



## Review

## Paying for performance and the social relations of health care provision: An anthropological perspective

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## ABSTRACT

Over the past decade, the use of financial incentive schemes has become a popular form of intervention to boost performance in the health sector. Often termed “paying for performance” or P4P, they involve “...the transfer of money or material goods conditional upon taking a measurable action or achieving a predetermined performance target” (Eldridge & Palmer, 2009, p.160). P4P appear to bring about rapid improvements in some measured indicators of provider performance, at least over the short term. However, evidence for the impact of these schemes on the wider health system remains limited, and even where evaluations have been positive, unintended effects have been identified. These have included: “gaming” the system; crowding out of “intrinsic motivation”; a drop in morale where schemes are viewed as unfair; and the undermining of social relations and teamwork through competition, envy or ill feeling. Less information is available concerning how these processes occur, and how they vary across social and cultural contexts.

While recognizing the potential of P4P, the authors argue for greater care in adapting schemes to particular local contexts. We suggest that insights from social science theory coupled with the focused ethnographic methods of anthropology can contribute to the critical assessment of P4P schemes and to their adaptation to particular social environments and reward systems. We highlight the need for monitoring P4P schemes in relation to worker motivation and the quality of social relations, since these have implications both for health sector performance over the long term and for the success and sustainability of a P4P scheme. Suggestions are made for ethnographies, undertaken in collaboration with local stakeholders, to assess readiness for P4P; package rewards in ways that minimize perverse responses; identify process variables for monitoring and evaluation; and build sustainability into program design through linkage with complementary reforms.

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### Introduction: the policy context: why financial incentives, why now?

Financial incentives, also termed “paying for performance” (P4P) or performance based financing (PBF), can be defined as: “...the transfer of money or material goods conditional upon taking a measurable action or achieving a predetermined performance target” (Eldridge & Palmer, 2009, p.160).

P4P have become a popular form of intervention in national health sectors over the past decade. A number of donors have promoted P4P including the World Bank, World Health Organization (WHO), the Global Alliance for Vaccines and Immunizations (GAVI), the Global Fund to Fight AIDS, TB and Malaria (Global Fund), the UK Department for International Development (DFID) and the

US Agency for International Development (USAID). P4P appears to have the potential to bring about rapid improvements in measured indicators of provider performance (Kalk, Paul, & Grabosch, 2010; Paul, 2009; Soeters, Habineza, & Peerenboom, 2006), although the evidence base remains limited (Eldridge & Palmer, 2009; Oxman & Fretheim, 2009) and doubts have been raised concerning effectiveness in settings with weak health infrastructure and information systems (Lagarde, Haines, & Palmer, 2007; Powell-Jackson, Morrison, Tiwari, Neupane, & Costello, 2009; Ssengooba, McPake, & Palmer, 2012).

P4P programs targeting health providers have been implemented in the US (Mehrotra, Damberg, Sorbero, & Teleki, 2009; Oldani, 2010), UK (McDonald & Roland, 2009), Haiti (Eichler, Auxila, Antoine, & Desmangles, 2007), Cambodia (Soeters & Griffiths, 2003), China (Yip, Hsiao, Meng, Chen, & Sun, 2010) and a number of African countries, including Rwanda (Soeters et al., 2006), Burundi, Zambia, Democratic Republic of Congo and Tanzania (Toonen, Canavan, & Vergeer, 2009). Following the apparent

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success of these programs, a number of other African countries are currently planning to introduce P4P (Meessen, Soucaf, & Sekabaraga, 2011; Soeters & Vroeg, 2011).

One reason for P4P's popularity lies in the pressure to achieve the Millennium Development Goals (MDGs) (Oxman & Fretheim, 2009). The use of market mechanisms to achieve these short term targets has appeared to make sense within the broader context of market based policy reforms, often termed "neoliberal", which assume markets to be the most effective mechanism for allocating resources and achieving results in the public as well as private sectors. This has led to a tendency to replace bureaucratic or professional based practices with market mechanisms (Rose, 1999). Neoliberalism has been variously defined as a "remarkably uniform" (Pfeiffer & Chapman, 2010, p.151) set of market based policies inspired by monetarist economists, particularly Milton Friedman (Harvey, 2007; Wacquant, 2012), and as assemblages of mobile technologies of government that take on different forms and effects in different contexts depending on their articulation with preexisting practices (Collier, 2012; Kingfisher & Maskovsky, 2008; Ong, 2006). The latter approach may be more helpful in understanding variation in responses to P4P, a technique of government that clearly predates neoliberalism, but has recently enjoyed a resurgence in popularity coinciding with the spread of "neoliberal" policies. The "neoliberal" flavour of contemporary P4P can be seen in its association with other market mechanisms such as contracting out to the private sector or NGOs (Eldridge & Palmer, 2009; Soeters & Griffiths, 2003). P4P's alignment with current policy assumptions may explain why enthusiasm for P4P persists despite limited evidence of its capacity to achieve stated aims (Bowman, 2010; Galvin, 2006), let alone broader social goals. Indeed, evaluations of financial incentive schemes rarely examine their wider impacts on health system performance over the long term, and there is even less evidence concerning cost effectiveness (Ireland, Paul, & Dujardin, 2011; Montagu & Yamey, 2011; Oxman & Fretheim, 2009; Toonen et al., 2009).

