Health sector reform and public sector health worker motivation: a conceptual framework

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Abstract

Motivation in the work context can be defined as an individual’s degree of willingness to exert and maintain an effort towards organizational goals. Health sector performance is critically dependent on worker motivation, with service quality, efficiency, and equity, all directly mediated by workers’ willingness to apply themselves to their tasks. Resource availability and worker competence are essential but not sufficient to ensure desired worker performance.

While financial incentives may be important determinants of worker motivation, they alone cannot and have not resolved all worker motivation problems. Worker motivation is a complex process and crosses many disciplinary boundaries, including economics, psychology, organizational development, human resource management, and sociology. This paper discusses the many layers of influences upon health worker motivation: the internal individual-level determinants, determinants that operate at organizational (work context) level, and determinants stemming from interactions with the broader societal culture.

Worker motivation will be affected by health sector reforms which potentially affect organizational culture, reporting structures, human resource management, channels of accountability, types of interactions with clients and communities, etc.

The conceptual model described in this paper clarifies ways in which worker motivation is influenced and how health sector reform can positively affect worker motivation. Among others, health sector policy makers can better facilitate goal congruence (between workers and the organizations they work for) and improved worker motivation by considering the following in their design and implementation of health sector reforms: addressing multiple channels for worker motivation, recognizing the importance of communication and leadership for reforms, identifying organizational and cultural values that might facilitate or impede implementation of reforms, and understanding that reforms may have differential impacts on various cadres of health workers. © 2002 Elsevier Science Ltd. All rights reserved.

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Introduction

Worker motivation

Motivation, in the work context, can be defined as an individual’s degree of willingness to exert and maintain an effort towards organizational goals. It is an internal psychological process and a transactional process: worker motivation is the result of the interactions between individuals and their work environment, and the fit between these interactions and the broader societal context.

Health sector performance is critically dependent on worker motivation: health care delivery is highly labor-intensive. Consequently, service quality, efficiency, and equity are all directly mediated by workers’ willingness...
to apply themselves to their tasks. While resource availability and worker competencies are essential, they are not sufficient in themselves to ensure desired worker performance. Worker performance is also dependent on workers’ level of motivation stimulating them to come to work regularly, work diligently, be flexible and willing to carry out the necessary tasks (Hornby & Sidney, 1988).

**Worker motivation and health sector reform**

Even in a stable work environment, what motivates workers fluctuates over time. Health sector reform, essentially a change process, adds additional destabilization to the work environment through its efforts to improve national policies, programs and practices by altering health sector priorities, laws, regulations, organizational structure, and financing arrangements. Yet, even reforms that have tried to improve working environments and incentives have not always had the anticipated impact on health system effectiveness. Workers have often displayed “unexpected” behavior patterns, reflecting the lack of internalization of health reform and organizational goals.

Although many technical aspects of health sector reform in the international context have been researched and low levels of worker motivation plague public health systems in developing countries, there has been a surprising lack of attention to the human (worker) elements of reforms. Only recently have meetings and papers begun to address human resource development issues in the context of health sector reform (Dussault, 1998; Martinez & Martineau, 1996).

Faced with little information about what motivates health workers and how reforms affect worker motivation, many countries (and organizations within them) have implemented measures or incentive programs designed to stimulate certain kinds of worker behavior without an empirical base to guide their choice of interventions. Policy makers have often relied primarily on financial incentives, as in Indonesia (Chernichovsky et al., 1995) and Thailand (Pannurunothai, Boompadung, & Kittidilokkul, 1997). There is substantial debate about the prospects for and effectiveness of performance-related pay in developing country public sector contexts (Nunberg, 1995). Even when financial incentives are not explicitly used to promote higher productivity, the underlying philosophy of many health sector reform programs often implies that money is a key motivator in the work context.

While financial incentives may be important determinants of worker motivation, it seems equally evident that they alone cannot and have not resolved all worker motivation problems. Moreover, excessive focus upon financial incentives in the public sector could lead to negative consequences. Workers may begin to view financial rewards as more important than other types of reward (e.g., praise from supervisors or appreciation by the community), and they could experience a conflict between their own notion of public sector values and messages about working for financial gain (Giacomini, Hurley, Lomas, Bjhatia, & Goldsmith, 1996).

