

Financial and Non-Financial Incentives to Improve Performance and the Quality of Health care in Hadiya zone, SNNPR, Ethiopia

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Abstract

Human resources for health are key for delivery of health care services. According to WHO's 2006 World Health Report, Ethiopia had 0.247 doctors, nurses and midwives combined per 1,000 population, and was one of the 57 countries with health workforce crisis. International Non-Governmental Organizations and International agencies utilizes financial and non-financial incentive to retain experienced health workers to deliver health services for targeted population. This study employed health facility based cross sectional survey. Quantitative and qualitative data collection techniques was used to gather primary information using tools. The study was conducted in the selected health facilities in Hadya zone, Southern Nations and Nationalities Region, Ethiopia. In Hadiya zone, there were 13 rural districts and 4 town administrations. The study targeted 4 rural districts selected randomly and all 4 town administrations. All health professionals who were working in the public health sector targeted for the study. The research aim was to examine the relationship between financial and non-financial incentives and health workers performance and quality of health care. This study found that 64.1% (Male 59.3%; Female 66.7) respondents reported that both financial and non-financial incentives were equally important to improve health workers performance and motivation in provision of quality of health care services. This clearly indicated that the importance of non-financial incentives on the top of financial incentive to motivate Health Workers for better performance and quality of health care.

Keywords: *Financial and non -financial Incentives, Health workers performance, Quality of health Care, Satisfaction of workers on Fringe Benefits.*

Introduction

According to WHO 2006 report, Ethiopia is one of the countries in the world with low health workforce density of 0.7/1000 population, which is far below the minimum threshold density of 2.3 health workers (MD, nurses & Midwives) per 1000 population for countries to achieve essential services (a targeted 80% coverage rate for skilled birth attendance). In the African region, the average threshold is 1.6 of doctors, nurses & Midwives per 1000 population. In the last two decades, an increasing number of developing countries have introduced incentive payments linked to results to widen access to care and to improve the quality and performance of health care services and systems. These incentive schemes, known collectively as Performance-based financing (PBF), play an important role in advancing progress toward universal health coverage, contributing to the achievement of the Sustainable Development Goals.

For over a decade, the World Bank's strategies have emphasized the importance of paying for results approaches to expanding access to and

improving health care services. The World Development Report 2004; Making Services Work for Poor People lists weak incentives for health providers as one of the drivers of poor-quality service, leading to low demand for health services. To address such barriers to service delivery, the report recommended the creation of incentives for better quality service and strengthening accountability. A continued misalignment between health service providers' compensation and key system goals drives the failure to deliver efficient and effective services for populations despite many efforts in the last decade to improve quality and performance.

As many countries change governance principles of their health systems from rules and regulations toward devolved, results driven systems that emphasize strategic planning and decision making oriented towards performance, they have realized that success requires individuals and organizations in the system have an incentive to act on information and use their capacities to meet the health system goals. The term incentive means an inducement, which rouses or stimulates one to action in a desired direction. An incentive has a motivational power;

many incentives, the modern organizations use to motivate their employees may be broadly grouped into (i) financial incentives, and (ii) non-financial incentives.

Financial incentive -Money is an important motivator. Common uses of money as incentive are in the form of wages and salaries, bonus, retirement benefits, medical reimbursement, etc. Management needs to increase these financial incentives making wages and salaries competitive between various organizations to attract and hold work force. In any organization, the financial capability of employees is a very important factor as it determines the level or the extent to which he or she is motivated to expend his/her effort on the job performance. Non-financial incentives do not involve money payments. These are also important in motivating employees as they bring in psychological and emotional satisfaction to them. These include so many techniques. People do work for money-but they work even more for meaning in their lives. Some of the important non-financial incentives include recognition, Better job titles, empowerment, competition and job rotation etc.