The MDGs encourage a focus on achievement of specific targets, but the global health community is finally waking up to the importance of strengthening national health systems in a more integrated manner (Bradley et al., 2011; Frenk, 2010; Mills, 2011; Mills, Gilson, Hanson, Palmer, & Lagarde, 2008; Travis et al., 2004). Global health is increasingly viewed by policy makers as an economic and security issue encouraging an "avalanche of resources" (Pfeiffer & Nichter, 2008, p.411), with development assistance to health in low and middle income countries tripling between 1997 and 2007 (Eichler & Levine, 2009). Until recently the bulk of this aid has been channelled via vertical, disease focused programs (Travis et al., 2004). Following decades of pressures to reduce spending on public services under "neoliberal" structural adjustment programs, national health infrastructures are now inadequate to the task of disseminating the benefits of these programs to intended populations (Pfeiffer & Nichter, 2008).

With increasing recognition of the need to strengthen public health systems, and of the important role of research in this process (Gilson, Hanson, Sheikh, Agyepong, & Ssengooba, 2011; Mills, 2011; Mills et al., 2008), an analysis of the role of P4P in promoting or undermining health systems is urgently required (Ireland et al., 2011). Sections 2 and 3 discuss the advantages and potential dangers of P4P as identified in the literature to date. This literature draws on human resource management and organizational theory and on the limited empirical data available. What is missing from this literature is an exploration of how or why responses to P4P might vary from one place to another. Although the importance of context in health policy design generally (Balabanova, McKee, Mills, Walt, & Haines, 2010; Faguet & Ali, 2009; Roberts, Hsiao, Berman, & Reich, 2004) and for P4P in particular (Eldridge & Palmer, 2009;

Ireland et al., 2011) has been emphasized in the literature, the term "context" means different things to different authors. For Roberts et al. (2004), context includes the political, economic and administrative environment. But as Faguet and Ali (2009) point out one has to go deeper than this in order to understand the underlying values and social processes that affect work place motivation. Section 4 draws on social science theory to suggest a framework for understanding contextual variation in responses to P4P impacts. Section 5 suggests how theoretically informed anthropological research can help critically assess P4P and adapt schemes to particular settings.

### Potential benefits of P4P: greater in theory than in practice?

P4P is appealing because the idea is simple and appears fair. If some people perform better, why not reward them? Theoretical support for P4P can be found in organizational theory and in economics. In organization theory, the "principal agent" framework provides a rationale for the need for incentives. Principals (such as employers) need to offer "carrots" to agents (such as employees) because the interests of the agent are not perfectly aligned with those of the principal. If health bureaucracies are viewed as a series of "principal agent" relationships, the use of financial incentives makes sense (Perry, Engbers, & Jun, 2009). Shifting from the institution to the individual, economics has contributed a number of models of individual decision making that suggest the use of financial incentives will have positive effects on performance. These include rational choice theory, expectations theory and reinforcement theory (Perry et al., 2009). These models assume that decision making is based solely on the individual's analysis of expected outcomes and on the pursuance of self interest. If there is some support for P4P in these deductive models, is there any evidence that it actually works in practice?

Much of the evidence for positive impacts comes from evaluations financed by the agencies implementing the schemes (Ireland et al., 2011). Such evaluations must be interpreted with caution since they focus on achievement of outputs in relation to project objectives rather than broader impacts on people and their health services, and because "failures" tend to receive less publicity than "successes" (Ssengooba et al., 2012). One of the most widely cited success stories is the Rwanda P4P scheme. Rwanda was the first developing country to scale up P4P in the health sector to the national level from 2006, following pilots initiated in 2002 (Basinga, Gertler et al., 2011; Ireland et al., 2011; Kalk et al., 2010; Rusa et al., 2009; Soeters & Vroeg, 2011). Donors include the World Bank, the Global Fund and bilateral donors. Performance indicators exclusively address MDG targets for maternal and child health, and bonuses are paid at the facility level based on achievement of quantitative and quality targets (Basinga, Gertler et al., 2011). Early evaluations found performance of program indicators had improved, staff motivation was strengthened, client satisfaction and utilization of some services increased, absenteeism had fallen, documentation improved, and management relations and team spirit were stronger (Kalk et al., 2010; Rusa et al., 2009). These results depended on improved monitoring and supervision, including auto evaluation by the health centres (Rusa et al., 2009) and community oversight (Ireland et al., 2011). However, unintended negative effects on staff morale and performance were also documented (Kalk et al., 2010; Paul, 2009). Furthermore, complementary reforms in the Rwandan health sector, including increased base salaries, render it difficult to link performance outcomes to the P4P scheme (Kalk et al., 2010). A recent evaluation by Basinga, Gertler et al. (2011) isolated the P4P effect through a randomized controlled trial. The incidence of facility visits for childbirth and child preventative care was higher for facilities under P4P than for