Worker motivation is a complex process and crosses many disciplinary boundaries, including economics, psychology, organizational development, human resource management, and sociology. This paper discusses the many layers of influences upon health worker motivation, and suggests that worker motivation will be affected not only by specific incentive schemes, but also by the whole range of health sector reforms which potentially affect organizational culture, reporting structures, channels of accountability, etc. By drawing attention to this broad range of influences, this paper aims to help policy makers view worker motivation in a more holistic manner. This broader view will enable them to structure reform programs to more effectively promote worker motivation, and hence, improve health system performance.

The paper draws primarily upon the existing literature; however, it was also influenced by a series of specially commissioned case studies (Abzalova, Wickham, Chukmaitov, & Rakhipbekov, 1998; Munoz, 1999; Mutizwa-Mangiza, 1998).

**Determinants of health worker motivation**

Motivational processes in the work context operate at the level of an individual, and are composed of two parallel components: the extent to which workers adopt organizational goals (“will do”) and the extent to which workers effectively mobilize their personal resources to achieve joint goals (“can do”). Yet, determinants of these two components originate at many levels: the individual, the immediate organizational work context, and the cultural context.

Health sector reforms influence worker motivation through their effects on organizational structures and community/client roles. Fig. 1 represents these various layers.

At the individual level, workers’ individual goals, self-concept, expectations, and experience of outcomes are some of the more important individual-level determinants of worker motivation. These determinants, coupled with the individual worker’s technical and intellectual capacity to perform and with the physical resources available to carry out the task, result in a specific level of worker performance.

Worker motivation also depends upon the organizational context in which the worker is situated. Organizational structures, resources, processes, and culture, as well as organizational feedback about performance, contribute to the motivational processes occurring at the individual level. These affect the individual’s real and
perceived ability to carry out his tasks, and stimulate worker adoption of organizational goals.

Although not part of the organizational context, communities also influence worker motivation through community expectations for how services should be delivered, the interactions that workers have with individual clients, and formal and informal client feedback on health worker performance.

While the generic concepts of individual, organizational and community determinants of worker motivation described above are relevant to all country situations, the socio-cultural context will affect the relative importance of the different determinants and the relationship between them. For example, in many industrialized countries, flat organizational structures, and worker involvement are valued and are prominent determinants of motivation, while societies in many developing countries are more accustomed to hierarchical structures and give more legitimacy to unequal distribution of power.

These various layers of determinants operate, whether the health sector or broader (political, economic, etc.) environment is stable or changing. Health sector reforms are likely to affect organizational systems and culture, and they frequently emphasize stronger links between performance and reward. Reforms commonly require training and the development of new capabilities in the workforce. Many of the reforms currently being implemented attempt to change the role of the community and clients, and provide them with a more effective means to offer feedback on the performance of health care providers. These processes all affect worker motivation.

However, the content of the health sector reform is only one aspect of its influence on worker motivation. The manner in which the reform is designed, communicated, and introduced will also impact on health worker motivation. Reforms can be designed and communicated in a variety of ways: for example, top policy makers can shape the reform with little input from health workers and communities, with some participation, or with extensive dialogue and consensus building. Reforms can be communicated widely and in great detail, or they can be only vaguely communicated. Both the content of the reform and how it is communicated will determine workers’ perceptions (correct or incorrect) of how these changes might affect them.

A specific example may help illustrate the many ways in which health sector reform may affect health worker motivation. An ambitious program of health sector reform in Zambia has included, decentralization training in planning and management, the creation of District Health Boards made up of community members, the introduction of user fees, and greater attention to supervisory issues. All of these reforms are likely to impact upon health worker motivation in some way—either through increasing worker capabilities, or resources available or channels of accountability or changing basic employment conditions. While the reform program has presented many opportunities for improving work motivation, communication of reforms has often been “too little, too late” (Lake et al., 2000). As a consequence, resistance from health workers has been encountered, and certain reforms, most notably de-linkage of health workers from the civil service have been suspended.

This paper seeks to clarify the ways in which worker motivation is influenced and how health sector reform can affect worker motivation. The paper is organized in the following manner. The section on “the internal determinants of worker motivation” discusses the basic motivational process as it operates at the level of an individual. The section on “organizational factors and their influence upon worker motivation” outlines the influence of organizational factors on worker motivation and how health sector reform might impact those influences. The section on “cultural and community influences” reviews the cultural influences on worker motivation and the mutual influence between cultural values and reform. The paper concludes with a brief discussion of implications for health sector reform policy.

