in Reid *et al* (1999) that clinical support, particularly for frontline clinical staff, is essential for effective healthcare delivery. In addition, the results here indicate that increased workloads impact negatively on workplace relationships, creating envy, finger-pointing, and thus suggest an implication for workers' capacity to perform at an optimal level.

9.5.2 Incentive to improve performance

Pay systems have been a concern over the years with respect to time and size of payment. This present research suggests that although there is a rich and diverse discussion highlighting a range of possibilities of the operation of performance-related pay (PRP) in achieving in particular the health reform target objectives, how this directly links to behaviour change is not straightforward. Yet, the most important assumption underpinning PRP is that workers' behaviour towards incentives is readily predictable; thus, linking rewards to performance provides a nudge that encourages and reinforces good behaviour, and improves individual performance. The findings, however, seem to contradict this classical economic assumption. Several reasons were attributed to this.

Against the claim that linking pay to performance will encourage individual competition, innovativeness and better performance, this study finds that selecting individuals for reward created a regressive work environment. It induces conflicts and unhealthy behavioural tendencies such as jealousy and envy among clinical workers. This study has provided evidence that individual-based rewards undermine existing corporate teamwork and helping attitudes among clinical staff, as well as hindering effective information sharing. There was a general perception that these behaviours and attitudes reduce cooperation and commitment to one another, trust and effective communication, and information sharing among clinical workers. The study has offered evidence that PRP may be disruptive in that it undermines good relationships and an organisational climate especially in a service-related organisation (such as healthcare organisation), where teamwork and cooperation is clearly required.

While the results remain inconclusive because of inadequate objective data, it nevertheless, offers evidence suggesting that frontline workers, in an attempt to win awards, often engage in behaviour which encourages misrepresentation of efforts or performance. This finding is, however, interpreted to be in harmony with health organisations in other contexts (e.g. the UK National Health Service) where such behaviour had often been reported as 'gaming' (Bevan and Hood, 2006a/b; Propper *et al*, 2008a/b). This study offers suggestion that the anxiety among hospital workers

that their colleagues may have cheated tended to crowd out individual intrinsic commitments and devotion to public service duty.

This study finds that the clinical staff did not indicate that performance related pay is necessarily essential or has had any positive influence in motivating them to perform better in healthcare delivery. It conclusively, shows that it is counterproductive in that it undermines their professional ethos and work culture of commitment, selflessness, cooperation and trust among colleagues.

Another conclusion advanced by this study is that the drive for individual reward erodes intrinsic motivation and "public service" behavioural tendencies. This tends to weaken the traditional or prevalent societal discourse that public servants are there to serve and not for self-interest. This study presents the view that there has been a changing trend which suggests that unless you win an award, you remain a poor performer. Consequently, those who may not have been given an award, but are very committed to their vocation, are drawn into rethinking their altruistic behaviour.

Despite the acknowledged evidence that workers pay has been increased in norminal terms, this study reveals that the perception of "inadequate pay" undermines individual worker's morale. This is because the perceived rising workload (efforts) is seen as not commensurate with real pay expectations, and this is consistent with past studies (e.g. Ackerlof and Yellen, 1990; Stutzer, 2004). Workers who spoke about the inability to "make ends meet" also commented that it affects their commitment, and altruistic behaviour in, their vocation. Past studies (e.g. Folger and Konovsky, 1999; Pfeiffer and Langton, 1993) demonstrate that pay operates as a mediator of organizational exchange relationships, and as a predictor of how workers perceive their work.

9.5.3 Health workers' Motivation

The first major conclusion in this study related to motivation is that the perception of being 'left out' of the reform's design and implementation impacted negatively on health workers' perceptions of motivation. Moreover, in terms of the policy implementation process, hospital workers expressed unhappiness and professional demoralisation because they perceived that they are being put under control.

Overall, the perceived lack of recognition of health workers' professional interest, and the imbalance of interest and power between different actors (e.g. reformers/implementer, frontline workers/managers, and patients) in the new form of management of public sector organisations creates a sense of professional humiliation, alienation and demoralisation.

The perception of professional demoralization and dissatisfaction among health workers in the context of organizational restructuring in the public health sector has also been reported by studies in other developing countries (Witter *et al*, 2007a-Ghana; Burnham *et al*, 2004; Kajula *et al*, 2004-Uganda; Walker and Gilson, 2004-South Africa) and in developed countries such as Germany, the USA, the UK and Canada (Aiken *et al*, 2001).

In general, the extent to which the policy reform has impacted on the motivation of individual health workers remain complex. The findings of this study also highlighted the fact that frontline hospital reported less motivation to do their work because of increases in workload with respect to hours worked, administrative paperwork, stress and anxiety, and pressure to achieve targets.

An important finding that emerged from this study was that outside pay, workers were motivated by their perceptions of fairness in the performance measurement process and distribution of individual rewards. This finding correlates with the procedural and distributional justice literature (Greenberg, 1990; Tyler and Bies, 1990) and equity-related studies (Adams, 1965) which suggest that a perception of unfairness de-motivates workers. It was suggested that feelings of unfairness erode the intrinsic morale of workers. As the motivation and behaviour of frontline health workers remain significant in delivering care in a changing work environment, this raises an important message of relevance to current and future settings of public sector incentive systems.

This study did not provide concrete evidence to suggest that performance measurement motivates workers, and, thus did not improve individual health workers' performance. The workers spoke about their lack of trust in the process because it lacks *"clinical orientation and relevance"* and does not give the *"whole picture of our work"*. The big picture that emerges relates largely to the performance measurement operations, which are, *"what to measure, how to measure it, and who*

is to do the measurement". The workers expressed discontentment regarding a lack of consistency in the performance measurement process in capturing the operational sequence of their work. The results here are consistent with the findings of other studies (e.g. McLntyre *et al*, 2001; Boyne, 2003a/b; Boyne *et al*, 2006a/b; Andrews *et al*, 2006; Adair *et al*, 2006), which highlight that performance measurement especially in a healthcare setting is problematic.

9.5.4 Health worker s' behaviour and attitude to work

Several findings emerged regarding the effects of the reform on the behaviour and work attitude of health workers. First, a major finding in this study with respect to workers' behaviour is that it did not seem to match with the expectations of the reforms. For example, rather than stimulating healthy relationships and competition, the perception of 'unfairness' in the performance measurement and reporting process [procedural injustice] and in the allocation of a reward to individual efforts [distributional injustice] resulted in negative consequences for individual worker behaviour. For example, the drive among the workers to avoid shame, or to improve one's self-esteem by winning pay awards, predisposed workers to misrepresent their work efforts, or neglect some vital aspect of their work.

Second, this study finds that measuring and rewarding individual performance undermines team spirit and collegial relationships. The finding suggests that individual frontline workers are now "on their own" as each struggles to outshine the other to win an award. A further implication of this, as revealed by this study, is the perceived erosion of cooperation or helping behaviour among frontline clinical staff. Apart from the fact that this development has often led to conflict, this study suggests that individual drive for awards undermine team spirit and effective work connectivity because it hinders effective information sharing among colleagues. The results correlate with past studies, for example, while Thorndycraft and McCabe (2008) found that lack of team spirit undermines individual and organisation performance in healthcare, Reid *et al* (2002) claimed that, in an organisation, this results in internalised aggression, not only causing poor individual performance, but also a willingness to leave the organisation.

Good relationships were perceived by hospital workers to be very important in their work. The findings from this study revealed a significant shift in these relationships. It is appropriate to bring to notice the widespread blame culture, rumours, hidden or secretive behaviour, the breakdown of teamwork, and the perceived hoarding of information as evident indication of broken relationships. The findings demonstrate that the implication presents interesting evidence. First, broken relationships which predispose individualism (i.e., undermine team spirit and professional trust) also predispose frontline workers to cut corners in clinical procedures. This pertains to misrepresentation and under-reporting of performance. Examining other studies (e.g. Propper *et al*, 2008a; Bevan and Hood, 2006a, Goddard *et al*, 2000; Goddard *et al*, 2002) it has been reported that subjecting workers to performance measurement culture by targets encourages gaming behaviour. As noted by Goddard *et al* (2000: 105), fear of failure or the joy of winning predisposes "unintended behaviour, which may encourage workers to behave in ways which are directly contradictory to what is expected". Bevan and Hood (2006a) reported that unintended behaviour among health workers arose because of the drive to meet individual targets. In line with other studies, (e.g. Karatepe and Uludag (2007), there is a suggestion that an office culture based on individual performance leads to conflict, exhaustion and de-motivation, particularly among frontline service providers.