Limitation of this research was it only focused on financial and non-financial incentives for improving performance and quality of care but other determinants for health care quality was not included in this study. The reason is that incentive alone can't represent for quality of care improvement, there are other factors that may affect quality of care such as working environment, infrastructure, pharmaceuticals and other supplies availability. This study focused on 82 health facilities in Hadiya zone, South Nations, Nationalities and People Region (SNNPR), Ethiopia. This may limit generalizing the finding of the study.

Therefore, this study found out that to maintain required health work force in the health facilities, the management should focus both on financial and non-financial incentives strategically link in to their performance objectives.

Methodology

This study was conducted in Hadiya zone, South Nations Nationalities and peoples Region, Ethiopia. In this study, the researcher employed a cross-sectional survey design to quantitatively assess the relationship between the financial and non-financial incentives, employee performance and quality of health care improvement using a questionnaire. Key informant interview was conducted with facility and district managers to get detailed qualitative information on how and why of the financial and non-financial incentives contribution for improved performance and

quality of health care services. According to Creswell (2014) and Sekaran (2016) quantitative research is an approach for testing objective theories by examining the relationship among variables. According to him these variables in turn can be measured, typically on instruments, so that numbered data can be analyzed using statistical procedures.

According to the information obtained from the zonal health department, the total number of the target population (different cadre of health workers) in the study area were 2,533. This figure includes all kinds of health cadres (doctor, Nurses, Midwives, Health officers, Pharmacist, laboratory technicians, Health Extension workers etc). To determine the sample size for this study, three key factors such as confidence interval (it is also called level of precision or sampling error), confidence level, and the population size were considered.

$$n = \frac{N}{1 + N(e)^2}$$

- Where 'n' is the sample size, 'N' is the population size, and 'e' is the level of precision/ Confidence interval.
- The study considered a 95% confidence level and a 5% confidence interval. Using the above portrayed statistical formula, the sample

$$n = \frac{2533}{1 + 2533 (.05)^2} = 345$$

5% non-responders in case of absence at the work station during data collection is 17

Therefore, the sample size for targeted population of this study was **362** employees.

Data collection was conducted by the trained data collectors using closed ended questionnaires distributed to the randomly selected sample of individual employees of ministry of health of Ethiopia working in Hadiya zone and collected physically from respondents at their site by the researcher and trained data collectors. Qualitative data was collected using Key Informant Interview guide by the researcher and trained data collector. The qualitative information was collected from health facility and district/Woreda health department managers in view of getting detailed information on how and why of the financial and non -financial incentives for health workers and its impact on performance improvement and quality of care.

The quantitative data collected by the structured individual questionnaire was cleaned and edited and responses to open ended questions were coded. Then the data were entered into the computer using CSPro (Census and Survey Processing) software. Following the completion

of the entry, the raw data were transformed to SPSS version 26 readable format for easy manipulation and processing as well as further analysis.

Then Health providers' survey data were analyzed using appropriate statistical techniques such as logistics regression and Descriptive statistics (frequencies, cross tabulations and charts) were used to identify the association between financial and non-financial incentives and the performance and quality of health care. Moreover, factor analysis also used to identify scaled constructs.

Qualitative data was analyzed by formulation of stories presented by respondents considering context of each case and different experiences of each respondent. The respondent's key points and related comments were analyzed and incorporated in the research findings.

Reliability tested using Cronbach 's alpha values for the items in each construct carried out. According to Sekaran and Bougie (2016) reliabilities less than 0.60 are poor, those in the 0.70 range, acceptable, and those over 0.80 good. Based on the above recommendation the reliability test done for this study using Cronbach's alpha values for items in each construct is more than acceptable.

Results

In total 362 questionnaires were distributed to 82 health facilities (3 hospitals, 18 Health centers and 61 Health posts). Out of 362 distributed questionnaires, 354 questionnaires completed with response, which is 97.8% of the targeted respondents. Non-respondents were 8 which is 2.2% only.