The internal determinants of worker motivation

Health worker motivation exists when there is alignment between individual and organizational goals, and when workers perceive that they can carry out their tasks. Workers’ willingness to devote time and effort to work tasks is not a function of external factors alone, but rather influenced by the interaction of these factors with unique personal factors. As a result, the internal motivation process will differ across individuals in the same environment. In addition, due to the contribution of changing environmental factors, an individual’s work motivation may also fluctuate over time or across situations.

Worker motivation should not be equated with job satisfaction, although the two concepts are related.
Greater satisfaction with one’s job is often associated with higher levels of work commitment and willingness to expend personal resources for job accomplishments (e.g., Hackman & Oldham, 1976), but it is not a prerequisite for motivation.

Over the years, numerous theories have been posited to explain how internal and external factors interact to affect worker motivation (Maslow, 1954; Adams, 1965; Deci, 1975; Vroom, 1964; Locke & Latham, 1984; Bandura, 1977). Although these theories differ in terms of the particular “person” factors emphasized, almost all theories acknowledge three broad classes of internal influences on worker motivation: (1) goals, motives, and values; (2) self-concept and other self variables; and (3) cognitive expectations about the relationship between various actions and consequences. These internal factors affect worker behavior and performance, as well as mediate how workers process the outcomes or consequences of their actions. Most of the research supporting this conceptual framework for worker motivation has been carried out in industrialized countries, but is also supported by research in developing countries (Mendonca & Kanungo, 1994). Fig. 2 outlines the internal motivation process.

The following paragraphs describe the three major internal influences on worker motivation.

**Goals, motives, and values:** Individuals differ greatly in terms of the goals, motives, and values they hold with respect to their work. Not all workers will have the same mix of motives and goals, and the relative importance of particular values and work goals will change over time and situations. Nonetheless, most theorists agree that such internal factors may be organized into two broad categories: lower-level needs, motives and goals related to satisfaction of basic survival needs (e.g., safety, job security), and higher-level motives and goals related to fulfillment and self-satisfaction (e.g., sense of competence, self-determination, fairness). Herzberg, Mausner, & Snyderman (1959), based on their research in the USA, indicated two types of factors that affect work behavior. **Hygiene factors** are those which, by their presence or absence, determine levels of worker dissatisfaction: supervision, interpersonal relations, work conditions, salary, job security, etc. **Motivating factors** determine the level of worker motivation and satisfaction, and include achievement, the work itself, recognition, responsibility, advancement, and growth.

According to Herzberg, worker motivation stems primarily from the presence of higher-order motivating factors in the work environment. In contrast to hygiene factors, these higher-order motivating factors are viewed as intrinsically motivating—that is, they stimulate worker motivation in the absence of extrinsic rewards.

Although individuals hold both lower- and higher-level motives, goals, and values, environmental factors greatly affect which of these categories of goals are likely to be most salient at any given time. In particular, as Herzberg noted, it is difficult to produce positive motivation if hygiene factors are absent, and recent studies among nursing personnel in the US provide partial support for Herzberg’s model (Rantz, Scott, & Porter, 1996). Herzberg’s model suggests, for example, that if salaries are not paid in a timely fashion, health workers are likely to become more concerned with getting paid and less willing to exert effort at their job as they seek an alternative means to gain an income and support their families. However, even when lower-order motives and goals have been met (e.g., pay is satisfactory), worker motivation may be negatively or positively influenced depending upon intrinsically motivating specific work conditions (e.g., recognition).

**Self-concept and “self” variables:** Self-concept and associated variables, such as self-esteem and self-efficacy, also play an important role in determining an individual’s interest and persistence in performing difficult work assignments. Self-concept refers to the individual’s evaluation of his/her competencies in specific domains, such as health care delivery. Self-efficacy refers broadly to the individual’s confidence in his/her ability to accomplish specific work tasks (Bandura, 1977). Health workers with a strong self-concept in work-related areas, and a strong sense of self-efficacy, are more likely to accept difficult organizational objectives and to persist at the task longer in the face of obstacles than persons with poor self-concept and low self-efficacy (Bandura, 1986). Self-concept and other “self” variables may be positively or negatively affected by external factors, such as when organizations provide health workers with training that enhances their work self-efficacy. A positive self-concept and sense of job self-efficacy enhances worker motivation by providing workers with a personal incentive for task accomplishments and by supporting sustained task effort once the worker has adopted or internalized organizational goals.
Cognitive expectations: The internal motivation process involves the worker’s judgments about the extent to which an individual’s allocation of personal resources will yield a positive outcome. Cognitively oriented theories of motivation indicate that an individual workers’ decision to adopt organizational goals depends on both workers’ expectations about whether they can perform the task and whether the performance desired by the organization has value to them (Vroom, 1964). These expectations develop as a result of both internal and external factors. For example, health workers may perceive an organizational reward to be inadequate (e.g. a bonus less than expected), and so reduce their work effort even though the organization provides an incentive for performance. Similarly, workers may demonstrate high worker motivation in the absence of organizational rewards if they perceive successful performance as highly intrinsically rewarding, such as when health workers devote substantial time to accomplish group tasks that provide individual workers with valued social benefits.

