

# IS IT (NOT) HIGH TIME TO INTRODUCE PERFORMANCE-BASED PAY IN UGANDA'S HEALTH SYSTEM?

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## **Introduction**

There are frequent reports of people crying foul about the poor quality of the care they receive in Uganda's health system. Several newspapers have recently serialized documentaries on the poor state of hospitals in the country. In many high-level fora of the Ministry of Health (MOH), policy-makers lament about the quality of care. Politically charged statements are made about the attitudes of health workers to the patients, especially in the labour wards. Low deliveries in health facilities have been blamed squarely on the attitudes of midwives. However, there is more than meets the eye. Defendants argue that health workers are over-worked, ill-equipped and too poorly paid to be motivated to provide good quality care. The three problems mentioned above arise from insufficient funding for the health sector. Therefore, they imply that if the health sector had sufficient funding, then the problem of poor quality of care would be addressed almost entirely. After all, nobody has accused the health workers of not knowing what to do. The complaints rotate about not wanting to do what they know (attitudes) and not having what to use (funding). For now, let us also assume that the staff is sufficiently knowledgeable about the process of care to provide good quality care, and that the two above are the only constraints – a very big assumption indeed. Some countries, and indeed even the private sector in Uganda, have attempted to address the two problems above by using one strategy – performance-based pay.

## **Incentives: The principle of performance-based payment**

Performance-based pay, the principle of which is that individuals, organisations and systems perform better when they perceive direct benefit to themselves, and that their performance varies directly proportionately with the benefits, comes under different brand names. Performance-based financing (PBF), payment by results (PbR) and pay-for-performance (P4P) are just some of the common brand names. The argument underlying P4P or whichever brand name the reader may prefer, is that individuals, systems and organisations are not motivated to work harder if they know that harder work will not bring them extra benefit

(remuneration, promotion or professional satisfaction in the case of individuals). There is therefore no incentive for harder work. On the contrary, if there is known or perceived direct benefit for harder work or punishment for poorer work, they will strive to work harder.

Under the current public service arrangement in Uganda, the three forms of incentive (remuneration, promotion or professional satisfaction) that would motivate health workers are severely curtailed. Regarding remuneration, the salary budget is small and fixed at low levels. Moreover, the salaries of health workers are fixed in comparison to other civil servants. In any case, once a health worker is on the payroll, their salary will come at the end of the month, come rain or shine, whether they work or not, whether they work harder or less than expected. And those who work harder will get the same as those who work little or not at all. Therefore, there is no incentive to work harder and no punishment for little or no work. Regarding promotion, again due to a limited budget, desk promotions (automatic, based on experience and duration of service) have been abolished. Promotions are only considered if a post in the higher establishment falls vacant. Moreover, corruption in the promotion process ensures that it is not the most technically qualified that will get the job. The performance appraisal process is in shambles. It is a useless routine which neither the appraisers nor the appraisees trust, and which the supervisors rarely consider during assessment for promotion. Therefore, no health worker is motivated to work harder in the hope of promotion, because none has been promoted due to hard work in the last very many years. Regarding professional satisfaction, this is a qualitative aspect of the health workers' life that the system is currently not capable of capturing. The system is currently so remote from their staff that it would never know their level of professional satisfaction. There are no formal employer-based structures through which the government would ever know the true satisfaction of the health workers. Professional associations e.g. the Uganda Medical Association through which the professionals would have expressed their satisfaction or otherwise, have gone on

a long vacation. In any case, there is no evidence that the system had ever given them an ear.