9.5.5 Healthcare quality

Overall, this study did not seem to have enough evidence to suggest that the reform has achieved its objective of improving the quality of health care. Nevertheless, this study provides evidence that suggests achievements in many ways. The findings demonstrate that there has been an improvement in clients' access to healthcare in terms of reducing crowded queues, and waiting times, and at the same time increasing workloads, which could be seen as an improvement in efficiency of operations and fairness of access because of the way customers are treated on a first-come-first-served basis. Added to this is the evident improvement in the information which is made available to clients, which also signifies an improvement in individual worker accountability.

However though the reform has contributed to reducing waiting times, it also resulted in an unintended outcome. For instance, this study finds that it reduces time for care and interaction with patients which, to the workers, is problematic. This study produced claims of an existing relationship between reducing time for care and perceived reduction in quality of care for patients. What was evident from the study was the suggestion that reducing waiting times which has resulted in changing the relationship and reducing the contact between providers and patients appear to be detrimental to patients' health and quality of care. While this finding remains preliminary and contentious, it is however useful because it gives a sense of what the frontline health workers think of the effects of the reform, and it also correlate with other studies (e.g. Simmons and Elias, 2002; Mannion *et al*, 2005; Propper *et al*, 2008a) which argue that reducing waiting time has implications for quality of care, and patients' health and safety.

Another most important insight from this study relates to the shift towards customer centeredness. This study concludes that the culture of customer services, which is considered critical to public health service delivery, has improved. In comparing their service attitude before the policy reforms, many workers said that they [and their hospital] are now customer-friendly as they attend to customers promptly, timely, responsively and respectfully. Yet, this study provided evidence that overall, clinical staff felt that, the new culture of "quick service" is not delivering quality care.

In general, the findings provide empirical support for the contention that prioritisation of work, performance measurement, and performance-related pay did not seem to have improved the capacity of health workers to perform better, or the quality of healthcare more generally. The implications of the above summarised findings of this study are highlighted below.

9.6 Conclusions

The objective of this study was to explore how different categories of hospital workers perceived and responded to a policy reform process implemented within the case hospital organisation in which they work. The study has indicated how day-by-day organisational processes and practices of healthcare professionals have been

influenced by the reform. Of course, reform is important in providing guidance for action, but everyday work processes and interactions among actors at organisation level, and within the wider sense of public health workers' culture, is also, or even more, important to the success of any reform.

Furthermore, in a context where individual workers are required to follow a defined performance measurement culture, work longer and change their relationship with patients (clients), this study provides an interesting perspective of how the reform has implied changing work roles and increased workload with negative impact on collegiality and cooperation among health workers. The results regarding the way the reform is being implemented, entailing the use of an external policing agency, suggest there is a sense of loss of professional control and autonomy. In other words, the presence of the regulatory agency implies that workers' agency and discretion are restricted, and their capacity to provide services based on their professional knowledge is constrained.

The findings of this study also suggest that while setting rules and rewarding "good behaviour" among frontline workers is intended to improve individual performance, it has failed to find a significant positive relationship between linking performance to reward and improvement in individual performance. Rather, there was convincing evidence to suggest that focusing on individual efforts/results and rewards degenerated to perception of unfairness in work processes and relationships. That is to say, it created disengagement, distrust and jealousy, envy, blame culture, and a retrogressive and unhealthy work culture. The results suggest that the reform does not specifically support the core professional culture and ethos such as teamwork. While the results remain contentious, the consensus view of the workers is that encouraging team spirit enhances patient recovery and good health, intead of focusing on individual results or the number of people coming in and out of the hospital's doors. At the same time, however, effective involvement and engagement of the professional ideas of the frontline health workers and their managers from the start in the policy reform process was strongly advocated as a good option to designing and implementing workable change options. While this seems crucial, there is no convincing evidence to suggest that it is guaranteed.

Arising from the findings, it seems legitimate and inviting to conclude that the on-going policy reforms in Nigeria have practical implications when placed next to current policy issues in other contexts e.g. the UK NHS. Examining the evidence as revealed by the clinical workers and their managers, the arguments presented fit well within the current debates of health policy reforms in the UK. What is evident is that the present coalition government in the UK tends to be responsive towards the professional views of healthcare professionals, and has accepted to scrap a target culture, which is described as a "pointless and disruptive reorganisation of the UK NHS (BBC News, 2011). This is also followed by a recommendation to downplay the role of audit agencies, i.e. a crackdown on centralisation and prioritisation policy, towards favouring decentralisation of hospital resources management. It also involves giving power back to professionals to do their jobs.

As noted in Chapter 4, the on-going reforms in the Nigerian public sector came into effect under joint efforts between the Nigerian government and the UK government through the office of Public Sector Reforms in UK. With the current policy events in the UK, the future of the reform in Nigeria seems bleak. This Nigerian case is an example of the dilemma often faced by governments of developing countries while trying to learn from more developed countries.

This study concludes that policy reform has the potential for promoting a progressive work environment, and ensuring that health professionals-those responsible for delivering healthcare- perform optimally in healthcare delivery, particularly in a developing country context like Nigeria. This study has suggested that while the on-going policy reform process, driven by dominant narratives, and new thinking about how public hospitals should be organised and managed, remain significant moves to bring about meaningful change, there is inadequate and convincing evidence to suggest that the initiative fits within the operating practice, context, and changing work circumstances associated with healthcare delivery. Yet, while the policy reform process remains an assiduous effort to generate good working environments in order to run government offices better and deliver better healthcare services, there is inconclusive evidence to suggest that this has been achieved. At the same time, the future of the policy reform process must await a wider testing in other hospital settings or industry.

9.7 Implications and Limitations of the Study

The main implication of this study is that the policy reform process within the healthcare sector is not as straightforward as often predicted. Based on the findings, this study argues that realising effective change through policy reform processes should be seen not as a discrete or linear event, but as a product of the day-to-day practice of actors, involving elements of interest, contradictions, manoeuvres and relationships among actors at the organisation level. Thus, policy-makers and organisational managers should take into account the existing practices, experiences, cultures and norms that are widely held by those involved in healthcare delivery when developing strategies to change how health workers do their work. Furthermore, not only the institutional aspect of change but also the perceptual views of frontline workers and their managers of their work and job contexts are important factors that shape the effectiveness of policy reforms.

This study, however, stands out for its in-depth focus, and has demonstrated how policy reform processes that are often construed based on dominant narrative and discourse operate in practice revealing how micro-processes and interactions engaged in by actors at the organisation level shape how policy operates. This clearly has implications for policy-makers, researchers and development professionals involved in policy processes in Nigeria. The understanding gained from this study has provided an input to the understanding of policy reform processes in the health care industry, and is intended to have practical applications for health care management and policy-making in general.

Overall, based on the findings from the case hospital, there is no convincing evidence to demonstrate that the current policy reform has been successful in achieving its objectives. It is true that some efficiency gains may have been recorded in terms of speed of operation and reduction in waiting times, but the way in which government is going about implementing the policy processes tends to have overlooked the prioritised interest of health workers based on their work culture, practice and experience. The study also suggests that the hospital workers felt ‘left out’ in the policy reform design, and the way the reform is implemented suggests that they are being policed, and, thus that they are losing control of their jobs. The findings of this study contribute to the understanding of policy reform processes in

practice. Drawing evidence from micro-level processes and as perceived by those involved in healthcare service delivery, this study provides a deepened understanding of what happens on the ground as policy reform is designed and implemented.

This study is thought to be the first of its kind in analysing health workers' perspectives and responses to the on-going health care reforms in the Nigerian health care service. While the study was focused on a case study of a hospital, it can as well serve as a platform for future research work not only in Nigeria, but also in other developing countries. This study has added to the literature by providing insight into how micro-level processes and professional norms and culture contribute to shaping how policy operates in practice, an aspect which is often ignored by researchers and policy-makers.