The internal components of motivation (goals/motives/values, self-variables, and cognitive expectations) mediate the impact of organizational or specific work goals, and in turn determine the time and effort that a worker will put into the task at hand. Kanfer (1999) suggests that such factors affect internal worker motivation in two ways: (1) by affecting the extent to which health workers accept and adopt organizationally prescribed tasks as personal goals, and (2) by affecting the extent to which health workers effectively mobilize their resources to accomplish joint goals. The adoption of organizational goals represents the culmination of the “will do” portion of the internal motivation process, and is reflected in workers’ task and job commitment. The effective mobilization of worker resources to accomplish stated goals represents the “can do” portion of the internal motivation process, and is reflected by the way that workers go about accomplishing their goals. Deficits in either the “can do” or “will do” portions of the internal motivation process have direct implications for worker performance, productivity, and satisfaction.

Organizational factors and their influence upon worker motivation

Organizations influence worker motivation through a variety of channels: through the organization’s efforts to improve worker capability; through the provision of resources and processes; through feedback or consequences related to worker performance; and through more indirect aspects such as work culture. Fig. 3 highlights these channels, and this section briefly summarizes the manner in which organizational structures, human resource management policies, and organizational culture impact on health worker motivation, and how these organizational factors are likely to be affected by health sector reform.

Organizational structures, processes and resources

Organizational structures, processes, and resources provide the day-to-day context in which health workers carry out their tasks. The internal structures of organizations reflect reporting hierarchies, level of worker autonomy, clarity of organizational goals, relative status of different workers and delegation of responsibility and authority. The processes determine how work gets accomplished and the level of resources necessary to accomplish them.

There are several routes through which organizational structures and processes impact on the two components of worker motivation: the worker’s adoption of organizational goals, and worker perception of the possibility of contributing to those goals.

Communication processes within the organization will determine how well information about the organization, its goals, norms, and standards are communicated to the worker.

Organizational support structures and processes shape workers’ perception about the possibility of task accomplishment. Ability to perform is not dependent only upon the worker’s own skills. System-wide support is also critical: giving sufficient authority and autonomy to complete the task; ensuring clarity about the roles and responsibilities of the different individuals involved; ensuring clear, efficient service delivery, support and management processes; and furnishing adequate resources (such as drugs, supplies, and equipment) to carry out organizational processes.

Organizational systems of providing information about organizational and individual performance determine the type of feedback received by the worker, and who provides this feedback. How a worker relates to the individual or group providing feedback will influence the value placed upon this feedback.

Health sector reform and organizational structure

There are several key ways in which reforms can impact upon organizational structure, processes and resources, and hence affect health worker motivation: e.g. creating a clearer, narrower organizational mission,
changing reporting structures and autonomy, creating more channels for worker feedback, and increasing resources available to accomplish organizational goals.

Organizational mission: Organizational reform in the context of health sector reform very often aims at creating a narrower and clearer organizational mission. For example, in Zambia, the Ministry of Health was effectively divided into two separate organizational structures: one responsible for policy-making, coordination and regulatory functions, and a second, new Central Board of Health that would oversee implementation functions. Similarly, in the UK, purchaser-provider splits removed the District Health Authority from responsibility for the organization and delivery of services and re-focused its mission upon defining needs and purchasing care.

Autonomy: Public sector health delivery organizations are typically embedded in cumbersome centralized bureaucracies which control human resource management systems and set (implicit and explicit) norms for organizational structure and processes. Consequently, many reforms seek to endow greater autonomy to decentralized units. For example, the establishment of autonomous hospitals is aimed at freeing organizations from such structures and giving these organizations responsibility to adopt more rational work processes. New structures can make the work environment more conducive to task achievement, and workers more likely to think that they can achieve specified goals.

