WHO/EDUC/93.201
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Training manual on management of human resources for health

SECTION I

Conceptual Basis
Additional reading – Annexes
Exercises

PART A

WORLD HEALTH ORGANIZATION
GENEVA

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PART A

Introduction
Objectives
Managing organizations
Leadership
Motivation

WORLD HEALTH ORGANIZATION
GENEVA

INTRODUCTION

BACKGROUND TO THE MANUAL

The implications of the implementation of the Global Strategy for Health for All by the Year 2000 for the health workforce were discussed in broad outline by the WHO Expert Committee on Health Manpower Requirements for the Achievement of Health for All by the Year 2000 through Primary Health Care (1983). The Committee drew attention to the lesser importance accorded to the management subsystem of the human resources development process as compared with the production and planning aspects. Predicting that human resource policies and plans will have little impact without an adequate management infrastructure to implement them, it recommended that the Member States, in collaboration with WHO, improve the effectiveness of their health personnel management systems.

It was in this context that WHO organized the First Interregional Consultation on Strengthening Health Manpower Management (1983). Participants recommended that a comprehensive Training Manual on Human Resources Management be developed since this would provide an effective and necessary training tool: the idea was reinforced at the Second Interregional Consultation on Strengthening Health Manpower Management in 1985. A series of eight training modules were produced and subsequently field-tested in workshops in 1986 (Jakarta), 1989 (Sydney), 1990 (Hyderabad) and 1992 (Kathmandu).

Based on the evaluation by potential users who attended the workshops, it was decided to revise the modules in order to increase their relevance to training needs of mid-level managers.

PRESENTATION OF MATERIALS

The learning materials are now presented in three parts:

- Section I (Parts A & B) presents the Conceptual Basis with annexes containing additional reading, followed by exercises;

- Section II is a guide for facilitators on their role during the workshop and contains session outlines, including overheads for use as discussion triggers.

It is important to note that individual facilitators are encouraged to use additional materials (case studies, exercises, overheads, etc.) that may be of specific relevance to the participants and/or situation. An evaluation form is appended to Section I (Part B).

A GLOSSARY OF COMMON TERMS USED IN MANAGEMENT TRAINING [1]

The simplified definitions that follow are intended solely for use with this manual and are not necessarily valid for other purposes.

Activities — A group of tasks with a common purpose.

Accountability — The results or outcome generated by the performance of tasks and responsibilities, and for which a person in office is answerable to other persons within the organization. A person in an office is usually answerable to a superior from whom she/he has received an assignment or appointment and from whom she/he has accepted delegated responsibilities.

Approach — A means or method of attaining an objective.

Authority — The right to make decisions and enforce them when necessary.

Baseline year — The first year in which information was collected and analyzed before the beginning of a project or programme.

Budget — A detailed estimate of the cost of a programme during a specific period.

Checklist — A list of items or descriptions of actions to be looked at, one at a time, to ensure that no item or action is overlooked.

Compatibility — The nature and extent to which a system is geared to a particular environment and the extent to which each part is relevant to the other parts or the whole system. This could be called compatibility within and without the system.

Communication — The transmission of meaning from one individual or group, by any means, to another individual or group.

Components — The parts of a system.

Concept — Plan or idea taking shape in the mind.

Constraint — Limitation or obstacle.

Control — Systematically following the activities and results of a programme to make sure it is achieving its intended results and meeting the agreed upon objectives.

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[1] Developed by the Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand and reproduced with their kind permission

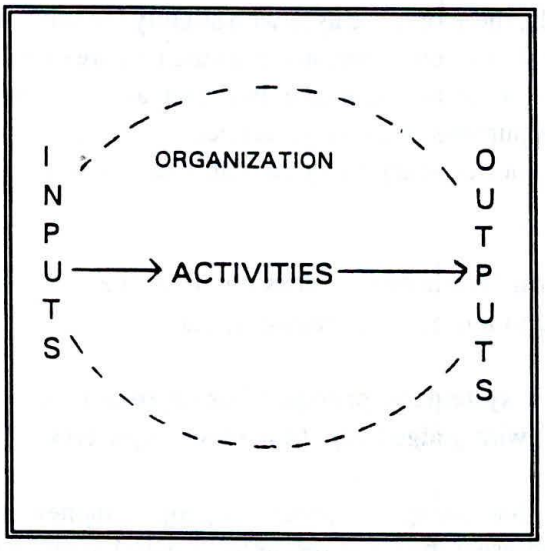
Coordinate	To relate different activities within the same or related programmes in such ways that the common goal(s) is/are efficiently achieved.
Criterion (plural criteria)	A guide or standard against which something is measured or judged, or which is used as a basis for making a decision.
Data	Facts and/or numerical information presented in a systematic manner suitable for communication, interpretation, or processing.
Data base (bank)	A collection of structured data.
Decision	A choice made between two or more alternatives.
Decision-making chart	A chart showing different possibilities for action, intended to assist the making of decisions.
Delegation of authority	The action of a person in entrusting authority to another person for a specific purpose.
Development	The economic growth of a society together with social improvements (for example, in health, education and housing).
Discrepancy	A difference between what is expected and what is found.
Dysfunctions	The negative indicators of a problem situation: the visible and observable manifestations of a problem.
Educational objective (Learning objective)	What the learner should be able to do at the end of a period of instruction that he/she could not do before.
Effective	The degree to which a stated objective is being achieved/the degree to which a stated strategy is succeeding in meeting objectives.
Efficient	The balanced use of resources (human, financial and material).
Element	A component/part of a larger activity.
Enabling objectives	These are the objectives which describe the concrete steps or means to be taken in order to achieve an expected level of performance.
Evaluation	A measurement or assessment of the results of a programme or activity.
Facilities	The buildings and materials available for a programme or activity.
Facilitator	In this context a facilitator assists and motivates a group of people with the process of learning.
Factor	Any object, activity, or issue likely to influence an outcome or result.

Feedback	Information from an activity or action that has taken place and which is used to either change or maintain the course of an activity or action.
Focal system	The system of prime concern or interest. As identified, it is the system which is made the focus of an organization.
Form	A document on which information of a certain type is to be inserted in a definite arrangement.
Formative Evaluation	This is a type of evaluation which is also called monitoring. It examines the performance of functions and the process of implementing a plan of action while the project is in progress.
Functions	The general areas of performance required by a specific office or role. Functions comprise the responsibilities pertinent to the office and the tasks to be done in order to fulfill these responsibilities.
Functional activities	Tasks (e.g. management, planning, coordinating) to be performed.
Functional chart	A chart/diagram showing the different functions of members of a team/unit.
Goal	The intended result or achievement of a programme or activity.
Guidelines	A systematic set of steps providing a plan for proceeding with a plan or activity.
Health centre	The base for a health team from where health services are provided to individuals and communities.
Health indicator	An indirect measure (usually a rate or ratio) of the level of community health (for example, an infant mortality rate of 90/1000 indicates a low level of community health; a fall in the neonatal tetanus rate from 40/1000 to 10/1000 indicates indirectly an improvement in community health).
Health planning	The process of defining community health problems, identifying needs and resources, establishing priority goals and setting out the administrative action needed to reach those goals.
Health policies	General plan of action adopted at central, regional or district levels. This plan provides the general objectives and framework for activity in both promotive and preventive health care.
Health status or level of health	The degree to which the health of a specified population meets accepted criteria.

1.2 THE ORGANIZATION AND ITS ENVIRONMENT

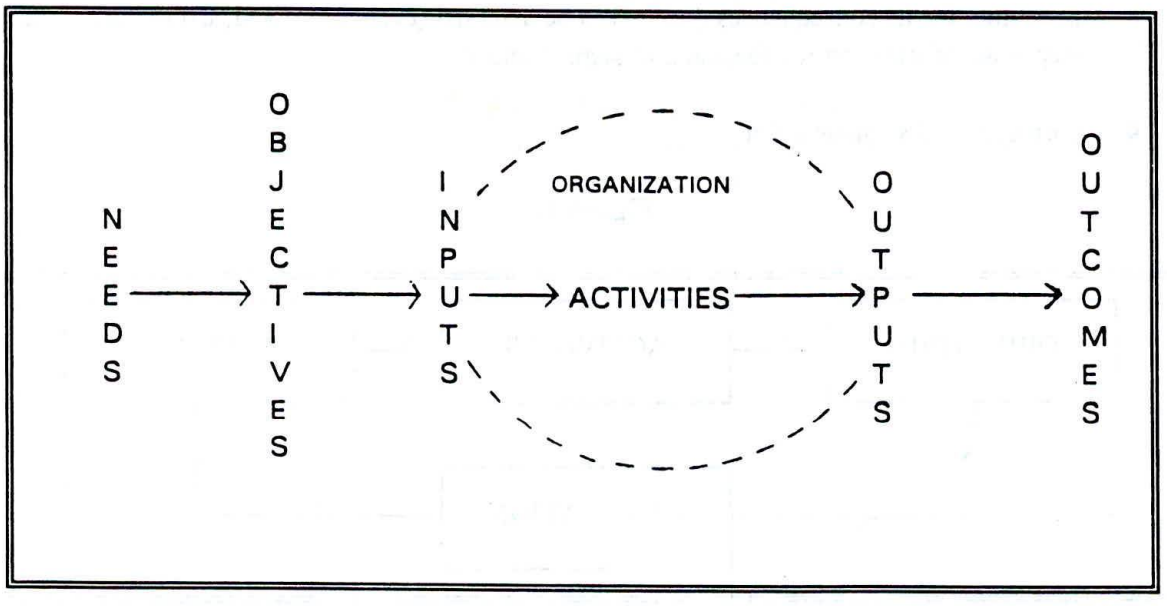
An organization exists to perform work. This is achieved by activities which transform (convert process) inputs into outputs:

Figure 2.



The organization can be of any size: a health centre, a district health service, a hospital, a department within a hospital, a provincial headquarters, a malaria control programme, a Ministry of Health.

Figure 3.



The ***inputs*** of most organizations include resources of money, materials and staff (with their skills, aspirations and attitudes) and in health organizations they include also communities, patients and quite often student health workers or trainees. The ***activities*** can be of various kinds according to the technical purpose of the organization: in a factory they might be manufacturing, packaging, marketing etc; in a health organization they might be health education programmes, family planning advice, disease prevention measures, diagnosis, treatment, nursing care, rehabilitation etc. In all kinds of organizations there will also be managerial activities such as supervision, co-ordination, financial control, communications etc. All such activities transform the inputs into the ***outputs*** of the organization: for the factory these are likely to include finished products for sale; in the health organization they might include family planning acceptances, immunized children, health centre patients seen, laboratory reports made, patients discharged (or died) and student health workers completed training. Most of these outputs are quantifiable (can be counted) and often form the substance of statistical reports on the organization's functioning.

The interdependence between any organization and its environment is an essential characteristic, but especially important for a health organization. The influences are numerous and often changing in their character and strength, but can be grouped under such headings as:

- ***demography and morbidity*** - the changing age structure and pattern of illness in a community will obviously influence the organization's work in response to needs and objectives. For example an ageing population increases the need for dealing with more problems of handicap and immobility, and the spread of AIDS requires substantial changes in the health education and screening programmes, blood donations and the care of relatively young dying patients.

- ***economics and finance*** - the changing availability of resources clearly has a strong influence over what is allocated to the health system as a whole, and to the organization within it. In general, Primary Health Care needs more resources to become universally accessible to everyone, but sometimes financial restrictions force the reduction of certain activities and services.

- ***social and cultural*** - the rising expectations of the populations often put pressure on health organizations to satisfy new demands, whilst cultural differences often lead communities to reject certain services (such as family planning) or demand others (such as medication by injection).

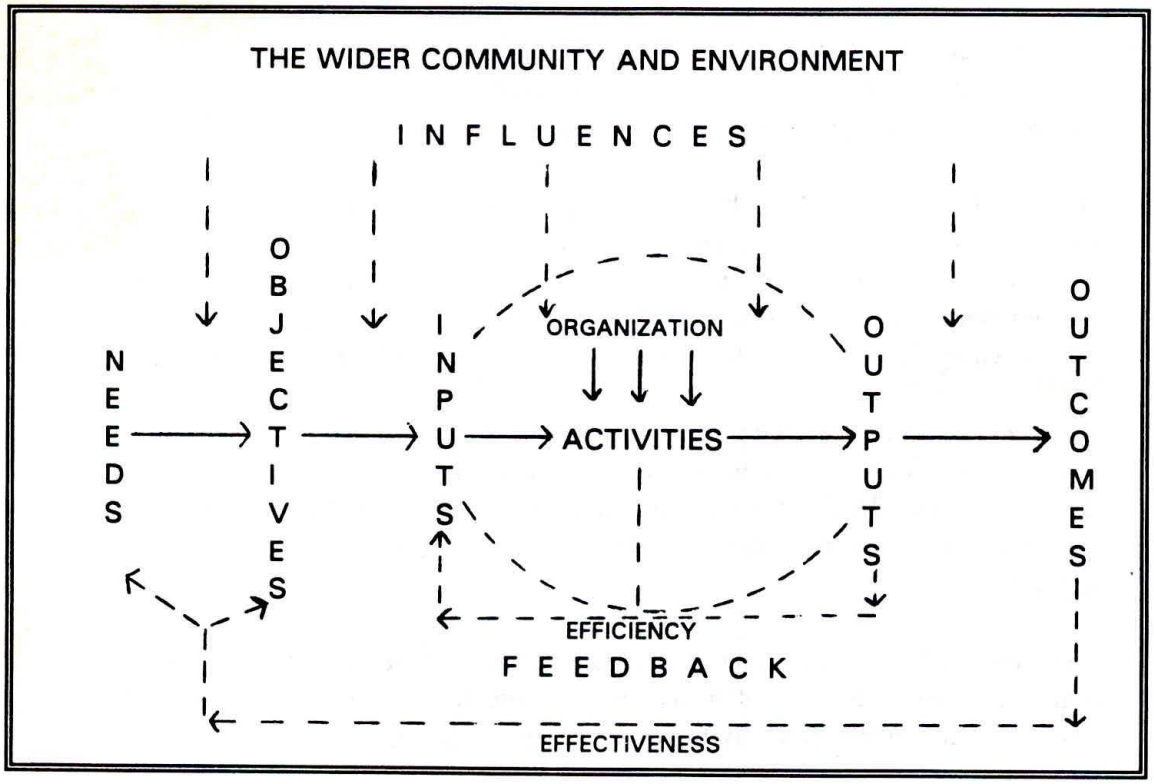
- ***legislation and political*** - these influences are apparent in changes in what the law allows or requires (as in legislation affecting the rights of employees against unfair dismissal); or in political pressures, for example to favour certain areas of population for special attention, or certain individuals for employment or promotion, not necessarily meeting the community's priority needs or the organization's efficient functioning.

- ***technological and professional*** - these influences affect the system by making more things possible (such as new medical treatments and drug therapies, better communications and data processing) which were not previously achievable, but requiring changes in the management and financing of care. In addition, the attitudes and actions of health workers within the organization are influenced by the priority concerns, technical and ethical standards of the wider professions and occupational groups/associations to which they belong.

The previous examples underline the many ways in which the organization's functioning in its system is influenced by considerations and pressures from the wider community and its demographic, economic, social, political, technological and professional environment; as well as from the internal policies of the organization itself. Successful management in this context requires knowledge of what is happening and changing in that environment, and the ability to plan the organization's services and improve its response to the needs of the community, which may need to be more fully involved in making decisions about its own health care.

Good management also involves ***evaluation*** of how the organization is working and affecting that community, as pictured in the next stage of the model:

Figure 4.



This illustrates the "feedback" role of evaluation, already mentioned - comparing effects with objectives - by finding out what is happening compared with what is intended or needed to happen, and using that information to take corrective action, where necessary and feasible, in the way the organization functions.

This evaluation is of two broad types:

1. the assessment of ***efficiency***, by examining the quantity, quality, cost and speed of the outputs by comparison with the inputs and activities which have produced them. Whatever the organization is doing within itself, how efficiently (accurately, speedily, cheaply) do these activities produce the required outputs?

   For example, how much of their time do trained nurses spend in giving direct patient care? Are medical supplies being purchased at the lowest possible price for the specified quality? How often are supervisory visits prevented by vehicle breakdowns or fuel shortages? ***These are efficiency questions.***

2. The assessment of ***effectiveness***, which raises deeper questions by comparing the outcomes of organizational functioning with the underlying needs and objectives, rather than comparing outputs with inputs and activities.

   The question is not how efficiently is the organization producing its outputs, but what impact is that work having on the community's welfare? Is that work, however efficiently performed, in fact what the organization **should** be doing ? (A health organization may be efficiently performing the most advanced surgical techniques on a few patients whilst in the surrounding community thousands die from easily prevented or curable diseases.) ***These are effectiveness questions.***

1.3 GENERAL PURPOSES OF MANAGEMENT

Management is a systematic process of using resources, with judgement, to achieve objectives. Three models summarizing theories of management are found in Table 1 (page 6). Because that work is done in an organization, the general purposes of management naturally reflect the same shape, direction and movements as the organization within which it functions and can be classified into four principal types, each with its typical management functions. These four types of management are not mutually exclusive and one can often find, within the same organization, all or a combination of these types of management.

A. ***Maintenance Management:*** to provide continuity for the organization; to keep it moving in the direction of its intended outputs and outcomes, in spite of all the problems, crises and interruptions which often distract the attention of management from its task of maintaining forward movement. Its characteristic skills include problem-solving and decision-making, managing time and priorities, managing staff, finance and materials.

B. ***Integrative Management:*** to secure the coordination of effort that brings together the organization's resources for moving forward. This is closely related to **Maintenance Management** and represents the need to mobilize and combine the capacities of people, material resources, information and ideas (from within and outside the organization itself) as a pre-condition for collective movement in the right direction. Typical skills include leadership and motivation, communications, interpersonal relations and team-building.

C. ***Evaluative Management:*** for taking corrective action in the light of information (feedback) on the organization's actual functioning. This managerial purpose is entirely devoted to evaluation in relation to health management development. Its most frequently required skills include work analysis, objective and standard setting, information and data analysis, monitoring individual and organizational performance, auditing and judging.

D. ***Adaptive Management:*** for achieving change in the organization's functioning or direction. The capacity to adapt to necessary changes arising from outside and inside the organization is essential if it is to give its best service to the community. This type of management takes the form of modifying some of the directions in which the organization is moving, and even stopping certain on-going activities that are of lower priority than some new development that needs to be started. This adaptation is undertaken in the light of the evidence by **Evaluative Management**, the two being closely related. Its usual skills include analyzing the environment, forecasting and planning, creative thinking, innovating and implementing change.

- a steady growth in membership of trade unions or professional staff associations wishing to negotiate with employers for the protection and improvement of their members' conditions of employment, accompanied sometimes by threats of disruptive action or withdrawal of labour.

- new employment legislation regulating the relationship between employers and their staff, particularly in the field of disciplinary action and discrimination, chiefly in the direction of restricting employers' freedom of action.

- a more frequent recognition of the value of teamwork and group assignments involving people from different departments and levels in an organization.

- a tendency, difficult to turn from theory into practice, towards decentralizing and delegating more responsibilities (including HRM responsibilities) to local managers who are closer to the problems requiring decision.

- generally an increased expectation on the part of employees for some influence on management decisions that will affect them, responded to by a more open, consultative style of management and leadership.

Priority Problems

Since the management of human resources is an integral part of general health services management, managerial issues differ significantly from country to country according to the nature of the health care system. However, an analysis of the issues in different countries indicates that, overall, the main problems are maldistribution of personnel, shortages or surpluses in one or more categories, poor utilization or low productivity, unsatisfactory career structures and promotion systems, ineffective continuing education and supervision, and poor living and working conditions.

The problems of highest priority may be grouped as follows:

Wastage of human resources may begin at the production stage. A combination of generous admission policies and stringent educational processes can lead to high drop-out rates in medical, nursing and other educational programmes. In some countries, production of health personnel results in under- or unemployment while in others, the public sector loses a large proportion of its health workers to the private sector, often to occupations totally unrelated to health, because of better pay, career prospects, and living and working conditions. On a global scale, such differences are a spur to emigration and many developing countries already short of health personnel have thus lost highly trained staff to the richer countries.

Ineffective use of personnel may result from poor planning of human resources, defective organizational design, unsuitable personnel deployment policies and practices, or political interference in administration. It may be manifested as maldistribution - as an imbalance between rural and urban areas, for instance, or between hospital care and primary health care. Alternatively, it may show up in the use of highly skilled personnel for tasks that require less sophisticated or different skills (e.g., pharmacists used as typists, doctors as nurses, nurses as auxiliaries, medical specialists as general practitioners). A manager's time may be wasted in handling requests for staff transfers, owing to lack of a transfer policy or interference by politicians, or in resolving conflict between staff stemming from role ambiguity, pay differences, conflicting instructions from higher levels of management, or vagueness about the chain of command.

Low motivation is a crucial issue, since motivation is the core of management. The theories of motivation, though evolved essentially to explain the differences in performance of personnel in business, are equally applicable in the health sector. Traditionally, the practitioners of such health professions as medicine and nursing have been motivated by their inner sense of professional commitment. In today's materialistic world, such commitment has become rather rare. Motivation must therefore be sought elsewhere. Research evidence pinpoints certain factors as "dissatisfiers" (conditions that lead to poor performance or even sabotage) and others as "satisfiers" (conditions that prompt high performance). The "dissatisfiers" include, *inter alia*, low salaries, poor working and living conditions, lack of continuing education, and non-responsive higher management. Among the "satisfiers" are participative decision-making, recognition of personal responsibility, and adequate opportunities for professional growth and career development (see section I.3 - Motivation).

Low productivity is often not recognized as a problem in developing countries because the productivity of the health workforce is rarely measured. In developed countries, however, where there is greater scrutiny because of mounting health care costs, low productivity causes more concern. Low productivity may result from ineffective use of personnel, incorrect working methods, failure to delegate authority, low motivation, deficient managerial or supervisory support, bottle-necks in the support services, inadequate skills, and low morale stemming from a low opinion of the health services among the people served.

A dichotomy between the private sector and the public sector is a major problem. With the rapid growth of the public health sector, many countries are finding it progressively more difficult to finance free health coverage. At the same time, a number of countries are training more health professionals than their government services can absorb. These two factors account for an expanding private health sector concentrated in urban areas and oriented to curative care, a trend magnified by the profit motive, which generates a high demand for laboratory and other support services. This continuing growth of the private sector, side by side with an underfinanced public sector, poses acute problems of management. The private sector, for instance, offers a type of care that is often more attractive to the public than that provided by the public sector. As the wealthier, more influential people take advantage of the private sector services, the quality of care in public sector institutions, used largely by the less affluent and the poor, falls off progressively since the people they serve are no longer a vocal and powerful constituency. This very often leads to the public sector being unfavourably compared with the private sector with respect to quality of care and efficiency in the use of resources.