those with an equivalent level of input based financing. There was no difference in the number of women completing four prenatal visits or of children completing immunization schedules. Eichler et al. (2007) report similar findings from Haiti, where NGOs were contracted to provide health services under a P4P scheme. Attended deliveries and immunization coverage improved, while prenatal and postnatal care was not significantly affected. In both cases it appears that outcomes with higher rewards under the scheme, and those less dependent on patient voluntarism, yielded the most robust results (Basinga, Gertler et al., 2011). In another positive evaluation, a P4P for public health providers in China helped realign incentives away from a profit motive that had encouraged overtreatment (Yip et al., 2010).

In addition to their impact on output measures, P4P have been reported to improve information and management systems (Eichler & Levine, 2009), encourage more creative use of resources, strengthen accountability and transparency (Toonen et al., 2009), clarify roles and responsibilities (Paul, 2009; Rusa et al., 2009), and recognize volunteer or low paid workers (Kalk et al., 2010). Furthermore, P4P may convince Ministries of Finance to increase funding to the health sector (Meessen et al., 2011) and help retain staff, even in remote areas.

### The potential pitfalls of P4P

#### *Measuring performance: P4P as a “fatal remedy”*

P4P schemes aim to improve health worker performance. Given the difficulty of measuring overall performance P4P schemes rely on indicators such as numbers of vaccinations delivered, patients seen or deliveries assisted. But it has been suggested that as soon as you measure something it ceases to be a good indicator of anything beyond that which is measured (Eldridge & Palmer, 2009). For example, a correctly completed partogram does not prove that a successful delivery has occurred (Kalk et al., 2010). Similarly, the achievement of P4P targets does not tell us whether health worker performance has improved in a comprehensive or sustainable manner. Form filling may operate more as a means of controlling workers than improving their performance. Measurement may even become a “fatal remedy”, leading to poorer, rather than improved performance (Power, 1997, p.97). Organization theory offers a useful framework for understanding behavioural responses to the *measurement* aspects of P4P, including various forms of “gaming”.

“Gaming” refers to strategies to maximize performance in relation to rewarded behaviours. “Gaming” observed in the health sector includes falsification of data (Ireland et al., 2011; Kalk et al., 2010; Paul, 2009; Powell-Jackson et al., 2009); oversupply of targeted services (Kalk et al., 2010; Rusa et al., 2009); retention of drugs to avoid a stock out (Kalk et al., 2010); and neglect of health care practices that are not included in the measures, such as prevention, care of chronic illness or care of “difficult” patients, including the poor or noncompliant (Ireland et al., 2011; McDonald & Roland, 2009; Oldani, 2010). Targets put pressure on health staff to use their social influence to recruit participants, often against their wishes, or for some token form of remuneration. This encourages the enrolment of unsuitable candidates (Ireland et al., 2011) and undermines the notion of “patient choice”. For example, women approaching or even past menopause were included in family planning programs that had enrolment targets in India in the 1980s, while coercive practices were reported for sterilization programs in Bangladesh and elsewhere (Hartmann, 2011). Although targets may be met in the short term, the reputation of health services and government programs more generally can be affected over the long term.

#### *Meddling with motivation: “can do”, “will do” and the generation of “double binds”*

Whereas P4P rests on the assumption that people are primarily motivated by material gain (Eldridge & Palmer, 2009), health sector workers appear to be motivated by a combination of professional ethics, public service and economic motivation (Andersen, 2009; Paul, 2009). Noneconomic forms of motivation have been found to be crucial to health sector performance (Franco, Bennett, & Kanfer, 2002; Paul, 2009; Rayner, Williams, Lawton, & Allinson, 2010; Toonen et al., 2009).

The human resources management literature provides a framework for understanding the complexity of worker motivation, dividing factors into “can do”, the ability of the health worker to perform, and “will do”, the desire or willingness to work towards organizational goals (Franco et al., 2002, pp.1260–1; Mathauer & Imhoff, 2006). “Can do” factors cover training; professional competence; working conditions; availability of resources, equipment and supplies; and the time and management support to perform adequately. P4P is based on the assumption that the lack of “will do” motivation is a primary cause of poor performance (Soeters & Griffiths, 2003). But in resource poor settings where “can do” factors are a key constraint, P4P can lead to “double binds” when health workers lack the resources needed to achieve performance targets (Eldridge & Palmer, 2009; Paul, 2009). Schemes may appear to favour facilities that are already better resourced, since these are more likely to achieve the targets (Eldridge & Palmer, 2009; Ireland et al., 2011).