Feedback: Many health sector reforms try to extend authority for providing feedback to agents situated closer to the health worker. For example, decentralization often transfers more authority for human resource decisions to local administrative units, which should be better informed about worker performance than distant public service commissions. Similarly, encouragement of hospital boards, district health boards, and health center committees try to place more authority for providing feedback in the hands of local communities (discussed further in the section on “cultural and community influences”).

Resources: Many reforms focus on increasing the availability of complementary resources at different points in the health care system. Schemes may be initiated to raise extra resources (such as health insurance or cost recovery schemes) or to improve efficiency in how existing resources are managed (e.g. overhaul of drug supply systems).

While reforms may lead to organizational structures more conducive to worker motivation, the transition process itself may also have significant, and possibly negative, effects upon worker motivation. Without adequate transparency and communication, individual workers may not understand the new organizational goals. In addition, changes in structures and processes may be disadvantageous for some groups. For example, health care reforms in the UK have granted greater authority to managers (commonly referred to as managerization) at the expense of other professionals (Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996).

Human resource management

Human resource management is an organizational system that incorporates “activities that mobilize and motivate people and that allow them to develop and reach fulfillment in and through work aimed at the achievement of health goals” (WHO, 1989). The core functions of human resource management include: procuring the workforce, structuring work, rewarding staff, controlling staff, training staff, staff participation, and staff exit (Farnham & Horton, 1996). Human resource management has a number of tools at its disposal which facilitate the “can do” and the “will do” components of worker motivation:

Will do:

- Through job definition and job descriptions, human resource management can help ensure that workers
are aware of organizational goals, and of the role which they are expected to play in achieving these goals.

- Through various packages of incentives, such as salaries, bonuses, promotions, performance-related pay, and training opportunities, human resource management can link performance to reward.

Can do:

- Recruitment procedures can ensure a fit between the tasks required of individuals and the skills and knowledge that they bring to bear on these tasks.
- Staff development can enhance worker knowledge and skills, making the worker better able to perform the tasks expected of them.
- Supervision and performance assessment processes provide corrective feedback to workers on performance.

It has been argued that, with the exception of manpower planning, many lower- and middle-income countries have ignored (or at best paid little attention to) the human resource management functions in health care (WHO, 1989). As a consequence, regular procedures for recruitment and promotion are often not established, job descriptions are not available, and dismissal procedures are overwhelmingly cumbersome. When basic human resource management systems are not functioning, scope to use more sophisticated incentive schemes to motivate workers appears limited (Moore, 1996). In this context, the recent growth of interest and work in human resource management (Dussault, 1998; Martinez & Martineau, 1996) as an integral part of health sector reform appears very pertinent.

Health sector reform and human resources management

Health sector reform and human resource management have a symbiotic relationship (Martineau & Martinez, 1996). On the one hand, organizational reforms in the human resource management system (such as improved staff mix, elimination of ghost workers) will further the objectives of health sector reform (such as efficiency, equity, and quality of care). On the other hand, certain specific health sector reforms (such as decentralization, purchaser-provider splits, privatization, and establishment of autonomous facilities) may transfer responsibility for the human resource management system, or conversely be constrained by rigidities in the human resource management system.

Reforms have also often included other human resource management strategies:

- improving education and training (both as a means to create incentives for employees and to improve capacity to perform);
- restructuring salary scales so as to provide a living wage and hence reduce “moonlighting”, and
- creating a closer link between performance and reward through performance appraisal and performance-related pay.

Organizational culture

Organizational culture is the least concrete aspect of organizational factors. Yet, its impact on organizational functioning and worker motivation is well recognized. It can be defined as: “a shared set of norms and behavioral expectations characterizing a corporate identity” (Grindle, 1997), reinforced through organizational “rituals”. Organizational culture is formed through the interaction of broader societal culture, organizational structures, and the personal characteristics of individuals and subgroups that make up the organization.

Some organizations have created a culture through specific and concerted efforts of management, with the intention of motivating individuals within the organization to pursue organizational goals. However, every organization will have its own specific organizational culture. Some organizations might value independent decision making and entrepreneurial spirit that can lead to greater innovation. Similarly, some organizations might place more value on collaborative approaches over individual action and decision making. Rituals, such as frequent staff meetings and extra-curricular social bonding activities may reinforce these organizational values.