Typical, more specific, problems in the management of personnel might include:

- absence of a clear view by managers of the purpose and future of the organization;
- uncertainty among staff as to how their work contributes to the organization's objectives;
- lack of team work;
- inadequate arrangements for maintaining the necessary numbers and types of staff within available funds;
- absence of a clear policy in the organization for the training and development of its staff;
- no systematic way of identifying the needs of staff for further training in the light of the organization's plans and problems;

MANAGING ORGANIZATIONS

INTRODUCTION

All organizations, and particularly health care organizations, are affected by many forces from both within and outside. Internal forces could be the creation of a new building or a department, the addition of new staff, or budget cuts. External forces could be the changing demands that patients and others are placing upon hospitals and health care systems. There is always a constant interaction between the organization and these forces. Unless management respond to these forces, the organization might move towards a crisis where it no longer can cope with the demands being placed upon it.

Organizational change may be generally defined as:

the process of planned transition from a present unsatisfactory situation in the organization towards an improved future.

For that kind of change-making contribution at the organizational level, where successful change is complex and challenging because many systems and people are involved, the health manager must understand the concepts and acquire the skills of organizational change.

APPROACHES TO CHANGE

It is valuable to have a clear approach to organization change, particularly in complex health care organizations. This note proposes two approaches. The first called "Now - Then" is more useful for relatively straightforward change: the second, "Open System Planning", is appropriate when the change is more complex. For example, it could be used when organizational units are being reviewed for their effectiveness; or when some external force is inevitably going to create changes within a unit.

The "Now - Then" Approach

This is a two-stage approach. It often begins when a manager has a vision or picture of a future for the department or organizational unit. The first step is to describe what this vision means in terms of policies, resources, attitudes, skills and practices. The result should be a comprehensive picture of the future; in other words an ***ideal scenario***.

The second step is to discover what is happening now. This often requires careful investigation and analysis. Do not assume that what is supposed to happen, does happen. As time passes many small changes may have been made and about which management could be unaware.

The third step is a comparison of "Then" with "Now". This will demonstrate what needs changing.

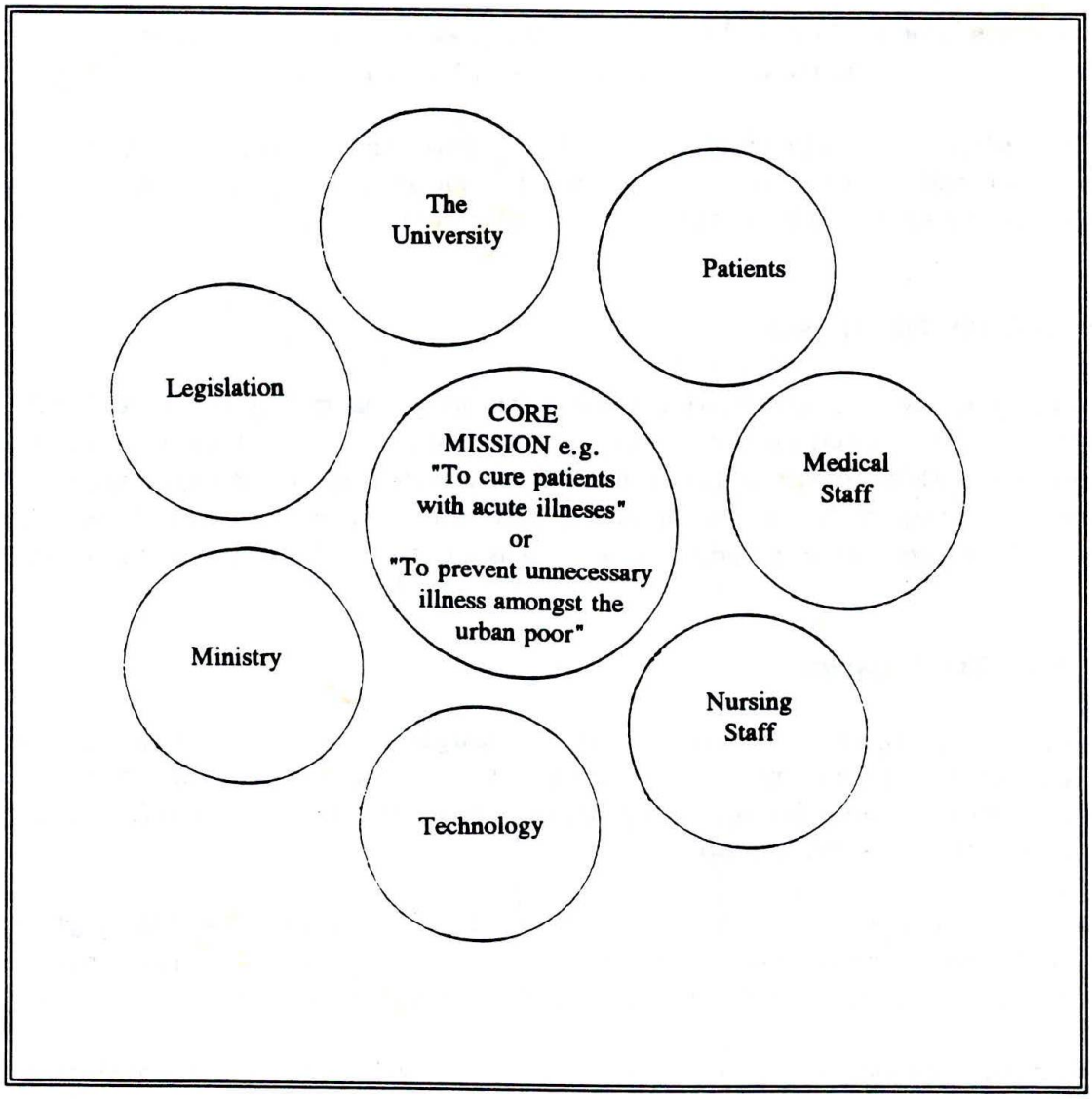
The Open System Planning

This approach takes into account the "core mission" of the organization, and the demands made on it by its environment. An organization has a core mission (its reason for existence) and receives inputs which are translated in some way to become outputs. But the organization exists within an environment that impacts upon it. The environment both makes demands upon the organization as well as responding to it.

The core mission: Identifying the "core mission" of an organization is a bit like trying to answer the question "What business are we in?" It is the reason why the organization exists. The core mission is decided upon by top management. There needs to be agreement to the decision as well, otherwise activities may well diverge from the mainstream purpose.

Demands by the environment: If you were to think of the organization's core mission as being at the centre of a number of pressures or demands being made upon it, you could, perhaps, visualize a "map" of a configuration, shown in Figure 1.

Figure 1



Having drawn up the map identifying the key "domains" that surround the mission, the next step is to make explicit what demand or demands each domain will make on the organization and its mission. It is sometimes easier to do this if the domains are "personalized" so that the demand can be phrased in terms of what it might be saying. For example, in the above illustrations the "Patients" domain might be demanding as follows:

"I demand that I do not have to wait longer than four weeks for admission".

or

"We the urban poor demand to be protected against preventable diseases".

Then the typical response to this demand should be identified and written down.

The sum of these demands and responses provides the basis for writing the ***present scenario;*** that is the environmental context in which the change is to take place. The ***doom scenario*** extrapolates these demands and responses into the future and anticipates what might happen unless change is brought about, particularly if the demands change and become more stringent. Such a doom scenario should create a level of dissatisfaction. It could be summarized as being "The Projected Future - What our world will look like if we don't do something about it". Dissatisfaction of the present is stressed to make even more attractive the vision of the future.

Just as the doom scenario is aimed at increasing the dissatisfaction, the ***ideal scenario*** is aimed at providing the vision. It describes what the ideal responses should be to the demands. It should include the responses to potential changes demanded in the organization. To achieve them, changes will be necessary in terms of people's knowledge, attitudes, skills, methods of working, organizational systems, style, technology and resources. One must make sure that the vision or model of the future is comprehensive, covering both **what** needs to be done and **how** it is to be done.

MANAGING THE CHANGE

The transition state is the same as passing from "Now" to "Then" or from the "present scenario" to the "ideal scenario".

The Organizational Framework

Organizations are a set of complex relationships, with many of them dependant on others. If you change one part of the organization, this is likely to have an effect on many other parts. The 7 "S" framework is a good way of tracing through the effects of change in one part on other parts.

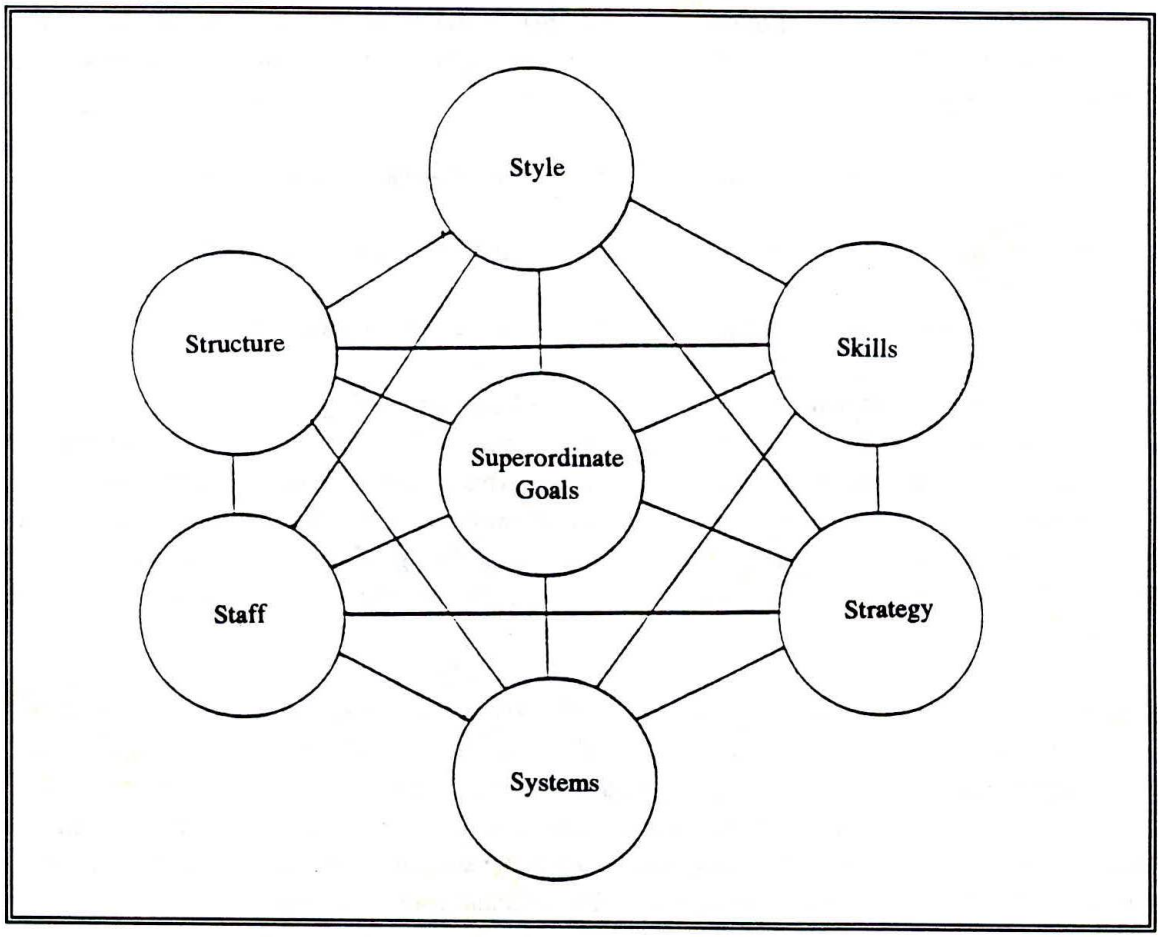
The framework was developed by Waterman, Peters and Phillips (1980), and is illustrated on page 4.

The 7"S" Framework

Change can be externally driven forces impacting upon the organization. For example, a shortage of skills may require changes in systems of work and style of supervision.

Change can also be internally generated when, for example, new information systems are to be implemented throughout the organization.

Figure 2. The 7"S" Framework



i) **Superordinate Goals.** Superordinate goals embody the vision and mission of the organization. They describe **what** the organization is there to do and **how** it intends to do it. Superordinate goals include the often implicit assumptions by which people in the organization relate to the outside world.

ii) **Structure.** Structure describes how the various organizational components relate to each other. Structure is often depicted in formal organizational charts showing lines of accountability and responsibility.

iii) **Strategy.** Strategy is the implementation of plans aimed at improving the performance of the organization. Strategies are developed in response to potential or actual changes in the environment.

iv) **Systems.** Systems describe how things are made to happen and are controlled within the organization. There can be formal systems where rules and procedures are written down (e.g. Health and Safety System). There can also be informal systems which individuals and work groups set up to regulate their own behaviour and actions.

v) **Style.** Style describes the way management, and especially top management, conducts itself. Style is essentially a behavioural phenomenon and can be observed by how management acts to make things happen, rather than by saying what it does. "Actions speak louder than words" enables a diagnosis of "style" to be made.

vi) **Staff.** Staff describes the "people" of the organization. Organizational change is bound to affect people. The way in which people are managed and developed through the change describes this "S" of the framework clearly. The management of "staff" is of vital concern in both times of change and stability.

vii) **Skills.** It is very probable that an organizational change will demand new skills of its people. For example, it is of little value to introduce a new piece of equipment without training people to use it properly.

The 7 "S" framework is an aid to analysis. Organization change is complex and difficult. By using the framework it is possible to identify how change in one aspect can affect the other aspects. You can, therefore, anticipate likely problems and prepare for these before they become critical and possible impediments to change.

Setting objectives

A key aspect of transition management is clarity about purpose (objectives) and the logic of a plan. Drawing up a plan is basically a straightforward process in which the various events are put into a timetable. However, many changes are actually quite complex and it may be useful to draw up a critical path network to show how various activities relate one to another, particularly where some actions are dependent on other actions already having been taken.

It is beyond the scope of these notes to describe how a critical path network is constructed. If the plan is complex, it is suggested that the "change manager" uses the services of an expert in drawing up such a plan.

Organization change is normally so complex and difficult that it is useful to try and organize a plan in terms of objectives. Set out below are four levels of objectives:

a) **Aspirations.** These tend to be very long term, open ended, couched in general terms, and relate closely to the vision.

b) **Strategic Goals.** These are time bound, realistic and are expressions of what has to be by year X (5 or more years ahead) if we are to reach the aspirations. Here there could be a mixture of business, organizational and value-based objectives. In a large complex organization, agreement about the strategic goal provides the sense of direction and framework within which individual units can operate. These goals should focus on establishing what has to be done long term in order to achieve the organization's desired position opposite the macro trends and pressures of the environment.

c) **Tactical Goals.** These focus on a time position, halfway between the present and the timing of the strategic goals. Agreement on tactical goals is the main tension-setting and energy-generating process. The goals are time bound, specific, and responsibility for their achievement clearly and publicly agreed or allocated.

d) **First steps.** These are the immediate things that have to be done and agreement on them has the purpose of making action legitimate.

By using these definitions, it should be possible to set objectives relating to the achievement of change and the resolution of problems.

Force Field Analysis

A manager who wishes to implement some form of planned change must be able to analyze the situation that confronts him. If he can identify the major forces at work in the situation then he can take action to influence them to bring about the desired change.

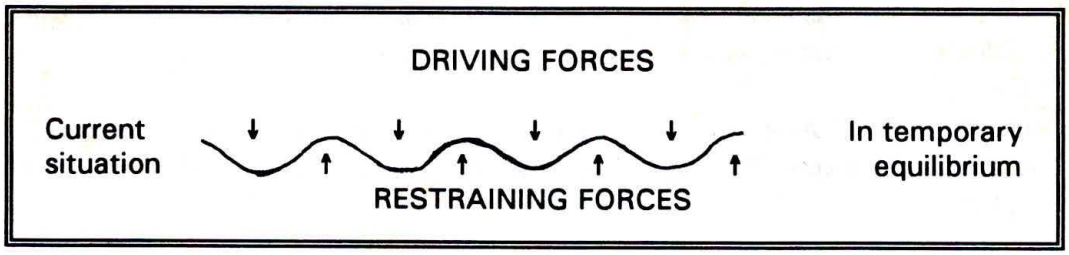
Force field analysis provides managers with a framework for use in problem-solving and implementing planned change. It was developed from Kurt Lewin's "Field Theory".

All situations can be seen as being in temporary equilibrium:

i.e. **The forces acting to change the situation are balanced by the forces acting to resist the change.**

This idea is pictured in Figure 3, with DRIVING forces arrayed against RESTRAINING forces within a field of forces. The line between the two sets of forces represents the current situation.

Figure 3



In this model, the term "force" covers any of the broad range of influences which restrain or support change. Examples of such forces are:

Current policies/procedures	Initiatives
Presence or lack of resources	Public opinion
Prejudice/attitudes	Distrust and fear
Loss or increase of status	Ambition
Preference for old methods	Personal rivalries
Things obviously going wrong	Professional aspirations
Organizational systems	Traditions
Political pressures	Legal considerations

Organizational tradition can be a particularly strong pressure: "We have never done it this way before" restrains people from trying new techniques.

Forces can either DRIVE or RESTRAIN depending on the situation and the kind of change desired. DRIVING forces are those which support, encourage, or push for changes. RESTRAINING forces are those which slow or stop the momentum for change.

Force Field Analysis offers the opportunity to change any situation, if you can identify the forces and seek to change their direction or strength.

This method is particularly useful for problems which seem insoluble, vague or very complex. Force Field Analysis gives more clarity to a situation requiring change, and makes the manager's options explicit.

Steps to a force field analysis

1. Specify the change required, or problem to be dealt with, as precisely as possible.

2. List **all** the forces influencing the situation.

3. Decide whether each force is a DRIVING or RESTRAINING influence.

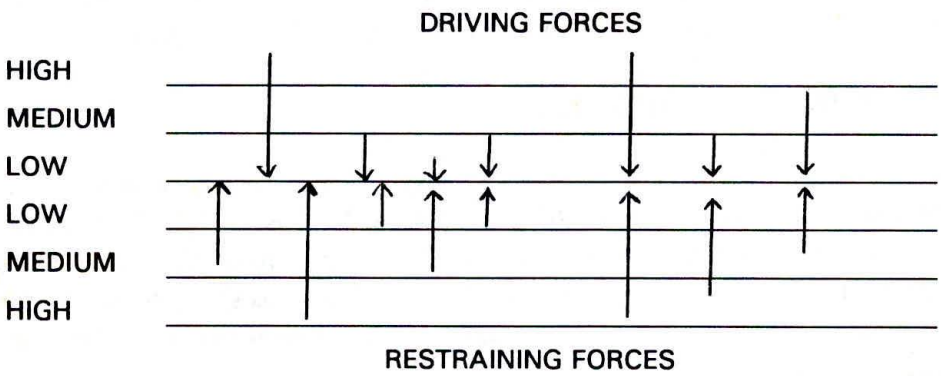
4. In a complex situation it is often useful to assess each of the forces by their importance in the situation.

   Are they of HIGH / MEDIUM / LOW) IMPORTANCE?

   Do this for both Driving and Restraining forces.

5. Set out the two lists on a Force-Field diagram, clearly specifying each force, and indicating its importance by the length of its line.

Figure 4



When considering change, a manager should obviously pay more attention to the most influential forces; but remember that some of the less powerful forces may require relatively less effort to change.

Altering the balance of forces

A manager can effect change by altering the balance of the forces. Change occurs if some of the forces are modified so the situation moves to, and restabilizes at, a new position.

These alterations come by:

- Strengthening or adding driving (positive) forces
- Reducing or removing restraining (negative) forces
- Changing the direction of some of the forces
- Any combination of the above.

You should be aware that strengthening the driving forces, without reducing the restraining forces, might increase resistance and tension. Removal of restraining forces will reduce tension and lead to more stable change.

You may be able to identify driving forces which, if strengthened, do not increase resistance. You may be able to divert restraining forces in other directions. It may be that your own enthusiasm and pushing for change (driving) created the resistance in the first place.

A very effective way of dealing with a restraining force is to convert it to a driving force. For example: can an individual who opposed change be helped to discover that it offers significant benefits, or that he overestimated its negative impact? Changing opposing forces into supporting forces doubles the positive effect of the change.

Always test the **reality** of the forces you have identified, especially the major ones. It may be that some of your expectations or assumptions are false. For example, if you anticipated that top management would disapprove of your initiative, that would be a powerful restraining force. But, if you test this assumption with a good case it may become clear that top management would enthusiastically support your project - an additional and strong driving force.

Having considered which forces you intend to modify, and how, you should ensure that your plans include:

i) The stages to occur in your plan, in sequence, and with target dates where possible.
ii) The resources you need at each stage (particularly people). Will they be available?
iii) Measurable events/results against which to regularly check your progress.

BUILDING COMMITMENT TO CHANGE

Change will only occur when there is an element of Dissatisfaction felt by those who have to change, when there is a Model or vision of the future which is perceived by those affected by the change and a Plan for moving towards this vision, which is perceived as being realistic; the total strength of all this must be greater than the "costs" of the proposed change. These costs may be social, financial, psychological or whatever, and if these costs to the individual are greater than the effort required to bring about change, then change will not occur.

Unless all three components are present we know that change will not happen. It is, therefore, for the manager to ensure that the three components are present.

It may seen odd to **create dissatisfaction**, but if people are to be motivated to change then dissatisfaction is a potent source of energy to change. A good way of achieving dissatisfaction is by presenting objective data on what is wrong with the present and then discussing the relevance of this with those who have to change: this would be a **doom scenario.**

A **model for the future** must cover all aspects that might be affected by the change. For example, it is not sufficient to consider the impact of introducing a disposable syringe just on the nurses who have to use it. You need to think about other systems which will be impacted by the change, such as the storage system and the disposal system. The model should cover both the technical way in which new tasks should be done and also the impact of these on people. Again, for example, if you introduced a new supply system you may have to build a large warehouse which could break up the

current way in which people work together in small groups. A good way of presenting the vision is by writing an ideal scenario.

Generally speaking, managers are quite good at planning for technical changes. They know what things have to be installed, commissioned, maintained, etc. What managers often ignore, however, is the people side of the plan. Who, for example, needs to be involved, how do we get their commitment, how do we persuade them to accept the change? A plan in this context is a systematic link of all the features in the change with particular emphasis on the "people".