“Will do” factors relate to personal goals that generate a willingness to work in line with organizational goals. These might include vocation and professional conscience, a desire to ease suffering or help patients, a sense of responsibility, commitment to public service ideals or the will to achieve. “Will do” factors are affected by personnel management, including clear job descriptions, career advancement, professional recognition, training, peer support, appreciation from clients, strong leadership and clear organization goals (Dieleman, Toonen, Touré, & Martineau, 2006; Mathauer & Imhoff, 2006). As well as these external factors, “will do” depends on internal factors including a person’s values and expectations, as well as “intrinsic motivation”, the desire to perform a task because it is interesting and provides satisfaction, regardless of expected consequences (Deci & Ryan, 2012). “Will do” motivation is thus the result of the interaction between external and internal factors (Franco et al., 2002).

Concern has been raised that P4P, by encouraging motivation for financial rewards, may lead to the “crowding out” of other forms of motivation. For example, those motivated by public service values may find the job less rather than more attractive, believing their image will be spoiled by the higher monetary rewards (Georgellis, Iossa, & Tabvuma, 2010). On the other hand, Yip et al. (2010) suggest that shifting motivation towards financial incentives is easier than regenerating social or moral commitment once this is lost. “Crowding out” of public service ethos and “intrinsic motivation” has been documented for P4P in health (Ireland et al., 2011; Rayner et al., 2010) and was a primary concern of health policy makers interviewed by one of the authors in several West African countries.

But P4P can undermine motivation and performance in other ways. For example, P4P may encourage mediocrity by setting limits on expectations (Bowman, 2010). P4P schemes may generate “double binds”, as when time taken to complete paperwork required for P4P conflicts with time attending to patients (Ireland et al., 2011; Kalk et al., 2010; Paul, 2009), or when receiving a reward upsets working relationships with others (Powell-Jackson et al., 2009). P4P schemes may add to an already heavy load of paperwork, perceived to be unnecessary or burdensome. New

monitoring systems may also interfere with informal aspects of supervision negotiated between supervisors and subordinates, which are seen as necessary in order for the formal systems to function (George, 2009). P4P thus has the potential to generate *disincentives* as well as incentives, either for those targeted or for others. A sense that rewards are being allocated unfairly can be a strong demotivator (Mathauer & Imhoff, 2006; Powell-Jackson et al., 2009; Toonen et al., 2009), creating jealousies between those receiving rewards and those who do not (Nichter, 1986; Ssengooba et al., 2012). Incentives for some can also create increased workloads for others, as when incentives offered to traditional healers to refer patients overburden public health workers not eligible to receive rewards.

#### *Measurement and motivation: synergistic and longer term impacts on the health sector*

“Crowding out” and “gaming” are related because the rewards that potentially lead to “crowding out” are linked to measured targets that potentially generate “gaming” behaviour. It has been observed that “crowding out” and “gaming” can reinforce one another. Willingness to engage in “gaming” can be a result of the “crowding out” of noneconomic forms of motivation, while increased surveillance to limit “gaming” can exacerbate “crowding out”, as workers’ self esteem and self direction falls (Paul, 2009).

Shifts in motivation can have impacts beyond the individual. “Crowding out” and resentment affect morale and job satisfaction at the institutional level (Rayner et al., 2010), or in the wider society. “Gaming” to achieve individual rewards can generate competition and envy among health workers, reducing information sharing, trust and teamwork (Mathauer & Imhoff, 2006). These shifting behaviours are likely to undermine continuity of care and damage the functioning of the health system, which is highly dependent on social relations of trust (Gilson, 2003; Gilson, Palmer, & Schneider, 2005) and on efficient information systems (Frenk, 2010). Allocating rewards to groups or facilities might address some of these issues, although it could also introduce the risk of “free riding” (Eijkenaar, 2012). Evidence of group P4P schemes is limited (Bowman, 2010; Perry et al., 2009). Under the Rwanda P4P scheme some staff contested the distribution of rewards among facility members even though rewards were offered at the facility level (Kalk et al., 2010).

“Gaming” and “crowding out” reveal how measuring and rewarding selected behaviours can potentially affect behaviours that are not measured or rewarded. Measurement transforms the operations of an organization, leading to a reallocation of resources, or “colonization” (Power, 1997, p.97). On the other hand, bonuses realign behaviour towards behaviours that are measured. P4P may lead to a focus on quantity at the expense of quality of health care, since quantitative targets are easier to implement and monitor and therefore likely to be selected under P4P schemes (Ireland et al., 2011). The restructuring of health systems under P4P schemes, including transformations in financing and monitoring systems (Toonen et al., 2009), may lead to “decoupling” (Power, 1997, 94), with individuals or resources being used to create a buffer between the organization and the supervisors who measure performance. This diverts resources away from the primary activity of delivery of health services (Eldridge & Palmer, 2009; Ireland et al., 2011).

