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Staff Satisfaction in the Context of Performance-Based Financing of Health Services in the Buea Health District

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ABSTRACT

BACKGROUND

Health research evidence from developing countries points to the challenges that are implicit in under resourced health sectors with associated lack of infrastructure, human resource capacity and supplies. This resulted in low productivity of health service providers and poor healthcare utilization. Public providers who are paid a low government salary have little incentive to provide more or better care. This paper reports the results of staff satisfaction, related job passion and staff self-evaluation and assessment of the scheme in the context of Performance-Based Financing of health services within the Buea health District-Cameroon.

METHODS

Data was collected using a structured questionnaire amongst health personnel working in private, confessional, or public health facilities involved in the PBF project within the Buea Health District. A proportional to size random sampling was employed in this study. Staff were classified according to their PBF involvement into the intervention group (T1 group-with PBF subsidies paid according to performance), control group one (C1 group-with PBF subsidies paid according to catchment population), and control group two (C2 group-with supportive supervision).

RESULTS AND DISCUSSION

This study revealed that percentage of staff satisfaction in the C2 strata was 57.1%, C1 was 28.6% and T1 was 14.3%. Also, job passion and self- evaluation was 60% for C2 and 20% for both C1 and T1. Staff assessment revealed that staff would want the PBF management to constantly verify staff motivation and ensure that all staff are motivated.

CONCLUSION

From the above results, it can be seen that participants in the C2 strata show a significant level of satisfaction while those of C1 and T1 strata are not satisfied. Hence, financial motivation is not the main source of staff satisfaction, though it contributes to staff satisfaction.

Participants in the C2 strata significantly had passion for their job while those of C1 and T1 did not have passion for their job and do not also evaluate their job as required by the scheme.

Staff assessment revealed that PBF management should verify the sharing of incentives to staff and also the purchase of equipment's as indicated in the business plans of the health units.

Key Words: Performance-Based Financing; Staff Satisfaction; Related Job Passion and Self-evaluation; Staff Assessment.

1. Background

The Performance-Based Financing (PBF) initiative in Cameroon is aimed at increasing health care provision and improving staff motivation (financial and job motivation). This PBF initiative will equally contribute to human resource development. The health system in Cameroon is fraught with a multitude of difficulties linked to health care delivery such as high staff absences and acute shortages of staff in the hard to reach areas[1].

Performance- Based Financing leads to the financing of health care and services of a health facility depending on its activity as depicted by predefined performance indicators [2]. Consequently, it constitutes a strong motivating factor for the amelioration of the quality of care, staff motivation (in order to satisfy the staff), and financial accessibility of patients. Within this system of health financing, the health facilities are expected to put in place new strategies to serve as many patients as possible while respecting the norms of the MOH and generating more funds for the facility [2]. These strategies range from just better reception of patients through the improvement of the state of the structure, equipment, staff motivation and reduction of charges (fees) to patients. With these strategies put in place, the health staff would be given greater autonomy in the management of the health facility resources (human, financial and material resources) [3].

Performance-Based Financing is a powerful means to improve the way health facilities respond to users. As health facilities are remunerated according to their outputs, they have strong incentives to satisfy users. Granted more autonomy in exchange for greater accountability for results, health facilities can tailor initiatives to the populations they serve [4]. They might, for example, extend opening hours or provide consultations during the weekend[1]. The pressure for results impacts on the entire system.

Studies have been done in many countries (Burundi, Rwanda, and Nigeria) and it has been established that staff motivation and managerial autonomy are amongst the key benefits of the PBF scheme. Despite all these, it is not known to what extent staff are satisfied with the PBF project[5].

Furthermore, the PBF program gives staff the managerial autonomy to freely carry out their activities without the influence of any hierarchy but for supervision. However, the related job passion and self-evaluation a staff has within the PBF program is unknown[6].

Lastly, a series of factors such as financial motivation, supportive supervision and training of staff have been shown to significantly affect staff satisfaction; but it is unknown what the level of staff assessment within the PBF scheme is [7].

2. Materials and Methods

2.1. Study Area and Settings

The study was carried out in the Buea Health District of the Fako Division. Buea is the capital of the South West Region of Cameroon[8]. The Buea Health District (BHD) is located within the administrative boundaries of the Buea Sub-Division and has a population of 133092 inhabitants [9] living in seven health areas namely: Bokwango, Bova, Buea Road, Buea Town, Molyko,Muea and Tole. The PBF activity started in the South West Region in 2012 with four health districts (Buea,Kumba, Limbe and Mamfe health district). The pilot phase was from 2012 to 2014; awaiting scaling up in 2015 in all the other districts after an impact evaluation.

2.2. Study Population

This study was conducted only amongst health personnel (Temporal, voluntary, and permanent staff) working in private, confessional, or public health facilities involved in the PBF project within the Buea Health District. This study was conducted in six of the seven Health Areas within the Buea Health District; reasons being that one of the health areas (Tole health area) had no functional health facility.