The findings of this study, though exploratory in nature, can positively serve as a basis for future research. Based on this study, one area that may need future attention relate to how to redistribute and balance the power and interest of actors (reformers/implementers, workers, and patients) in such a way to facilitate meaningful negotiation, strengthen relationships, and promote engagement in the wider issues of what should be done, how, and for whom. There is a need for clear timeliness of what need to be set as performance measures, how performance should be measured, as well as how to instigate rewards for performance that is consistent with the existing professional culture of public healthcare practice. Clearly, the findings suggest that effective and transformative change happens through dialogue. Such dialogue will need to involve responsibility, trust and power balance among all actors. In particular, given that responsibility is required to ensure that frontline workers and their managers are held accountable for the implementation of government reform and the delivery of quality healthcare outcomes, somehow frontline health workers need the power to be able to make informed decisions to change the way they do their work. There is a need to look at the issue of changing public health workers' behaviour in its broadest sense and to focus on issues that enhances their engagement, intrinsic motivation and professional culture, as it relates to the social context in which they do their work.

Appendix

Appendix: 1A Demographic characteristics of research participants

Demographic Characteristics	Executives managers (n=6)		Operational managers (n=16)		Doctors (n=40)		Nurses (n=45)	
	Number	(%)	Number	(%)	Number	%	Number	%
Sex								
Female	**2**	**33**	**4**	**25**	**7**	**17**	**39**	**87**
Male	**4**	**67**	**12**	**75**	**33**	**83**	**6**	**13**
Length of service								
< or 10 years	-	-	-	-	**4**	**10**	**8**	**18**
11-20 years	-	-	**2**	**12**	**6**	**15**	**12**	**27**
21-30 years	**1**	**17**	**8**	**50**	**20**	**50**	**18**	**40**
>30 years	**5**	**83**	**6**	**38**	**10**	**25**	**7**	**15**
Age in years								
<30 years	-	-			-	-	**4**	**9**
30-39 years	-	-	**1**	**6**	**4**	**10**	**5**	**11**
40-49	**1**	**17**	**5**	**31**	**8**	**20**	**12**	**27**
50-59	**3**	**50**	**8**	**50**	**20**	**50**	**18**	**40**
60 and above	**2**	**33**	**2**	**13**	**8**	**20**	**6**	**13**

Demographic Characteristics	Planning office (n=6)		Performance agency (n=5)		Administrators (FMOH) (n=4)		Policy consultant (n=1)	
	Number	(%)	Number	(%)	Number	%	Number	%
Sex								
Female	**2**	**33**	**2**	**40**	**3**	**75**	**1**	**100**
Male	**4**	**67**	**3**	**60**	**1**	**25**	-	-
Length of service								
< or 10 years	-	-	-	-				
11-20 years	-	-	**1**	**10**	**1**	**25**		
21-30 years	**1**	**17**	**2**	**40**	**2**	**50**	**1**	**100**
>30 years	**5**	**83**	**2**	**40**	**1**	**25**		
Age in years								
<30 years	-							
30-39 years	-		**1**	**25**				
40-49	-		**1**	**25**	**1**	**25**	-	
50-59	**5**	**83**	**2**	**50**	**3**	**75**	**1**	**100**
60 and above	**1**	**7**	-				-	

Appendix 1B Interview number and types

	Policy makers	Executive manager	Operational manager	Doctors	Nurses
No of interviewees	**16**	**6**	**16**	**40**	**45**
No of interviews	**19**	**9**	**24**	**54**	**62**
Interview types					
Semi-structured	**16**	**6**	**16**	**40**	**45**
In-depth	**3**	**3**	**8**	**14**	**17**

Appendix 1C List of demographic and job characteristics questions

Name of unit……..

Specialty……..

Date ……

i. How many years have you worked at this public hospital?
   a) Less than 10 years
   b) 11-20 years
   c) 21-30years
   d) More than 30years

ii. Are you working part-time or full time in your job?
   a) Part time
   b) Full time

iii. Are you a male or female?
   a) Male
   b) Female

iv. What is your age?
   a) Under 30
   b) 30-39
   c) 40-49
   d) 50-59
   e) 60 and above

v. How many years have you been a government worker?

a) Less than or 10 years
b) 11-20years
c) 21-30years
d) Above 30 years

Awareness of the reform

vi. How did you hear about the reform?

a) Memo/circular
b) Seminar/workshop
c) Media
d) Through our union

Would you like to be involved in further interviews in respect of this research? Please kindly sign to confirm your agreement to be involved. The participation is voluntary and has no monetary reward. All your comments will be treated confidentially. May I also ask that you provide your contact details?

Name: ……

Ward/unit: …….

Mobile Phone Number: ……..

1D Key informants (government policy-makers and top administrators)

i. Could you please describe the changes in the public service arising from the policy reform and as it relates to your work?
ii. How was the change created, initiated and expected to be implemented in the public service?
iii. What is the government rationale for creating and initiating the changes and what specific objectives do the changes seek to achieve?
iv. Do you think that the ongoing changes have made any significant impact? If so how? If not why?

1E Policy consultant

i. What were the terms of reference for your involvement in the public service reform in Nigeria?
ii. How did you become involved and who contacted you? Was this based on experience with public service reform in UK and other developing country contexts [based on past experience] or in partnership with your office?
iii. How were your experiences of doing the Nigeria project? To what extent did you become familiarized with the local context, especially at the service delivery end? Are there other contacts/informants through you I can also speak to?
iv. What input did you provide to the policy reform design, implementation and monitoring process? Was this just at the research level, writing the service delivery map or in its implementation?
v. What is your view about the transferability [adaptation and learning] of policy reform from the United Kingdom to Nigeria?
vi. Does the Nigerian public service have the same or similar problems such as operations of the public service, initiation, implementation of policy, worker behaviour and customer experience? What are the similarities and differences at the policy- and workers-level?
vii. Do you think that the policy reform outcomes in terms of worker behaviour, hospital performance and general policy implementation outlook will be comparable with other experiences such as those in the UK or in other developing country contexts?
viii. What is your view and experience of performance targets and their influence on service provision and hospital performance? What have they done for the UK? What are the possible expectations for Nigerian public service workers such as doctors and nurses in public hospitals?
ix. Generally, have you been working [or worked] in other developing countries apart from the UK? Is it possible to comment on your experiences from other developed or developing country contexts in relation to the Nigerian case?
x. Based on your experience, do you think that the Nigerian public service is different in any way from that in the UK or other countries?

1F Hospital executive and operational managers

i. Could you please describe the nature of the specific changes (named) in the public service as in this hospital?
ii. What is the focus of the change (named); how did the change come about and what do you think is driving the change?
iii. What do you feel about the conceptualization and initiation of the change in this hospital?
iv. Do you think there are other surrounding issues about the change?

Process and operations

i. How is the change currently being implemented, and are work processes clear and adequately structured?
ii. Are roles within the organization clearly defined and aligned?
iii. Does the reform operating structure support clear lines of authority and the accountability of managers and workers?
iv. How do you feel about the performance audit agency and its competence to do its work?
v. Do you think that making available public performance information on service providers is helpful appropriate and likely to lead to better performance?
vi. How helpful is the published performance information for management decisions and clinical operations?

Effects and outcomes

i. What do think are the effects and outcomes of the change at the management level of this hospital organization?
ii. How and to what extent has the change (named) impacted on your perceived role as a manager?
iii. How and to what extent has the change (named) shaped your understanding of and commitment to public service management?
iv. Is there anything about the reform that seems to enhance or hinder public hospital management and operations?
v. How has the reform enhanced organizational performance?

1G Workers union representatives

i. I understand that you are a member of the [named union]; what is your union's opinion regarding the state of heathcare in this country?
ii. What have been the big changes in this hospital and in public health sector in the past?
iii. What have been the changes between 2000 and 2007? How did they happen and what have been your union's opinions regarding the reform?
iv. What are the big issues your union members have had to deal with concerning the reform?
v. What have been the views of your union about the ongoing changes?
vi. How and to what extent is your union involved in the design, initiation and implementation of the ongoing change in public hospital organizations?
vii. What impact do you think these changes have had or are having on your profession?
viii. Do you think that making available public performance information on service providers is helpful appropriate and likely to lead to better performance?
ix. Do you think that the ongoing changes have helped in service delivery? If so how? If not why?

1H Service performance audit agency (SERVICOM)

i. What do you think is the focus of your work?
ii. Does SERVICOM have a clearly defined way of assessing the performance of service providers?
iii. How motivated and trained are SERVICOM staff to do their work?
iv. Does the Social Charter provide an adequate framework and guide for creating client-focused care?
v. Do you think that this is adequate in dealing with the challenges of service delivery?
vi. How do you collect and analyse the performance data?
vii. Does SERVICOM have the mechanisms to ensure that the performance information collected is error-free?
viii. How would you describe your relationship with the service providers?

ix. What have been the outcomes of your work and what possible challenges do you face in doing your work?