Expectations can also be affected over the long term. Evidence suggests that bonuses rapidly come to be seen as part of the salary package (Ireland et al., 2011; Mathauer & Imhoff, 2006), while their impacts dissipate over time (Montagu & Yamey, 2011). Performance may even fall below pre P4P levels if funding is stopped (Kalk et al., 2010), although the “half life” of an incentive is likely to vary from program to program. A further problem is that subsequent policy

interventions that do not offer financial incentives may fail to generate enthusiasm.

Incentive schemes are also likely to have long term effects on relations between providers and patients. Performance bonuses for providers could increase utilization and trust if performance improves (Soeters & Griffiths, 2003), or decrease it if patients feel that providers are oriented towards targets and bonuses rather than patient welfare (Kalk et al., 2010). Uneven distribution of funds to mothers under Nepal’s safe delivery program created mistrust of public health services, “thereby reducing demand for all health services, not just delivery care” (Powell-Jackson et al., 2009, p.10).

This review of the potential pitfalls of P4P suggests that market mechanisms in the form of P4P will not necessarily improve the performance, efficiency or cost effectiveness of health bureaucracies, especially given the high cost of administering these programs (Bowman, 2010; Ireland et al., 2011; Lagarde et al., 2007; Toonen et al., 2009).

Analysts of P4P tend to assume opposing positions based either on the potential benefits or the negative consequences of P4P (Basinga, Mayaka, & Condo, 2011). This polarization is exacerbated by limited evidence, the focus in P4P evaluations on short term outcome variables and the difficulty of isolating P4P effects from confounding factors (Ireland et al., 2011; Macq & Chiem, 2011; Toonen et al., 2009). We know very little about how outcomes are achieved, hence whether they are sustainable over the long term or transferable to other settings (Ireland et al., 2011; Ssengooba et al., 2012). Understanding the processes by which P4P targets are reached demands a reorientation away from unidimensional quantitative measures and towards an understanding of motivation as a component within a complex adaptive social system.

#### **Using social science theory to understand responses to P4P**

Understanding responses to P4P and how they vary cross culturally demands theory that recognizes motivation as a social as well as individual phenomenon. The sociologist Pierre Bourdieu offers a useful starting point. Bourdieu regards human behaviour as structured by the “habitus”, a system of dispositions which frames people’s attitudes, perceptions and actions. According to this framework, motivation can be seen as a disposition that orients actors towards actions that improve performance. Dispositions are learned behaviours, acquired through socialization and framed by past experiences. Bourdieu argued that people from the same social group or class tend to have similar experiences, based on shared “conditions of existence” giving rise to a shared “habitus” that generates regularities in the behaviour of members of a social group, even in the absence of conscious coordination (Bourdieu, 1977, 1986b). Bourdieu regarded the “habitus” as durable and not susceptible to change, suggesting a limitation in the applicability of his theory to contexts of rapid behavioural change (Weiss, 2008). But others have explored the ways in which government policy can interact with the “habitus”, as well as how assumptions concerning the “habitus” frame such policies. In an ethnography of a participatory development project in India, Mosse (2005) describes how “participation” was translated into existing routines and agendas. The policy idea underwent different transformations within the bureaucracy of the government civil service and within a private company contracted by the project, leading to outcomes that were not always intended by policy makers. Similarly, Nichter (1986, 1999) has documented how community participation in primary health care programs in the 1970s was based on unrealistic expectations about the existing “habitus” of primary health care centres, and that this was one reason for the failure of these programs to impact the poor. On the other hand, new policy agendas often involve shifts in assumptions concerning people’s

dispositions. According to Greener (2002), social welfare policy in Britain was based on the assumption of a collective public service disposition within the civil service, whereas the more recent market based New Public Management policy is based on the assumption that civil servants are “free agents” motivated primarily by material gain. Greener suggests that this latest policy is likely to fail due to a misapprehension of the nature of individual agency within the civil service “habitus”.

Although the “habitus” is shared within a social group, there is no assumption within Bourdieu’s theory of a “level playing field”. The arena in which dispositions are played out is a structured “social field”, involving sets of positions that determine access to resources or capital. Bourdieu distinguished between different forms of capital including economic, cultural, social and symbolic capital. Cultural capital signals competence to operate in a particular social field. It includes educational qualifications, such as medical expertise, as well as embodied knowledge of appropriate behaviour, such as the use of correct manners and language in relation to peers and supervisors. Social capital refers to the social networks that an individual can draw on for social, economic or professional support. Symbolic capital refers to forms of recognition, such as promotions, certificates or titles and to the prestige associated with one’s social position or professional status. These forms of capital are acquired by individuals through investment of time and labour, or in some cases through inheritance, in ways that are allowed and encouraged by the “habitus” of their social group. The dynamics of the social field determine the extent to which individuals can convert one form of capital to another (Bourdieu, 1986a). For example, cultural capital could, under certain circumstances, be converted to economic capital through securing a job for which the candidate is considered “suitable”.