2.3. Sample Size

Buea Health District has an estimated staff strength of 645 personnel (civil servants, temporal workers, voluntary workers), working within 22 health facilities. Since an evaluation of staff satisfaction in the context of PBF has not been documented, a proportion of 50% satisfaction was used in order to have a representative sample size. Taking a 95% confidence interval and a precision level of 5%, the sample size of staff within the Buea Health District was calculated using the formula[10]

$$n = \frac{Z^2\, pq}{d^2}$$

where n = sample size, Z=1.96, p=prevalence, d=precision, q=level of significance

$$= \frac{(1.96)^2(0.5)(1-0.5)}{(0.05)^2}$$

$$= 384$$

2.4. Sampling Method

Proportional to size random sampling was employed in this study. All staff was classified according to their PBF involvement into the following strata: T1 group, C1 group, and C2 group. This is because each stratum has a different intervention. Based on the fact that hospitals were automatically considered as T1, and that they constitute a greater majority of the staff strength, a proportional stratified sampling was carried out in order to have a representative sample size for statistical comparison. The number of respondents selected from each stratum was proportional to the size of the stratum in the entire study population. Respondents were attributed to their various strata according to the proportional sample size. Each respondent was given a conservative number. To select those who are to be included in the sample, random numbers were drawn by ballot from the individual strata.

2.5. Ethical Consideration

Ethical approval was obtained from the Faculty of Health Sciences Institutional Review Board of the University of Buea. Authorization from the Dean of the Faculty of Health Sciences University of Buea was also sought.

Administrative authorization was also sought from the regional delegate of public health Buea and the various heads of health facilities.

2.6. Data Collection Tool

Data collection was done using a structured pre-tested questionnaire that was adapted from employee satisfaction survey question by Smith [11]. The questionnaire was sub divided into three sections: section A contained the socio-demographic data (age, sex, marital status, highest certificate obtain, and health facility), Section B assessed general staff satisfaction and Section C assessed job passion and self-evaluation in the PBF scheme.

3. Results

3.1. Staff Satisfaction with the PBF Scheme

Of the seven questions that were used in accessing staff satisfaction, three were statistically significant while four were not statistically significant in the C2 group giving a percentage satisfaction of 57.1%. In the T1 group, six questions were statistically significant while one question was not statistically significant giving a percentage satisfaction of 14.2%. Hence, the percentage satisfaction for the C1 group was 28.7%. Table10: (summary table of responses on staff satisfaction per PBF strata)

3.2. Job Passion and Self-evaluation per strata

Of the five questions that were used in accessing job passion, two were statistically significant while three were not statistically significant in the C2 group giving a percentage passion of 60 %. In the T1 group, four questions were statistically significant while one question was not statistically significant giving a percentage passion of 20%. Hence, the percentage satisfaction for the C1 group was 20%. Table 12 (summary table of responses on job passion per PBF strata)

3.3. Staff Assessment with the PBF Scheme

Of the 223 participants who advocated that PBF management should verify how staff incentives are being shared, 76 (34.0%) respondents were from the C1 group, 22 (9.9%) from C2 and 125 (56%) were from the T1 strata. Respondents who advocated that there should be financial motivation to all units were thus: 16 (51.6%) from the C2 group, 15 (48.4%) from the T1 group and no respondent from the C1 group. Of the 50 participants who responded that there should be training of all staff on what PBF is all about, 11 (22%) respondents each came from the C1 and C2 group respectively while 28 (56%) of respondents were from the T1 group. Participants said PBF should verify the purchase of equipment that is indicated in the business plans of all health facilities. There should be adequate supply of equipment and materials for staff to work with. From this response, 9 (10.0%), 6 (6.7%), and 75 (83.3%) responded from the C1, C2 and T1 group respectively. It was also assessed that feedback information from PBF does not get to all staff. Hence respondents advocated that PBF should regularly hold feedback meetings with staff of the various units of the health facilities. The proportion of responses were 13 (46.4%), 3 (10.7%), and 12 (42.9%) from C1, C2, and T1 groups respectively. Of the 38 participants who said PBF should respect timely payment of subsidies, 9 (23.7%) respondents were from the C1 group, 29 (76.3%) from the T1 group and none from the C2 group. 10 (40%) respondents from the C1 and 15 (60.0%) respondents from the T1 strata said motivation should be given to all staff, while there was no respondent from the C2 strata. This response came mostly from the voluntary staff working in the various health facilities. Of the 11 respondents who reported of supervisors poor attitudes, 3 (27.0%) responded from the C1 strata, 8 (72.7%) from the T1 strata and non from the C2 strata. Table14 below.

