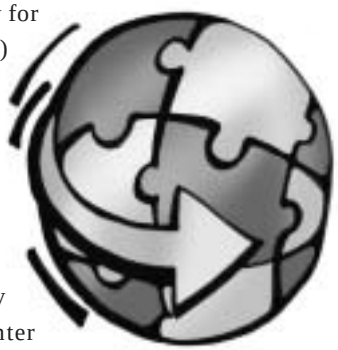
The Future of Performance Improvement in International Health

by Marc Luoma

Hardworking public health professionals have been helping health care providers improve their performance and the quality of care they deliver for decades. So it would be foolish to claim that performance improvement in international public health is a new idea. Only five years have passed, however, since a customized version of the International Society for Performance Improvement (ISPI) human performance technology (HPT) model was introduced to improve public health in developing countries. Is it possible to have historical perspective after only five years? Perhaps not. But by looking at the many projects completed and under way, we can speculate about what lies ahead for HPT (called simply performance improvement in our community) in the places we work. As one of the few people in our field with performance improvement in his or her job title, I have the good fortune to participate in many discussions about PI and the challenges and experiences we encounter using these approaches in developing countries. Drawing on this collaboration and more direct input from other colleagues, I'd like to be so bold as to make some predictions for the future of performance improvement in developing country public health. I think performance improvement use will become ubiquitous, more flexible, more inclusive of other approaches, and more comprehensive in looking at performer support systems.



Performance Improvement Will Become Endemic to Human Performance Issues

Even 5 or 10 years ago it was not uncommon for global health projects to report as their results the number of health care providers trained. Often, scores from pre- and post-training tests served as impact-level results. The simple idea that even very good training is not sufficient to improve performance is what brought performance improvement into our world, and this recognition is spreading.

Clearly, the days of the single-intervention mindset are over. In the future, asking questions about all the factors affecting performance, not just knowledge and skills, will become a matter of course. This is perhaps a safe prediction, as we're well along that road. Even before the widespread use of performance improvement, global projects were urging us to meet clients' rights *and* staff's needs (Huezo & Diaz, 1993). Performance improvement offers a systematic way to analyze those needs and ensure they are met.

In the future, asking performance improvement-like questions about providers' needs will become not only the way we do business, but also the way our clients request our assistance. As performance improvement use becomes ubiquitous, the ways in which it is implemented will vary from a single, rigid set of steps and methods. Performance improvement has been well accepted because the ISPI model represents an easily taught set of steps. But as practitioners reach fluency, and as the approach spreads, its application will vary in terms of time taken, dollars spent, rigor used, and number of people involved. In a given program, performance improvement may look much as it does in the ISPI model, with carefully thought-out phases, each well facilitated and attended by many stakeholders. In another case, the entire performance improvement process may happen in 10 minutes, in the mind of one supervisor trying to solve a single-person performance problem in his or her clinic.

Clearly, the approach is flexible enough to meet both these needs, and all those in between. In the future, those of us who provide technical assistance in performance improvement will need to be clear about how to apply performance improvement faster and for less moeny. We'll also have to be clear about what one gives up as degrees of rigor scale down.

Many Quality Techniques Will Be Used to Address Human Performance Issues

When people were generally accepting but still trying to understand the introduction of performance improvement in our work, the most frequent question was, "What's the difference between performance improvement and…"—Then the alphabet soup: QA, QI, TQM, QAP, CQI, CDQ, OD, and so on. One renowned speaker, when asked how he compared performance improvement to total quality management (TQM), answered, without hesitation, "I don't" and quickly moved on.

Clearly, these approaches have more similarities than differences. All require that before implementing interventions we carefully define the problem and use only interventions that will fix the causes of the problem. While we can (and have) pointed to differences in origin, tool sets, and entry points, mapping differences is unproductive. When discussions about differences lead to discussions about which approach is better, we lose as practitioners by excluding worthwhile techniques that are not part of "our" approach.

I ask readers with experience using performance improvement to consider all the quality tools they use every day in their work. As an adjunct to the ISPI framework, practitioners regularly use goal alignment techniques from organizational development (OD), data-gathering techniques from quality improvement (QI), and several TQM tools such as flowcharting, cause analysis, and pareto diagrams. These and other proven techniques from TQM continue to influence our performance improvement applications. The use of standards, team empowerment for problem solving, a focus on quantitative measurement, and a strong client focus are all being emphasized more and more in our work. Likewise, we find colleagues with a quality assurance (QA) background borrowing from performance improvement to analyze the factors that influence human performance. And we see OD colleagues teaching performance improvement to managers as a way to support the performance of their direct reports.

In the future there will be less worry about which approach is being used and more practical application of the best tool for the job at hand. Clearly, having a framework to focus our efforts toward a goal is valuable and should be maintained. I think there will be less concern, however, about using all and only the tools in "our" approach, whatever that may be. As the arguments have fallen away in the performance improvement community about whether to use Gilbert's (1978) six-cell model or Rummler and Brache's (1995) three-cell model, so will the QA versus performance improvement discussions cease to have importance. We will use what works best in the field, choosing carefully from a personal toolbox of proven techniques and guided by our chosen framework as a roadmap for reaching our clients' goals.