P4P schemes aim to bring about a change in health worker motivational disposition through increasing their access to economic capital. Bourdieu offers a useful framework for understanding how this process is mediated by preexisting social formations. According to this framework, P4P will be translated into the social field of the health service, comprising the overlapping medical and social hierarchies in which doctors, nurses, midwives, administrators and patients operate (Nichter, 1986). P4P acts on the social field by introducing new positions and responsibilities and by altering access to different forms of capital. Schemes thus bring about a “game change” with potential knock on effects throughout the system. Although P4P is defined by the offer of a material reward, all forms of capital and behaviours oriented towards acquiring them are potentially affected. New *cultural capital* will be required to navigate systems of indicators, targets and rewards while maintaining existing relationships with patients or colleagues.

*Social capital* may be increased if performance bonuses are earned by and strengthen a team, or if individuals share their bonus with others, thereby converting economic capital into social capital. But the “bonus culture” could also reduce social capital, fragmenting social networks if it encourages competition with peers, or is perceived as unfair. There is some evidence that this has, in fact, occurred under some P4P schemes. According to Powell-Jackson et al. (2009, p.8), under the Nepal safe delivery program “There was widespread discontent with the health provider incentive, even amongst those who benefit directly such as midwives. It strained relations between health staff, particularly when some felt the distribution of money was unjust or higher qualified staff were ineligible to receive the incentive.”

P4P schemes also affect the distribution of *symbolic capital*. Reputations may be enhanced through improved performance, publicity events, or simply through participation in the scheme. Conversely, symbolic capital may be lost if behaviours go “against

the grain”, perhaps due to neglect of other duties or to “crowding out” of public service motivation, leading to a perception that health staff are “just in it for the money”. The acquisition of symbolic capital marks a shift in power relations that may be open to contestation (Shenkin & Coulson, 2007). Nichter (1999, p.303) refers to the “tendency of the health care bureaucracy to resist innovations which undermine preexisting power structures”. The distribution of bonuses to lower level staff may be perceived as a threat to senior staff, especially where rewards normally reflect one’s seniority rather than current performance (Nichter, 1986). Conversely, existing power structures may be reinforced where supervisors are perceived as acquiring too much power in “do as I say performance pay” (Bowman, 2010, p.75). In cultures where envy is associated with witchcraft accusations, earning a bonus could even be perceived as dangerous to the recipient.

Bourdieu’s concept of convertible capital is useful for understanding how P4P might impact motivation differently depending on the structure of local social fields and reward systems. However, it may not capture all of the impacts of P4P on motivation. Bourdieu focuses on different forms of social or material gain but does not address the issue of “intrinsic motivation”, not dependent on external rewards. A number of psychologists have studied “intrinsic motivation”. Under experimental conditions monetary rewards have been found to undermine “intrinsic motivation”. One explanation is that “when extrinsic rewards are introduced for doing an intrinsically interesting activity, people tend to feel controlled by the rewards” (Deci & Ryan, 2012, p.234), leading to a loss of self determination and self esteem (Paul, 2009). Concerns that P4P schemes may lead to the “crowding out” of “intrinsic motivation” (Ireland et al., 2011; Paul, 2009) suggest the need for further ethnographic studies focused on this issue.

#### *Wider impacts*

One advantage of regarding the health system as a complex, evolving social field embedded in wider sociocultural systems is that it alerts the analyst to impacts of health policies that extend beyond the formal health system. Focused ethnographies by anthropologists have confirmed that health policies typically do have social impacts on the wider society even where these are not intended (Castro & Singer, 2004; Hahn & Inhorn, 2009; Janes & Corbett, 2009; Tesler, 2010). Pfeiffer’s (2004) ethnography of the impact of health policy in Mozambique illustrates one way in which this can occur. Pfeiffer describes how international donor policy to support NGOs in health service delivery in Mozambique not only undermined the public health system but also increased socio-economic inequality within communities served by the NGOs. The recruitment and funding of a new cadre of NGO staff drained the public service of skilled human resources while at the same time creating a new elite enclave class. These wider impacts would be missed in conventional programme evaluations.

Although there is limited empirical evidence to date, it appears that P4P schemes can also have impacts beyond the health system. For example, Toonen et al. (2009) argue that centralized management of P4P has compromised decentralization and community involvement in Rwanda.