1I Frontline Doctors and Nurses

General context and content

i. Could you please describe the nature of the specific public service changes (named) in this hospital?
ii. What is the focus of the change (named); how did the change come about and what do you think is driving the change?
iii. What do you feel about the conceptualization and initiation of the change in this hospital for example?
iv. Do you think there are other surrounding issues about the change?

Process and operations

i. How is the change currently being implemented? What do you think about the performance implementation agency (SERVICOM)?
ii. Did you contributed to the policy design and how do you assess the policy process?
iii. How do workers see the introduction of performance measurement and changes in pay including salaries and fringe benefits?
iv. Do you think that making available public performance information on service providers is helpful/appropriate and is it likely to lead to better performance?
v. What do you think about the process and operations of the change and your work as a public worker including hours worked and time you actually spend on healthcare provision?

Effects and outcomes

i. What do think are the effects and outcomes of the changes in work practices at the level of the hospital organization and hospital workers?
ii. How do you think the pay (salaries, fringe benefits and allowances) of public health workers compares within and between worker categories and levels?

iii. How and to what extent has the change (named) impacted on your perceived motivation, behaviour and performance/that of the general workers?

iv. Do you think there is a significant difference in the motivation, behaviour and performance of public health workers because of this reform? If so in what ways? If not, why?

v. As a healthcare service provider, would you say that the changes in work practices have worked well in improving service delivery and meeting the needs of patients (clients)?

vi. How and to what extent has the change (named) shaped your understanding of and commitment to the public service mission, vision and ethics or that of the general workers?

vii. What are your key concerns about the reform with respect to your work and workplace organization?

viii. Do you think the changes have had influence on work relationships and interactions in this hospital? If yes, can you give examples?

ix. Has your experience of the changes in work practices and pay influenced the way you feel about your work and government work generally?

Job satisfaction and pay fairness

i. Kindly indicate whether you agree or disagree with the following statements:
   a) I consider my salary as fair in relation to other workers in the same category/level in this hospital
   b) I consider my salary as fair in relation to others workers in different categories/levels in this hospital
   c) I consider my salary as fair in relation to others workers in the same category/level in private sector hospitals

ii. The difference in salary between top-level and lower-level workers in this hospital is too large.
   a) Strongly disagree
   b) Disagree
   c) Agree
   d) Strongly agree

iii. Overall how satisfied are you with your salary with respect to your expectations?

a) Very dissatisfied
b) Dissatisfied
c) Somewhat satisfied
d) Very satisfied

iv. Overall how satisfied are you with your work in the context of change in salaries?

a) Very dissatisfied
b) Dissatisfied
c) Somewhat satisfied
d) Very satisfied

v. Overall how satisfied are you with your work in the context of change in fringe benefits?

a) Very dissatisfied
b) Dissatisfied
c) Somewhat satisfied
d) Very satisfied

vi. Overall how satisfied are you with your work in the context of the changes in work practices?

e) Very dissatisfied
f) Dissatisfied
g) Somewhat satisfied
h) Very satisfied

vii. Besides the above issues that we have discussed are there other concerns workers have regarding the reform's design and implementation process, and in respect of how you do your work in this hospital? Do you have any specific questions for me?

Appendix 3 SERVICOM Evaluation forms

Appendix 3a: The SERVICOM Charter Check List

SERVICOM Charter Checklist

MINISTRY/DEPERTMENT/AGENCY
LOCATION

CHECKLIST OF CONTENTS OF CHARTER : PLEASE TICK AS APPROPRIATE.

Serial Number	Contents	Availability	
		Yes	No
i.	Introduction/background		
ii.	Mission Statement		
iii.	Vision Statement		
iv.	Details of Customers (May be included in Introduction)		
v.	Details of Service Provision and Delivery - Statement of Service to be provided as a right - Statement of the standards of service delivery to be expected - Statement of performance monitoring and publishing arrangements		
vi.	Details of complaints/grievance mechanism		
vii.	Obligations/Expectations - Customers - Staff - Management - Federal/State authorities		
viii.*	Indication of Stakeholders participation		
ix.*	Special Needs Provision		
x.*	Statement of Existing Limitations		
Date Issued			
Date for review			
Checked by			

** Denotes optional items, which may not be applicable to all organisations*

Appendix 3b: The SERVICOM Charter Evaluation Form

SERVICOM Charter Evaluation

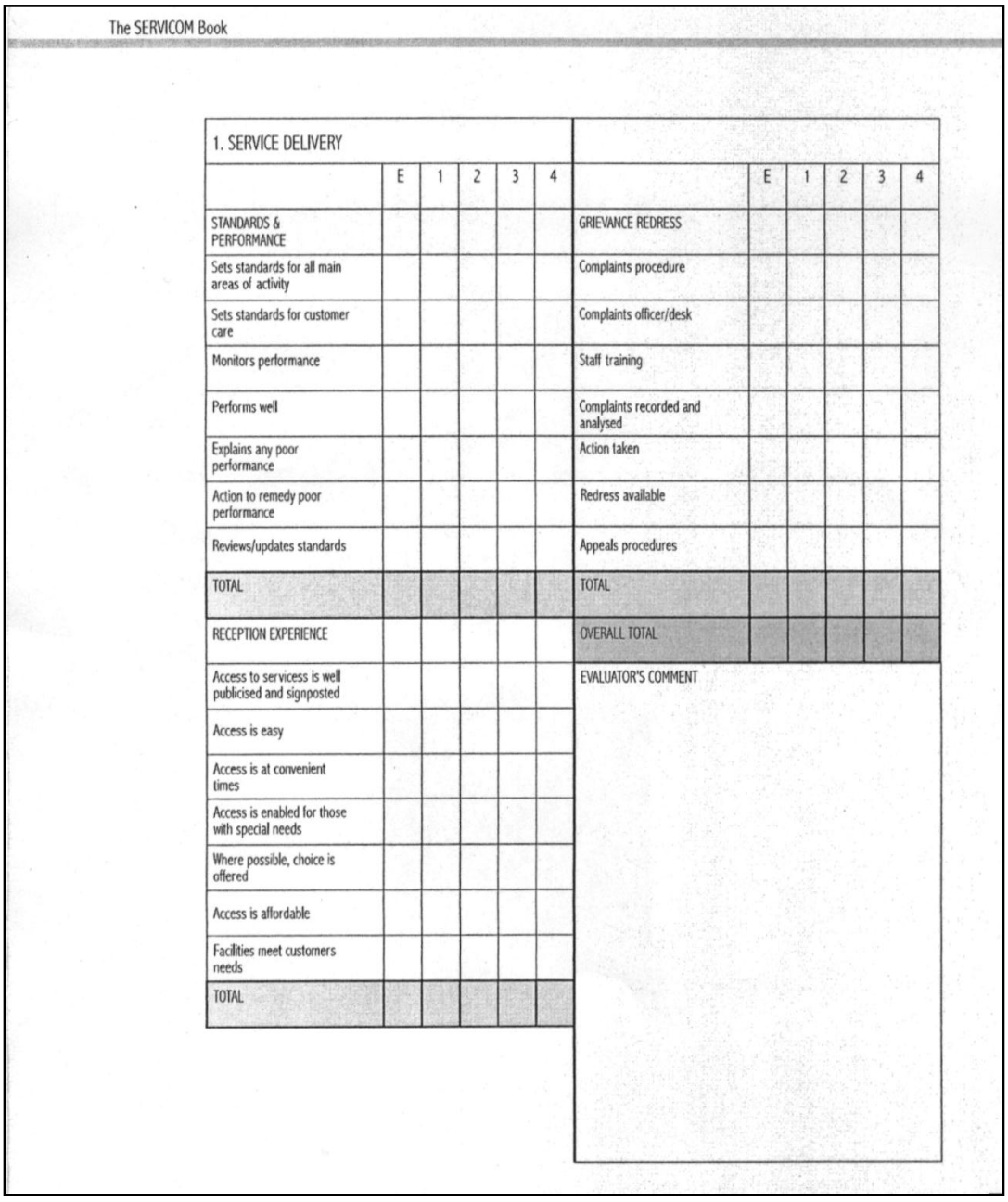
Serial No	Comments	Evaluation	Yes	No	Comments
i.	Clarity	a. Is the Charter easy to read and understand? b. Is it written in plain language? c. Is it concise and logical?			
ii.	Realism	a. From your knowledge of the organization and discussions with the Nodal Officer, is the Charter realistic?			
iii.	Introduction/ Background	a. Is the service described? b. Is the purpose of the Charter described? c. Are the customers identified? [This may be a separate entry]			
iv.	Mission Statement	a. Is it clear that this is a mandate from the appropriate authority? b. Is the expected service provision indicated?			
v.	Vision Statement	a. Does this contain a statement of long term goals for service provision and delivery? b. Is any timeframe attached?			
vi.	Service Provision and Delivery	a. How clear is the statement of customer expectations? b. Do the standards of service provision and delivery include: - Services to be provided - prompt and courteous treatment - information and consultation - provision for those with special needs? c. Are there clear descriptions of performance monitoring and publishing arrangements?			
vii.	Complaints/Grievance Mechanisms	a. Is there a clear explanation of these mechanisms? b. Does this explanation include who to complain to, time limits for response and available redress?			