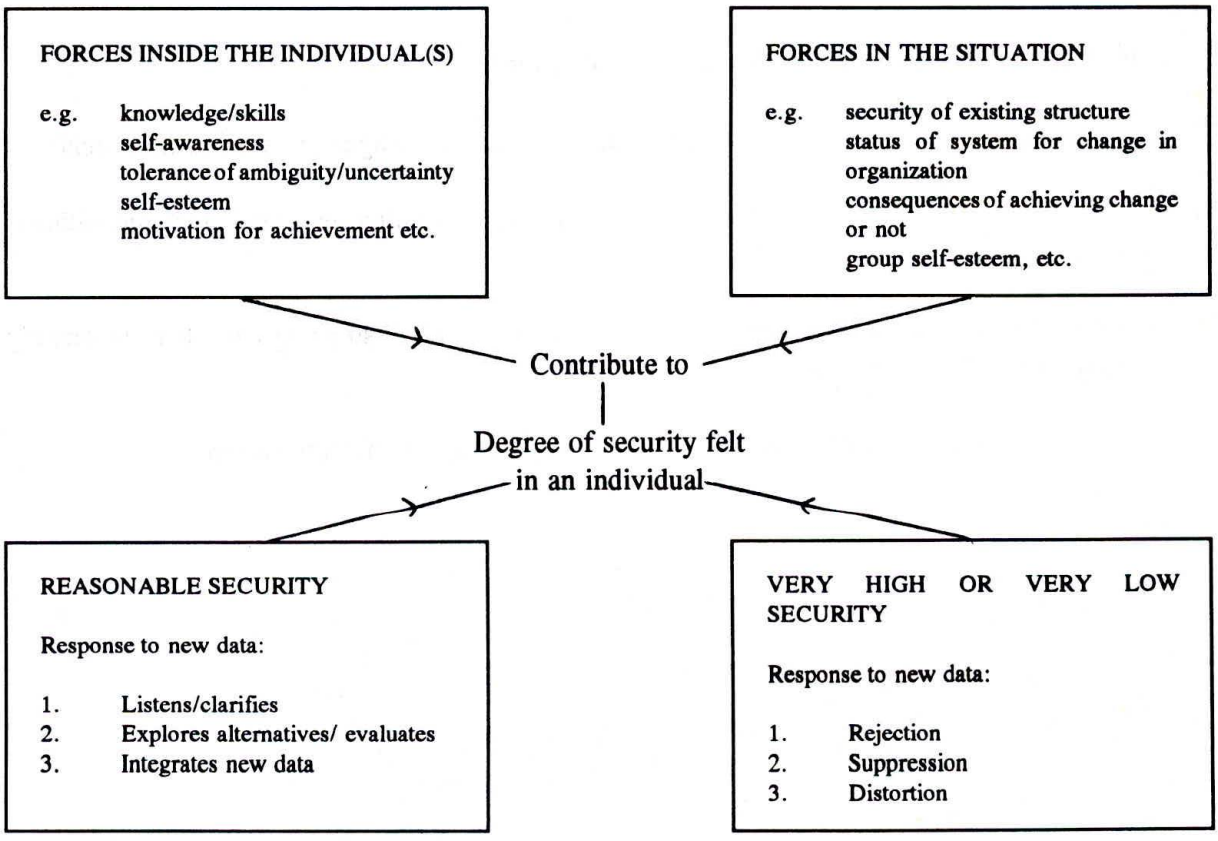
Readiness and capability for change

In many change situations individuals are not aware that they may need to change. In fact they may prefer to remain as they are. To achieve a successful change, people need to be both prepared or "ready" to change and have the capability to actually change.

Readiness to change is when an individual wants to change the way he works or behaves. When he is not ready to change he, by definition, prefers the existing situation. Capability to change is where the individual has the ability to bring about the change because he has the appropriate skills or sufficient power or, if the change is to do with his behaviour, the relevant insight. Lasting change will not occur if someone does not have both readiness and capability.

A way of **diagnosing readiness** to change is to look at the forces impinging on the security felt by an individual. If those forces make the individual feel reasonably secure, then providing he experiences some dissatisfaction with the present situation, he is likely to change. In the first case, why should he bother? And in the second, the major feeling of security left to him is the status quo which he knows and understands.

Figure 5 illustrates the situation:



Even though a person may be ready to change, unless he has the new skills required he will not be able to change or even sustain the change. In **diagnosing capability** you need to examine whether the individual has the appropriate skills, whether he has the power to bring about the changes he wants. If any of these are lacking then, however ready, change will not occur. The change manager has to ensure that the individual is capable of change. It is of course possible that however ready individuals are they will never have the capability to change because they are not able to acquire the relevant resources or competencies.

Planning Commitment

This note focuses on how to gauge commitment and increase it where necessary, as well as suggesting the criteria for a sequence for transition activities.

First analyze what you consider to be the current state of commitment to the change. You need a "critical mass" of committed people to move the change along.

Next consider in what ways commitment can be enhanced and finally work out how you can tell whether there is commitment from your target group.

In time order the process looks like this:

- Decide whose commitment is essential
- Decide how many people form the critical mass
- Decide the state of each individual's commitment level
- Decide how to increase commitment (if necessary)
- Assess as you go whether resistance to the change outweighs the support for it.

In attempting to build up commitment, you are in the business of changing attitudes; a few suggested approaches are set out below:

i) Problem-focused interviews of a "counselling" nature.

ii) Group discussions, using the problem that the "change" is designed to solve as the agenda.

iii) Seminars or other educational mechanisms aimed at informing and developing individuals' views.

iv) Demonstrating the value of the change by working with some system that is already experiencing "pain" caused by the problem.

v) Deliberately rewarding behaviour which demonstrates support for the change.

Exercise 1.1 - Relating purposes of management to your own experience

We have reviewed ideas about the purposes of management in the functioning of organizations. Can you relate these propositions to your own experience in the health system by thinking of examples which illustrate:

Needs

Objectives

Inputs

Activities

Outputs

Outcomes

Environment

Evaluation

And can you identify where your organization's function could be improved through better:

Maintenance Management

Integrative Management

Evaluative Management

Adaptive Management

Please make notes ready for discussion of these questions.

Exercise 1.2 - Prioritizing Management Skills

Having in mind the requirements of high performance in your managerial work, study this check-list of relevant skills and distribute a total of no more than eight ticks (✓) against those in which you most need to improve your competence. You may use two ticks (✓✓) from your eight to indicate a specially high priority. Please make notes on these training needs ready for discussion.

A checklist of Management Skills

1. ***Skills of Managing People***, e.g.

   Leadership, including motivation and supervision of staff
   Job analysis, description and specification
   Interviewing and selection of personnel
   Appraisal, counselling and disciplinary action
   Staff development, training and delegation
   Initiating and handling change
   Managing yourself and your time.

2. ***Skills of Communication***, e.g.

   Report writing and presentation of information
   Public speaking and public relations
   Group discussion leading, chairmanship and working in committees
   Conveying information and instructions and securing feedback
   Effective staff relations and negotiation
   Group decision-making and problem-solving
   Effective liaison with other organizations

3. ***Skills of Organizing Work***, e.g.

   Planning, forecasting and programming of workload
   Setting objectives and standards
   Monitoring individual and organizational performance
   Method study and analysis of work activity
   Collection and processing of quantitative information
   Survey methods
   Organizing an office

4. ***Skills of Managing Resources***, e.g.

   Estimating future expenditure
   Economic use of accommodation, equipment and staff
   Financial control and cost consciousness
   Basic cost/benefit analysis of alternative decisions
   Selection and use of equipment and materials
   Organizing the maintenance of buildings and equipment
   Use of transport and distribution systems

Exercise 1.3 - Problems of Organizational Change

1. AIM

The aim of this exercise is to consider the management of organizational change.

2. STRUCTURE

The exercise is undertaken in groups of 6 or 7.

3. TASK

Each group should address the following problem:

> Consider some recent examples of organizational change within your own health organization that affected its functioning in some way.
>
> Describe in what ways such changes were successful or unsuccessful and try to analyze the causes.

4. TIMING

There are 45 minutes for the exercise. The rapporteur should be prepared to report back on your findings.

2. LEADERSHIP

2.1 DEFINITION

Leadership is a word covering the human dimension of activities which initiate and foster the process of change. The subject is both challenging and complex. It includes issues such as the nature and cultivation of vision and values, and the development of leadership skills of individuals, who are in a position to mobilize others.

By ***leadership development*** is meant the improvement and strengthening of abilities and effectiveness of both current and prospective leaders. This process centres on understanding why change is needed and how it occurs, understanding of the role of leadership in managing and motivating change, and an understanding of the importance of shared responsibilities.

FUNCTIONS OF EFFECTIVE LEADERSHIP

- Conceptualizing/Understanding Vision
- Projecting/Communicating Vision in own context
- Initiating/Guiding Change
- Mobilizing Commitment and Support for Change
- Managing Change - Resolving Conflicts and Issues
- Building of Trust
- Building Sustainability - Developing Others
- Confidence in one's vision and oneself.

2.2 HEALTH FOR ALL LEADERSHIP

The goal of Health for All by the Year 2000 is a vision founded on social equity, on the urgent need to reduce the gross inequality in the health status of people in the world between developed and developing countries, and between different regions within countries. It is a vision based on the principle that health and development are closely interlinked. It is a vision whose range of view encompasses fundamental change - in the way health is perceived, promoted, protected, and delivered. Leadership is vital for the processes and activities by which change can be brought about. This being stated, it should also be stated that the definition of leadership is not an easy task. It is simple to recognize "leadership in action" or even to list characteristics that contribute to leadership, but what is the combination of qualities, and in what circumstances, that propel people to assume leadership in a given situation?

Some of the assumptions about the "leadership tasks" related to the changes needed for HFA are:

- Those in positions of leadership should be fully informed about Health for All and the strategies for its achievement, and be able to communicate it to others;
- They should be able to identify central issues affecting implementation of their national strategies;
- They should be able to specify their own personal role in resolving those issues which fall within the scope of their responsibilities;
- They should be able to define strategic actions to resolve these issues;
- They should be able to initiate the process of change required and create networks of support for the implementation of change;
- They should be able to involve and mobilize others, by infusing them with a sense of purpose, commitment and a focus of action.
- They should be able to clearly demonstrate a willingness to commit themselves.

Developing and Mobilizing Leadership

There is a paradox about leadership. Formally-trained and experienced leadership is in short supply, and often over-used. At the same time, there are vast numbers of people with leadership potential who are untrained and inexperienced. Those already in leadership roles, often too few in number, need support, while at the same time training and experiential opportunities need to be created for others. Incentives need to be developed to help sustain those in leadership roles.

Areas critical to the development of Health for All leadership include: (i) intersectoral dimension of health; (ii) health policy and strategy development based on HFA principles; (iii) mobilizing commitment; and (iv) initiating leadership development.

Related to these issues, people must have:

- ***clear understanding*** of the stated vision;
- ***commitment*** to guide policy decisions towards social equity;
- ***comprehension*** of the health aspects of policies of other sectors in order to argue for health in an intersectoral setting;
- ***capability*** to identify critical issues affecting the achievement of accepted objectives;
- ***confidence*** stemming from the knowledge of having the relevant skills and experiences;
- ***capacity*** to motivate others and to ***mobilize commitment***.

2.3 LEADERSHIP IN MANAGEMENT

Leadership in management is the task of setting goals and objectives, and obtaining the commitment of others to reaching them. This is not easy, but successful managers gain such commitment through the constructive involvement of people in the work of the organization. It requires not only the manager's basic ability to achieve objectives and standards through setting and checking the work tasks of other people, but in addition the capacity to motivate, enthuse and energize them to work well and willingly towards goals in which they also believe. Consequently leadership, in the managerial context, may be defined briefly as:

> **the capacity to secure the willing support of people in the achievement of the organization's worthwhile goals.**

Managerial leadership depends on the exercise of interpersonal influence. It is clear that all managers at all levels of the organization, who depend on other people for efficient and effective work performance, require leadership ability. And that this capacity to secure the willing support of people in the achievement of worthwhile goals is needed to a very high degree by those who have the biggest workforce management responsibilities, in numbers or complexity, or have the biggest organizational changes to achieve, in scale or difficulty.

This ***proactive*** approach (taking responsible initiatives to change situations and attitudes through people) is the essence of leadership in management; it contrasts with the ***reactive*** approach which responds only to events and instructions from outside. It is clear that leadership is vital to provide vision, direction and energy to the whole managerial process. In particular, leadership of this type and quality will radically influence the ways in which the health workforce is managed, through its emphasis on sound employment practices, positive staff development and good management/staff relations as the means of securing the willing support of people.

2.4 LEADERSHIP RESPONSIBILITIES AT DIFFERENT LEVELS OF THE HEALTH SYSTEM

The many and complex changes implied in the strategy to promote equity in health are directed at all levels of the health system, as well as related systems. Therefore, leadership is needed for every single unit, at every level that comprises the health system, and throughout the spectrum of a national structure, i.e., in the community, health professions, political organizations, health sector institutions, universities, research establishments, and non-governmental organizations.

At each level of the health system itself, different leadership functions evolve according to the responsibilities of the leadership position and the nature of the changes sought. At the central level of the system, leadership usually rests with political leaders such as ministers of health or ministers of other relevant sectors, heads of research and educational institutions, and directors of non-governmental organizations and professional associations at the national level. Their key leadership responsibilities involve directing and guiding policies, evaluating and orienting change, influencing other top level leaders, mobilizing support for change from critical influential groups, resolving central policy issues, mobilizing and directing resources in support of change, and motivating others.

At the intermediate level of leadership are the bureaucrats and technocrats, for example, the national and provincial level administrators in health and other relevant sectors, senior officials of non-governmental organizations, political and other elected or appointed leaders at provincial or district levels, and senior representatives of educational institutions. Their leadership responsibilities include providing managerial direction for the implementation of policy, monitoring and evaluation, motivating others, mobilizing support of influential and pressure groups, resolving implementation issues and participating in policy-making, including allocation of resources. At this level, leadership functions become an integral part of managerial functions and effective managers are therefore characterized by their leadership qualities.

At the community level, leadership devolves on a wide range of people including health workers, locally elected community leaders, religious leaders, representatives of voluntary agencies or non-governmental organizations, representatives of other sectors, such as school teachers or even of the private sector, e.g., sports/entertainment personalities, shop-keepers, and village volunteers, etc. Their leadership responsibilities embrace mobilizing and coordinating community action for health, including resources, setting community-level targets and monitoring them, and influencing those at higher levels for support towards community health programmes.

2.5 DEVELOPING A VISION

All organizations exist for a purpose. Leadership ensures that everybody is clear about what has to be done. This is referred to as the process of setting objectives.

The organizational vision is a view of the future which the leader has committed his energies and enthusiasm to achieving. It is a picture that can easily be expressed and understood by others.

What is "vision" in organizational terms? It is looking into the future, noting what is happening in the environment and what likely developments there might be, and from this setting a general direction for the organization. Vision statements are important because:

- people then know what the whole organization is trying to do and can see how their contribution fits into this;
- they create a unity of purpose which reduces role and job confusions through a greater ability to set priorities;
- the clarity of direction challenges individuals' creativity in finding better ways of reaching the vision;
- they release people's energies to accomplish tasks that have a clear purpose.

The statement of the vision can include a description of how the organization will be in the future in terms of culture, style, function in the community, sources of income, human resources management policies, etc. Or it can be a statement of what the organization's mission is. The key ingredients are that it is possible for all to understand it and relate positively to it, and it thereby secures people's attention and generates their enthusiasm.

Verbal Communication

Many people think of verbal communication as a straight line between the sender and receiver, e.g.

(Double Messages) (Filters)
Sender _____ Receiver
A B

It is not as straightforward as this. Distortions occur in the process of the message being sent and received. There are two basic types of distorting mechanisms. The first is inside the receiver; these are called "filters". The second is the way in which the sender sends the message. It may be that his body posture, or tone of voice, contradict the verbal message. These are referred to as "double messages".

a) Filters

There are many filters - for example our ability to genuinely understand what the other person is saying to us can be affected by:

- ***prejudices:*** the most obvious examples are prejudices based on colour or race, which may make you reluctant to listen, or to speak, to people who are different from you.

- ***attitudes:*** we all make assumptions, for example that we already know the background or purpose of someone's conversation, but by so doing we may distort a communication from someone else.

- ***expectations:*** this filter is similar to that of assumptions. It is based upon the fact that we tend to stereotype people and then mis-hear their communication in terms of what we **expected** them to say, as that type of person, instead of what they actually **did** say.

- ***self-image:*** the image we have of ourselves is a powerful filter. What happens here is that the communication from others has to penetrate a layer of "self protection". This guard attempts to prevent us receiving comments about ourselves which may be critical. So the guard functions to reject such criticism, explaining it in any terms except that of acknowledging our own possible faults.

These are just a few examples of filters which can impede our ability to hear and understand the communications of others.

b) Double messages

Double messages occur when we communicate by our body or tone of voice something which is contradictory to what we are actually saying. If someone is leaning over the reception desk, trembling, with his knuckles white and teeth clenched, and says "I am quite relaxed - I am not worried about anything at all" it is probable that there will be no response to this apparent communication but to the hidden one of "I am feeling very anxious indeed!". Double messages can seem quite harmless, but can still cause considerable social disruption, because they say one thing but mean something different: They are a powerful distortion of communication. However, by being an acute and sensitive listener one can detect such messages and use them to build the relationship, by showing concern for the un-said but vitally important extra message.

2.7 BUILDING TRUST

Trust is a difficult idea to describe. It reflects the relationship between organizational members and, in this context in particular, the relationship between the leader and everyone else. In essence, trust means having confidence in the judgement and decisions of the leader.

How is this trust to be earned? The answer lies in the style used to develop the vision and the way it is communicated to the organization. The development of the vision comes about through a careful analysis of the organization's position in relation to external events and to internal characteristics such as its tradition and culture. If members of the organization have been involved in producing a statement of the vision, then that participation will begin the process of building trust between the leader/manager and his employees.

Where, on the other hand, there has been little involvement of others, there may be problems of credibility leading to lack of trust. The vision statement has to be perceived as relevant, logical, ethical and meaningful. For the leader to earn the trust of his staff, his own behaviour has to reflect the requirements of the vision. His decisions and decision-making processes have to be consistent with the overall spirit and direction of the organization, as made explicit by the vision statement.

The leader needs to involve staff in those decisions that are going to affect them. This involvement can ideally be gained by the participation of the individuals themselves in the decision-making processes or, where this is not possible, by explaining the logic of the decision and its underlying purpose in relation to the achievement of the vision.

Confidence in Oneself

Good leaders have confidence in what they are doing. They believe in their vision and are able to inspire others with the likelihood of success.

Such belief in success, however, is not blind to the problems and setbacks that might occur. It is a belief that the vision can and will be accomplished. The belief inspires others to believe in their own abilities and have the confidence to succeed. Leaders recognize that to achieve success means taking risks. Risks can lead to failure, but effective leadership accepts such failures as "opportunities for learning". The organization can be used as a learning environment and, when things go both well and badly, each occasion is used as an opportunity to discover and learn about the capacity of the organization to respond, and about their own capacity to understand why events happened as they did. The following aspects have been identified as the competencies needed by organizational leaders:

- Acknowledging and sharing uncertainty
- Accepting failures and mistakes
- Responding to the future
- Becoming competent in interpersonal relations (listening, developing people, resolving conflicts, etc.)
- Gaining self-knowledge.

There is a clear need for leadership in health and in other sectors at every level: in communities, where the need is for self-reliance; in non-governmental organizations, where their flexibility and creativity can be brought to bear on problems of national interest; in universities, where their capacity for generating and trying new ideas and new programmes can contribute to the effectiveness of health policies and services; in government, where the responsibility resides for reaching the poorest and most deprived, and where effective policies and programmes in pursuit of Health for All must be developed.

Beyond all else, leadership is to be people-centred .... people leading people in order to benefit people. The ultimate impact is to be at the community level, where the need is the greatest and the opportunity to respond must be extended to those who are on the path towards self-reliance. Leadership formation must be a central theme in the larger scope of the development of human resources for health.

Additional reading in Annex 2.

LEADERSHIP
BUILDING TRUST THROUGH GROUP WORKING

1. Introduction

This note examines some aspects of effective group working. It begins by quoting some research by Argyris published in his book ***Intervention Theories and Methods - A Behavioural Science View***, which suggests some criteria for achieving group competence. Groups come together for many purposes, for example:

- to play games
- to hear a speech
- to exchange information
- to solve problems and make decisions
- to change attitudes

2. Criteria of Group Competence

From his research into effective problem-solving groups, Argyris concluded that the most competent groups demonstrated the following features:

(a) There was a high level of involvement from all members of the group and they worked together to make progress.

(b) The person most qualified at that point in the group's work tended to lead the group for a period.

(c) The group was conscious of the way they were working and frequently analyzed this "process" (that is, not ***what*** we are doing but ***how*** we are doing it).

(d) The group was clear about the goals it was trying to achieve and was able to search for alternative solutions for its problems. The atmosphere of mutual support helped this.

(e) The group was able to resolve conflict successfully by discussing it openly. Team members' contributions added to the discussion rather than raising anything irrelevant or unhelpful.

(f) The group was able to deal openly with the feelings which the members had.

(g) When decisions were made they were based on consensus, so all the group members had a strong commitment to them. (Consensus is discussed in detail later in this note.)

3. Task and Process

From this analysis by Argyris it is obvious that members of effective groups not only consider the actual issue or problem (Task) but how they, as group members, should work together to solve it (Process). In considering the "how" there are two elements - the logical sequence of problem-solving, and the interpersonal relationships between group members.

4. The Problem Solving Sequence

When a number of individuals are talking together, there needs to be a discipline which prevents one of them coming up with hundreds of ideas, whilst the others are still defining the problem or, worse still, planning action to solve it. A simple procedure which you could display for everyone to see is as follows:

i) Define the problem to be solved.
ii) Gather the information that is required.
iii) Define the objective to be achieved.
iv) Develop many alternative solutions to the problem.
v) Judge these alternatives to find the best solution(s).
vi) Plan the action to achieve this solution.
vii) Take the action to implement that plan.
viii) Evaluate the outcomes of that action.

5. Interpersonal Relationships

It is useful to consider the interpersonal relationships in terms of behaviour which is useful to the group as a whole in the performance of its tasks.

Below are examples of behaviour which will at some time or other be of value in helping the group to make progress:

- **Initiating**: proposing tasks or goals; defining problems; suggesting procedure; contributing ideas.