#### **Where do we go from here?**

In this section we suggest how some of the insights emerging from this review can be operationalised in qualitative research aimed at critically assessing P4P schemes. Following Ulin, Robinson, and Tolley (2005, p.52) and Nichter, Quintero, Nichter, Mock, and Shakib (2004, p.1914) we advocate a “cyclical formative reformative research approach” involving a number of distinct but

interactive stages, from initial situational analysis and problem identification prior to implementation of a scheme, through monitoring and evaluation to critical assessment of wider impacts.

#### *Assessing readiness and keeping options open*

Before introducing P4P, it is important to inquire how health system performance is currently being framed and addressed by policy makers, managers, public and private providers, health financiers and populations served. How will P4P interact with existing policies and initiatives? How will it help to achieve national as well as international goals? *Discussion of a range of options* will allow people to raise concerns (Ireland et al., 2011, p.696), identify who would support P4P, who might lose out, and what would need to be in place for success over the long term. Achieving local goals through P4P schemes may require developing broader sets of indicators than those used in MDG focused programs in Rwanda and elsewhere (Basinga, Gertler et al., 2011; Toonen et al., 2009).

#### *Planning for “gaming” and “crowding out”*

It has been suggested that the risk of “crowding out” can be reduced by aligning performance measures with existing professional norms and values that provide a foundation for “intrinsic motivation” (Eijkenaar, 2012). In addition, it is necessary to understand how external reward systems work for people holding different positions within the health social system. If new responsibilities and targets or the level and distribution of rewards are viewed as clashing with existing norms, or if health workers are not happy about the way in which indicators and targets are set, this could cause resentment (McDonald & Roland, 2009). Some targeted providers in Rwanda felt that “gaming” was encouraged by the purchasers setting inappropriate indicators and targets (Kalk et al., 2010, p.186). “Gaming” might also be higher if rewards are seen to emanate from a seemingly unlimited foreign source, rather than from limited national or local government funds. On the other hand, “gaming” might be reduced by ensuring that information about the supervisory and reward system is transparent to health service users as well as to those targeted by rewards (Greener, 2002). Involving health workers and the communities they serve in the selection of indicators and targets might help reduce “gaming” and “crowding out” (Eijkenaar, 2012; Paul, 2009; Toonen et al., 2009).

#### *Packaging rewards*

Responses to P4P will depend on how the packaging of rewards is interpreted, as well as on the meaning of money and the connotations it evokes in particular contexts. P4P packaged as per diems, training fees or sitting allowances, may evoke different reactions, depending on whether they are regarded as a one off performance bonus, an entitlement, an aspect of the job, or a part of the salary package. The packaging of rewards, including the size and frequency of payments, also affects whether financial rewards can be hidden or converted into other forms of capital, and their perceived fairness. Money paid to encourage behavioural changes may be regarded as a bribe or a form of coercion in some contexts (Hartmann, 2011; Marteau, Ashcroft, & Oliver, 2009) or as a gift generating a moral obligation to provide a good service in others (Nichter, 1983). When “Stop Buruli” social scientists discussed offering cash payments to traditional healers in Ghana who referred patients with Buruli ulcer to the public health service it was warmly received. But in a neighbouring country this same payment was interpreted as “paying for diseased bodies” in

a cultural context where traditional healers may be implicated in inflicting disease as well as healing.

Interpretations and responses to P4P may also vary with the professional or social subgroup within the health system. In a qualitative study of health worker motivation in Mali, Dieleman et al. (2006, p.4) found physicians were more strongly motivated by “feeling responsible” than were nurses, whereas “increase in salary” was more motivating for nurses and midwives than for physicians. Similarly, providers in the private sector may respond differently to the package of “carrots and sticks” offered under a P4P scheme than do public sector practitioners (Bennett et al., 1994, p.1). Traditional healers interviewed by one of the authors in Cameroon said they valued respect, particularly from the medical community, at least as much as money. This suggests that participation of local stakeholders is needed to identify the optimal presentation and levels of rewards for each location and social or professional group. Understanding what kinds of symbolic capital are valued by different groups could lead to incorporation of nonmaterial rewards such as trainings, exchange visits or the publication of collective achievements on a website, which might be more effective at rewarding *collaboration* than bonuses.

#### *Understanding the role of teamwork in health systems*

Ethnographic research has revealed the important role social relations and teamwork play in the performance of a health service (Gilson, 2003; Nichter, 1986). P4P risks undermining cooperation and trust among health workers, even where rewards are allocated to teams (Kalk et al., 2010). More research is needed to understand how teams of health workers operate within stable or evolving reward systems. Social network analysis to identify patterns of collaboration in low and high performing facilities would provide a foundation for discussing this issue with stakeholders and for monitoring the impact of P4P schemes on teamwork.