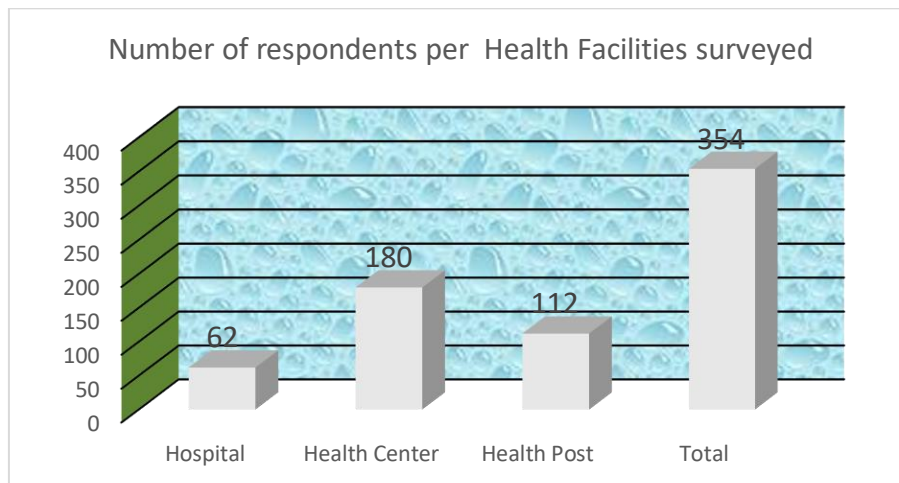


Figure 1. Number of respondents per facilities

Table 1. Sex of the respondents

Demographic Characteristics		Sex		Total
		Male	Female	
Sex	Number	123	231	354
	%	34.7%	65.3%	100.0%

From the above table 34.7% were males and 65.3% were female

Table 2. Age structure of the respondents

Age group		Male	Female	Total
20-24	Number	8	9	17
	%	6.5%	3.9%	4.8%
25-29	Number	53	98	151
	%	43.1%	42.4%	42.7%
30-34	Number	40	98	138
	%	32.5%	42.4%	39.0%
35-39	Number	12	16	28
	%	9.8%	6.9%	7.9%

40-44	Number	10	9	19
	%	8.1%	3.9%	5.4%
45+	Number	0	1	1
	%	0.0%	.4%	.3%

42.7% of respondents were between the ages of 25 to 29 years, Whereas, 39% of respondents belongs to the age range of 30 to 39 years.

Table 3. Marital Status of the respondents

Marital Status		Male	Female	Total
Married	Number	49	142	191
	%	39.8%	61.5%	54.0%
Living in union	Number	3	5	8
	%	2.4%	2.2%	2.3%
Divorced	Number	0	1	1
	%	0.0%	.4%	.3%
Never married/never in union	Number	71	83	154
	%	57.7%	35.9%	43.5%
Total	Number	123	231	354
	%	100.0%	100.0%	100.0%

54% (Male 39.8%; Female 61.5%) respondents were married and never Married/never in union are 43.5% (Male 57.7%; Female 35.9%) of respondents.

Table 4. Educational status of the respondents

Educational status		Sex		Total
		Male	Female	
Primary	Number	2	0	2
	%	1.6%	0.0%	.6%
Technical/vocational	Number	3	18	21
	%	2.4%	7.8%	5.9%
Higher education (college diploma)	Number	54	162	216
	%	43.9%	70.1%	61.0%
Higher education (First Degree)	Number	63	51	114
Higher education (Second Degree)	%	51.2%	22.1%	32.2%
	%	.8%	0.0%	.3%

Above table shows 61% (Male 43.9%; Female 70.1%) of respondents attended higher education (college diploma) with significant number of female respondents. When it comes to Higher

education (first degree) level 32.2% (Male 51.2%; Female 22.1%) of respondents attended with higher number of Male.