In a public health care system, there are multiple organizations. Where there are strong and charismatic leaders, a more uniform organizational culture might permeate throughout a health care system. However, generally, organizational culture will vary considerably among individual organizational units (such as different hospitals and health centers). It is common to find the performance of one particular health care unit considerably better and staff motivation considerably higher than another health care unit which operates with similar structures and levels of resources.

In addition to the mutually reinforcing aspects of organizational structure and organizational culture, two important contributors to organizational culture are discussed here: the characteristics of leadership styles and the presence of sub-cultures.

Transformational leadership within an organization can both shape organizational culture and inspire loyalty to the organization. By communicating both a vision and goals for the organization, transformational leaders stimulate the willingness to internalize organizational goals and to mold worker perceptions of their ability to contribute to goal attainment.

Sub-cultures are formed within an organization when a group of individuals in an organization have a
common set of specific experiences (such as professional training, or prolonged service in rural areas or overseas training). In the public health care sector, one of the most prevalent sub-cultures may be that associated with clinical professionals. This professional sub-culture, often further divided between physicians and nurses, is generally considered to entail: (i) a certain autonomy in one’s job due to the technical nature of the work and the difficulty of supervision; (ii) adherence to professional norms and standards; and (iii) enforcement of norms and standards through peer group pressure (Leonard, 1993, Ginsburg & Chaturvedi, 1988).

In some countries, the very fact of being a public sector worker (or civil servant), particularly at more senior levels, is thought to encourage a set of attitudes and values commonly referred to as a “public sector ethos”. In England, the values commonly thought to be shared by civil servants include political neutrality, loyalty, probity, incorruptibility, honesty, trustworthiness and public service (Farnham & Horton, 1996). A similar sense of public sector work ethos is reported in many East Asian countries.

**Health sector reform and organizational culture**

Health sector reform can have far-reaching effects on organizational culture (and hence, worker motivation) by changing the role of specific leaders, by modifying the relative positions of various sub-groups and sub-cultures, and by shifting organizational goals and the inherent values associated with them. For example, reform programs that place an excessive emphasis upon financial incentives may diminish the sense of public sector ethos amongst workers.

Reforms often embody values contrary to those held by health workers. For example, reforms promoting competition between providers, or which introduce fees for health care services, might conflict with individual worker’s beliefs of health care as a social good, and hence, make it difficult for workers to commit to new organizational goals. In Chile, health workers have a strong belief in the importance of the public sector, probably as a reaction to Pinochet’s attempts to privatize the health care system. Democratic governments since 1990 have aimed to modernize the sector with little concern as to whether care is offered by public or private providers. However, proposed policy measures have frequently been interpreted by health workers as incremental moves to privatization and have consequently met with resistance (Munoz, 1999). Communication of organizational objectives (for example, how modernization may promote greater responsiveness to clients while retaining key public sector features) may mitigate this problem, but there may still be an uneasy transition process. Any reforms that threaten values shared between workers, whether this be a sense of team spirit, or a desire for autonomy due to one’s professional status, are likely to be resisted.

**Cultural and community influences**

Outside the immediate organizational environment, the broader cultural and community context will also contribute to the individual’s motivational processes. Fig. 4 shows the direct links of community and clients on the internal motivational process. The broader cultural influence is more pervasive, affecting health reforms, communities, organizations, and the individual worker, and is shown as a backdrop to all other factors.

Culture can be defined as “all the patterns of thinking, feeling and acting that are shared by the members of a society or other bounded social group” (Schwartz, 1997).
Culture has, at its heart, shared values, which contribute to a type of “mental programming” carried out by family, neighborhood, school, and community. This “mental programming” frames an individual’s notion of what is possible, what is expected, and what consequences will occur for deviant thoughts and behaviors (Hofstede, 1980). Several analysts have suggested key differences between developing country and industrialized country cultures, such as the degree to which individuals find meaning through social relationships, or through their own uniqueness and individual action. Similarly, the extent to which individuals are socialized to comply with the obligations attached to their hierarchical role in the system, versus a more egalitarian view which encourages voluntary cooperation, will vary systematically between cultures (Schwartz, 1997).

Two dimensions of cultural influence on motivation will be examined here: the relationship between organizational functioning and societal culture, and the effect on worker behavior of their interactions and links with their patients.