### **Effects of and questions about performance-based payment**

The use of P4P has been touted as one approach that could revive health workers' interest in their work at least for one of the three incentives mentioned above. Where it has been applied, e.g. the US, UK, and Rwanda, it is reported to improve health worker performance. The health workers directly see something in it for themselves (a common concern in Uganda) and are incentivised to work hard, to pay attention to the details of their work and to pay attention to their clients (Petersen et al., 2006; Rusa and ; Miraldo et al., 2006, Soeters et al., 2006; and Meessen et al., 2007). Preparations are currently also currently underway to start the approach in Burundi (Soeters, 2007). P4P may also be used to incentivise entire organisations e.g. hospitals, sub-sectors e.g. the private-not-for-profit (PNFP) providers etc (Loevinsohn, 2008). In some countries, it has been used to introduce competition among different providers, in order to improve quality. The theory of this approach lies in these questions: "Who follows who? Does the money follow the patient, or the patient follows the money?" In other words, those whose quality is appreciable will receive more patients and thus more money, unlike in the current system in Uganda where clients are obliged to go to specific facilities which have been allocated fixed funding in advance.

Various questions arise before implementation of P4P. Is P4P desirable in Uganda today? Is it feasible today? What would be the stakeholders' views about it? Does Uganda's health system have the will and capability to implement a P4P system? Is the Ugandan health system capable of managing the attendant implications e.g. strong governance, increased costs, prompt payment, quality assessment and monitoring etc? This editorial will not attempt to answer these questions for now but leaves them open for research and debate. It is aware that such debate has featured briefly in the second Health Sector Strategic Plan (HSSP II) but not much has been done about it since. It is the view of this paper that the time is ripe for P4P in Uganda, and that dissenting views should be brought on board progressively, by a carefully designed educational plan especially for health managers at different levels of the health system.

### **Suggested further reading**

Bodenheimer T, May JH, Berenson RA and Coughlan J, 2005: Can money buy quality? Physician response to pay for performance. Issue Brief No. 102, Center for Studying Health System Change.

De Brantes F, 2007: Lessons learned from a national pay for performance program. Available from [www.HCT.com](http://www.HCT.com) (accessed 27<sup>th</sup> December 2008)

Dudley AR and Rosenthal MB, 2006: Pay for performance : A guide for purchasers. Final contract report. AHRQ publication No. 06-0047. Agency for Healthcare Research and Quality. USA.

Gravelle H, Sutton M and Ma A, 2007: Doctor behaviour under a pay for performance contract: Evidence from the Quality and Outcomes Framework. CHE Research Paper 28, Centre for Health Economics, University of York, UK

Loevinsohn B, 2008: Performance-based contracting for health services in developing countries: A toolkit. The World Bank Institute, The World Bank. Washington DC.

Meessen B, Kashala JPI and Musango L, 2007: Output-based performance to boost staff productivity in public health centres: Contracting in Kabutare District, Rwanda. *Bulletin of the World Health Organisation* 2007;85:108-115

Miraldo M, Goddard M and Smith PC, 2006: Incentive effects of payment by results. CHE Research Paper 19, Centre for Health Economics, University of York, UK

Petersen LA, Woodard LD, Urech T, Daw C and Sookanan S, 2006: Does pay-for-performance improve the quality of health care? *Ann Intern Med* 2006; 145:265-272

Roberts MJ, Hsiao WC, Berman P and Reich MR, 2004: *Getting Health Reform Right: A Guide to Improving Performance and Equity*. Oxford, New York

Rusa L and Fritsche G, 2007: Rwanda: Performance-based financing in health. In *Emerging good practice in management for development results: Sourcebook*. 2<sup>nd</sup> Ed.

Soeters R, 2007: Enquête ménage de base, enquête qualité des structures de santé, analyse des constats, pour le programme Achat de Performance 2006-2007. Cordaid, Les Hayes et Bujumbura

Soeters R, Habineza C and Peerenboom PB, 2006: Performance-based financing and changing the district health system: Experience from Rwanda. *Bulletin of the World Health Organisation* 2006;84:884-889

Stapledon GP, The pay for performance dilemma Available on [www.pay-without-performance.com/Stapledon-Pay-for-Performance-Dilemma%20.pdf](http://www.pay-without-performance.com/Stapledon-Pay-for-Performance-Dilemma%20.pdf) (accessed 29<sup>th</sup> December 2008)