viii.	Obligations	a. Are there clear statements of what is expected of customers, staff, management and higher authority in order for effective services to be provided? b. Are these obligations reasonable?			
ix.	Stakeholders Participation	a. Is this clearly described? b. Does it constitute an essential element in providing the service?			
x.	Special Needs Provision	a. Is the organization particularly involved with serving those with special needs? b. Is there a specific commitment to provide services to meet these needs?			
xi.	Existing Limitations	a. Is there a clear indication/explanation of how existing limitations and constraints affect the achievement of the Mission and Vision? b. Is this credible?			
xii.	Overall Evaluation	a. Is this Charter fit to publish? b. If not, what are the essential ingredients that are missing?			

SIGNATURE SERVICOM OFFICER	DATE
SIGNATURE TEAM LEADER	DATE

CHARTER PUBLISHED	DATE
REVIEWED	DATE

Appendix 3c: The SERVICOM performance measurement Evaluation Form

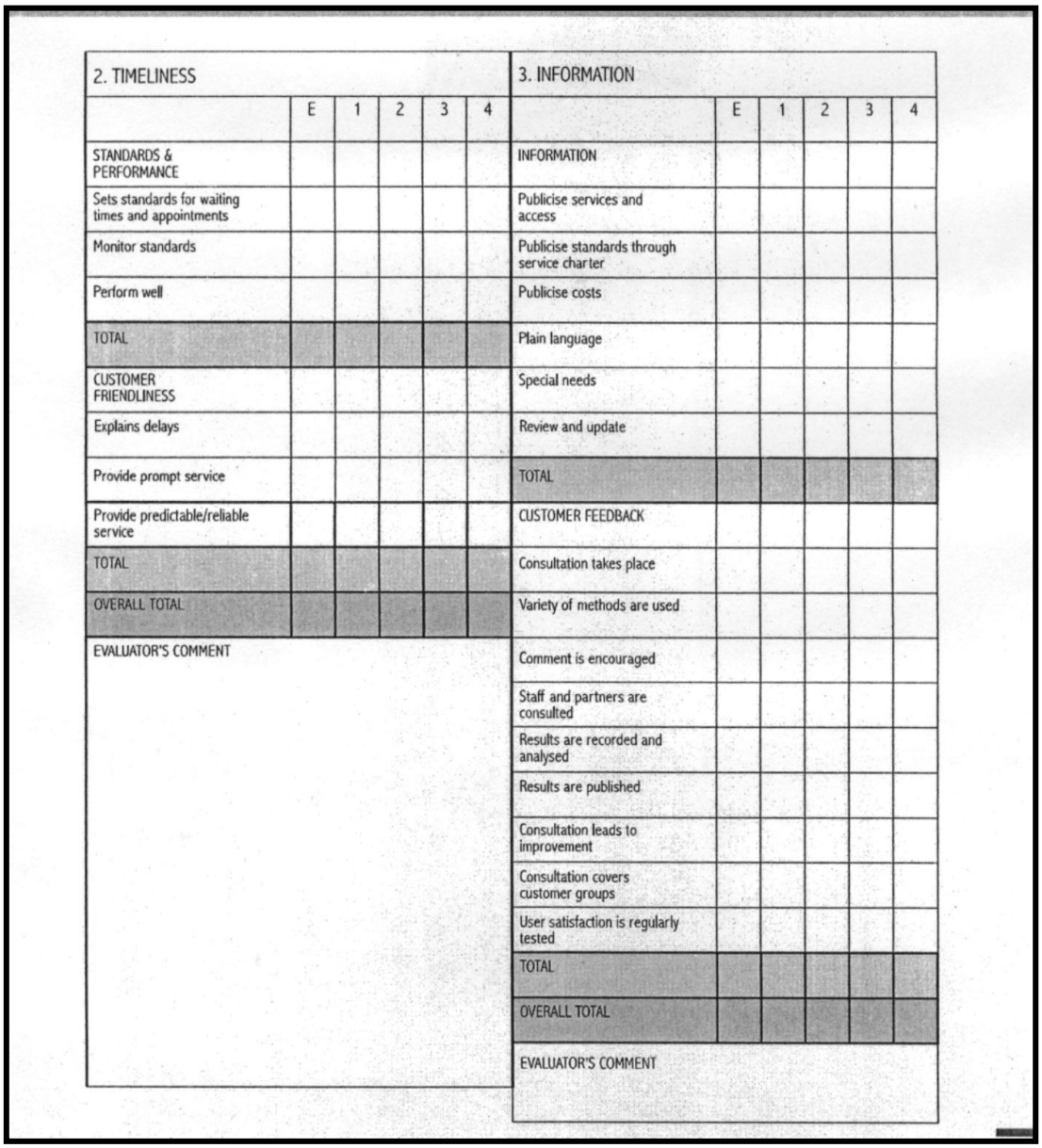


The SERVICOM Book

1. SERVICE DELIVERY	E	1	2	3	4
STANDARDS & PERFORMANCE					
Sets standards for all main areas of activity					
Sets standards for customer care					
Monitors performance					
Performs well					
Explains any poor performance					
Action to remedy poor performance					
Reviews/updates standards					
TOTAL					
RECEPTION EXPERIENCE					
Access to servicess is well publicised and signposted					
Access is easy					
Access is at convenient times					
Access is enabled for those with special needs					
Where possible, choice is offered					
Access is affordable					
Facilities meet customers needs					
TOTAL					

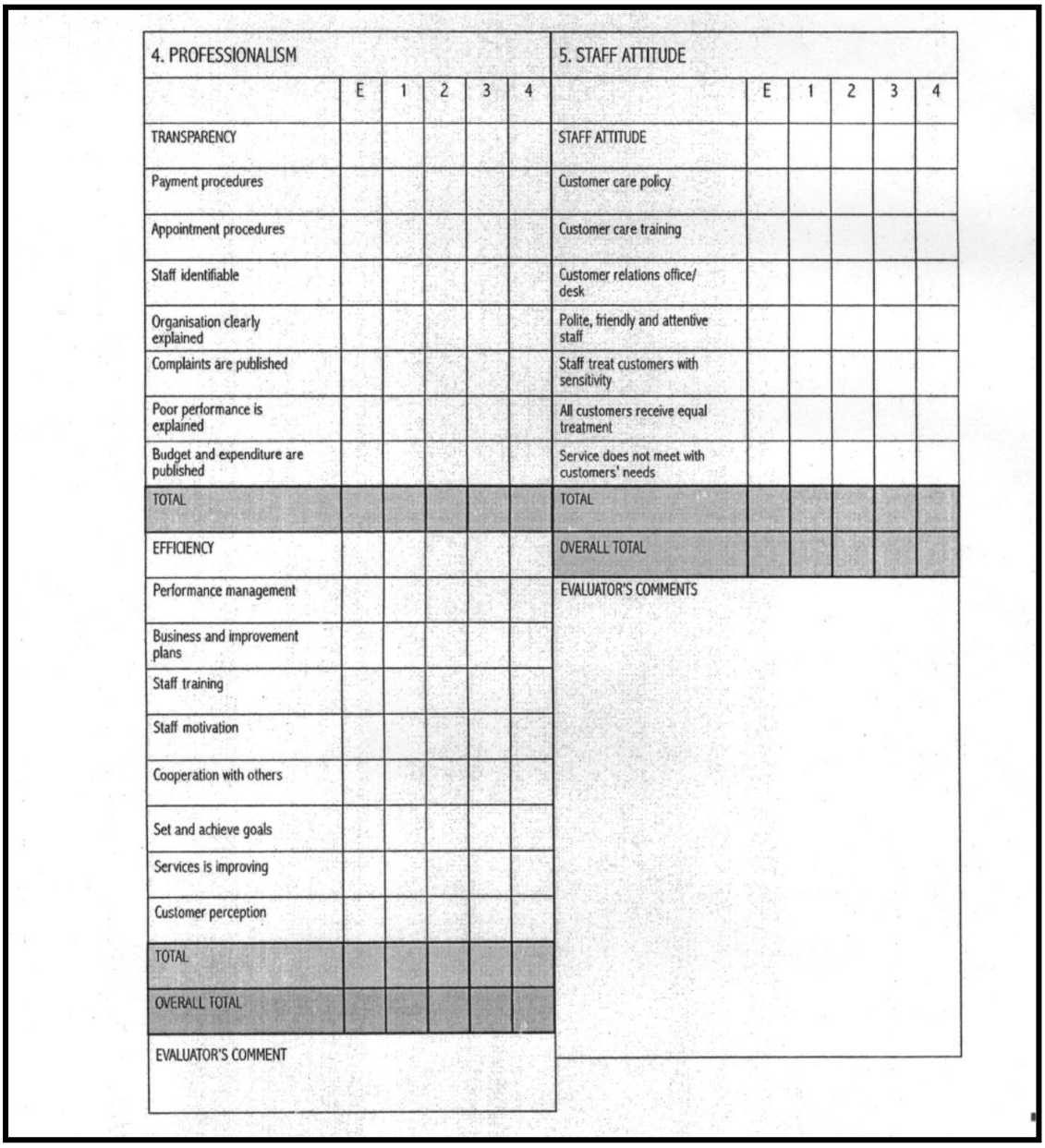
	E	1	2	3	4
GRIEVANCE REDRESS					
Complaints procedure					
Complaints officer/desk					
Staff training					
Complaints recorded and analysed					
Action taken					
Redress available					
Appeals procedures					
TOTAL					
OVERALL TOTAL					