Table 5. Professional Category of the respondents

Profession		Male	Female	Total
Medical Doctor	Number	7	2	9
	%	5.7%	.9%	2.5%
Nurse	Number	49	49	98
	%	39.8%	21.2%	27.7%
Health Officer	Number	26	20	46
	%	21.1%	8.7%	13.0%
Midwife	Number	6	22	28

	%	4.9%	9.5%	7.9%
Laboratory Technician	Number	8	9	17
	%	6.5%	3.9%	4.8%
Pharmacist/ Druggist	Number	8	5	13
	%	6.5%	2.2%	3.7%
Health Extension worker (HEW)	Number	3	111	114
	%	2.4%	48.1%	32.2%
Others	Number	16	13	29
	%	13.0%	5.6%	8.2%

Above table shows 32.2% of the respondents are HEW followed by 27.7% Nurses. Respondents in professional categories like Medical doctors were 2.5%.

Table 6. Responders years of services in current profession

Number of Years in current profession		Male	Female	Total
Less than 2 years	Number	22	30	52
	%	17.9%	13.0%	14.7%
2 up to 5 years	Number	52	92	144
	%	42.3%	39.8%	40.7%
6 up to 10 years	Number	37	62	99
	%	30.1%	26.8%	28.0%
11 up to 20 years	Number	4	37	41
	%	3.3%	16.0%	11.6%
More than 20 years	Number	8	10	18
	%	6.5%	4.3%	5.1%
Total	Number	123	231	354
	%	100.0%	100.0%	100.0%

In the above table, almost 40.7% of respondents served in their current professional categories for 2-5 years. The percentage of respondents 'years of services in the current position for 11-20 years was only 11.6%, whereas more than 20 years was only 5.1% which indicates that HWs were

migrating from the rural and relatively rural towns after few years of services, most probably after finishing the obligation entered by the government as part of educational expenses cost sharing.

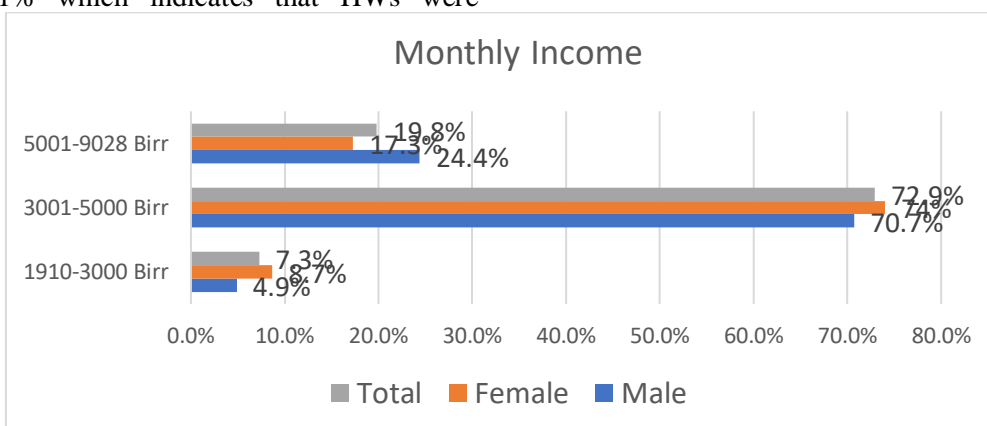


Figure 2. Responders monthly income

In the above figure, most of the respondents (72.9%) monthly income falls in the range of 3001-5000 Ethiopian birr. Only 19.8% of the respondents getting monthly income in a range of 5001-9028 Ethiopian birr.

Table 7. Effectiveness of financial and non-financial incentives on employees' performance and quality of health care provision

Motivational factors		Sex		Total
		Male	Female	
Financial or monetary benefits	Number	39	64	103
	%	31.7%	27.7%	29.1%
Non-financial or non-monetary benefits	Number	11	13	24
	%	8.9%	5.6%	6.8%
Both	Number	73	154	227
	%	59.3%	66.7%	64.1%

In the above table, most of the respondents 64.1% (Male 59.3%; Female 66.7) reported that both financial and non-financial incentives were equally important to improve HWs performance and motivation in provision of quality of health care for people in need. 29.1% of respondents

reported that financial or Monetary benefits motivates Health workers for better performance. Whereas 6.8% of the respondents reported that non-financial or non-monetary benefits motivate HWs for better performance.