- **Seeking information or opinions**: requesting facts; seeking relevant information about how the group is working; asking for opinions; seeking suggestions and ideas.

- **Clarifying and elaborating**: interpreting ideas or suggestions; clearing up confusion; defining terms; indicating alternatives and issues before the group.

- **Summarizing**: putting together related ideas; restating suggestions after the group has discussed them; offering a decision or conclusion for the group to accept or reject.

- **Seeking decision**: testing for readiness to make a decision; seeking a decision-making procedure.

- **Taking decision**: stating the group's feelings in terms of a group decision; using the decision-making procedure.

The following is a list of behaviours which will help the group's emotional character to be maintained in balance:

- **Harmonizing**: attempting to reconcile disagreements; reducing tensions; helping people to explore their differences.

- **Encouraging**: being friendly, warm, responsive; indicating, by verbal or non-verbal behaviour, the acceptance of other people's contributions.

- **Standard setting**: expressing or suggesting standards for the group to attempt to achieve.

- **Standard testing**: attempting to evaluate the quality of the decision-making process in the group; testing whether the group is satisfied with its procedures.

6. Decision Making

There are many ways for the groups to make decisions. The most appropriate method for each group depends on a number of factors such as the need for speed, the extent of members' commitment, their level of understanding, the group's existing practices and traditions.

The following are the types of decision-making most commonly observed in management groups.

(a) Decision by lack of response

This is a common but rather negative way of making decisions. Someone suggests an idea and, before anyone else has had a chance to comment, someone else puts forward another idea and so on until the group finds an idea that is acceptable.

There tends to be a lack of commitment to decisions made in this way because most people's ideas have been ignored or abandoned. It can also be a very time-consuming way of finding a not very effective solution to a problem.

(b) Decision by Authority Rule

Sometimes groups will set themselves up in such a way that the chairman or someone in authority makes the decisions. Members have free discussion, but the chairman, after listening to the discussion, will make the decisions. The effectiveness of this method of decision-making is very dependent on the abilities of the one person who eventually makes the decisions, and the commitment to the decision by the other group members is often low because they have been involved only to a limited extent. Results however are speedy and decisions do get made, even if they are not always very effective.

(c) Decisions by Minority

We are all familiar with this type of decision-making where someone with high status or a powerful personality pushes the other members into accepting his decisions by giving them very little opportunity to speak or to influence the decision.

This is a speedy way of making decisions, but is a waste of group resources and concentrates decision-making on a minority. Other members of the group often feel dissatisfied and uninvolved and their commitment to implement the decision is low.

(d) Decision by Majority (Voting)

This method of decision-making is probably the most familiar to us and is often acceptable as a fairly speedy and satisfactory way of representing majority interests. However, it can be most unsatisfactory in some circumstances and may reflect group loyalties and political motives rather than the soundness of the decisions taken. Voting can split a group into two separate camps of "winners" and "losers", and those camps can become preoccupied with their rivalry instead of making sound

decisions. Those on the losing side are often left with no commitment to the decisions made and are very reluctant to share in the group's responsibility.

(e) Decision by Consensus

Consensus decision-making is becoming increasingly popular as a method of making effective group decisions, although it is necessarily a fairly time-consuming method.

Consensus is a state of affairs where communications within the working group have been sufficiently open in a supportive climate to enable each member to feel that he has had a fair chance to have his say and to influence the final decision. The decision is not necessarily unanimous agreement, but discussion will have been sufficiently long and open to enable all group members to understand the decision and to have a high commitment to it.

Consensus is also a psychological state in which anyone whose views have not been accepted can nevertheless think as follows:

> "I fully understand what most of you would like to do. Personally I would not do that and I think you all understand what I would like to do and why. I have had the opportunity to persuade you to my point of view, but it is clear that I have not been sufficiently convincing. Therefore I will go along with what most of you would like to do and I shall be happy to support the decision."

For consensus to exist, each member of the group must listen carefully to the points of view of the other members and there must be a high level of trust and understanding for the decisions to be effective.

If there are no remaining feelings by members of the group about being misunderstood or ignored, then a high commitment will be evident in implementing the decisions.

Be aware, however, of "false consensus". This can happen when individuals are fearful of upsetting the other group members by voicing their reservations about the decision. They feel they will be spoiling the "warm" feelings in the group. In fact it is possible that many other group members might share these reservations if they were openly expressed.

This is false consensus.

(f) Decision by Unanimous Consent

This is the logically perfect method of making effective decisions, but unfortunately is the least attainable. The search for unanimous consent, while ideal, is time-consuming and normally ends in achieving very little except a great deal of frustration.

7. Analyzing the Process

It is useful to have a simple check list in your mind on which you can base a review of the group's functioning.

b) **To Team Members:** "Please mark the questions to indicate how you yourself feel about your own work."

6. Give participants the name and address of the scorer and advise them to send their completed questionnaire direct to that person. If this is not possible, supply everyone with a plain envelope and forward them to the scorer.

HOW TO SCORE THE QUESTIONNAIRE

1. Group completed questionnaires first according to job similarities (rank and title).

2. Using a blank questionnaire form, plot the replies for each group on one questionnaire. Highlight the replies showing great satisfaction and great dissatisfaction.

3. If a strong pattern emerges, this may be a sufficient indication of areas requiring attention.

4. If no particular pattern emerges, plot other groups, e.g.

   a) Male Female

   b) Under 40 Over 40

   c) Living alone Family, married, with dependents

5. Report back the relevant findings in terms of predominant patterns. Take as much care as possible to ensure that no replies could be readily identified as coming from a particular individual (although they may inevitably be linked to a particular type of job).

QUESTIONNAIRE ANALYSIS

The questionnaire links to different types of satisfaction or dissatisfaction as defined by Maslow and explored in Annex 3. Accordingly, once a pattern has been identified, the supervisor can refer to the relevant section(s) for reviews of possible remedies.

Sources of job satisfaction/ dissatisfaction	Questionnaire numbers
Survival/personal maintenance	1, 2, 3
Security	4, 5, 6
Companionship	7, 8, 9
Quality and style of supervision	12, 13, 16, 17, 18
Quality of work	26, 27, 28, 35
Status	10, 11
Recognition	14, 15, 19, 20, 21
Autonomy	29, 30, 31, 32, 33, 34

MOTIVATION
Exercise 3.8

The three aspects of my job which I value most are:

1. .....
2. .....
3. .....

The three aspects of my job which I dislike most are:

1. .....
2. .....
3. .....

The main reason I work in the Health Service is:

* * *

The following is such a check list:

- **Goals**

  How clear were the goals to all members of the group?
  How committed were people to these goals?

- **Involvement**

  Was the group dominated by one or more members?
  Were people listened to?

- **Awareness and Understanding of Feelings**

  How did people feel in the group?
  Were feelings openly discussed and their reasons explored?

- **Leadership**

  Did the group depend entirely on one person for leadership?
  Was the expertise of group members used?

- **Decisions**

  How were decisions made? Were alternatives explored?

- **Trust**

  Did people feel they could express themselves freely?
  Were any people rejected?

- **Creativity and Growth**

  Was the way the group worked together examined?
  Were alternative methods of working explored?

Exercise 2.1 - Good Leaders

1. AIM

The aim of this exercise is to consider and discuss what are the keys to effective leadership. By understanding how effective leaders lead people in a variety of circumstances, it is possible to learn in what ways any individual can improve that part of their management which requires them to lead others.

2. STRUCTURE

Participants should divide into groups of between 5 and 7 individuals.

3. TASK

Step 1

During your lives you will have encountered people whom you thought were good leaders. They may have been leaders of a nation, or a village, or leaders of a community project, or leaders of an enterprise. It does not matter what they were leaders of or even whether you knew them personally; it does not matter whether they are alive or dead. What does matter is that you should know a little about them and how they went about trying to lead others. You may have gained this knowledge from books, or from newspapers, or from personal experience.

The first part of this task is for you to write an imaginary piece about the person which could go into a book entitled "Great Leaders". Your essay should be about three hundred words long describing with examples some of the reasons why you think your chosen person is or was a good leader. Try to think of about three or four characteristics which your individual possessed that distinguished him from the majority of other people. You have 45 minutes for this step.

Step 2

When all members of your group have finished their essays, each individual should read it aloud to the others. One member of the group should lead a discussion after each essay in which the main leadership characteristics are agreed, if necessary classified, and then written up on the blackboard or flip chart. You have one hour for this step.

Step 3

When all the essays have been read out, the group should, through discussion, try to identify about three or four main characteristics that seem to be common in all the essays which distinguish good leaders. The discussion will be easier if you refer to the notes written on the blackboard. You have 45 minutes for this step.

Step 4

All groups should reconvene in a plenary session when the results of the analysis will be discussed and related to leadership in health systems.

Exercise 2.2 - Vision Building and Setting Objectives

1. AIM

The aim of this exercise is to give participants the opportunity to build a vision and set objectives for their own organization, or some particular part of it; and to help another person do the same for their organization.

2. STRUCTURE

The exercise is done in "consulting" pairs, with each participant taking a turn to be the consultant to the other.

3. TASK

After preparing on your own for a few minutes, outline your own work and your organization to your "consultant" and together try to describe a vision for your organization and define its mission; then identify about three objectives which would help you and your organization to move towards the vision.

Then reverse the roles so that the other one of you becomes the consultant.

4. TIMING

The time available is 60 minutes.

Participants should be prepared to discuss the results of their work with the whole workshop.

Exercise 2.3 - Confusing Objectives

1. AIM

The aim of this exercise is to explore reactions to the way in which objectives are expressed.

2. STRUCTURE

The workshop should divide into groups of 6-8 people. One person should be selected as an observer. Immediately after being selected the observer should meet with the workshop leader to be briefed, and then return to his group - sitting outside the group circle - prepared to observe the two discussions the group will have.

3. TASK

Step 1

The workshop leader will give you a task to discuss for 8 minutes. You will be warned when 7 minutes have passed, and then stopped one minute later.

Step 2

Your workshop leader will give you a second task to discuss for 6 minutes. You will be warned when 5 minutes have passed, and then stopped one minute later.

Step 3

Observers feed back a summary of their observations to their group. During this step, share your various perceptions; do not try to argue or force agreement.

Step 4

Each group (including the observer) should now produce a list of characteristics of good and bad objectives.

Step 5

From this list, identify three or four of the most common characteristics of good and bad objectives and describe the effect of these on people working in an organization like a health centre or hospital.

Step 6

Select a rapporteur who will outline to the whole workshop what has been learned about objectives from your group discussions.

4. TIMING

The time available for this activity, excluding Step 6, is 60 minutes.

Exercise 2.3 - Confusing Objectives (cont.)

OBSERVATION GUIDE
(for use by the Observer in Exercise 2.3)

1. Number of times the task was clarified, or clarification was asked for.

2. Assessment of the "working climate" in the group. Was it cooperative, hostile, pleasant, critical, accepting, etc.

   At the beginning

   In the middle

   At the end

3. Extent of verbal behaviour not directly related to getting the task done (side conversation, jokes, comments, etc.)

4. Extent of non-verbal behaviour not directly related to getting the task done (looking around the room, horseplay, bored withdrawal, hostility, etc.)

5. How much progress did the group make in achieving the task?
   (Make a very general estimate.)

3. MOTIVATION

3.1 NEED FOR IMPROVEMENT

This section looks at the area of staff motivation and commitment, and explores what can be done to improve this vital aspect of health service operations. The need to address this issue can be argued on straightforward financial grounds: in the health services it is invariably people who account for the major share of annual expenditure. It makes especially good sense to use these people cost-effectively. Effective leadership motivates people. Moreover, many health service staff are community leaders and their commitment can influence the behaviour pattern of entire communities. If they are highly motivated, the effect will extend far beyond the exercise of their own immediate tasks.

It is not easy to improve staff motivation, nor can results be expected quickly. Many of the factors that impinge on attitude and behaviour are frankly negative in their impact on individual health service staff: salaries are low; housing and accommodation are difficult; career development is uncertain; rewards for performance are minimal; supervision is punitive rather than supportive; and so on. For some of these factors (e.g. salaries), there can be little expectation of much change.

The concepts around increasing staff motivation may well be accepted by many managers, but given the often difficult circumstances in which they operate, they may question whether it is feasible for them to consider achieving significant gains in staff motivation. Against this, there is now good evidence of success in increasing motivation in almost every type of circumstance likely to be encountered. A number of programmes, for example the smallpox eradication programme, family planning and malaria programmes, have in many countries a laudable record of gaining high staff commitment and sustaining it over long periods. It is not enough to say they are special. They provide a fertile ground of well-tried approaches to improving staff motivation which can be harvested by a wider body of the public sector. Each manager will need to explore which factors are amenable to change, and which not, within the realities of their organizational circumstances.

It has to be said that, in many health services, conditions are often such that large groups of staff suffer strong demotivating forces over extended periods. Poor staff motivation is a far from negligible problem in developed countries. In some developing countries, it is severe. There are four main reasons why this is so:

1. The phenomenal growth of health services in developing countries has resulted in many managers being able to exercise controls only at the most basic levels.

2. Related to the above, the administrative machinery of the service and the skills of its managers have often failed to develop fast enough to cope with the demands placed on them.

3. Policies in developing countries have frequently focussed on growth rather than on performance, and on scale rather than on quality.

4. Many countries still have strong centralized control which limits the ability of health services to respond flexibly to local and individual needs.

It is only as health services have become more established and mature, and/or under greater pressure to use resources effectively, that their performance has come under scrutiny and, with it, the performance of individual health service employees.

Too often it has been assumed that poor motivation can be remedied in some simplistic way, for example by the provision of more management training, or an increase in salaries. In reality, poor motivation involves almost every aspect of the way in which an organization functions (see discussion of the "7-S" framework, Annex 3, page 20).

3.2 FACTORS IMPACTING ON MOTIVATION

The Need for Achievement and Success

Pride in oneself and one's work is linked to the opportunity to exercise skills, to achieve goals, and to be recognized as having succeeded. This opportunity has been successfully provided in some health service projects. The smallpox project in particular, but also many family planning projects, have been highly successful both at setting realistic targets toward which individuals can strive, and also at recording and publicizing their successes. Elsewhere, in too many sectors of health services:

- targets for performance do not exist;
- job specifications (which define the individual's tasks and responsibilities) are often out-of-date or non-existent;
- goals have never been translated from national level into a workable set of objectives for local units; and,
- reports on progress are used simply to provide statistics and not to recognize achievement.

In short, the health services have failed to provide an environment in which the individual can see what he or she has achieved and others can recognize the achievement.

The Need for Companionship, for Identification with the Group, for an Emotional Focus

Most people seek identification with some group, and want to be associated with successful activities. Many large industrial organizations have found to their cost that the apparent benefits of large-scale operations have been offset by deterioration in staff motivation. In centralized production units and bureaucracies, employees have generally lost both their sense of identification with a particular group, and also their sense of contributing usefully.

Health services have considerable opportunities to satisfy these needs which they too often ignore. For example, they can:

a) Set targets for individual or unit achievements.

This management technique brings many benefits. It requires recognition of individual contributions, enables people to measure their own performance, and helps to ensure that successful achievements are recognized and rewarded. This method has contributed notably to the success of special health campaigns such as family planning projects and disease eradication programmes.

Unfortunately this technique is often neglected, largely through ignorance of the benefits it can bring, and sometimes through lack of understanding of what is involved in setting precise and useful targets. To be useful, targets must be specific, achievable and measurable. Generalized aims such as "Improve bed occupancy" must be replaced by precise statements such as "Increase bed occupancy in male acute wards from 65% to 80% within six months (by a given date) without increasing staff hours."

b) Identify roles.

This begins with a job description, but it goes beyond a written account. It involves recognition of the individual's special contribution to the work of the team, of their range of responsibility and how far it can extend, as well as a definition of the constraints within which they must work. In an operating theatre, for example, roles are identified with precision which is essential to the smooth and safe performance of the task.

A clearly identified role brings status and security, even when given to a humble task. In one hospital, staff shortages in the laundry had resulted in the least experienced staff being moved from one job to another to make up for deficiencies. They were often reprimanded for poor quality work, the result of inexperience and lack of training, and they suffered from low morale and a sense of worthlessness. The situation was remedied by taking a group of staff, training them to a good standard on a range of tasks, and renaming them "The Flying Squad", considered competent to help out anywhere at short notice.

c) Delegate decision making.

In too many health services, power is highly centralized and virtually all decisions are taken at the top. Initiative at any lower level is positively discouraged and those who venture to take it risk punishment rather than reward.

Health service decisions, of course, may have serious implications for patients, and those in authority cannot lightly hand over their responsibilities. However, many senior staff are involved with tasks which could be easily delegated. This would have to be very carefully planned, and subordinates trained and closely monitored until their performance was reliable. The result is likely to be a reduced load on senior staff and much more highly motivated teams below them.

The Need for Personal Growth

For many, the reward sought for merit and hard work is career advancement. Unfortunately, health services in general find it difficult to identify meritorious individuals or to reward them appropriately. In many developing countries, such difficulties can seem insurmountable: there may be no adequate or trained supervision; no means of judging an individual's work or worth; no way of comparing their performance with that of similar workers; and no clear lines of promotion. In these circumstances, the service usually resorts to promotion by seniority alone or simply on the recommendations of senior officers with all the attendant risks of "favouritism". To satisfy the need for personal growth, an employee must feel that his employing organization recognizes and fairly rewards extra effort. For this, it is necessary to have a good appraisal system that allows an objective and honest appraisal of a staff member's work.

A sense of injustice, leading to frustration and apathy, is generated by:

- an inability to select between individuals on merit;
- a lack of systematic organizational rewards for merit and hard work;
- an inability to rotate staff in order to provide career opportunities which keep them stimulated and productive;
- career structures which do not allow for "horizontal" job changes;
- financial rigidities which impede the ability of the organization to provide financial rewards to meritorious individuals; and,
- promotion systems which depend more on gaining the attention of senior officers than on performing well.

The Need to Belong to a Successful Team with a Committed Leader

A very simple cause of poor morale and poor team spirit is the lack of good personal leadership. In many health systems, there are plenty of words from senior people reminding staff of the importance of their service to the public, and the need to work with vigour and dedication. However, corresponding action is too often lacking. Health service leaders have to recognize that actions speak louder than words. People work with vigour and dedication, not because they are exhorted to do so but, at least in part, because they see these traits in their leaders. If the standards which senior people demand are not demonstrated in their own performance, those lower down quite reasonably conclude that the kind of commitment asked of them is not seriously valued, and need not be attempted. Much of the failure to improve motivation and performance can be attributed to the failure of leaders to apply to themselves the rules they attempt to impose on subordinates.

What can be accomplished when leaders lead by example has been well-demonstrated in the vertical projects (e.g. smallpox) where commitment went from the highest to the lowest. On a smaller scale, one of the authors once worked with a senior officer who, by consistently attending and starting meetings on time, gradually instilled in all his staff a respect for good time-keeping.

The Need for Meaning

Many individuals join a health service because of a strong urge to serve the community and contribute to the common good, but all too often they are assigned roles and tasks of little obvious value. For example:

- it is not made clear how their work relates to the overall aims of the local unit and the greater goals of the health service;
- the quality of their work is rarely assessed;
- little effort is made to recognize those individuals who perform especially well;
- established roles may be summarily changed simply to meet the unplanned changing needs of the management;
- little effort is made to identify an individual's particular contributions and skills.

Often, this results in the individual looking outside of work to give meaning and purpose to life, and the health service loses his or her commitment and energy.

The Need for Autonomy and Control

The centralization of many health services, often combined with an authoritarian culture, produces "top down" management in which the superior hands down orders and the staff are required merely to carry them out. Junior staff are not encouraged to contribute to decision making, nor to realize and use their full abilities. This state of affairs is characterized by:

- lack of local planning or targets to which individuals can link their own work;
- no opportunity to cooperate with management in determining tasks and work goals;
- little or no discussion with management about problems or issues of concern;
- very little systematic help for the individual seeking to improve and develop.

Staff members feel they are nameless and faceless, simply pawns to be moved as the situation dictates. They respond by reducing their involvement to a minimum.

3.3 IMPROVING MOTIVATION

It is clear that increased motivation cannot be achieved in one step, that it is a long and complex process, and that there will never be a stage where the search for a better bargain between organization and individual remains static. Constant adjustment will be needed, and for this to occur, change must be acceptable to the staff. To create such a climate of change and reduce the blocks to innovation, the organization must aim for:

a) ***Encouragement of a culture of recognition.*** Highlight the achievements of staff through visible awards, through applying an innovation from one area to the problems of another, and through encouraging experienced innovators to serve as "consultants".

b) ***Greater access to "power tools" for innovative problem solving.*** Provide mechanisms (such as a council, a Research & Development committee with direct access to a higher-level steering committee) for supporting proposed experiments and innovations, especially those involving teams of collaborators across areas.

c) ***Improvement of lateral communication.*** Bring departments, institutions and units together. Encourage cross-fertilization through exchange of people and mobility across areas. Create cross-functional links and perhaps even overlaps. Bring together teams of people from different areas who share responsibility for some aspect of the same type of service.

d) ***Reduction of unnecessary layers of hierarchy.*** Eliminate barriers to resource access. Make it possible for people to go directly after what they need. Push decisional authority downward. Create "diagonal" slices, cutting across the hierarchy, to share information and to provide quick intelligence about external and internal affairs.

e) ***Increased - and earlier - information about health service plans.*** Where possible, reduce secretiveness. Avoid surprises. Increase security by making future plans known in advance, making it possible, in turn, for those below to make their plans. Give people at lower levels a chance to contribute to the shape of change before decisions are made at the top. Empower and involve them at an earlier point, e.g. through task forces and problem-solving groups or through open-ended, change-oriented assignments, with more room left for the **person** to define the approach.

A wide range of activities, often new and demanding, is needed before changes in motivation and performance can occur. Before such changes can be made, of course, health service leaders must make a personal commitment to support these innovations. They must believe that times are different, understand that the transforming nature of our era requires a different set of responses. They need a sufficient sense of personal power to feel comfortable about sharing it. They need a commitment to longer-term objectives and long-term measures. They must think in terms of integration rather than segmentation, of making connections between problems, of pulling together ideas across disciplines and viewing issues from many perspectives.

The dominant characteristics of change will be:

- movement away from centralized management;
- enhanced communication;
- clearer and more meaningful targets for individuals;
- increased recognition of outstanding performance;
- more efforts directed towards meeting the living and working requirements of staff;
- stronger links between reporting and subsequent actions; and
- better assessment of individuals and more support in their individual development.