EVALUATOR'S COMMENT



2. TIMELINESS	E	1	2	3	4
STANDARDS & PERFORMANCE					
Sets standards for waiting times and appointments					
Monitor standards					
Perform well					
TOTAL					
CUSTOMER FRIENDLINESS					
Explains delays					
Provide prompt service					
Provide predictable/reliable service					
TOTAL					
OVERALL TOTAL					
EVALUATOR'S COMMENT					

3. INFORMATION	E	1	2	3	4
INFORMATION					
Publicise services and access					
Publicise standards through service charter					
Publicise costs					
Plain language					
Special needs					
Review and update					
TOTAL					
CUSTOMER FEEDBACK					
Consultation takes place					
Variety of methods are used					
Comment is encouraged					
Staff and partners are consulted					
Results are recorded and analysed					
Results are published					
Consultation leads to improvement					
Consultation covers customer groups					
User satisfaction is regularly tested					
TOTAL					
OVERALL TOTAL					
EVALUATOR'S COMMENT					



4. PROFESSIONALISM	E	1	2	3	4
TRANSPARENCY					
Payment procedures					
Appointment procedures					
Staff identifiable					
Organisation clearly explained					
Complaints are published					
Poor performance is explained					
Budget and expenditure are published					
TOTAL					
EFFICIENCY					
Performance management					
Business and improvement plans					
Staff training					
Staff motivation					
Cooperation with others					
Set and achieve goals					
Services is improving					
Customer perception					
TOTAL					
OVERALL TOTAL					
EVALUATOR'S COMMENT					

5. STAFF ATTITUDE	E	1	2	3	4
STAFF ATTITUDE					
Customer care policy					
Customer care training					
Customer relations office/ desk					
Polite, friendly and attentive staff					
Staff treat customers with sensitivity					
All customers receive equal treatment					
Service does not meet with customers' needs					
TOTAL					
OVERALL TOTAL					
EVALUATOR'S COMMENTS					

Appendix 3 The SERVICOM's Report on performance of federal tertiary hospitals in Nigeria 2007

Hospital Agency	Overall rating	Major weakness	Major strength	Recommendations
Federal Medical Centre, Umuahia	2.4 out of 4 (60%)	-There are no clearly defined processes involved in monitoring performance against ALL set standards to show that the organization adheres to its set standards in rendering services to its customers -The complaints procedure has no set time limit for responses to customer complaints which negatively affects the resolution of complaints -Though customer satisfaction is tested but there is need for regular customer satisfaction surveys to be carried out to further strengthen the process of ascertaining their actual needs	None recorded	-There should be clearly defined processes involved in monitoring performance against ALL set standards. This will ensure that set standards are adhered to for continuity of good service -The existing system of record keeping in the general outpatient department should be overhauled to forestall bureaucratic bottlenecks and strengthen efficiency -Detailed standard waiting times for initial and subsequent waits should be set and adequately published at all service points for use by both customers and the staff. This will prevent preferential treatment being given to some customers and eliminate unnecessary delays -Front line staff should be trained to develop standard waiting times for initial and subsequent visits. Staff should show sensitivity at the service window and ensure timely service delivery to all customers -The office and desk of officials should be clearly marked to indicate names and functions for easy location by customers -The organizational chart of the general outpatient department should be displayed at all service points for easy access to the required service -Systems should be put in place to monitor performance and to ensure that staff comply strictly with them; Management should provide water dispensers in all patients' waiting areas for both patients and staff

Hospital Agency	Overall rating	Major weakness	Major strength	Recommendations
University teaching Hospital, Benin	2.4 out of 4 (60%)	-Systems are not in place to monitor performance against standards -Costs for services are not within the reach of all customers as most customers complain of high charges for drugs compared to what is obtainable in private drug shops -Complaint and redress procedures not efficient -Hospital does not achieve most of the targets and no explanations given	-There are clear directions and signage leading to various service points -All information is given in plain language with minimal technical jargon -Feedback process to track customer satisfaction exists	-Systems should be put in place to monitor performance -Alternative ways of reducing cost of drugs should be considered -Summary of customer complaints received should be published
Federal Medical Centre, Yola	2.2 out of 4 (55.5%)	Systems are not in place to monitor performance against All standards No refreshment is provided in the customer waiting areas Front line staff have not been trained to handle complaints	Customers can reach the service without difficulties and there are no physical or bureaucratic obstacles Services are provided throughout the advertised times The hospital sets standards for customer care	-Systems should be put in place to monitor performance -Managers should provide water dispenser in all patients waiting areas -The hospital should publish information in other languages for the benefit of customers who may not understand English
Ahmadu Bello University Of Teaching Hospital, Zaria	2.1 out of 4 (52.5%)	Poor performance is not explained • No set standards for waiting times • Consultation with customers not recorded • Cost and payment procedures not displayed.	Customer friendliness	-Honest explanations should be given for delays -Standards for monitoring should be set -Cost and payment procedures should be displayed.

Hospital Agency	Overall rating	Major weakness	Major strength	Recommendations
The Federal Medical Centre, Ido-Ekiti	1.7 out of 4 (42.5%)	-Summaries of budget, expenditure and audit reports are not published and available for the benefit of the public. -The Hospital has not provided suitable facilities for customer's privacy especially during consultations		-The Hospital should provide refreshment facilities (i.e. water dispensers at all patients' waiting areas. -Frontline staff should be trained to handle complaints. -This will ensure that customers' complaint are promptly dealt with -Recorded complaints should be analysed and published for the benefit of customers
National Hospital: Out-Patient Department (Office of the Secretary to the Government of the Federation)	1.8 out of 4 (45%)	- Set standards where available are not met - Existing complaints procedure is not structured and managed to address the complaints of customers - Services have high charges -Poor staff attitude - Services are not adapted to suit the needs of customers - No arrangement is made for the needs of special customers.	Reception experience	-Documentation for set standards and targets to monitor performance should be provided, regularly reviewed and raised -The hospital should encourage consultation with customers to address the issue of high charges -There should be set standards for waiting times -Staff should be trained on customer care -Summary of budget, expenses and audit reports should be provided in the public domain -Services should be adopted for the benefit of those with special needs -There should be a clearly identified customer relations officer.
Asokoro Federal Capital territory (FMC)	1.9 out of 4 (47.5):	-No provision for the needs of physically-impaired customers -No set standards for main service provided by the organization. -Results of consultation with customers are not recorded -Appointment procedures are not detailed at service outlets and summary of budget, expenditure and audit reports are not provided for the benefit of customers.	Customer friendliness	-Performance should be monitored and honest explanations provided for service failure -Detailed standards for waiting times and appointments for initial and subsequent visits should be provided for all customers -Summary of budget, expenditure and audit reports should be provided for the benefit of customers.