Table 8. Responders rate of financial incentives

Rate of financial incentive		Male	Female	Total
Very good	Number	18	26	44
	%	14.6%	11.3%	12.4%
Good	Number	33	57	90
	%	26.8%	24.7%	25.4%
Fair	Number	36	72	108
	%	29.3%	31.2%	30.5%
Bad	Number	34	65	99
	%	27.6%	28.1%	28.0%
Very bad	Number	2	3	5
	%	1.6%	1.3%	1.4%
discouraging	Number	0	8	8
	%	0.0%	3.5%	2.3%
Total	Number	123	231	354
	%	100.0%	100.0%	100.0%

Above table shows ,30.5% of respondents rate the current financially incentive is fair, 25.4% good and 12.4% very good. 28.1% respondents' rate financial incentive is bad, 1.4% very bad and 2.3% discouraging. This indicates dissatisfaction

of the HWs with current financial incentives. Respondents who rated very good is only 12.4%, this significantly show that majority of HWs were not happy with the incentives provided by the employer.

Table 9. Respondents beliefs on financial incentives alone to motivate for better performance and quality of health care services delivery

Respondents believe financial incentive alone motivates for better performance		Sex		Total
		Male	Female	
Yes	Number	46	76	122
	%	38.7%	36.0%	37.0%
No	Number	73	135	208
	%	61.3%	64.0%	63.0%
Total	Number	119	211	330
	%	100.0%	100.0%	100.0%

Table 9 shows ,63% of the respondents believe that financial incentives alone can't motivate for better performance. This clearly indicated that the importance of non-financial incentives on the top of financial incentive to motivate HWs for better

performance and quality of health care services delivery. 37% of the respondents believe only financial incentives alone can motivate for better performance and quality of health care provision.

Table10. Respondents perception on management leadership style

Respondents perception on the management leadership style		Sex		Total
		Male	Female	
Very good	Number	16	29	45
	%	13.0%	12.6%	12.7%
Good	Number	61	95	156
	%	49.6%	41.1%	44.1%
Fair	Number	39	73	112
	%	31.7%	31.6%	31.6%
Bad	Number	7	31	38
	%	5.7%	13.4%	10.7%
Very bad	Number	0	3	3
	%	0.0%	1.3%	.8%
Total	Number	123	231	354
	%	100.0%	100.0%	100.0%

Table 10 shows, almost 56.8% of the respondents perceived that the management leadership style was good to very good and 31.6% of respondents perceived as fair, where 11.5% perceived the management style was bad to very bad. The Key

informant interview participants also indicated that management leadership style was one of the important factors for key HWs retention and better performance.

Table 11. Perception of respondents on Employees Performance increase through Motivation trends.

Motivation increase Employees performance		Sex		Total
		Male	Female	
Always	Number	27	46	73
	%	22.0%	19.9%	20.6%
Occasionally	Number	60	122	182
	%	48.8%	52.8%	51.4%
Not at all	Number	36	63	99
	%	29.3%	27.3%	28.0%

Table11 shows ,51.4% of respondent's perception on employee's performance increase through motivation was an occasional trend, where as 28% of respondents perceived that

employees were not at all motivated. Only 20.6% of respondents were perceived HWs were motivate always.

Table 12. Response on the type of in-service training

Training type		Male	Female	Total
On - the - job training	Number	30	67	97
	%	24.4%	29.0%	27.4%
Off - the - job training	Number	24	66	90
	%	19.5%	28.6%	25.4%
None	Number	68	94	162
	%	55.3%	40.7%	45.8%
Others, specify	Number	1	4	5
	%	.8%	1.7%	1.4%

Above table shows,45.8% of the respondents attended none of the in-service training in last one year, whereas 27.4% of respondents attended on the job training and 25.4% of respondents attended off-the-job training.