In most health services, additional resources and manpower will be needed to develop and maintain the initiatives outlined in this chapter. Investment - of money, of personnel, of commitment - is required to achieve increased motivation and improved performance. Only through this investment can health services and staff members make the best of the work bargain, and only through this investment can the public obtain the volume and quality of service that they pay for.

3.4 IMPROVING PARTICIPATION

Participation is defined as the creation or enlargement of the possibility for employees to influence their work and its context. It creates a sense of ownership. Participation can be achieved informally, particularly through the enrichment of individuals' jobs or the creation of teams to undertake work. Participation can also be more formal where representatives of employees share in the power of decision-making to govern the enterprise as a whole. This may be by having places on the managing committee or by members of staff being elected at regular intervals to represent employees' views. For the purposes of this note we are going to concentrate on the individual, informal approach to participation, rather than on the institutional aspects of the distribution of power between managers and staff in the organization as a whole.

Before any strategic efforts are made to increase the level of participation within an organization, thought needs to be given to the implications of such action. There is ample research to suggest that increasing the level of participation is likely to lead to improved performance in most circumstances.

The qualification "in most circumstances" is added because in some highly structured process of work, for example those in an operating theatre, it is obvious that an increase in the level of participation by staff in the actual conduct of the operation is more likely to lead to ineffectiveness than effectiveness. Nevertheless, in the same operating theatre participation can be encouraged in the undertaking of less structured work, for example, the way in which the theatre should be cleaned, and possibly even its work-flow, can be discussed amongst the staff themselves. A second implication of any strategy aimed at increasing participation is the consequence for some supervisory staff. Obviously, if employees are given more opportunity to take decisions about their own work, it means

that there is apparently less work and responsibility for the next level of management. This may mean a reduction in the duties of managers or possibly a major reconstruction of all roles and responsibilities in the managerial levels. It may also mean that managers can spend more time on planning and development work, less on routine supervisory duties.

Strategies to Improve Participation

This section deals with examples of strategies aimed at increasing the level of participation by people in their work. It is not intended that this strategy should be seen as a general prescription. Participation is aimed at improving the overall effectiveness of the organization and it is quite possible that some strategies will be totally irrelevant and impracticable in particular local circumstances. We have already quoted the obvious impracticability of everyone participating in a major surgical operation. Increasing participation may mean a major cultural change in the organization. It might also bring about major social changes and the need to develop new skills. If, however, there is a wish to increase the level of participation, such a change needs to be planned with clear goals and a strategy.

a) Creation of Autonomous (Self-Regulating) Work Groups

A number of organizations which have traditionally used production lines have abandoned these and formed autonomous groups taking collective responsibility for the production of goods or services. The responsibility extends from the ordering of materials to the eventual distribution of the product in some cases. In a health setting this may have implications for the work of organizing health education, or family spacing programmes, or the building of a village health post, in all of which community participation and self-help is generally to be encouraged with the support (not the dominance) of health professionals.

b) Job Enrichment

The enrichment of a job increases the discretion open to an employee and often results in higher levels of production. Job enrichment often goes hand in hand with the creation of autonomous work groups.

c) Projects Groups

Participation of employees is often accomplished by involving them in project groups which have a special task to undertake. Group members from many parts of the organization (and in some cases from different levels) work on the assigned project, after which the group can be disbanded.

d) Problem-Solving Groups/Quality Circles

Groups of employees who work together are sometimes encouraged to break off from their normal work to deal with a specific problem related to that work. Such a problem might be to do with the quality of the work or the efficiency with which it is undertaken. Quite often these problem-solving groups are trained in a particular technique to solve problems and have the opportunity to report their conclusions to higher levels of management.

e) Changes in Management Style

Many organizations, when reflecting on their prevailing style, recognize that it restricts the opportunity for individuals to come forward with ideas and initiatives. Deliberate efforts (often of a training nature) are aimed at changing such style so that managers work with their subordinates frequently in the context of a team to resolve joint problems and pursue agreed upon objectives.

f) Staff suggestion schemes

Although not really achieving a high level of participation, a staff suggestion scheme can increase the sense of involvement that the staff have with their work, provided that a sufficient number of the useful suggestions are seen to be acted on by management. Sometimes financial or other incentives are used to encourage suggestions.

Participation is not a solution to all problems, even though an organization might successfully create a higher level of participation in the way that staff are involved in work. It does require a constant effort to ensure that the participation really works. Managers may feel threatened by it and staff become disenchanted if they see their ideas constantly ignored by management. Participation works well when the organization is concerned about the employees as well as about performance.

Additional reading in Annex 3.

MOTIVATION

1. THE BASIS FOR MOTIVATION

Introduction

It is perhaps true of most people that they spend very little time thinking of what motivates them or others to behave in the way they do, or to understand what causes them to do some things with more energy than others, or indeed to withdraw from doing anything at all. They respond instinctively to their circumstances and, as will be shown later, in a way which reflects their expectations of life and their view of the social setting in which they live. While the ways in which individuals respond vary, the sequence of needs which generates this response appears to be universal and largely to transcend national and racial boundaries.

What are the forces that motivate individuals?

Much research has gone into trying to categorize the great range of personal needs which motivate us all. The basis proposed here is derived from the hierarchy of categories originally established by Maslow (see Figure 1). This hierarchy has not been overthrown (although modified) by subsequent theorists and, moreover, it appeals to good sense.

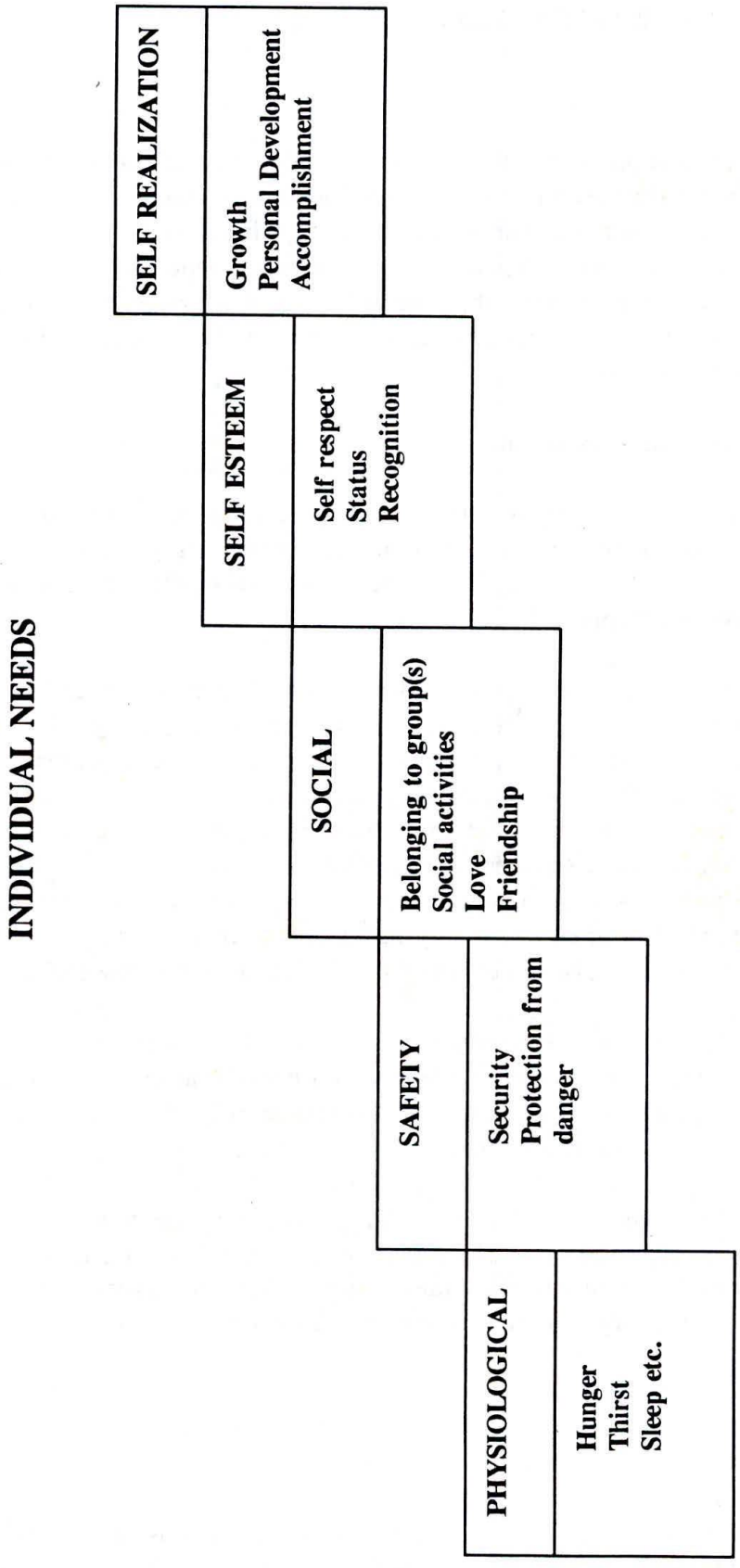
Maslow (the psychologist who developed the hierarchical "Pyramid of Needs") proposed that at the most fundamental level we are totally driven by the need for physiological survival. We must breathe, eat, drink, sleep, exercise, keep warm and so forth; if these needs are denied, they ultimately take precedence over anything else. But once they are satisfied, other needs develop, firstly the need for security. We seek to be physically safe, free from danger, sheltered, assured that we understand our environment, that we have some essential control over it and that we can expect some future. The resistance to transfer shown by young nurses in some developing countries provides ample evidence of this need: they often risk losing the support of their families if they move to a new location, and moreover may have no guarantee of safe housing in the new environment.

Again, if these security needs are threatened, we are likely to set aside many other needs. Conversely, once we feel fairly secure, we look for further satisfaction. The third group of needs, Maslow suggests, are the social needs. Once assured of existence, we seek companionship, affection, love, sex, the opportunity to care for others and to enjoy their company, and to reproduce.

We all differ in the strength of our physiological needs and still more in the amount of security we need. There is an even greater range of differences in our needs for affection and companionship. But even so, few people are capable of the life of a hermit, and only a very small minority would be likely to deny that appropriate companions contribute greatly to personal happiness.

Maslow also suggests that once social needs are satisfied, we look for self esteem - for feelings of personal competence and for other people's acknowledgement of our competence. We seek some area of personal achievement which will exercise our talents and gain us recognition and the right to some special position in our community. At this point, motivation is even more individualized and particular talents and temperament are unceasingly influential. In this category come all the roles a person may wish to play in a group, from powerful dominance to submissive dependence.

Figure 1 Individual Needs



Looking predominantly at life histories in industry and the Western world, Maslow observed a fifth and final group of needs, unlikely to be developed until the previous four were satisfied. These were the needs for self actualization, seeking one's own best development and fulfilling one's personal potential.

Needs and Age

It is not hard to see that these levels of need are somewhat linked to age. The infant needs survival and security; the small child, while still requiring security, is increasingly concerned with affection; and young people even more concerned with seeking peer friendships and sexual partners. By the time people reach their mid-twenties, many have become concerned with status and are seeking to establish their careers and lifestyles. Then comes the desire for autonomy and freedom to develop one's particular abilities. This is a phase which is most likely to develop once certain career ambitions are achieved, including, for some, retirement from work.

The Hierarchy of Needs in Working Life

Relating Maslow's ideas to working life, it can be supposed that the individual will look for a job with a salary at least sufficient to live on; that is as secure as possible; and, probably, that offers companionship and/or status and a chance to progress. How much each of these needs matters, even at the outset of a working life, will be greatly affected by the individual's heredity, environment and early training. To what extent these later motivations develop, or can be satisfied, depends greatly on the society in which the individual finds himself. Moreover, circumstances may change at any time and require him to revert to the satisfaction of more basic requirements. A country plunged into war, or faced with famine, forces many of its citizens to address the urgent problem of survival.

Heredity and environment bring differing gifts of health, vigour and physical competence, mental abilities, aptitudes and temperament, all of which are developed, directed or subdued by training in childhood. In the parental home, children learn appropriate work ambitions, what is desirable work, what is worth striving for, who is worth being with, what roles in a family or a community will gain affection and respect.

It is not surprising that motivation has been found to be affected by a person's sex, position in the family, family circumstances, and its attitude toward religious, social and cultural thought in the country.

If one takes position in the family as an example, first-born children tend to accept responsibility and feel an obligation to achieve, while the youngest often have a more easy-going approach. It is not hard to relate this to the likely experiences of the oldest child, and of the baby in the family.

Outside the home, the young person most probably enters the world of education. Educational opportunities are the first major influence outside the family. What is provided, for how long, the quality of instruction and the values instilled with it, will all affect the ways in which the adult sees his or her environment and what he or she perceives to be the opportunities it offers, e.g. education for girls. The controversy over whether to educate boys and girls together or separately, which persists in some western countries, is a case in point.

Thus, the individual's reasons for entering employment will range from necessity to personal advancement to fulfillment. Similarly, reasons for staying in that employment or for leaving differ, and indeed change with time, even for the same individual, since personalities change, family obligations alter, and society's values modify.

How do the different needs develop?

By the time people reach adulthood, most have already experienced a great deal of training. Their individual gifts of health, stamina, general appearance, mental and physical abilities and aptitudes will have been recognized or not, developed, permitted or suppressed according to social pressures in family and school, and the standards of care and training which family and school have provided.

They will have learned more or less consciously what are "desirable" sorts of work, what work is "appropriate" for their sex and/or position in society, whether they should be looking for a modest occupation or planning a career, and what responsibilities they should expect to carry. Some studies have shown that by the age of seven, children are beginning to accept themselves as heading for jobs carrying little authority, being no more than a means of earning money, filling time before marriage, or for a career which will enrich their lives and for which they must train and prepare. Social training will also have taught them how to relate to other people: whether they should submit or take the lead, how to converse and what role to play in any group they join.

It has not been demonstrated that there are appreciable differences between men and women as regards range of abilities, basic needs or desire for achievement(s). What variations there are can be linked, to some extent, to differences in reproductive functions and physical strength, but these linkages are far stronger in relation to cultural and social pressures, particularly in attitudes toward women's work.

Whatever the individual's society, his motivation is likely to change through life. London Business School studies have shown that among the British, personal relationships dominate the concerns of 18-year old male job seekers. By the time they reach their mid-twenties to early thirties, survival and companionship needs, though important, have been overtaken by needs for recognition and status. But the picture changes again with marriage and children. When a man's family is first established, he again becomes concerned with survival and relationships. Moving on into the forties, these needs recede again and recognition and fulfillment become paramount.

Concluding Comments

The basis for any action to improve motivation rests on the ability to satisfy individual psychological needs, both present and in the future. People are motivated when they perceive that the consequences of their actions will be favourable to them, i.e. when they believe that they will achieve goals that they as individuals desire. These goals are never simple, and can be expected to change as life situations change.

2. INDIVIDUAL NEEDS AND ORGANIZATIONAL PERFORMANCE

The previous section set out the "ground rules" that define the source of an individual's motivation and the way in which the different psychological needs of people can be influenced by their sex, age, family position, education, expectations of life, and their role in society.

In this section, the degree to which these individual needs be met by work is explored. Also examined is the extent to which an organization can benefit from having staff whose motivations are satisfied by the work situation. The purpose of the chapter is to establish what it is in the work situation that will stimulate individuals in terms of commitment and motivation, and to define whether this has any effect on an organization's performance.

What individual needs can a job meet?

Survival

Most obviously, the financial rewards of paid employment can help to meet our survival needs. Only those who are supported in other ways can ignore this element of employment. Anyone who needs money to survive is motivated to stay, even in unsatisfactory employment, if it pays above subsistence level and there is no alternative work.

This is not to deny individual variations even in this basic need. Some people can survive on very little and take little interest in financial rewards. Subsistence is seen differently by different individuals and cadres of staff. The subsistence talked about by the doctor, for example, is different from that described by the night watchman. Others link money with self respect and demand little of a job beyond that it should produce an increasingly large income. Whatever the attitude, however, there is the basic requirement that pay and benefits should, at the very least, meet subsistence requirements.

However subsistence is defined, it is apparent that in some countries this requirement is not being met by the health service for a number of different cadres. Governments are being caught in the trap of expanding services and creating employment at a rate greater than the growth of real national income. In such circumstances, it is not surprising that staff absenteeism (mostly unofficial) is high, and that staff spend much time and energy elsewhere supplementing income to meet their perceived survival needs.

Security

Most jobs offer a degree of physical and emotional security, even in times of social and economic upheaval. The job holder has a role, if only because the organization cannot operate unless people have an idea of the work they are to do, to whom they are to report, where they are to work, and what hours.

Even the most poorly paid job offers a role and some way of contributing and relating to others, which is a major source of personal well-being. One of the major problems experienced by the unemployed is the difficulty of providing themselves with a timed, structured and useful day.

In addition to this level, a job can offer routine, predictability, rules, explanations, standards, and an environment which, however far from perfect, is generally organized and protected by others. The majority of job holders do realize to some extent their needs for a dependent relationship. However "unfair" the duties and rewards, they are unlikely to be as unfair as the distribution of duties and rewards experienced in home and community life. In addition, any injustice is relatively more remediable. Lest we underestimate the value of this function, let us recall the number of women who run demanding households and to out to work "for a rest". Also, most countries have some legislation pertaining to health and safety at work, often much more stringent than that which applies to domestic situations.

Companionship

Most people, especially women whose family life may be socially narrow, or the increasing number of people who find themselves living alone,would agree that companionship and friendship are major reasons for going to work. Unhappy relationships at work are major reasons for changing employment.

The great majority of jobs offer some companionship and most of it, like the physical work environment, is controlled and safe. While we are often concerned about the stresses and strains of relationships at work, this is in part because our expectations are high. In general, we expect to work among competent, cooperative equals, compatible in age and education level, in a way we never demand and do not always achieve in domestic and other environments.

Most work permits a range of relationships, interactions and opportunities to exercise social skills. The active can contribute, the passive can watch the passing scene with the variety of personalities and social entertainment which much work provides. The highly convivial (who at home may exhaust their families) can contribute usefully, perhaps in work such as politics, selling and organization. A basic level of communication skill may be enough to ensure retention of some jobs; a vast range of skills in speaking, presenting, arguing, teaching, training, negotiating, selling, encouraging and persuading may be needed in others. All of these skills must be exercised in relation to any number of people and in any number of situations. Work companions may provide the benefits of working with a skilled team at tasks which could scarcely be completed if working alone.

Finally, companionship at work can provide standards against which to compete, and a way of monitoring personal performance. Even people who do not feel any great need for personal friendships, still seek the stimulus of company at work for one or another of these reasons.

Status, Recognition and Esteem

The work environment provides, for most people, the best opportunity of gaining status and esteem outside their own families. Indeed, it may offer status when private life offers none. There are great differences between individuals in their need for recognition at work, but most people want at least recognition for work well done by those they respect. It can be argued that giving public recognition and status for good work is the most neglected of all methods of improving staff morale. What can be done in this direction is discussed in the section on the employer's contribution.

Jobs which carry power over others are also a source of self esteem for many. They may not be jobs which appear at the top of the organizational chart. An apparently low-ranking job may bestow power if it requires the job holder to interpret and administer regulations, to protect or receive information, or to determine who has access to more senior people, or the right to carry out some operation. Examples are the clerk in charge of the filing cabinets, someone with access to the organization's personnel records, or the secretary who decides who can and who cannot see the boss.

Regardless of whether these privileges are exercised selfishly or beneficially for the organization as a whole, they are often sources of self esteem for the job holder. More senior jobs may permit the exercise of considerable personal power, and the hope of attaining such posts feeds the motivation of the more ambitious.

Self Fulfillment and Personal Growth

The forms these final needs may take are as varied as people themselves; and by no means can all of them be fulfilled at work. While some attain the positions of power which enable them to achieve their own ambitions while developing the business, others experience what is called the "mid-life crisis", a growing realization that while some goals have been attained, others are probably not attainable or even not desirable after all. The individual begins to feel that he or she must develop in other ways and to experience growing frustration if not able to do so.

Some people want more opportunities to develop their own ideas, some want to return to a student role and learn new subjects or skills. Some simply want more time in which to develop abilities which work has forced them to neglect. Recent changes in the structure of many organizations (usually in the direction of decentralization and the introduction of new technology), and also changes in the types of contracts of employment, have indicated ways in which people might stay in useful employment while still realizing personal ambitions. When this can be done, both the organization and the individual benefit.

What are the implications for the organization?

The very act of working in an organization provides most people with the basis for satisfying many fundamental needs. How well these needs are satisfied in practice depends both on the structure of the organization, and its concern to ensure that appropriate bargains are formed and maintained with its staff.

An organization attempting to meet as many of these needs as possible would:

- provide the best financial rewards and personal security it could afford;
- provide an environment that encouraged team work and friendship;
- offer opportunities for status and recognition early in the career;
- offer staff the security and support during the years of childbearing and rearing; with real chances for status and recognition when the family is established;
- ensure opportunities to explore new avenues of endeavour late in the career; and
- continuously review its bargain with the individual to ensure that appropriate needs were being met.

Crucial to these provisions is the capacity to manage the careers of individuals through assessment, training, placement, promotion and the establishment of realistic career structures.

Does motivation matter?

The previous section suggested that motivation of individuals in the work situation can be influenced by the way in which their needs are met. This is important for the organization. It is all too obvious that the behaviour of poorly-motivated staff is damaging. They are distinguished by poor attendance and bad time keeping, cynicism, carelessness, apathy, lack of interest, and sometimes, by their aggressive attitude to colleagues and militancy with supervisors. They are under stress themselves

and they provoke stress in others, both in the extra work of monitoring and supervision which they require and in the irritation and distress which they cause. If only their motivation could be improved, frustrated seniors say, then how much more could be achieved.

It certainly seems reasonable to suppose that high motivation would indeed improve matters. People who feel committed to their jobs can be expected to work with dedication, to put in fair (and often more than fair) hours, not to be absent, to cooperate with colleagues, to respond cheerfully to orders and, very importantly, to try to succeed at the tasks to which they are assigned.

At managerial level, highly-motivated people have been shown to need less direction and control, to welcome more responsibility, and to seek more feedback on their performance than do their less-motivated colleagues. The potential benefit to the organization of having highly-motivated employees is obvious.

Does motivation improve organizational performance?

It cannot, however, be assumed that if only employee motivation is improved their work performance will also automatically, and in all respects, improve. The evidence is that highly-motivated staff:

a) come more regularly to work,
b) work more diligently, and
c) are more flexible and more willing.