3.4. Discussion

Participants in the C2 strata are developing more health care initiative with the help of the PBF scheme more than those of the T1 and C1 strata which is the intervention group though PBF is an innovative, results-oriented, and practical approach [1].Participants in the C2 strata participate in the business plan meetings more than T1 and C1 strata even though consolidation of the business plan is supposed to be done by all actors within the health care system regardless of their position, qualification, or status [12]. From the District supervisors, PBF verificators and community verification, the results of this study reveal that participants from the C2 strata receive feedback from supervision more than those in the T1 and C1 strata. The PBF subsidies paid to health facilities is expected to be used in varied ways including purchase of working tools and equipment [13]. Results of this study did not actually reveal any difference in the purchase of equipment amongst the C1, C2 and the T1 strata though it was expected that participants of the C1 and T1 should show a significant difference in the purchase of equipment since they are being paid PBF subsidies. Senior managers of each health facility are administrators within the health facility. Study results revealed that senior managers of the C2 group demonstrated more commitment to quality health care than those of the T1 and C1 group. This implies that there will be a general laxity at the operational level (the subordinates) leading to low quality of care.

One of the main objectives of the PBF scheme is to encourage staff to acquire greater responsibility and accountability for their patients[12, 13]. Study results shows that participants in the C2 group are more encouraged to do so than those in the T1 and C1 group. The results of this study showed no difference amongst

participants in the C2 strata and those of the T1 and C1 strata in terms of PBF rewarding the quality of staff efforts. 30-50% of subsidies paid into health facilities are meant to be used for staff motivation which in turns rewards the quality of their efforts [1]. Results of the C2 strata are self-explicit since they are not paid PBF subsidies. The T1 and C1 strata are being paid PBF subsidies yet staff efforts are not rewarded. Financial motivation is one of the main motivating factors that boost job passion and promote staff self- evaluation. The absence of this financial motivation is what has proliferated private practice (PP) in most of our health facilities especially the big hospitals. This has pulled staff attention to the aspect of money making than the provision of quality care to patients. Participants in the C2 strata tend to experience personal growth such as updating skills and learning new ways of improving on their job due to PBF supervisions and training more than those in the T1 and C1 strata. This can be due to the fact that the C2 strata has a smaller staff strength that can easily be controlled and managed while the staff strength of the T1 and some C1 strata are more vast. Hence, corrections done during supervision do not reach the operational level. Results of this study also reveal that participants in the C2 strata respond quickly and courteously to fulfill patients' needs since PBF assesses patient satisfaction more than those in the T1 and C1 strata. The degree of patient satisfaction is a clear evaluation of quality of care given. If participants of the T1 strata who see most of the patient's do not follow up to fulfill patient needs, for which they will be paid, then the attainment of quality care is still far-fetched.

C2 participants have shown from these results that PBF has improved the likeness of their job more than those of the T1 and C1 strata. This implies that more quality care will be rendered in the C2 strata than in the T1 and C1 strata. However, the T1 strata tend to see more patients than those of the C2. Hence, quality of care to the population is still threatened.

The results of this study to determine staff assessment working with the PBF scheme reveals that participants from the T1, C1 and C2 strata (in decreasing order) advocate that PBF should verify how staff incentives are distributed. Respondents from the C2 strata advocated that there should be payment of subsidies to all health units. The response is obvious because C2 health units are not paid PBF subsidies. The results of the study also points to the need for training of all health staff on what PBF is all about; that is educating all health staff on the various activities of PBF. Participants also indicated that the scheme should be able to verify that materials and equipment's are bought as indicated in the business plans of the health facilities. More of this assessment was indicated by participants of the T1 and C1 strata (in decreasing order). About 25% of subsidies paid in to the facilities is supposed to be used in the purchase of equipment and working tools. Further staff assessment with the PBF scheme reveals that there is need for the PBF management to hold regular meetings with all the staff of the units to provide feedback and other patient concerns. Staff further assessed that PBF does not respect the terms of contract of timely payment of subsidies. Payment at times is delayed for as long as six months when health facilities have respected their own part of the contract by providing the care and producing the results which once validated requires prompt payment as stipulated in the performance contract. This attitude injures confidentiality and thereby demotivating the staff from delivering further quality care. It was also noticed that not all staff in the T1 and C1 strata are motivated with the PBF subsidies. It was evident that the voluntary staffs of all the hospitals were not financially motivated. Participants assessed that some supervisors exhibit very poor attitudes especially the District medical team during supportive supervision. It is a supportive supervision and not a control of health facilities. Supervision is meant to help the health worker to work in a better way according to norms stipulated by the ministry of Public health. Once supportive supervision becomes scaring, the learning process becomes compromised.

3.5. Conclusions

The above results reveal that participants in the C2 strata (which benefit only from supervision and no bonuses) show a significant level of satisfaction while those of the C1 and T1 strata (which has PBF bonuses, independent monitoring of results, and systematic supervision) are not satisfied. Hence, it can be concluded that financial motivation is not the main source of staff motivation, though it contributes to staff satisfaction.

Furthermore, staffs of the C2 strata demonstrate a high level of job passion and self-evaluation while those of the C1 and T1 group do not have passion for their job and do not also evaluate their own activities to see if goals are met or not.

Staff assessment of the PBF scheme reveals that the PBF management should verify how staff incentives are shared, train staff on all PBF activities, verify purchases planned, ensure timely payment of subsidies to health units and follow up with health units to ensure that all staff are motivated with the PBF funds since it is paid based on performance and not qualification.

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