Table 13. The significance of the incentive provided and effect towards performance improvement

Has the incentive provided had significant effect towards performance improvement?		Male	Female	Total
Yes	Number	107	206	313
	%	87.0%	89.2%	88.4%
No	Number	16	25	41
	%	13.0%	10.8%	11.6%
Total	Number	123	231	354
	%	100.0%	100.0%	100.0%

Table 13 shows ,88.4% of the respondents say 'yes' the incentive provided had significant effect towards performance improvement, where as 11.6% of respondents says 'no' the incentive provided has no significant effect toward performance improvement.

Table 14. Reasons of People's work beyond getting Money

People work for		Sex		Total
		Male	Female	
Recognition	Number	30	65	95
	%	24.4%	28.1%	26.8%
Achievement	Number	74	106	180
	%	60.2%	45.9%	50.8%
job challenge	Number	15	46	61
	%	12.2%	19.9%	17.2%
Don't know	Number	4	14	18
	%	3.3%	6.1%	5.1%
Total	Number	123	231	354
	%	100.0%	100.0%	100.0%

Table 14 shows ,50.8% of respondents were working for achievements, where as 26.8% of respondents works for recognition and 17.2% for Job challenges beyond getting money.

Table 15. Satisfaction of respondents with the fringe benefits (Medical care, pension scheme, Housing benefits, lunch subsidy, Transport allowance) offered

Are you satisfied		Sex		Total
		Male	Female	
Yes	Number	32	63	95
	%	26.0%	27.3%	26.8%
No	Number	91	168	259
	%	74.0%	72.7%	73.2%

Table 15 shows, 73.2% of respondents were not satisfied with the benefits (medical, pension scheme, Housing benefits, lunch subsidy, Transport allowance) offered, whereas only 26.8% of the respondents were satisfied with the fringe benefits provided.

Table 16. Type of benefits that respondents are not satisfied

The benefits respondents are not satisfied with		Male	Female	Total
Medical care	Number	31	60	91
	%	34.1%	35.7%	35.1%
pension scheme	Number	4	9	13
	%	4.4%	5.4%	5.0%
Housing benefits	Number	30	60	90
	%	33.0%	35.7%	34.7%
Lunch subsidy	Number	0	1	1
	%	0.0%	.6%	.4%
Transport allowance	Number	23	32	55
	%	25.3%	19.0%	21.2%
Others, specify	Number	3	6	9
	%	3.3%	3.6%	3.5%
Total	Number	91	168	259
	%	100.0%	100.0%	100.0%

Above table shows that the benefits respondents were not satisfied include medical, housing and transport allowances, presented as 35.1%, 34.7%, and 21.2% respectively.

Table 17. Mean score of Perception of Respondents on Health facilities performance

Variables	Cronbach's Alpha	Mean Score
Workers will still perform very well even if their salary is delayed by week	.455	2.67
Workers' welfare should be a paramount issue of concern to top management who wish to have higher productivity.	.341	3.55
Monetary rewards only can bring best in workers performance	.632	3.13
Inter-Personal relationship between top management and staff should be encouraged	.541	4.25
Rewarding good work and excellence can contribute to more excellence and healthy competition	.498	4.18

As per the above table, respondents were slightly disagreed that health workers will still perform very well even if their salary was delayed by week. On the other hand, respondents were slightly agreed that workers' welfare should be a paramount issue of concern to top management who wish to have higher productivity. Respondents also slightly agreed that monetary rewards only can bring best in workers performance. Most of the respondents strongly agreed that inter-personal relationship between

management and staff and reward good work and excellence can contribute to more excellence and health competition which can lead to better performance. This indicated that good inter-personal relationship between management and employee will facilitate employees' performance in the form of motivation and rewarding good work in any form including recognition and thank giving through certificate will improve employee's performance.