**Culture and organizational functioning**

Cultural characteristics will influence organizational structure, decision making processes, acceptable levels of autonomy, and organizational culture. Organizations with internal cultures and structures not in alignment with the broader societal culture may encounter difficulties in their functioning. Broader cultural values translate into specific types of work behaviors. Kanungo and Mendonca (1994) posit that in developing countries where cultural values emphasize the collectivistic, hierarchical, and harmonious, workers and organizational culture are more likely to emphasize:

- fate beyond one’s control,
- fixed human capabilities,
- the importance of past and present over the future, and
- focus on short term goals

In turn, workers may prefer to be passive, moralistic (rather than pragmatic), and authoritarian. Some difficulties encountered in reform programs may result from importation of structures and processes that function best when supported by certain types of cultural values. For example, transposing certain types of management structure and processes from Japanese to American businesses has not had the intended performance consequences because the collectivist orientation and moral commitment to the organization, common in Japan, is not part of broader American culture.

There has been very little research examining how societal culture affects worker behavior in health care organizations in developing countries. However, Aitken’s study of health service workers in Nepal (1994) demonstrates the importance of understanding “values in use” or implicit cultural values in order to make sense of health worker behavior. Aitken (1994) describes a separate informal set of values and objectives parallel to those formally espoused by the Nepalese bureaucracy. She proposes that the following statement accurately describes an unstated, informal organizational goal: “The purpose of the District Public Health Office is to create incomes for its staff, not to deliver services.” This goal reflects two additional values: “posts are seen as salaries and not work” and “the main duty of staff is to account for the budget."

**Culture and provider–patient relationships**

In service organizations, societal culture also affects worker behavior through worker interactions with their clients. The culture of workers’ clients affects worker motivation through two main channels: the worker’s links to the community served, and the degree of congruence between client expectations and organizational norms.

Social embeddedness of workers affects their motivation to provide good service and their desire to be appreciated by their clients. In instances where there is a social relationship between patient and provider, providers may seek to provide more polite and empathetic treatment. While organizational reforms can attempt to create and structure relationships between provider and patient (e.g. through the establishment of village health committees), cultural factors may be of over-riding importance. For example, health care workers in northeast Brazil were more concerned about gaining the respect of their clients than their supervisors:

When agents talked about why they liked their jobs, the subject of respect from clients and from ‘my community’ often dominated their conversation... Agents saw their clients not only as subjects whose behavior they wanted to change, but as people from whom they actually wanted and needed respect. Tendler and Freedheim (1994)

Client expectations also affect worker behavior. Although Ministry of Health protocols may support organizational goals of cost-effective treatment that is affordable for the government, clients may expect and value certain types of treatment, such as multiple drug therapies, injections, or vitamins. When such a situation occurs, public sector health workers experience a conflict, and the outcome (in terms of their behavior) will depend on worker values and their degree of social embeddedness.
Culture and health sector reform

Recognition of the specific cultural characteristics of different country environments may help frame a reform program which meshes better with health worker values, and hence is more likely to have a positive effect upon worker motivation. On the other hand, health sector reform frequently aims to change some of the “developing country environment” characteristics. This may, in the long run, bring about improved performance but such reforms may face considerable resistance when attempting to change work behaviors, which are deeply embedded in the cultural fabric.

The diversity and complexity of local cultural contexts, combined with the lack of health sector-specific analysis of the relevance of culture to organizational functioning, makes it difficult to draw specific conclusions for the design of health sector reform. Literature on the relationship between the success of health reform and local culture is very scarce. A few examples of how health sector reform might interact with societal context are provided here.

In Zimbabwe, a number of socio-cultural factors were identified which were likely to present obstacles to the successful implementation of reforms (Mutizwa-Mangiza, 1998), for example widespread patronage was likely to undermine efforts to regulate health workers better and to implement performance-based pay.

Often, a key thrust of reform programs is to create a stronger link between performance and reward. However, this may conflict with values present in many developing country societies which emphasize the importance of seniority, age, and experience. In these societies, implementation of merit-based promotion systems may lead to uneasiness among workers if younger people are promoted to higher positions than more senior employees. If the cultural values are very strong, this may paralyze the organization: employees may feel reluctant to take orders from younger bosses and instead seek informal advice from more senior, but lower level, staff. On the other hand, cultural values in some developing countries emphasize collective rather than individual action. In such a cultural context, reforms resulting in a performance orientation among a group or team of workers may be found very acceptable.

Some reforms have tried to reinforce worker links to their communities by making service providers more accountable to community members. This has been attempted through the establishment of district health boards, hospital boards, empowerment of village health committees, etc. These new (or re-invigorated) organizational structures may create an alternative feedback loop, but their effectiveness also depends upon the nature of social relations between health staff and the communities whom they serve.