Conversely, there is no evidence that motivation alone will ensure that people work fast or well. People who are highly motivated do not also automatically work efficiently. They do not necessarily use their time well, or avoid making mistakes. Neither is dedication to one's job any guarantee of commitment to the well-being of the whole organization. A doctor who is totally committed to the care of his or her patients may well turn out to be the most extreme opponent of new methods, or redeployment of resources, however desperately the changes are needed for the sake of other patients or staff.

Increased motivation creates the conditions for a more effective workforce. To translate this increased motivation into improved health service performance, it must be matched with effective management practices and supervision.

Concluding Comments

Work can satisfy many important needs which all individuals are likely to have. It is worthwhile for every employing organization to meet these needs as well as possible, and to organize employment contracts and agreements to achieve a mutual sense of fairness in regard to individual needs and local circumstances. In searching for appropriate bargains with staff, organizations must recognize that everyone assesses the effort required to invest against the results achieved, and the result against the rewards offered for achievement. If the balance seems wrong, the individual becomes dissatisfied and demotivated.

Motivation is a critical element in the success of any organization, and even more so in health services which, more than most other organizations, depend upon the dedication and commitment of their staff. However, as stated earlier, motivation by itself is not sufficient to ensure a high level of performance. It must be combined with good standards of management to ensure that human endeavours are employed in the most effective manner.

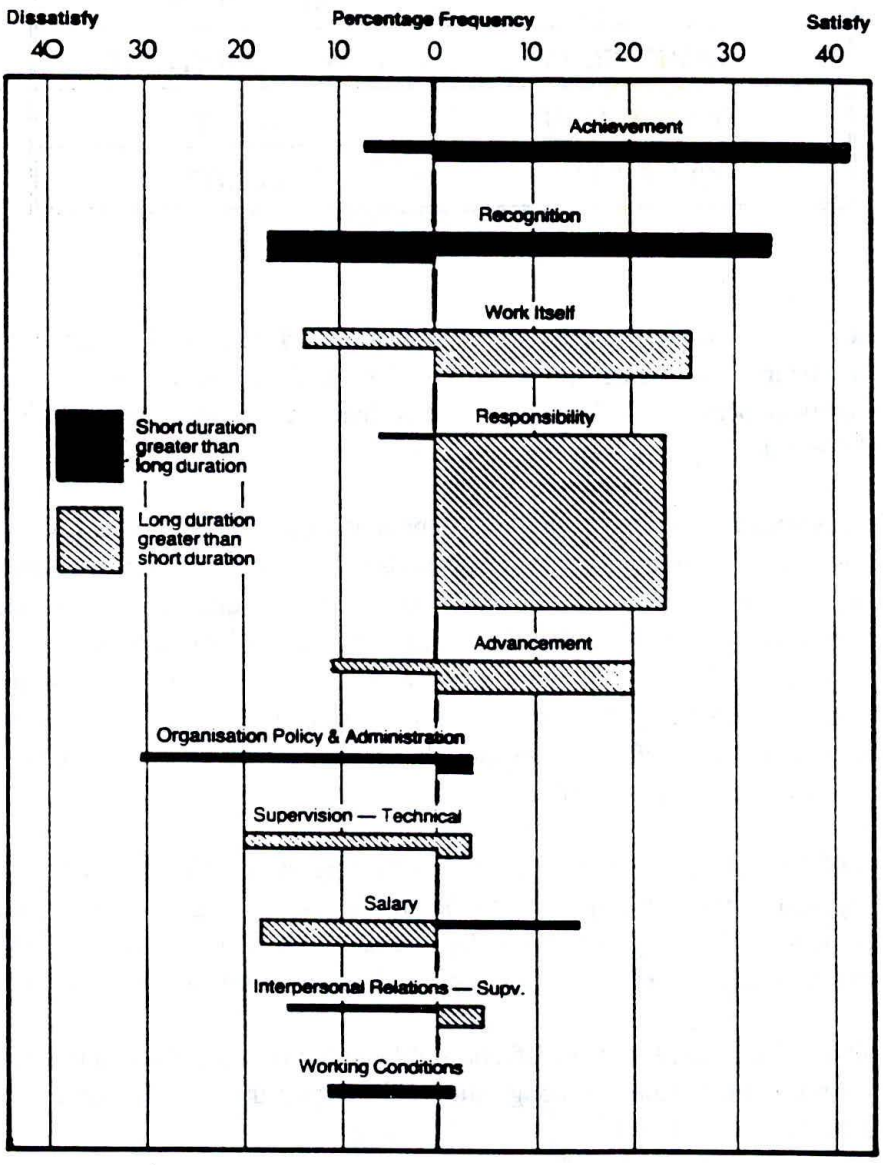
3. CAUSES OF POOR MOTIVATION AND LOW PERFORMANCE

What motivates and what demotivates in the workplace?

Working initially with accountants and engineers, and subsequently with people in a broader range of occupations, Herzberg[1] found that individuals responded differently in terms of work behaviour when different needs were ignored. He established a group of needs which must be met if the individual is not to become dissatisfied and a second group of needs which, if satisfied, will encourage the individual to work hard.

Figure 2, summarizing Herzberg's conclusions, indicates the percentage of people in his studies who mentioned a particular factor, either as a cause of satisfaction at work and enthusiasm for the job, or as a consideration in deciding whether to stay or leave.

Figure 2 Comparison of Satisfiers and Dissatisfiers



[1] Source: F. Herzberg et al. ***The Motivation to Work***. John Wiley, 1959.

The drive to work hard and put in extra effort derives from other factors: being able to achieve something personally; being recognized for one's contribution; having responsibility; and being able to grow and progress. A summary of these key factors is shown in Figure 3.

Figure 3 Summary of Herzberg's Key Factors

POTENTIAL SATISFIERS (MOTIVATORS)	POTENTIAL DISSATISFIERS (HYGIENE FACTORS)
ACHIEVEMENT	COMPANY POLICY AND ADMINISTRATION
RECOGNITION	SUPERVISION
WORK ITSELF	INTERPERSONAL RELATIONS
RESPONSIBILITY	WORK CONDITIONS
ADVANCEMENT	SALARY
GROWTH	SECURITY

The diagram also shows that the basic needs for survival, security and social relationships have to be met (through provision of adequate working conditions and salary, fair supervision, acceptable colleagues and equitable personnel policies) if the individual is not to become dissatisfied with the job. Herzberg called these the "hygiene" factors.

In the health field, senior nurses have been found to be motivated primarily by social concerns (ability to help others and working relationships), and secondarily concerned about their own security and freedom to make professional decisions (self fulfillment). The less-qualified nurses cared more about working relationships and about survival and security (no doubt reflecting their poor salaries). It is scarcely surprising that nursing attracts people with a high need for a socially-rewarding environment, including the opportunity to care for others. An important national study also demonstrated strong links between nurses' work satisfaction, physical health, length of stay, and the amount of social support and communication they enjoyed.

The significance of different needs of course varies with different people. Those with high needs for survival, security and companionship tend to be found undertaking simple, repetitive and safe "production line" work. Very high achievers, by contrast, care relatively little for these things and are very much more concerned with gaining power and opportunities for personal fulfillment.

A study of health service managers' dissatisfactions related to their jobs showed that men and women agreed on their top ten frustrations, although they did not pub them in the same order. Figure 4 shows these frustrations in rank order.

Figure 4 Manager's View of Work Frustrations

TYPE	RANK ORDER	
	Women	Men
Excessive stress	1	10
Inadequate opportunity for rapid advancement	2	5
Too little freedom or independence	3	2
Lack of status	4	6
Lack of recognition of the individual's achievements	5	4
Little opportunity to grow	6	9
Lack of intellectual challenge	7	7
Poor financial rewards	8	3
Little opportunity for innovative work	9	1
Limited opportunity to lead	10	7

For some people, security needs are met by working under strong management with defined standards. In one organization with a strong, disciplined style of management, the happiest workers were those who valued the strict regulations, the high standards of cleanliness, the insistence on time keeping, and the great concern for quality. Less happy were those who valued friendship and social support.

Given this complexity, it is clear that no one employment factor will influence good or poor motivation in any given situation. Nevertheless, we can accept our common needs for survival, security, companionship, status, recognition, esteem, self fulfillment and growth, and look to see to what extent health services meet these needs, and so promote constructive behaviours which are shown by well-motivated staff.

Impediments to motivating health service staff

It has to be said that, in many health services, conditions are often such that large groups of staff suffer strong demotivating forces over extended periods. Poor staff motivation is a far from negligible problem in developed countries. In some developing countries, it is severe. There are four main reasons why this is so:

1. Many new nations are in an initial phase of strong centralized control which limits the ability of health services to respond flexibly to local and individual needs.

2. The phenomenal growth of health services in developing countries has resulted in many managers being able to exercise controls only at the most basic levels.

3. Related to the above, the administrative machinery of the service and the skills of its managers have often failed to develop fast enough to cope with the demands placed on them.

4. Policies in developing countries have frequently focussed on growth rather than on performance, and on scale rather than on quality.

It is only as health services have become more established and mature, and/or under greater pressure to use resources effectively, that their performance has come under scrutiny, and with it, the performance of individual health service employees.

Too often it has been assumed that poor motivation can be remedied in some simplistic way, for example by the provision of more management training, or an increase in salaries. In reality, poor motivation involves almost every aspect of the way in which an organization functions.

Why do these problems occur?

Four major causes of these difficulties in the health services of developing countries are listed on page 11. But they also occur in the health services of developed countries, and at least part of the reason for this is that health services everywhere are subject to strong social and professional pressures. Public opinion regarding the quality of health care is highly sensitive, and relevant government policies are thus particularly liable to adjustment. Within the service, conflicts may arise between the requirements of the medical practitioners and management's need to make the best possible use of scarce resources.

Often this results in senior staff being preoccupied with these issues, and paying little attention to staff motivation. Not surprisingly, surveys of staff attitudes often show them to differ widely from the attitudes which their seniors presume they hold. The results of one such survey appear in Figure 5.

Figure 5 What do Employees Really Need?

JOB FACTORS	EMPLOYEES' RANKING	SUPERVISORS' EXPECTATION OF RANKING
Feelings of being in on things	2	10
Job security	4	2
Interesting work	6	5
Personal loyalty to employees	8	6
Tactful disciplining	10	7
Good working conditions	9	4
Promotions and growth in the company	7	3
Good wages	5	1
Sympathetic help on personal problems	3	9
Full appreciation of work done	1	8

Concluding Factors

The factors in employment which influence motivation have been well-researched and tested in many different work situations. They are undoubtedly complex. There is no single formula that can be applied to stimulate motivation, nor is the environment static. On the other hand, all staff have important needs in common which health services can do much to satisfy, certainly more than is being attempted at present.

There is little doubt that most individuals entering a health service are willing to commit themselves to the service of the public. It is just as apparent that many health services themselves are responsible for reducing motivation. In some cases, this is due to the stresses of development, but more often it is because the factors that influence motivation in a particular setting are not known and, just as importantly, the health service has not set itself the task of systematically fostering high motivation.

4. THE EMPLOYER'S CONTRIBUTION TO EMPLOYEE MOTIVATION

This section explores what organizations can do, in practical terms, to enhance motivation through greater attention to the working environment and conditions of employment.

Most health services are conservative in their outlook, and continue to maintain policies appropriate to days gone by. The continuing practice of requiring young medical house officers to perform prodigious feats of stamina, with excessive time on duty, is an example of this phenomenon. It is probably true that many health services (in both developing **and** developed countries) have made only limited attempts to improve morale and productivity through changing employment terms and conditions, and upgrading the work environment.

Yet opportunities for such changes are present in all health services, and many of these changes could be made without the introduction of new regulations. What is mainly needed is a willingness on the part of health service management to explore these opportunities and continually seek ways of improving motivation.

What kind of environment is needed to stimulate motivation?

As will be apparent from the previous chapters, the specific opportunities for increasing motivation vary from organization to organization. What remains common to all is the need for an environment which addresses individual needs for:

SURVIVAL	RECOGNITION
SECURITY	SELF ESTEEM
COMPANIONSHIP	SELF FULFILLMENT
STATUS	GROWTH

As we have seen, the strength and importance of these needs in any one individual will vary over their working lives. Nevertheless, a number are prevalent among us all. We all need conditions which ensure our survival - in terms of work, enough pay to live on and, perhaps, provision of essential accommodation. The core of staff motivation is likely to be the provision of adequate pay and physical security. Thereafter, employees seek appropriate companionship, due recognition of their particular contributions, and opportunities to exercise their individual abilities and skills. In general, employers should:

1. Seek to provide the best possible levels of pay and job security, and aim at rewards and conditions at least level with the average pay and perquisites for similar work elsewhere.

2. Promote supervisory styles and practices which will encourage high motivation (see below) and do what they can to establish work teams of people compatible with each other.

3. Put maximum effort into staff selection, placement, and appraisal as the crucial systems for matching individual abilities to job opportunities and ensuring that people continue to feel fairly treated and are given appropriate work and responsibility.

4. Use every means possible to maintain good and open communication with all employees. The appropriate means will vary and could include all or any of the following:

   a) friendly, consultative supervision;
   b) formal joint consultation between management and staff;
   c) regular discussions with trade unions or other staff representatives;
   d) effective appraisal of staff performance;
   e) briefing groups; and
   f) periodic attitude surveys.

Such systems of communication can make management aware of group and individual needs, can give early warning of areas of dissatisfaction, and will demonstrate management's interest in, and concern for, staff well-being.

What are the practical options open to the organization?

The Pay Problem

Most health staff feel underpaid, particularly in developing countries, where pay is often close to subsistence level, or below it, for lower level staff groups. In most health services, the major part of the recurrent budget is spent on salaries and staff benefits. Thus, even small pay increases massively affect the accounts. Scope is often further limited by pressures to extend the service and provide more employment.

Nevertheless, health services can consider some options:

1. Redistributing the salary budget to the greater advantage of critical cadres of staff.

2. Increasing the number of financially-linked benefits (housing in particular) which may come out of other budget sources.

3. Providing more supporting services which have financial implications, such as free or subsidized travel, child care centres for staff who do not have relatives able to help look after young children, etc.

4. Creating more opportunity for merit awards (many health services do now give some merit awards, at least at local level) in the form of training or assistance with travelling while on duty, or other help which effectively relieves the individual of some expense.

5. Being more explicit at both local and national levels as to the level of service expected in return for the organization's rewards, and being more supportive of staff efforts to generate outside income.

Some of these options are already exercised, but in clandestine ways. Regulations are endlessly manipulated by staff to allow better basic rewards: travel expenses may be raised to staggering levels; absences for extended periods to earn private incomes are overlooked; per diems are inflated; petrol

is syphoned off and sold; and so on. While these practices may help meet employees' basic survival needs, the health service loses the energy which staff expend in order to "beat the system". A more open acknowledgement of the need to help when salaries are low would make for fairer rewards and greater general cooperation.

Once survival needs are met, dissatisfactions with pay generally relate to comparisons. One comparison is with external alternatives. The organization needs to be aware of what is being paid for similar work outside, and some strong counterbalancing influences must be provided if the pay levels in the service are below what is attainable elsewhere. In many countries (though not all), social recognition of the value of health service work acts, at least partially, as a counterbalance.

The individual also makes comparisons within the service. Staff compare their own efforts and standards with those of comparable colleagues. When large groups are working together, it is important to ensure that jobs of similar difficulty carry similar rewards. This is best achieved by regular job analyses and comparisons of key jobs, but which in practice is often argued out between management and union or staff representatives. Whether in a large group or with only a few colleagues, the individual will compare his or her work and efforts with those of others, and not find it "fair" that one person works hard and the other idles, but both are paid the same amount. Neither will they find it "fair" if a job carrying additional training and responsibility is rewarded at the same rate as another without those requirements. Midwives in Britain have long argued on these grounds that they should receive higher pay than, for example, health visitors.

Bonus or merit schemes can relieve these difficulties, the first usually applying to work with a quantifiable outcome, and the second to work to which accuracy and care of other qualitative factors particularly apply. Merit rating permits a range of payment for particular work within which the individual's pay is determined by effectiveness. The individual must understand why pay has been fixed at a certain level, and must have the opportunity to do better and earn more. Appraisal systems provide a way of ensuring this understanding, and also opportunities for advancement. They have been introduced in some countries, accompanied by target setting and monetary rewards for achievement for health service managers, and in a modified form for consultants and general practitioners. Worldwide, however, few health services operate effective appraisal systems.

Paying a bonus to a group or team for good work has also proved helpful in certain circumstances. For example, it would be appropriate in mounting special campaigns, such as immunization. The evidence is that groups must be small (five to seven people) and able to affect the outcome of their work. In addition, everyone in the group should have a clearly defined role to play which is recognized as necessary for achieving the stipulated target.

Job holders think it is "fair" that they should be paid more this year than last, and they expect their incomes to rise steadily. This may be justified insofar as their skills and experience develop, and insofar as the real value of their earnings is eroded by inflation. But inflation index-linking, which is quite a usual way of dealing with part of this problem, carries the limitation of all percentage awards - the rich (well-paid) get richer much faster than the poor. As the gap widens, so dissatisfaction increases.

It has to be repeated that people differ greatly in their need for money, both through circumstance and because of their interests and temperament. At one extreme is the person who is happy on a survival income provided he or she is free to undertake interesting work. Health services are blessed that so many people in this category are attracted to caring work. Nevertheless, they may still come to resent exploitation. Health services are also not without staff who value a good income and whose

self esteem is related to the size of their earnings. Whatever the individual's needs, the desire to be "fairly" paid in relation to others is more or less universal.

Security and Structure

Much of our need for security is satisfied by working in a structured environment. We demand variety, too, but most of us mean variety within some form of organization. The adventurer who will set forth on journeys of indefinite length into entirely unknown territory is rare.

The structure we demand of work, with differing emphases according to temperament, is that it shall provide the following:

1. **A clear objective.** We need to know why the organization exists and how our own work contributes to its purpose.

2. **A defined job.** In many countries today, employees are legally entitled to be given their job descriptions, laying out their duties, responsibilities and conditions of employment.

3. **Defined rules and standards** for personal conduct and job performance, with relevant and "fair" penalties and rewards, and appropriate supervision.

4. **A prospect for personal growth or advancement.** This involves knowing the organizational hierarchy, where one's own job is placed, what promotion is possible, and what career development one might expect.

5. **Work which suits our abilities**, a requirement which involves that the organization provides adequate and competent selection, placement, training and appraisal.

6. **Feedback on how we are performing** and what we must do to progress, which again demands appropriate appraisal, training and fair promotion procedures, as well as competent supervision.

As anyone who has worked in an organization knows, these demands are difficult to satisfy, very difficult to relate together and exceptionally difficult to harmonize over any period of time. Commercial undertakings may devote considerable resources to the maintenance of these conditions. While health service authorities may argue that they lack the resources for such luxuries, commercial undertakings might well reply that these provisions cannot be categorized as luxuries at all, but as essential elements in maintaining the workforce needed and achieving the objectives. It is unfortunate that personnel management in health services, where it exists at all, is too often at the level of junior management, and concerned more with administration than policy.

A major stumbling block in developing systems to identify individual contributions in the health services is that, too often, national objectives are known at highest levels but are not transmitted down: and are certainly not linked to individual or unit objectives at local level. The option to overcome this particular problem does not require more than sufficient effort and commitment throughout the service.

The above goals stated are worth striving for. If these demands can be met, then a great range of individual needs can be satisfied, in addition to the need for a secure structure. In any event, the procedures required form the essential bases for good management and leadership.

Providing Companionship

For some people, the quality of companionship they enjoy at work is a prime reason for continuing in employment. Studies of motivation indicate that for many people, incompatibility with colleagues is a strong incentive to leave a job. The quality of companionship is particularly important at two levels: for people who are happy in routine tasks provided they can enjoy sociable, friendly relationships; and for teams of skilled people who must trust each other and rely on each other's abilities and integrity to achieve their work objectives. Both these situations appear extensively in health services. In a hospital, basic housekeeping work is an example of the first level, and a theatre operating team an example of the second.

The high level of communication which prevails in harmonious groups gives each member much emotional support, and facilitates the exchange of information, whether personal or technical and professional. Some important studies in the 1950s and 1960s yielded dramatic evidence of how this rich exchange could improve the quality of work performed.

To capitalize on the need for companionship, health services, like other organizations, need to focus more on the management of work groups. This would involve:

1. Stronger emphasis on team learning during basic and post-basic training.

2. Establishing group and institutional objectives on a routine basis.

3. Creating work teams within organizational units.

4. Strengthening the understanding and appreciation of individual staff roles in working groups.

5. Rewarding good group performance (see section on merit schemes, page 15).

Meeting the Need for Recognition and Status

Fair selection and promotion are fundamental to granting appropriate recognition of individual talent and effort. For these procedures to work well, the following conditions are necessary:

1. **The criteria must be understood**. People need to know the abilities required for appointment to a post, and for promotion.

2. **Assessment must be based on performance**. Whether in selection or promotion, individuals have to be judged in terms of their actual record of achievement in employment, or in other spheres.

3. **The opportunity for improvement must exist**. An individual whose progress is handicapped through lack of some training or experience needs the opportunity to make good these limitations.

A special need for fair selection arises when trained newcomers are introduced into an organization over the heads of existing staff, an issue of considerable debate in many countries whose nationals wish to return home after work abroad. For them to gain acceptance and be able to operate efficiently, it has to be apparent to everyone from the outset that their contribution will be sufficient to offset the disadvantage of not being familiar with the organization's procedures and personalities.

Promotion opportunities are not always plentiful, and many people who require status and recognition may not be suitable for more senior management posts. It is therefore important to develop alternative ways of meeting these needs for competent staff.

A method much favoured in the public services is the provision of status symbols: office size, furnishings, vehicle use, etc. Such privileges can act as incentives, but only if they are seen to be going to those who clearly deserve them. It also has to be said that however much the individual may enjoy his or her privileges, these distinctions can produce barriers to communication and may be inappropriate for some sections of the caring professions.

The possibly adverse effects of permanent status symbols may be avoided by provision of other types of reward. Sabbatical leave for staff who have satisfactorily completed a certain number of years of service is a valued reward which is common in universities and some private organizations. Greater freedom in decision-making, or a larger budget, are also forms of recognition which need not so obviously distinguish one employee from another, and yet prove to be great sources of personal satisfaction.

Administrators of health services that have extremely limited budgets might comment that all these methods of meeting the need for recognition and status are expensive. There remain other ways of satisfying these needs which cost nothing but time and care. Prompt praise for good work; ensuring that the recognition is generally known; small inexpensive privileges such as occasional time off or flexible adjustment of hours; permission to attend a seminar or training programme; opportunities for visits; or a special project assignment, are all examples.