Effective Nontraining Interventions Will Become Increasingly Important

It has been widely reported in this journal and many others that only 15%–20% of human performance problems stem from a lack of knowledge and skills. Indeed, as stated above, the increase in use of performance improvement in developing country health care systems began with the recognition that even very good training is usually not enough to solve performance problems. Unique health care provider situations demand unique intervention packages with training and nontraining components.

Meanwhile, practitioners in the field are finding that often little is known about nontraining interventions. Because of the reliance on training as the sole intervention, developing country organizations have relatively little experience with or knowledge about fixing performance problems that are caused by something other than knowledge or skill deficits. What can we learn from developed country nontraining interventions? While training does translate reasonably well (and we have had 40 years of work to refine approaches), we should expect that nontraining interventions taken from the United States and Europe may work less well, or not at all in developing country health settings.

Take, for example, incentive and motivation interventions. One doesn't need a careful analysis to predict that a cash bonus incentive system designed at IBM will not work well in a poor country where many health care workers have not

been paid even their base salaries in more than 18 months. We can have similar doubts about the translation of the body of nontraining intervention research to our world. When we read the many studies that tell us what makes workplace feedback effective, how will we translate this to cultures where face-to-face dialogue about one's performance is not only unknown, but discouraged as rude and degrading? It is true that people are people the world over, and human psychology may point to a few universal truths. But how we set expectations, provide feedback, and reward good performance needs to be well considered before we dust off our tried and true U.S.-based techniques and apply them in developing countries. Some may translate well, but many will not; our trials, successes, and failures in applying nontraining interventions need to be well documented and widely shared.

In the future there will be greater reliance on and greater knowledge about effective nontraining interventions in our work. We will need to measure our efforts, their costs, and the results. As we try to solve the 80% of performance problems that cannot be fixed with training, our successes and failures will tell us what works. To the extent that we choose interventions wisely, document our efforts carefully, and share our successes and failures widely, our profession will develop a body of evidence and a level of experience and expertise in nontraining interventions.

Performance Improvement and Human Resource Management Will Converge

While some important work is being done looking at organizational-level performance improvement, our work usually, eventually, focuses on a cadre of performers and their needs. Even when the individual performer is our unit of analysis, our search for causes and solutions quickly leads us "up" the organization. Health care providers lack feedback from supervisors. Supervisors lack feedback skills. District managers have no supervisor orientation program available to give the supervisors the feedback skills they need. There is no performance review system in place so that any of these workers can systematically get their performance assessed and their performance needs addressed.

New performance improvement practitioners often ask, "Where do we stop?" Our quick advice is to stop when one reaches causes the team cannot solve. One stakeholder group reached performance gap causes that included "The Ministry of Health is underfunded in our country." Clearly, the stakeholder group in this remote village could not tackle such a cause. But our analyses almost always uncover a lack of support *systems* that we take for granted in developed countries. Why is there not enough staff? Because there is no hiring/recruitment function. Why do providers not understand their roles? Because there is no job description and no employee orientation program. Why do providers not receive feedback or support? Because there is no supervision system and only twice-a-year record audits. Why are staff members unmotivated to meet the needs of clients? Because there is no system to recognize good performance or sanction poor performance. The human resource department functions that most of us take for granted are wholly absent in many organizations in developing countries. Or the human resources function may exist on paper only. When they exist, human resource functions are immensely complicated and difficult to change; they may be spread across three or more different ministries. High staff turnover makes human resource functions hard to implement. To the extent that we hope for our interventions to have wide impact, we will increasingly need to focus on the human resource systems that set the occasion for good performance *by design*.

Performance improvement will become a natural way of doing business when approaching the needs of health care providers and systems.

In the future, we will not only analyze the performance of individual performers and work our way up, but we will also start by looking at human resource systems and whether they are designed to meet staff needs. Only then will we be able to affect large numbers of health care providers in one stroke. Changing these entrenched, often politicized systems will be difficult work, but it is work that we must take on. We need to ensure that Ministries of Health and other organizations have human resource support systems in place that are focused on supporting those who support clients (that is, the patients). Even now important work is being done by global projects to teach the basic components of good human resource systems. Governments are using the associated tools to assess their own human resource efforts and identify areas they can improve. Our efforts will start at the bottom *and* the top, by knowing what providers need in order to deliver high-quality health care services, and by helping to create national systems that meet those needs, by design. Once basic human resource systems are in place, many of the large-scale performance problems we see today will be lessened or eliminated. Our efforts can then become more focused on smaller systems and individual performance issues.

In Conclusion

In conclusion, I predict that performance improvement will become a natural way of doing business when approaching the needs of health care providers and systems. Performance improvement will be conducted in flexible, quick, and efficient ways, using techniques and tools borrowed from many quality approaches. Focusing on the basic human resource systems needed to support health care providers will create an enabling environment for large numbers of health care professionals that does not exist today. Ultimately, clients will benefit with improved accessibility and quality of health care.

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