Table 18. Mean score of perceptions of Respondents on Health facilities quality of health care

Variables	Cronbach's Alpha	Mean Score
I can participate in “setting goals” which are related to my job and main factor for better quality of health care provision for the clients.	.647	3.71
There are opportunities to use my abilities to do tasks differently for quality health care services delivery and better results	.673	3.67
I have freedom to take decisions (job task, its timing, and required resources) in relation to my role, which makes me more productive in delivering quality health care services	.643	3.47
Management is engaging in delivering training programs for employees to improve skills and knowledge of their job for better quality health care service delivery.	.682	3.50
I am happy and motivated to perform better and encouraged to improve quality of health care services when I receive non-financial rewards in different forms including recognition	.698	3.51
I am happy and motivated to perform better and encouraged to improve quality of health care services when I receive better financial rewards	.735	4.32
I am happy and more engaged when I receive both financial and non-financial rewards to improve quality of health care services.	.709	4.23

In the above table, respondents are agreed that participating in “setting goals” which were related to their job was main factor for better quality of health care provision for the clients. Respondents also agreed if they were given opportunities to use their abilities to do tasks differently for quality health care services delivery and better results. Respondents agreed that if they have freedom to take decisions (job task, its timing, and required resources) in relation to their role, which makes them more productive in delivering quality health care services. Respondents agreed if Management was engaged in delivering training programs for employees to improve skills and knowledge of

their job for better quality health care service delivery. Respondents agreed that they would be happy and motivated to perform better and encouraged to improve quality of health care services when they receive non-financial rewards in different forms including recognition. Respondents are strongly agreed that they would be happy and motivated to perform better and encouraged to improve quality of health care services when they received better financial rewards. Respondents were strongly agreed that they would be happy and more engaged when they received both financial and non-financial rewards to improve quality of health care services.

Table 19. Respondents fringe benefits satisfaction by Demographic Characteristics

Demographic Characteristics			Are you satisfied with the fringe benefits (Medical care, pension scheme, Housing benefits, lunch subsidy, Transport allowance) offered	
			Yes	No
Sex	Male	Number	32	91
		%	26.0%	74.0%
	Female	Number	63	168
		%	27.3%	72.7%
Age group	20-24	Number	1	15
		%	6.3%	93.8%
	25-34	Number	79	209
		%	27.4%	72.6%
	35-49	Number	14	34
		%	29.2%	70.8%
Marital Status	Married	Number	52	139
		%	27.2%	72.8%
	Living in union	Number	0	8
		%	0.0%	100.0%
	Divorced	Number	0	1
		%		

		%	0.0%	100.0%
	Never married/never in union	Number	43	111
		%	27.9%	72.1%
Total		Number	95	259
		%	26.8%	73.2%

Above table shows that there is no significant satisfaction difference based on the demographical characteristics except few differences in female verses male and age group

from 25-34 years. This means dissatisfaction on fringe benefits reflected uniformly despite different demographic characteristics.

Table 20: Respondents' fringe benefits satisfaction by Socio Economic Characteristic

Socio economic Characteristics			Are you satisfied with the fringe benefits (Medical care, pension scheme, Housing benefits, lunch subsidy, Transport allowance) offered	
			Yes	No
Education	Primary	Number	0	2
		%	0.0%	100.0%
	Technical/vocational	Number	1	20
		%		
	Higher education (college diploma)	Number	60	156
		%	27.8%	72.2%
Higher education (First Degree)	Number	34	80	
	%	29.8%	70.2%	
Higher education (Second Degree)	Number	0	1	
	%	0.0%	100.0%	
Profession	Medical Doctor	Number	1	8
		%	11.1%	88.9%
	Nurse	Number	36	62
		%	36.7%	63.3%
	Health Officer	Number	5	41
		%	10.9%	89.1%
	Midwife	Number	7	21
		%	25.0%	75.0%
	Laboratory Technician	Number	2	15
		%	11.8%	88.2%
	Pharmacist/ Druggist	Number	1	12
		%	7.7%	92.3%
Health Extension worker (HEW)	Number	29	85	
	%	25.4%	74.6%	
Others	Number	14	15	
	%	48.3%	51.7%	
Monthly Income	1910-3000 Birr	Number	5	21
		%	19.2%	80.8%
	3001-5000 Birr	Number	52	206
		%	20.2%	79.8%
	5001-9028 Birr	Number	38	32
		%	54.3%	45.7%
Total		Number	95	259
		%	26.8%	73.2%

Above table shows that respondents' fringe benefit satisfaction by socio economic characteristics was not significantly linked. Even the monthly income indicated weak satisfaction.