All these forms of recognition are highly-motivating for many staff. It remains crucial that they should be seen to be allocated fairly as rewards for good work, and for this the supreme requirement is fair and effective supervision.

Self Fulfillment and Personal Growth

Finally, there are those individuals who have met their personal requirements for survival, security, companionship and recognition, and are primarily concerned with self fulfillment and personal growth. Many people experience these needs to some extent. Unfortunately, they are often denied expression at work even though self fulfillment can prove the most powerful motivator of all.

People with strong needs for personal growth need to feel that their work is meaningful; they must feel responsible for the outcome of their work and need to know the results of their activities. They need to see the point of their work and to consider it important; they need to feel committed to attaining a standard. In the right job, they are goal-oriented and prepared to work long and hard for their objectives, and they work best if given considerable autonomy for planning their own work and defining and meeting deadlines.

Bureaucracies are not usually structured to support such needs. If they are to be met, some degree of decentralization is likely to be required to allow local adaptation and delegation according to individual abilities. Jobs may need re-designing, and working conditions changed beyond the traditional roles in a health service.

Concluding comments

A great many measures can be taken by the employer to increase individual motivation. All require careful appreciation of the relationship between the individual and the opportunities the job provides. All have the general aim of moving the individual from a state where he or she feels driven to fulfill responsibilities because of external pressures, to one where personal satisfaction gained from the activity is the motivating factor. Overall, and despite the differences in motivation, this shift appears most likely to occur when:

1. Adequate concern is shown for employee well-being;

2. Accurate information is given regarding career options, opportunities for advancement and the standards which have to be attained;

3. Opportunities for personal initiative are provided, with appropriate rewards;

4. Individuals are encouraged to develop personal career plans and objectives; and

5. Regular appraisal provides accurate feedback on performance and a chance to review and facilitate career planning.

5. GAINING COMMITMENT TO BETTER PERFORMANCE

Improving motivation mainly ensures that staff:

- come more regularly to work,
- work more diligently, and
- become more flexible and more willing.

These characteristics are important, but do not by themselves necessarily improve organizational effectiveness. Their contribution is greatly modified by the way in which the organization as a whole is managed and operated. Conversely, of course, it is unlikely that the workforce will be well-motivated if the organization is badly managed in other respects.

What does organizational performance mean?

Measures of organizational performance vary depending on whether the organization is in the public or private sector, is profit-making or not, and so on. For health services, particularly in the developing world, the most commonly used measures of performance are:

Impact, or to what extent do the activities of the health service affect the health of the population?

Outcome, or to what extent do the activities of the health service lead to positive health change?

Output, or what volume and type of health service is delivered?

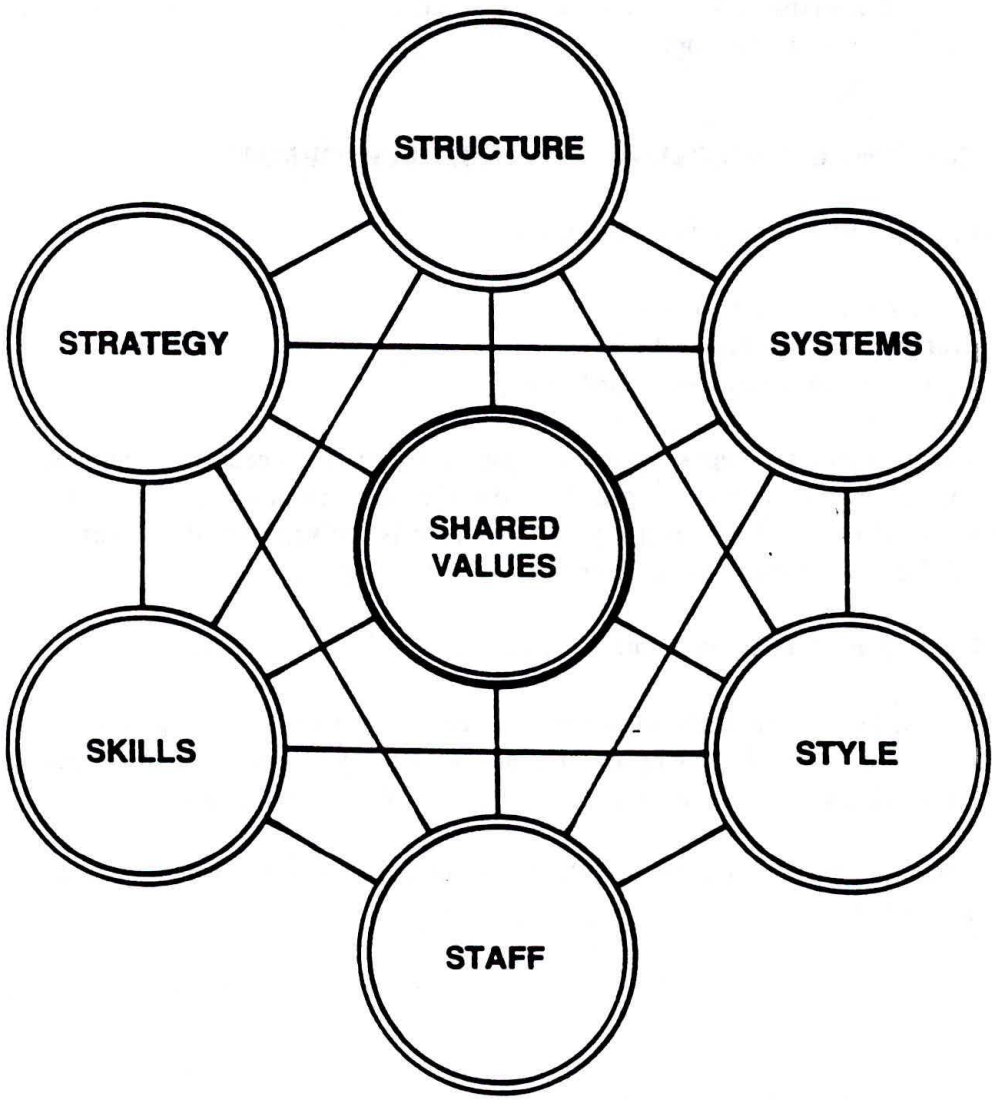
Some of the typical measures used are changes in mortality, disease incidence and deaths and discharges.

In the past there was little interest in efficiency (i.e. the relationship of inputs to outputs) or effectiveness (i.e. the relationship between input and impact), in the health services. These measures are now receiving more attention as they are seen to be offering major contributions to the provision of the greatest good for the greatest number. Efficiency, productivity and value for money are performance issues that health service managers will increasingly have to consider.

What causes change in organizational performance?

Organizational performance is determined by the interaction of many different organizational variables. In this document, we use the McKinsey "7-S" framework to identify seven major variables which have an impact on the performance of an organization (see Figure 6). Among these variables is "shared values" and within this variable comes staff motivation. It is central to the concepts of organizational performance.

Figure 6 Organizational Performance Variables



Source: T.J. Peters & R.H. Waterman Jr. ***In Search of Excellence***. New York, Harper & Row, 1982

In the diagram:

STRUCTURE is the arrangement of functions and posts in an organization. In highly-structured organizations such as Ministries of Health, the structure is well-documented with explicit descriptions of hierarchy, authority, responsibility, function and so on.

SYSTEMS indicate the processes within the organization through which individuals and activities are managed, coordinated and directed to achieve the goals of the organization. For example, the personnel system governs the way in which staff are selected, recruited, promoted, transferred, etc.

SKILLS covers the sum of individual capabilities within the organization. While in a Ministry of Health the focus may normally be on technical medical skills, it will also have to include administrative and managerial skills.

STAFF stands for the type of people employed by the organization in terms of their expertise and experience, intelligence, abilities and training.

STYLE refers to the way in which powers and responsibilities are distributed within an organization; this may be structuring or supportive.

SHARED VALUES indicates those beliefs, expectations and attitudes about work, the organization, and acceptable work behaviour, which are widely shared by the organization's employees.

What actions should health services undertake?

The variables are all inter-dependent. This results in many processes and pressures which affect the way in which individual employees feel and behave. Theories abound on how motivation (shared values) is differently influenced by changes in any of the variables. There is no general formula which will ensure across the organization that all staff are equally motivated and contributing to effectiveness. However, there are pointers to the direction in which an organization must move to increase staff motivation and improve organizational effectiveness. Managers may note that:

- public sector managers who are getting the best results are those who emphasize motivation. They do not ignore other tools such as target setting, cost accounting and management information systems (i.e. other organizational variables), but they deliberately focus on strengthening individual commitment and motivation.

- organizations which plan their goals and measure results do better than those which do not.

- people feel better about their jobs when they participate in setting goals for themselves and tracking their own performance.

- resistance to planning and controlling individual performance generally runs high in the public sector, and considerable effort and evidence are needed to help individuals accept target setting.

The health services, like other organizations, need firstly to create opportunities to ensure that motivation improves, and secondly to ensure that motivation is directed so as to achieve better organizational performance.

How can health services address these issues?

First and foremost, staff at all levels must be encouraged to contribute to target setting for their own units. In the first instance, this implies a movement for organizations toward more decentralized responsibility and "bottom up" planning. It also requires that planning skills and mechanisms must be developed at all levels of the service. This is already happening in a number of countries, with demonstrable effect on local performance.

However, for many health services, there are difficulties when political pressures force the generation of national targets, which are recognized from the outset as unrealistic. Nevertheless, there are processes within most health services that committed senior staff can use to overcome the difficulties. For instance, they can separate the targets for health impact from targets for service delivery.

Secondly, staff at all levels must know the targets for their units, and how these targets relate to the goals of their division/unit, and to the goals of the organization as a whole. All members of staff need to know how their own work contributes to the whole as a basis for building a sense of common identity. Work plans must become the common language of operational units.

Thirdly, managers and staff alike must be trained to give and to accept greater delegation of authority and responsibility. For many health services, this will involve a conscious change in managerial style and, indeed, in the culture of the organization, starting at the top. It is pointless to expect middle managers, the "engine room" of the organization, to change behaviour if those at the top continue in the old patterns.

Fourthly, individuals need achievable targets established with their involvement and cooperation. This is likely to involve assessing individual achievement in a supportive, non-threatening way. Formal appraisal processes will be needed which can be seen to benefit the individual's personal development, and which will give an opportunity for local recognition of exceptional performance. A method known as Individual Performance Review (IPR) has been introduced into the British National Health Service and is being tested in several other countries. This method meets the requirements for objective setting, performance appraisal and staff development.

Fifthly, individual managers must be trained in leadership and interpersonal skills, and then given freedom to supervise staff in ways that seem to them most likely to ensure motivation and good performance. In many health services, managers are receiving the necessary training, but for many this is not yet supported by the organizational change that will allow them to apply their new skills.

It can be seen that these recommendations for change touch on the style, systems, structure, shared values and skills elements of the performance model in Figure 6. It becomes apparent that no adjustments can be made to any one element of the model without making adjustments elsewhere.

All the propositions mentioned here have been introduced in varying degrees in health services around the world, as well as in other types of organization. The most prominent examples in the developing world come more from successful vertical projects than from the central processes of health ministries, as follows:

In the smallpox eradication project, the involvement of community and staff at all levels was fundamental to its success. It was not at all unusual for team leaders to be advised by local team vehicle drivers on how best to seek out cases and track potential carriers.

Malaria projects generally had a highly developed system of monitoring and target setting which kept staff at all levels in touch with the overall situation, and defined their roles and duties in the current campaign.

Family planning projects have often provided particularly good examples of delegated responsibility, allowing local managers and staff to determine how best to work with local communities. Project managers also spent considerable time and effort in establishing realistic targets with both staff and managers, and in monitoring achievement against those targets.

Finally, experience in the development of primary health care systems has increasingly demonstrated the need for leadership skills among "front line" staff. Health services in many countries are exploring ways of enhancing the necessary interpersonal skills of their staff.

Concluding Comments

The issue of motivation cannot be divorced from that of organizational performance. Improved performance must go hand in hand with improved motivation, even though it is not solely determined by the commitment of the staff. The basis for motivational improvements lies in clarifying the purpose and objectives of the organization, and relating them to individual needs.

The concept of target setting for both organization and individual, which is discussed here, is called "management by objectives". A large body of experience of its practice has been built up in both the public and private sectors. Management by objectives is an effective procedure, but only when managers are trained in the necessary skills, when individuals trust their managers, and when the organization is committed to making the procedure work.

6. CREATING AND MAINTAINING THE BARGAIN

The way forward

There are a number of separate paths to follow. They are linked and, to be realistic, it will be necessary to make initiatives along each path. It will not be possible to proceed along all the paths with equal speed. Recognizing at the same time that health service strategies will need related attention, the specific areas of change are likely to be in:

- terms and conditions of service;
- personnel and career planning;
- selection, promotion and reward procedures;
- performance indicators;
- job analyses and evaluation;
- staff assessment and appraisal;
- supervision and staff management;
- communication; and
- staff and management training.

All health services incorporate some or all of the elements in this list. However, many readers will be conscious of the deficiencies: the transfer budget that does not meet the costs of staff moves; the unfair distribution of personal development opportunities; the out-of-date and irrelevant job specifications; the staff assessments that mean nothing; and many more. These things can be changed, and indeed must be changed, to satisfy more fully the needs of individual members of staff. Through these changes can be developed an organizational culture in which the individual seeks for improvement through a desire for excellence.

What is a culture of excellence?

There are many variables that lead to an organization's being recognized as exceptional, both internally and externally. It is perhaps easier to make this recognition in the private sector. Nevertheless, all readers of this document know institutions which are recognized to be superior in their performance. Surveys suggest that all excellent organizations share a common set of dominant beliefs which are:

1. A belief in being the "best".
2. A belief in the importance of detail.
3. A belief in the importance of people as individuals.
4. A belief in superior quality and service.
5. A belief that members of the organization should innovate.
6. A belief in the importance of informality to enhance communication.
7. A belief in economic growth and profits (private sector) or a belief in achieving targets and improving service (public sector).

These beliefs need to be generated in all staff in the organization. The stimulation must come through the behaviour and example of the managers, and through the systems, structure and processes of the organization. Many of the actions required to build this set of attitudes and beliefs are also an integral part of those needed to improve motivation. This is demonstrated in the later sections of this chapter, when we examine how the bargain between individual and organization is established and maintained.

How is a better bargain created in practice?

Terms and Conditions of Service

As have been emphasized in earlier sections, survival and security needs are dominant concerns. For many health services, there is little scope for changing basic salaries. Some horizontal (upgrading) promotion and accelerated advancement is possible, when ranks are attached to individuals or functions. This certainly has been done. In one case, for example, sanitarians were given promotion to twice the normal rate in an attempt to overcome staffing shortages. However, such an approach is not possible for a very large proportion of the staff as it just raises the overall fraction of the service budget which gets allocated to staff salaries at the cost of other budget headings. If there is more money available, serious thought certainly needs to be given to its distribution to satisfy the survival needs of critical staff. More than this, however, there is a need for flexibility which means, as a first step,

> **more autonomy and responsibility for personnel away from the centre of the health service.**

With this decentralization comes greater opportunity to meet individual needs. Local managers should be encouraged to take more positive steps which might include:

a) Helping to find suitable accommodation for staff;

b) Managing staff needs for, and access to, private work, not simply allowing it to develop randomly and be studiously ignored;

c) Examining jobs more closely and operating an incremental pay scheme that more "fairly" recognizes differences in the demands of skill and effort between jobs; and

d) Training appropriate staff in the skills of job analysis and evaluation, so as to apply these skills in matching individuals with jobs more effectively.

Other similar actions are possible. They are positive in nature, but clearly cannot be operated from the centre, and must be locally managed. The centre's function is to guide and motivate local managers to engage in these practices within broad parameters. At the very least, staff will recognize that the organization is trying to improve the bargain.

Personnel and Career Planning

To address both the conditions of employment and other issues, there will be a need to strengthen the organizational framework within which necessary changes can be made. Central to this is the need to develop health personnel planning to:

a) Better determine the number of staff needed, and to better adjust requirements to supply;

b) Create career plans which provide as many staff members as possible with some opportunity for growth; and

c) Develop more realistic recruitment and deployment processes to reach a more satisfactory match of abilities and job needs.

Through these and similar steps, the organization is seeking to create an environment in which, as part of the bargain, staff are presented with sufficient time to do the work required of them, and have the necessary skills, motivation and aptitude to do the job well.

Selection, Promotion and Reward Procedures

Planning by itself is not sufficient and it has to be backed up by selection, promotion and reward procedures which build on the planning. It is in this area that many health services are under social, political and bureaucratic pressures. Political appointments, promotion by seniority alone, and unmerited awards, particularly in training, all work against individual motivation. There is clearly no quick answer to these problems as they involve agencies and individuals outside the control of the health service. Nevertheless, there are actions that can be taken which will start to lead in the right direction. These are:

a) Provision of more precise descriptions of the skills required in a particular job, and a more precise analysis of candidates' skills;

b) Provision of additional training to ensure uniform standards where geographic quotas require employment of under-qualified people; and

c) Development of more objective measures of individual performance for determining promotion and merit awards.

Steps such as these are intended not only to ensure a better match between individuals and job, which is in itself a strong motivator, but also to increase among staff the sense of fairness, and the recognition that rewards reflect ability and effort.

Performance Indicators

It has already been stated that one problem in many health services is that objectives and targets, which are centrally determined, are not communicated to local units. Even when they are, the relationship between individual efforts and organizational goals is rarely made clear. It is essential that these two shortcomings be remedied if other proposed initiatives are to prove effective. In view of this:

a) National targets must be broken down to institutional, functional and individual objectives, which ultimately must involve a two-way dialogue at all levels of the service.

b) Performance indicators must be established which have meaning at local as well as at national level. They need to be measures that can be understood by individual staff and local managers, not simply epidemiological or statistical information for national purposes. The indicators used will depend very much on the local situation. The indicators for supervisors, for example, might be quantifiable (such as absenteeism), but might also require an increased use of attitude surveys (for morale) which can be matched against local or national norms.

c) Greater emphasis needs to be placed on wider and faster communication of performance achievement, within local areas and between areas across the country.

How is the Bargain to be Maintained?

Staff Assessment and Appraisal

The establishment of individual goals provides the basis for a more objective appraisal of individual performance and training needs, and for assessing an individual's potential for more demanding work or more senior posts. If a goal-setting approach is to be successful, it will require:

a) Annual meetings between supervisor and staff member to review past achievements and to set new targets for the future;
b) Training of appropriate staff in assessment and appraisal techniques to ensure that the process is productive and not punitive; and
c) Adequate managerial skills in supervisors so that staff members feel sufficiently confident to engage fully in the discussion.

Supervision and Staff Management

The assessment and appraisal processes discussed in the previous section are events which occur at regular intervals. The need for guidance and support continues, however, on a day-to-day basis and this can be provided through the processes of staff supervision and management. The goal-setting discussed earlier provides the necessary vehicle for giving a purpose to supervision and management activities. For this to happen successfully, the following will be required:

a) More emphasis on training supervisors and managers in interpersonal skills and supervisory techniques;
b) Increased opportunities for local managers to manipulate resources to achieve targets;
c) Strengthening the team concept through regular team meetings; and
d) Encouraging participation by all staff.

The essence must be that supervision and management are seen not just as recording and, too often, punitive processes, but as processes by which staff are being encouraged and supported to meet targets for which they are responsible.

Communication

The issue of communication is perhaps one of the essential themes for improving motivation. It is in this area that health services are often the least proficient. The purposes of communication are for the individual staff member to:

a) Understand more of the wider arena in which an individual works;
b) See how he or she compares with others; and
c) Understand more completely what the organization is doing and why.

For the above to happen, the organization will need to ensure that:

a) Regular communiqués on its intentions are published;
b) Bottom-up planning is encouraged, involving staff at all levels;
c) Performance is recorded regularly; and
d) Outstanding individuals and institutions are acknowledged publicly and widely.

Exercise 3.1 - Individual Needs

A set of basic needs have been identified that each of us has in some combination or other. These are:

SURVIVAL	RECOGNITION
SECURITY	SELF ESTEEM
COMPANIONSHIP	SELF FULFILLMENT
STATUS	PERSONAL GROWTH

a) Your own organization will satisfy these needs to a greater or lesser extent. Rearrange the list to show in reducing order from best to worst, the extent to which you feel these needs are met by your organization for a cross section of different cadres of staff.

b) Given the circumstances of your health service and country, identify which of these needs could feasibly and most easily be better met than they are now.

c) Taking the different cadres of staff identified in your answers to (a), what changes would be feasible in your organization which would enable it to better meet the needs of staff?

MOTIVATION
Exercise 3.2
Exercise 3.3
Exercise 3.4

Exercise 3.2 - Hygiene Factors

In many organizations, it is likely that certain actions or procedures create a negative impact on individual staff members.

Identify those actions or procedures at national level and local level which you feel have a negative impact on most staff in the service.

Order the list to show those you believe to be the most damaging down to those that are the least damaging.

How does your list compare with the demotivators suggested in the text?

Exercise 3.3 - Demotivators

List for yourself or for your immediate colleagues undertaking similar tasks, those actions or factors which diminish enthusiasm for the job.

Exercise 3.4 - Staff Needs

Figure 5 on page 12 of Annex 3 gives a list of employees' needs in priority order.

a) Reproduce the list, substituting your own set of priority needs.

b) Compare your list with those of others in your group and identify which needs are given similar priority by most of the group members.

How does this compare with the results of the survey shown in Figure 5?

Exercise 3.5 - Enriching Jobs

1. AIM

The aim of this exercise is to give workshop members an opportunity to practise enriching jobs.

2. STRUCTURE

The workshop should divide into groups of 5-7. Each group should appoint a leader for the discussion and a rapporteur who will share the group's conclusions with the full workshop.

3. TASK

Step 1

Think of situations - and select one to use in this exercise - where a group of health workers, doing rather routine tasks, is showing signs of low morale such as careless mistakes, boredom, absenteeism and frequent resignations.

Step 2

Imagine that you have recently been given responsibility for that group of people. Using your background knowledge generally, and referring to the note on "Individual Needs and Motivation - A Brief History", what do you imaging you could do to enrich their jobs?

Step 3

Make a list of how you would use motivators to enrich the job.

Step 4

Be prepared to discuss your ideas with the rest of the workshop.

4. TIMING

You have 30 minutes for this exercise.

Exercise 3.6 - The John Kasega Story

Aim

The aim of this exercise is to give participants an opportunity to analyze leadership and managerial behaviour using the theories and ideas so far discussed in the workshop.