Hospital Agency	Overall rating	Major weakness	Major strength	Recommendations
Asokoro Federal Capital territory (FMC)	1.9 out of 4 (47.5):	-No provision for the needs of physically impaired customers -No set standards for main service provided by the organization. -Results of consultation with customers are not recorded -Appointment procedures are not detailed at service outlets and summary of budget, expenditure and audit reports are not provided for the benefit of customers.	Customer friendliness	-Performance should be monitored and honest explanations provided for service failure -Detailed standards for waiting times and appointments for initial and subsequent visits to the hospital should be provided for all customers -Summary of budget, expenditure and audit reports should be provided for the benefit of customers
National Hospital: Out-Patient Department (Office of the Secretary to the Government of the Federation)	1.8 out of 4 (45%)	Set standards where available are not met Existing complaints procedure is not structured and managed to address the complaints of customers Services have high charges Poor staff attitude Services are not adapted to suit the needs of customers No arrangements for the needs of special customers.	Reception experience	-Documentation for set standards and targets to monitor performance should be provided, regularly reviewed and raised -The hospital should encourage consultation with customers to address the issue of high charges -There should be set standards for waiting times -Staff should be trained in customer care -Summary of budget, expenses and audit reports should be in the public domain -Services should be adopted for the benefit of those with special needs -There should be a clearly identified customer relations officer

Appendix 4: Pay data

4a: Nominal salaries of different categories of doctors in Naira currency (1983-2007)

Year	Entdoctor	d10term	d11ent	d11term	EntMdoctor	d12term	d13ent	d13term	d14ent	d14term	EntTdoctors	d15term
1983	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1984	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1985	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1986	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1987	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1988	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1989	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1990	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1991	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1992	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1993	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1994	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1995	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1996	20800	31142	22100	32960	24203	35687	26743	37008	28693	41483	32046	46221
1997	20800	31142	22100	32960	24203	35687	26743	37008	28693	154,632.00	127,380.00	173,328.00
1998	73,980.00	102,168.00	82,524.00	111,332.00	91,176.00	123,332.00	102,780.00	136,464.00	114,144.00	154,632.00	127,380.00	173,328.00
1999	73,980.00	102,168.00	82,524.00	111,332.00	91,176.00	123,332.00	102,780.00	136,464.00	114,144.00	475,783.00	371,743.00	533,315.00
2000	**227,640.00**	**314,364.00**	**253,920.00**	**345,612.00**	**280,543.00**	**379,250.00**	**316,260.00**	**419,916.00**	**351,216.00**	**475,783.00**	**371,743.00**	**533,315.00**
2001	227,640.00	314,364.00	253,920.00	345,612.00	280,543.00	379,250.00	316,260.00	419,916.00	351,216.00	475,783.00	371,743.00	533,315.00
2002	227,640.00	314,364.00	253,920.00	345,612.00	280,543.00	379,250.00	316,260.00	419,916.00	351,216.00	603,675.00	497,299.00	676,672.00
2003	291,605.00	402,703.00	325,272.00	442,731.00	359,382.00	485,832.00	401,271.00	532,794.00	445,622.00	603,675.00	497,299.00	676,672.00
2004	291,605.00	402,703.00	325,272.00	442,731.00	359,382.00	485,832.00	401,271.00	532,794.00	445,622.00	603,675.00	497,299.00	676,672.00
2005	291,605.00	402,703.00	325,272.00	442,731.00	359,382.00	485,832.00	401,271.00	532,794.00	445,622.00	694,226.00	571,894.00	778,175.00
2006	335,348.00	463,108.00	374,063.00	509,141.00	413,289.00	558,707.00	461,462.00	612,713.00	512,465.00	2,875,791.00	2,875,791.00	12,000,000.00

4b: Real salaries of different categories of doctors in Naira currency (1983-2007)

cpi (1985)=100	Year	REntLdoctors	RTLdoctors	rd11ent	rd11term	REntMdoctors	RTMdoctors	rd13ent	rd13term	rd14ent	rd14term	REntTdoctors	RTTdoctors
67.9	1983	306.33	458.65	325.48	485.42	356.45	525.58	393.86	545.04	422.58	610.94	471.96	680.72
94.8	1884	219.41	328.50	233.12	347.68	255.31	376.45	282.10	390.38	302.67	437.58	338.04	487.56
100	1985	208.00	311.42	221.00	329.60	242.03	356.87	267.43	370.08	286.93	414.83	320.46	462.21
105.4	1986	197.34	295.46	209.68	312.71	229.63	338.59	253.73	351.12	272.23	393.58	304.04	438.53
116.1	1987	179.16	268.23	190.35	283.89	208.47	307.38	230.34	318.76	247.14	357.30	276.02	398.11
181.2	1988	114.79	171.87	121.96	181.90	133.57	196.95	147.59	204.24	158.35	228.93	176.85	255.08
272.7	1989	76.27	114.20	81.04	120.87	88.75	130.87	98.07	135.71	105.22	152.12	117.51	169.49
293.2	1990	70.94	106.21	75.38	112.41	82.55	121.72	91.21	126.22	97.86	141.48	109.30	157.64
330.9	1991	62.86	94.11	66.79	99.61	73.14	107.85	80.82	111.84	86.71	125.36	96.84	139.68
478.4	1992	43.48	65.10	46.20	68.90	50.59	74.60	55.90	77.36	59.98	86.71	66.99	96.62
751.9	1993	27.66	41.42	29.39	43.84	32.19	47.46	35.57	49.22	38.16	55.17	42.62	61.47
1180.7	1994	17.62	26.38	18.72	27.92	20.50	30.23	22.65	31.34	24.30	35.13	27.14	39.15
2040.4	1995	10.19	15.26	10.83	16.15	11.86	17.49	13.11	18.14	14.06	20.33	15.71	22.65
2638.1	1996	7.88	11.80	8.38	12.49	9.17	13.53	10.14	14.03	10.88	15.72	12.15	17.52
2863.3	1997	7.26	10.88	7.72	11.51	8.45	12.46	9.34	12.92	10.02	14.49	11.19	16.14
3149.2	1998	23.49	32.44	26.20	35.35	28.95	39.16	32.64	43.33	36.25	49.10	40.45	55.04
3357.6	1999	22.03	30.43	24.58	33.16	27.16	36.73	30.61	40.64	34.00	46.05	37.94	51.62
3923.8	2000	58.02	80.12	64.71	88.08	71.50	96.65	80.60	107.02	89.51	121.26	94.74	135.92
4268.1	2001	53.34	73.65	59.49	80.98	65.73	88.86	74.10	98.38	82.29	111.47	87.10	124.95
5151.5	2002	44.19	61.02	49.29	67.09	54.46	73.62	61.39	81.51	68.18	92.36	72.16	103.53
5493.3	2003	53.08	73.31	59.21	80.59	65.42	88.44	73.05	96.99	81.12	109.89	90.53	123.18
6318.4	2004	46.15	63.73	51.48	70.07	56.88	76.89	63.51	84.32	70.53	95.54	78.71	107.10
7446.4	2005	39.16	54.08	43.68	59.46	48.26	65.24	53.89	71.55	59.84	81.07	66.78	90.87
8059.6	2006	41.61	57.46	46.41	63.17	51.28	69.32	57.26	76.02	63.58	86.14	70.96	96.55