#### *Process evaluation*

There is an urgent need for process variables to complement the outcome variables that form the basis of current monitoring and evaluation systems. Process variables would help researchers, policy makers and health workers understand how outcome indicators have been achieved (Mills, 2011; Mills et al., 2008; Ssengooba et al., 2012). They would involve tracking social relations throughout the system to assess the impact of P4P schemes on cooperation, trust, and information sharing and on the quality of interactions with patients. As Ireland et al. (2011, p.696) have pointed out, “the successful referral of a pregnant woman to a health centre or hospital for delivery is, above all, dependent on the quality of the relationship between the woman and her health provider”. Process variables should also measure the incidence, effects and costs of “gaming” and “crowding out”. Currently these social impacts are addressed in an ad hoc manner during occasional qualitative research rather than being built into design, monitoring and evaluation (Toonen et al., 2009). Those targeted, including populations served, should be involved in identifying and monitoring process variables in relation to targeted and non targeted activities (Ireland et al., 2011).

#### *Expecting expectations*

Short term interventions can have long term impacts on expectations. Local historical research is needed into the types of incentive schemes that have been tried before in health and other sectors, how past experiences are likely to shape responses to proposed P4P schemes, and how these in turn might affect

expectations regarding subsequent interventions. Schemes in the public health sector can have knock on effects in the private sector, and on patient trust and loyalty with respect to other government services. The way in which P4P is presented both in policy circles and in the media also impacts expectations. For this reason, it is useful to monitor media representations of health sector performance and of particular interventions, since these both reflect and frame public perceptions, which in turn influence the way problems are addressed and policies are forged in future (Nichter, 2008).

### Building sustainability

Health sector P4P schemes in developing countries remain heavily dependent on donor support, both for financing and capacity building, bringing into question their long term sustainability (Ssengooba et al., 2012; Toonen et al., 2009). Furthermore, experience suggests that impacts on performance can be short lived, as bonuses quickly come to be seen as part of the normal salary package. In Rwanda Ireland et al. (2011, p.696) report “waning enthusiasm from health workers who have become accustomed to receiving financial incentives”. *Ethnographic research is needed to help assess what would be required in a particular location not only to stimulate motivation but to sustain it over the long term.* Evidence from community health worker programs suggests that maintaining motivation requires a *mix of incentives*, including symbolic recognition of achievements and investment in career enrichment as well as material support. Incentives need to be reviewed periodically in relation to changing workloads, competing job opportunities and other changes in the health system (Basinga, Mayaka et al., 2011; Bhattacharyya, Winch, LeBan, & Tien, 2001, pp. 1–68). Communities can also be involved in sustaining motivation, for example through health insurance schemes such as that implemented with the Rwanda P4P. The idea was that as P4P boosted performance, demand for health insurance would rise, generating financial resources to sustain quality services. Given the uncertainty and unpredictability of national and international funding, novel forms of community participation in maintaining health sector performance are likely to be needed (Toonen et al., 2009).

### Discussion

Anthropology can provide a bridge between social theory and practical health policy work. Anthropology's strengths in this regard include the methodology of sustained participant observation in the research setting, the validation of local perspectives, and a tradition of drawing on a wide range of theoretical foundations (Hahn & Inhorn, 2009, pp.1–34). This paper has attempted to draw together the theoretical insights and empirical evidence relevant to an understanding of the wider impacts of P4P schemes and how these might vary with the setting. Following recent anthropological scholarship (Collier & Ong, 2005; Kingfisher & Maskovsky, 2008), we regard P4P as a mobile and transferable “neoliberal” technology of health governance that articulates with preexisting assemblages of governance practices, social relations and nonhuman factors such as disease events. We have focused on motivation as one component within these complex assemblages because of its relevance to the goals of P4P. A key contribution of this paper lies in our analysis of motivation as a social behaviour rather than a characteristic of individuals. In developing this perspective we drew on Bourdieu's concepts of “habitus”, field and forms of capital. A number of suggestions have been made as to how these insights could be operationalised through anthropological research to assess P4P schemes critically in relation to local sociocultural contexts.

This approach is in line with that advocated by Mills et al. (2008), Bradley et al. (2011), Gilson et al. (2011), Bennett et al. (2011) and others in a recent series of articles on health systems research. Bradley et al. (2011) suggest that renewed interest in health systems research from WHO and other funding agencies is related to the shift from an “international health” to a broader “global health” perspective, a shift that has been accompanied by involvement of a wider range of disciplines in health research, including anthropology, sociology and psychology. Gilson et al. (2011, p.1) argue that: “...as health policies and systems are themselves social and political constructions, it is important to acknowledge the particular value of social science perspectives in the field”. These authors also argue for more systematic and rigorous approaches to social science research into health systems, including the development of case study methodologies linking processes to outcomes across different settings (Mills et al., 2008). This paper is intended as a first step in moving this agenda forward in relation to P4P.

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