Structure

Participants should divide into groups of between five and seven members, including a chairman selected by the workshop tutor or the group members. A rapporteur should also be chosen by each group to report the group's discussion and conclusions to the whole workshop.

Task

Step 1

Begin by reading the John Kasega Story.

Step 2

On your own, consider each of the characters in the story and decide in what ways they have demonstrated both good and poor leadership. Identify specific examples.

Step 3

When everyone has completed step 1 individually begin a discussion sharing your analysis of the characters and come to a consensus decision on the group's view of each of them. Decide also what you, as a group, would do to improve the management of this particular organization.

Step 4

Be prepared to report your conclusions through the rapporteur, to the rest of the workshop.

Time available

You have 75 minutes for this exercise.

THE JOHN KASEGA STORY - CASE STUDY

The John Kasega Story describes the interaction between managers in a Medical Records Department. John Kasega, manager of the Medical Records Department, is one of several department heads who are responsible to the Medical Director, Dr Daniel Musowe. Similarly, four junior managers are responsible to John Kasega, each of them being head of one of the four sections into which the work of the whole department is divided. And each section manager has several supporting staff, who are not individually named.

The organization chart is set out as follows:

Dr Daniel Musowe
(Medical Director)

John Kasega
(Medical Records Department Manager

Stephen Otaru (Filing Section Manager)	Helen Kigutha (Manager of Medical Secretaries)	Clement Dlamo (In-patient Admissions)	Ben Mukundi (Out-patient Clinics Manager)
6 staff	8 staff	6 staff	9 staff

Such an organization chart from a large hospital in Africa, or the existence of a specialized department for medical records, may or may not be familiar to you or to your country's health system. But the basic situation for study is that of any mid-level health manager (John Kasega in this case) interacting with his subordinate managers on the one hand and with his senior manager on the other. That situation exists in all organized health systems in Primary Health Care and in hospitals and in Ministries of Health. The learning offered by the case study is therefore applicable in all HMM.

John Kasega sighed as he looked at his watch. Fifteen minutes remain before his monthly meeting with his subordinate section heads. He used to enjoy these gatherings: the meetings used to be relaxed and informal with quite a lot of exchange of hospital gossip. Recently things seemed to be going wrong. People were irritating each other. He sat back in his chair, put his feet on the desk and remembered the last few occasions when he had called the meeting.

Was it one or two meetings ago that Stephen Otaru said what a waste of time they were and he had work to do and would not be coming to any more meetings unless he, John, exercised more control and told people what to do.

John remembered thinking how typical this was of Stephen. He had probably been in the job too long. How old was he now? About 52, John thought. Stephen was responsible for the filing section - not the most exciting of jobs; it was difficult to keep staff in this section. They always seemed to be leaving. John was worried about this. Whenever he visited the section he tried to make jokes with the filing girls but he had to admit that few of them found his humour very funny. Stephen was a problem but, thought John, he was vital if the introduction of the computer-based record system was to be successful.

He then considered Helen Kigutha. John thought her fairly attractive - rather like a rose past its first flowering. But she was another problem. She had been a very good medical secretary; so good that John had encouraged her to apply for the job she now held of Senior Medical Secretary in charge of all the other secretaries. John had thought that she would do a good job, but frankly standards were falling and the medical staff were increasingly complaining about the long time it took to have their letters typed - and when they were typed they frequently had many errors in them. John had become so worried about this that he had spoken privately to Helen and asked how she was and whether she had any problems. But apparently she felt perfectly well.

What a pity, thought John, that they could not all be like Clement Dlamo. He was in charge of the in-patient admissions unit. Clement was young and very enthusiastic. He believed strongly in participative management and held frequent meetings with his staff to discuss how well they were working as a team. Clement took his group section staff for lunch and picnics at the weekends to

ensure that everyone was well integrated. John smiled as he considered the efforts the young man was making. He reckoned that in a year or two when Clement matured, he would be a very good manager.

But just at present John remembered, there were too many poor decisions coming from Clement's group. They certainly talked about the work a great deal but, for example, John remembered how the new admissions policy devised by Clement and his group had been rejected by the Medical Director as being completely unworkable. The deficiency was obvious but somehow Clement had not noticed it. Ah well. Time will remedy his lack of wisdom, thought John.

Then his thoughts turned uncomfortably to Ben Mukundi. Ben embarrassed John. he was about the same age - approximately 35 - but he constantly raised difficult problems. Ben, in John's opinion, was ambitious and far too clever. He scorned the way in which John conducted his meetings and the Medical Records Department overall. Ben frequently pointed out to John how he, Ben, in managing the out-patients clinics had to work with all types of staff - doctors, nurses, clerical - as well as patients; and frankly in his - Ben's - opinion, he should be of the same salary grade as John. In his more depressed moods, John tended to agree with Ben, who was always receiving compliments from the Consultants and the Medical Director.

"Time for the meeting," his secretary said as she entered his office.

"Oh dear, I don't enjoy these meetings any more, you know. Have you noticed a change in the atmosphere - it seems more ... more hostile than it used to be."

"Probably because of all this talk about computers and so on", his secretary replied, "the staff are not sure what is happening and whether they will be able to learn how to use the new equipment - or even whether they themselves will actually be needed at all".

"Well, I have told them there is no need to worry."

John walked slowly along the corridor to the meeting room. All his staff were there - apparently in a fairly good mood, thought John.

Clement Dlamo was talking ... "and when we got there, we left the bus and walked along by the river. I suggested that we have a game of football and then we could all go for a swim before the picnic. Well everybody except Dorothy agreed; she just wanted to sit, but eventually she was persuaded to join in. We had a lovely time - came back refreshed on Monday for work."

"Do you always go about with your group?" Stephen asked, "I should think you would get bored with each other after a while."

"Oh no, we never get bored. By keeping the group together I create a harmonious working relationship which helps enormously when we have to solve problems at work. Would you agree Ben?"

"Yes, I think you are right to some extent, but in my view ...."

Stephen Otaru now interrupted the conversation. He could see that they were going to have another episode of managerial philosophizing from Ben.

"Look, it is now ten minutes past three and this meeting was due to start at three. What are we waiting for? Come on John, the sooner we start the sooner we can finish and return to work."

"OK, shall we make a start?" John beckoned the group to the chairs round the table. Helen Kigutha stood by the window looking out.

"Anything wrong Helen?" asked John, "we want to begin."

Helen took her place.

"First let me say", began John "how glad I am that the department is running so smoothly. I am most grateful to each of you for all your efforts. I know that there have been on or two disagreements with the Consultants and others about our work, but I am quite sure that any faults on our side - if indeed there are any - are not due to any lack of effort by anyone". John was starting to enjoy his speech.

"It would be wrong for me to identify one of you for special commendation because you have all done well".

"John, before we go any further can we be clear what this meeting is for?" Ben had interrupted John in the middle of his speech. "I agree with Stephen these meetings are becoming a waste of time because we do not organize them properly. What do others think?"

There was general assent to Ben's view.

"I think the meetings are a waste of time anyway" said Stephen, "I tell my girls what to do - and they do it."

"Yes, and that is why they are always leaving" Clement made his point forcefully.

"Why - how dare you. I was a manager while you were still a baby" retorted Stephen.

"Yes - and that is why you have learned nothing new."

"Gentlemen ... gentlemen" John tried to calm them both, "there is no reason to quarrel over this - you are both excellent managers in your different ways" he said, although he felt uncertain about what he was saying.

"Helen, you have been quiet ... what do you think of our meetings" Do you think we can improve them?" Ben asked.

"Well - I think we probably could a little, although to be fair most meetings everywhere seem to be like ours. At least coming to them gives me a rest from having to cope with all the problems in my section. Honestly, the secretaries these days are incompetent - and the Consultants are so rude. We all do our best under the circumstances, but frankly unless the Medical Director tells the Consultants to stop complaining I shall resign."

"No - you must not do that" said John, "I appreciate that you are having a very difficult time but you must rely on me. You know that you can talk to be at any time and I will give you all the help I can." John heard the whisper from Stephen: "Best thing if she did resign. You can be sure that I could make those girls work properly."

"As I was saying" Ben began again, "I propose that we have a proper structure for our meetings, with an agenda. I think that we could all work much better on that basis."

"I absolutely agree" added Clement, "if we do it that way the kind of arguments that we have been having will disappear. By having a clear structure everyone will work well together as a team. I know that Stephen dislikes meetings and, to be frank, I have never been very happy with these. But I am sure that if we organize ourselves and perhaps have lunch together more often, we will begin to work cohesively and harmoniously together. After all it is really vital for the Senior Manager in a medical records department to be seen as part of an integrated group who have a friendly relationships with each other."

"Thanks Clement" Ben replied, "I see from the faces of the others that they do agree with me that we need a structure. How do you feel about that, John?"

John felt the whole situation was slipping from his grasp. He disliked people being upset in the way that Stephen and Helen had appeared to be. And he did not like being organized by Ben, yet he had to recognize that the others seemed to be supporting what Ben had said.

"Right" said Ben, "could I make another suggestion John? As we have had a little quarrel this time, we would close the meeting now and suggest items to you for discussion at our next meeting. We will leave it for you to put them in whatever sequence you think best. And we will limit our meeting to, say, no more than an hour and a half."

So the meeting was adjourned, a little to John's relief as he felt the whole thing was being taken out of his control by Ben.

On his return to his office, John found a note asking him to telephone Daniel Musowe, the Medical Director.

"Dan? ... John here."

"John can you come to my office? I want to discuss a staffing matter with you and I would appreciate your advice."

In fact, thought Dan, he did not really want John's advice but after all John was the Medical Records Manager....

"John is a good man" Dan thought to himself, "he works well with others who seem to like him, but he lacks the energy that Ben Mukundi, for example, has." With this thought, Dan recognized that the session with John was not going to be very easy.

"Come in John. Sit down." The two men greeted each other. "I have been thinking about your staff and their careers. There will be a senior vacancy soon in my medical staffing section and I need a good person to fill it. I have been thinking about Ben, for example. What do you think?"

"Ben is all right, but for your job you need someone, I would imagine, with great sensitivity; someone who cooperates well with others. In my view I would have thought you would do better with Clement Dlamo. I know Clement's ideas are sometimes a little strange but, under your guidance, I am sure he will progress very well. He shows great sensitivity to his people and involves them in what they are doing. Ben, on the other hand, is aggressive. He will annoy the clinicians with his manner. For example, this afternoon at my .... " John was going to describe his meeting this afternoon but decided against it. Fortunately Dan Musowe did not notice the hesitation and commented:

"But I have heard good things about Ben. I believe he has some target-setting approach in the out-patients section, and has reduced the staff turnover and absenteeism rates there."

"Well ... yes" John had to reluctantly agree, "but I am always a little anxious about the people who work for him. He makes them work very hard and I am sure that one day there will be an explosion."

"All right. We can leave it for the present. I will probably ask both of them to see me and decide for myself. You are quite right that I do need someone who is sensitive to people and situations. Consultants can be difficult people if they are not treated properly. Can we change the subject now to your department as a whole? I hear that you are thinking about computerizing some of your systems. How is that progressing?"

"Very well - although it is only at the early stages". John thought angrily. This was another of Ben's clever ideas! He had suggested that they should investigate whether computers could help them in their work at one of his meetings. The result had been considerable anxiety amongst the staff who thought that they might all be made redundant.

"I expect," he said "that we will be exploring the possibilities at my next meeting." He made a mental note to have it included on the agenda as he knew that Dan Musowe was in favour of new technology.

"Good. Let me know how you progress. Could you let me have a report in a month?"

"Yes. Certainly." Anything to stop this discussion.

John left Dan Musowe's office, and returned to his own. He was worried that he had not created the right impression with Dan and had not supported Clement Dlamo for promotion as strongly as he would have wished.

During the week Clement Dlamo visited the filing section to see Stephen Otaru. He felt that he had been wrong to criticize Stephen at the meeting and it was time to restore normal relations.

"What ideas do you think we should be discussing at our next meeting?" Clement began the discussion.

"You know what I think, Clement. There is too much management theory in this department. I have a job to do and it takes me all my time to check that the girls are doing the filing properly. As soon as I leave them on their own, you will find them talking rather than preparing the files for the next clinic. I know filing is not very exciting and unless I watch things closely files will be put back in the wrong place."

"Do you think this idea of Ben's of computerizing some of the work will help then?"

"Frankly no. Do you know how many records I have in here? Let me tell you. 100,000. How can you computerize all those?"

"I can see the problem". Clement felt that he might get into another argument with Stephen because he believed that it was actually <u>because</u> of the huge number of records that computerization was necessary, so he moved away from this topic.

"What about the next meeting, then; what should we be discussing?" Clement asked again.

"I suggest that we talk about not having meetings at all. That is item number one. And if they insist that we do, then my second item would be how can we recruit a better type of staff who will act responsibly and not make all the mistakes the present staff do."

Also during the week John decided to see Helen Kigutha. He did feel concerned about her and was distressed that she was so obviously unhappy in her work.

"How are things, Helen?" he began, trying a cheerful approach that he did not feel at all.

"Hello John. Not too bad, I suppose. Fortunately no-one has caused trouble for me today and the instructions for Hilda, one of my secretaries, from Dr Muasa, which I had to pass on, caused no difficulties.

"How about our next meeting? What do you think we should discuss?"

"Quite frankly, at the moment I do not care. My elderly mother is in bed at home with chronic influenza, the roof of the house leaks and my car needs about $200 to be spent for repairs. I come to the meetings for a rest".

"What about Ben's ideas on computing? Do you think they may affect your staff?"

"I have no idea. I know very little about these things. The girls have only just learned how to use these word processors. I must admit that I do not understand them myself. I still prefer the electric typewriter.

"Well, we all have to change with the times, I suppose." John wanted to encourage Helen and preferred not to emphasize the difficulties. Anyway, as I said at the meeting - if there is anything I can do, just let me know." John left Helen apparently trying to decide which girl should try to decipher Dr Nditolo's terrible handwriting....

Before the date of the next meeting John had received two items for the agenda. One was from Clement about how the various teams in medical records could be developed. The second was from Ben on the topic of computerization in the department.

John decided that they would discuss the item about teams first and then the computerization, if there was any time.

He opened the meeting with this suggestion. They all agreed, except Ben.

"John - I am sorry if I appear to be difficult, but I think it might be more logical to take the computerization issue first. After all if we do computerize some of our work, it could mean that we will be working in different groups. I absolutely agree with Clement that teamwork is important but we must base it on real work."

"Here we go again" Stephen was getting angry, "we cannot even decide what we should be discussing! What is the point of wasting time in these meetings arguing about the sequence of agenda items. There are probably dozens of files being misplaced in my section at this moment. For everyone's sake, John, get started." Stephen turned towards Ben. His face was red and his voice loud and harsh.

"You are always talking about computerization. What is wrong with the way we do things now? Your modern ideas cannot help us. What we need is common sense and good discipline ... when I was a young..."

"Be quiet Stephen", Ben stopped him suddenly, "I will tell you why we need to consider computerization. First the number of records that we are dealing with is increasing by about 15 per cent per year. Secondly, the proportion of records that are not available, or are incomplete, for out-patient clinics is about 20 per cent and increasing. Thirdly, I believe we could improve our procedures by reducing a great deal of clerical work, especially where it is repetitive, such as writing a patient's name and address four or five times. Fourthly, I think we might be able to reduce some of the boredom that our staff experience in having to look for missing records. Fifthly, by providing a more efficient service we could reduce the amount of time patients have to queue to be registered. And I could go on. That is why it is an important topic."

"Alright, alright, you have explained your point of view, Ben", John wanted to regain control of the meeting. "How should we start?"

"By first defining the problem" said Ben.

Exercise 3.7 - Testing for a Healthy Organization

The fifteen items in the questionnaire on the following page provide a measure of the health of an organization in relation to its ability to provide the necessary environment for change in general, and for change in motivation and performance in particular.

a) Firstly, on a scale of 1 to 6, rate your organization as it is today by putting a cross in the appropriate box. Having completed the list, repeat the exercise, this time putting a tick in the box that, in your view, represents the ideal organization in your environment. (NOTE: This is not necessarily a 6 for each characteristic.)

   The difference between the value of the tick and that of the cross provides an indication of how far you see your organization from being healthy. The individual differences can be averaged to produce an overall rating. Where individuals place the marks on each scale will be very subjective but the value of the differences can be compared in a group. In this way it is possible to check the diagnosis of the need for change.

b) How would you rate your organization in terms of effectiveness? Please circle one of the following descriptions:

   One of the best, extremely effective

   Better than many, very effective

   OK, generally gets the job done

   Effective in some areas, needs revamping in others

   Marginally effective

   As a group, review the results of the questionnaire and propose what feasible actions could be taken to improve the characteristics exhibiting the most serious deficiencies. Which improvements would be especially important for change programmes directed at staff motivation and service performance?

MOTIVATION
Exercise 3.7

CHARACTERISTICS OF HEALTHY ORGANIZATIONS

CHARACTERISTICS	(1 is low; 6 is high) 1 2 3 4 5 6	Difference
1. The organization has a well-defined, well-known set of guiding beliefs stated in qualitative terms.	☐☐☐☐☐☐	☐
2. General objectives and values are set forth and widely shared throughout the organization.	☐☐☐☐☐☐	☐
3. The organization operates in a purposeful and goal-directed mode.	☐☐☐☐☐☐	☐
4. Structures are designed based on work requirements. Form follows function.	☐☐☐☐☐☐	☐
5. Decisions are made based on location(s) of information rather than roles in hierarchy.	☐☐☐☐☐☐	☐
6. Managers assume that individuals want to take on more responsibility and provide opportunities for them to do so.	☐☐☐☐☐☐	☐
7. Rewards are balanced between what you know and what you do.	☐☐☐☐☐☐	☐
8. Communication is relatively open (differences are valued).	☐☐☐☐☐☐	☐
9. Collaboration is rewarded when it is in the organization's best interests.	☐☐☐☐☐☐	☐
10. Conflict is managed, not suppressed or avoided.	☐☐☐☐☐☐	☐
11. The organization is seen as an open system. Demands of the environment (other systems and sub-systems) are managed.	☐☐☐☐☐☐	☐
12. Individuality and individuals are valued.	☐☐☐☐☐☐	☐
13. Management respects people and treats them as adults.	☐☐☐☐☐☐	☐
14. An effort is made to inspire people at the very bottom of the organization.	☐☐☐☐☐☐	☐
15. There is a "learning" mode of management. Feedback systems for assessing, regulating and responding to plans and actions are built in.	☐☐☐☐☐☐	☐
OVERALL RATING		☐

MOTIVATION (WORK SATISFACTION) QUESTIONNAIRE

INTRODUCTION

Various studies have pinpointed the reduced performance of poorly-motivated staff. They have also shown that poor motivation is by no means exclusively caused by poor pay or prospects, and that the causes are not always those which are assumed by supervisors and management. Once the real causes have been precisely defined, however, the remedies introduced have generally proved relevant and effective. Accordingly, the following questionnaire has been designed to help supervisors, faced with poorly-motivated staff, to define the causes precisely.

The questionnaire is intended for completion by teams of health service employees and their immediate supervisor(s) rather than by random samples from large categories of staff. Examples might be a team of nurses with their senior nurse; a health team and its chief; or a group responsible for a project, e.g. an immunization drive.

Results from the questionnaire will indicate the degree of importance a particular group attaches to different aspects of its work and the group members' main areas of satisfaction or dissatisfaction. These results can be related to their supervisors' assumptions about their views. When the causes of poor morale are correctly identified, the supervisor can refer to the relevant chapters in this book for ideas for remedying matters.

BACKGROUND TO THE QUESTIONNAIRE

A cross-cultural questionnaire

The questionnaire is derived from a range of studies relating motivation to job satisfaction and performance. Most of these studies have been done in developed countries, principally the USA. Can it be assumed that the same motivation will apply in developing countries?

Indications that this is a reasonable assumption come from the few studies which have been done in developing countries (India, Latin America, Philippines) and also from cross-cultural studies of managerial motivation in multi-national organizations. Nevertheless, there are likely to be different emphases in different cultures and there may be some communities for whom parts of the questionnaire are irrelevant.

Variations in individual motivation

The motivation of individuals is known to vary with age, changing circumstances and changing responsibilities. It is also much influenced by cultural and community pressures. In view of these differences, can a questionnaire yield valid information?

The assumption that it can is based on the knowledge that despite variations, human motivation does seem capable of categorization in ways which are valid for most people in many societies. Moreover the questionnaire is directed at a group which is in some senses homogenous. All the members will be adults working in a health service. The questions relating to personal circumstances which appear at the beginning of the questionnaire should give some indication of the extent to which different circumstances are influencing replies.

Work motivation

There is reasonable support for the theory that some aspects of work serve to prevent people leaving their jobs (hygiene factors) but do not of themselves promote good work. Other aspects are required to do this. Nevertheless, if hygiene factors are neglected, staff will become disaffected. The questionnaire therefore includes hygiene factors and factors associated with good work.

Predominant among "satisfiers" are elements contributing to feelings of personal worth: being trained, appropriately rewarded, fairly treated, kept informed; belonging to a respected group; being able to contribute; having responsibility for a complete task; being able to set one's own pace of work; having variety and a challenge. Studies which have measured individual satisfaction before and after the experimental adjustment of work to increase these factors uniformly show an average increase in staff satisfaction. The increase never shows 100% satisfaction because of individual differences etc., but in many studies it is nevertheless marked.

The correlation between increased satisfaction and productivity is less straightforward. Increased satisfaction does appear to improve the quality of work, particularly if that work is intellectually demanding. Productivity also benefits from the retention of willing staff who can be given sustained guidance and training. The correlation between increased satisfaction and reduced absenteeism and labour turnover is very high. To reap full benefits, however, additional measures may be needed, such as:

a) Precise targets for performance (preferably established by mutual agreement).

b) Fast and precise feedback on target attainment.

c) Linked relevant rewards.

USING THE QUESTIONNAIRE

To use the questionnaire, follow these steps:

1. Select an appropriate group and leader.

2. Read the questionnaire through carefully to ensure that the questions are intelligible and relevant to the group you have selected. If any questions are not intelligible, either strike them out or alter the language appropriately. If any question is irrelevant, strike it out.

3. Select an independent person who can be trusted to score the questionnaire carefully. (Scoring guidelines are included.)

4. Explain to the group the purpose of the questionnaire. Reassure everyone that there are no right or wrong answers, that no-one is required to give their name, and that scoring will be undertaken independently.

5. If the group is prepared to complete the questionnaire, please give the following instructions:

   a) **To Supervisors:** "Please mark the questions to indicate how you think the members of the group you supervise generally feel about their work."