4c: Nominal salaries of different categories of nurses in Naira Currency (1983-2007)

	n8ent	n8term	n10ent	n10term	n12ent	n12term	n13ent	n13term	n14ent	n14term
1983	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1984	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1985	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1986	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1987	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1988	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1989	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1990	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1991	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1992	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1993	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1994	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1995	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1996	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1997	14576	26902	18843	31142	22268	35687	24690	37008	26135	41483
1998	43,428.00	63,084.00	60,264.00	86,004.00	70,848.00	102,168.00	79,212.00	112,332.00	87,612.00	123,332.00
1999	43,428.00	63,084.00	60,264.00	86,004.00	70,848.00	102,168.00	79,212.00	112,332.00	87,612.00	123,332.00
2000	**157,512.00**	**235,123.00**	**218,004.00**	**314,664.00**	**269,580.00**	**379,250.00**	**301,452.00**	**419,916.00**	**333,420.00**	**475,788.00**
2001	157,512.00	235,123.00	218,004.00	314,664.00	269,580.00	379,250.00	301,452.00	419,916.00	333,420.00	475,788.00
2002	157,512.00	235,123.00	218,004.00	314,664.00	269,580.00	379,250.00	301,452.00	419,916.00	333,420.00	475,788.00
2003	205,617.00	306,949.00	279,263.00	402,703.00	345,332.00	485,832.00	382,482.00	532,794.00	423,043.00	603,675.00
2004	205,617.00	306,949.00	279,263.00	402,703.00	345,332.00	485,832.00	382,482.00	532,794.00	423,043.00	603,675.00
2005	205,617.00	306,949.00	279,263.00	402,703.00	345,332.00	485,832.00	382,482.00	532,794.00	423,043.00	603,675.00
2006	236,459.55	352,991.35	321,152.45	463,108.45	397,131.80	558,707.00	439,854.30	612,713.00	486,499.45	694,226.00

4d: Real salaries for nurses in Naira currency 1983-2007)

Cpi (1985=100)	Year	REntLnurses	RTLnurses	rn10ent	rn10term	REntMnurses	RTMnurses	rn13ent	rn13term	REntTnurses	RTTnurses
67.9	1983	214.67	396.20	277.51	458.65	327.95	525.58	363.62	545.04	384.90	610.94
94.8	1984	153.76	283.78	198.77	328.50	234.89	376.45	260.44	390.38	275.69	437.58
100	1985	145.76	269.02	188.43	311.42	222.68	356.87	246.90	370.08	261.35	414.83
105.4	1986	138.29	255.24	178.78	295.46	211.27	338.59	234.25	351.12	247.96	393.58
116.1	1987	125.55	231.71	162.30	268.23	191.80	307.38	212.66	318.76	225.11	357.30
181.2	1988	80.44	148.47	103.99	171.87	122.89	196.95	136.26	204.24	144.23	228.93
272.7	1989	53.45	98.65	69.10	114.20	81.66	130.87	90.54	135.71	95.84	152.12
293.2	1990	49.71	91.75	64.27	106.21	75.95	121.72	84.21	126.22	89.14	141.48
330.9	1991	44.05	81.30	56.94	94.11	67.30	107.85	74.61	111.84	78.98	125.36
478.4	1992	30.47	56.23	39.39	65.10	46.55	74.60	51.61	77.36	54.63	86.71
751.9	1993	19.39	35.78	25.06	41.42	29.62	47.46	32.84	49.22	34.76	55.17
1180.7	1994	12.35	22.78	15.96	26.38	18.86	30.23	20.91	31.34	22.14	35.13
2040.4	1995	7.14	13.18	9.23	15.26	10.91	17.49	12.10	18.14	12.81	20.33
2638.1	1996	5.53	10.20	7.14	11.80	8.44	13.53	9.36	14.03	9.91	15.72
2863.3	1997	5.09	9.40	6.58	10.88	7.78	12.46	8.62	12.92	9.13	14.49
3149.2	1998	13.79	20.03	19.14	27.31	22.50	32.44	25.15	35.67	27.82	39.16
3357.6	1999	12.93	18.79	17.95	25.61	21.10	30.43	23.59	33.46	26.09	36.73
3923.8	2000	40.14	59.92	55.56	80.19	68.70	96.65	76.83	107.02	84.97	121.26
4268.1	2001	36.90	55.09	51.08	73.72	63.16	88.86	70.63	98.38	78.12	111.48
5151.5	2002	30.58	45.64	42.32	61.08	52.33	73.62	58.52	81.51	64.72	92.36
5493.3	2003	37.43	55.88	50.84	73.31	62.86	88.44	69.63	96.99	77.01	109.89
6318.4	2004	32.54	48.58	44.20	63.73	54.65	76.89	60.53	84.32	66.95	95.54
7446.4	2005	27.61	41.22	37.50	54.08	46.38	65.24	51.36	71.55	56.81	81.07
8059.6	2006	29.34	43.80	39.85	57.46	49.27	69.32	54.58	76.02	60.36	86.14

Appendix 4e: Trends in the distribution of bonuses (allowances and finge benefits) for doctors																		
Real basic salaries (Doctors)				Rent 60%	60%	75%	Transport 29%			Utility 20%			Furniture 40%			Meal 40%	60%	80%
year	Entryd	Midd	Endd	Entryd	Midd	Endd	Entryd	Midd	Endd	Entryd	Midd	Endd	Entryd	Midd	Endd	Entryd	Midd	Endd
2003	53.08	88.44	123.18	31.85	53.06	92.39	15.39	25.65	35.72	10.62	17.69	24.64	21.23	35.38	49.27	49.27	53.06	98.55
2004	46.15	76.89	107.10	27.69	46.13	80.32	13.38	22.30	31.06	9.23	15.38	21.42	18.46	30.76	42.84	42.84	46.13	85.68
2005	39.16	65.24	90.87	23.50	39.15	68.15	11.36	18.92	26.35	7.83	13.05	18.17	15.66	26.10	36.35	36.35	39.15	72.70
2006	41.61	69.32	96.55	24.97	41.59	72.41	12.07	20.10	28.00	8.32	13.86	19.31	16.64	27.73	38.62	38.62	41.59	77.24

Call Duty all 4%			Total allowance			Basic salary and Allowances			% All to Total			Ratio of All to Basic		
Entryd	Midd	Endd	Entryd	Midd	Endd	EntryDBB	MidDBB	EndDBB	%allTEntryD	%allTMidD	%allTEndD	Entryd	Midd	Endd
84.93	141.51	197.09	213.30	326.35	497.65	266.39	414.79	620.83	80.07	78.68	80.16	4.02	3.69	4.04
73.84	123.03	171.35	185.45	283.73	432.67	231.60	360.62	539.76	80.07	78.68	80.16	4.02	3.69	4.04
62.66	104.39	145.40	157.35	240.75	367.12	196.52	305.99	458.00	80.07	78.68	80.16	4.02	3.69	4.04
66.57	110.92	154.48	167.19	255.80	390.07	208.80	325.12	486.62	80.07	78.68	80.16	4.02	3.69	4.04

Appendix 4f: Trends in the distribution of bonuses (allowances and fringe benefits) for nurses																		
Real basic salaries Nurses				Rent 60%	60%	75%	Transport 29%			Utility 20%			Furniture 40%			Meal 40%	60%	80%
	EntryN	MidN	EndN	EntryN	MidN	EndN	EntryN	MidN	EndN	EntryN	MidN	EndN	EntryN	MidN	EndN	EntryN	MidN	EndN
2003	37.43	73.31	109.89	22.46	43.98	82.42	10.85	21.26	31.87	7.49	14.66	21.98	14.97	29.32	43.96	43.96	43.98	87.91
2004	32.54	63.73	95.54	19.53	38.24	71.66	9.44	18.48	27.71	6.51	12.75	19.11	13.02	25.49	38.22	38.22	38.24	76.43
2005	27.61	54.08	81.07	16.57	32.45	60.80	8.01	15.68	23.51	5.52	10.82	16.21	11.05	21.63	32.43	32.43	32.45	64.86
2006	29.34	57.46	86.14	17.60	34.48	64.60	8.51	16.66	24.98	5.87	11.49	17.23	11.74	22.98	34.45	34.45	34.48	68.91

Shift Duty all 1.7%			Total All			Basic salary and allowances			% All to Total			Ratio of All to Basic			Ratio of Doc all to Nur		
EntryN	MidN	EndN	EntryN	MidN	EndN	EntryNBB	MidNBB	EndNBB	%allTEntryN	%allTMidN	%allTEndN	EntryN	MidN	EndN	EntryN	MidN	EndN
25.45	49.85	74.73	125.18	203.06	342.87	162.61	276.37	452.76	76.98	73.47	75.73	3.34	2.77	3.12	1.70	1.61	1.45
22.13	43.34	64.97	108.83	176.55	298.09	141.38	240.28	393.63	76.98	73.47	75.73	3.34	2.77	3.12	1.70	1.61	1.45
18.78	36.77	55.13	92.35	149.80	252.94	119.96	203.88	334.01	76.98	73.47	75.73	3.34	2.77	3.12	1.70	1.61	1.45
19.95	39.07	58.57	98.12	159.17	268.75	127.46	216.63	354.88	76.98	73.47	75.73	3.34	2.77	3.12	1.70	1.61	1.45

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