Table 21. Logistic Regression analysis of incentive factors that determine performance improvement and quality of care

Independent variables	Sig.	Exp(B)
Workers obtained Low salary (workers obtained high salary [R])	0	5.516
People do not work only for money but work for other reasons (Job challenge [R])	0.045	
Recognition	0.005	2.871
Achievement	0.005	4.772
Satisfied with the fringe benefits provided (Are not satisfied with the fringe benefits provided (R)	0.003	0.201

Above table reveals those employees who have obtained low salary (below the average salary of workers) believe that incentives provided as motivation to workers had significant effect towards performance improvement 5.5 times more likely than those obtained high salary. In terms of purpose of people work, employees who said people are working not only for money but also for recognition and achievement believed that incentives provided as motivation to workers had significant effect towards performance improvement 2.87 and 4.77 times respectively more likely than those who said for job challenge. On the other hand, those employees who are satisfied with the fringe benefits offered by their health facility believed that incentives provided as motivation to workers had significant effect towards performance, 20 percent less likely than those who are not satisfied by the fringe benefits.

Discussion

Incentives can play a role in providing a means by which health systems can attract and retain essential and highly sought-after health care professionals. Effective incentive schemes also help to build a better motivated, more satisfied and better performing health workforce. In general, the qualitative and quantitative information collected and analyzed indicated that systematically planned and balanced financial and non-financial incentives were key for improving quality of health services delivery in the public health facilities. As these facilities supporting the health care need of most of the people in the country, it must have conducive environment for health workers attending the health of the community with all kind of benefit packages to motivate and retain them. If motivated key staff in place, the health care system would be able to deliver the quality health care for the people in need.

The key informant participants mentioned that incentive in monetary form is very important to cover the cost of living where as non-financial incentive need to be added in balanced manner for the HWs who committed his/her time in delivering health care services differently than the other fellow colleagues in the organization. Choosing the right incentive package requires a consideration of both the effects of different packages on employee choices and the cost of those packages.

An incentive programme represents a substantial investment for most organizations. Receiving a sufficient return on that investment requires the full participation of the programme participants. Incentive programmes should be based upon the concept that effort increases people perceptions progressing towards their goal. Therefore, programs should offer participants a variety of incentive packages based on their unique interests and diverse needs. Successful programs need to develop their reward methods carefully to keep participants eager to approach a goal to receive intended reward. Workers in general (even the most dedicated) thrive on constant encouragement, effective rewards and suitable recognition.

Conclusion

Rewards tend to motivate people to do more and to do it better or continue to do it better. Without rewards, workers tend to lose interest in excelling and innovation. As some interviewees have stated, in this sense incentive can be considered as a "right compensation" for HWs working in difficult context, without resources (Pharmaceuticals and infrastructure), tools and adequate facilities and career opportunities. Incentives also contribute to reduce the brain drainage of HW from Ethiopia to other countries. The brain drainage often due to a chance of better salary, career opportunities and better living conditions. If health workers received adequate

salary in their country they are less willing to leave their country.

During the discussion on incentive mechanisms some health managers mainly referred to the financial incentives. But HWs interviewed have underlined the important of non-financial incentives. The word recognition had a lot of importance among HWs, they asked recognition for their work and more when there were working in rural and remote areas of Ethiopia. This has been indicated in the WHO user guide for HRH in rural and remote areas. A good incentive mechanism includes both financial and non-financial incentives to be positive and useful to the empowerment of HWs in improving performance and quality of health care services.

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