Certain broader environmental conditions also impact on worker motivation. For example, an effective police and legal system may deter some of the most adverse forms of worker behavior (such as theft and corruption). Political systems based upon rent seeking and patronage may jeopardize the credibility of leaders. The larger economic situation may bring certain work conditions (such as salary) into prominence. Externally driven reform processes with limited local “ownership” are likely to undermine worker commitment to the reforms. While acknowledging the critical importance of these broader environmental factors, there is insufficient space here to address them in depth.

Implications for health reform policies

The conceptual framework presented here paints a complex picture of health worker motivation, because worker motivation is a complex and dynamic process. By “unpackaging” the various channels through which worker motivation can be affected, this framework can be used both to assess already implemented reforms, as well as assist policy makers seeking to evaluate how proposed reforms might affect worker motivation.

At the core of the motivation question is how well individual health worker goals are in alignment with the goals of the employing organization. This theme runs through all the implications discussed below. Policy makers need to assess how well organizational structures and processes facilitate clear communication of organizational goals, provide timely feedback on performance to health care workers, and ensure that higher levels of desired performance are met with greater reward.

Each country experience will be different, as its culture, organizations, and broader reform environment are different from others. Thus, there can be no universal blueprint for how to design reforms that promote worker motivation. Each country must analyze its own particular constellation of organizational structures, culture, and broader societal culture to determine how best to approach the design and implementation of health sector reform. The following sections outline issues that health policy makers should consider in developing health sector reform programs which will facilitate better goal congruence and improved worker motivation.

Multiple channels influencing motivation: It is clear that health sector reform can and does influence worker motivation via a number of channels. Often, reform programs have focused on a very limited number of channels (e.g. financial incentives) to influence worker behavior, and neglected other less tangible incentives, such as the work itself, achievement, and recognition. Many of these reforms have resulted in little improvement in worker motivation, or even in reductions in
motivation due to unanticipated influences. Hertzberg argued that the more concrete “hygiene factors” could only avoid dissatisfaction while the more intangible factors engendered positive motivation. The categorization of financial incentives solely as hygiene factors is difficult to maintain, since salary increases and bonuses may be valued both for their financial value and for the prestige and status they endow. Nevertheless, focusing solely on financial incentives to improve worker motivation is likely to be problematic. At a practical level, most hygiene factors have “escalating zero levels” which means that such strategies can become prohibitively expensive in the long run. But in addition:

Policies depending upon funding tools rely either on the pre-existence of this drive, or the creation of this drive (sometimes to the detriment of other drives.)
Giacomini et al. (1996)

There is, currently, very scarce empirical evidence on what the key determinants of worker motivation are in developing country health care contexts. Variations in work environment and broader cultural context may lead to a different constellation of key determinants. Given this lack of information, it is critical that policy makers consider a broad range of motivational determinants, that they initiate incentives which all work in the same direction (organizational goals), and that the potential negative effects of new incentives are considered and counteracted with balancing measures.

Communication and leadership: Health sector reforms sometimes entails quite radical reforms of organizational structures, processes, and culture. To health workers accustomed to a particular way of working, reforms often seem strange and threatening. Clear communication of the objectives and rationale for reform are necessary to help bring about goal alignment between health workers and the broader organization, and will help prevent de-motivation by reassuring and reducing levels of uncertainty. Design of reforms needs to include design of the transition process including communication and change management strategies.

Strong transformational leaders can play a critical role in communicating the vision behind reform programs and also in gaining worker commitment to implement that vision. Conversely, weak leadership that lacks credibility is unlikely to gain worker commitment or willingness to exert effort in order to implement reforms.

Values: Health sector reforms are rarely confined to changing organizational structures. The thrust of the reform is often more far-reaching, and aimed at changing values within an organization. In such circumstances, even with effective communication of reforms, it may not be feasible to generate commitment among all health workers, without adequate recognition of prevailing values and examination of implicit and explicit values associated with the reform. When health workers feel that the values associated with a reform program are not values to which they personally can subscribe, there is likely to be a disaffection with the reform process and a concomitant lack of motivation.

Differential impacts: Finally, worker motivation is an individual and a transactional process. Public sector health worker motivation is not uniform. Different cadres may have differing determinants of motivation, as seen in differences among physicians and nurse aides. In addition, the organizational context in which the worker is situated will mediate the impact of reforms. For example, reforms will affect hospital workers and workers in primary care settings differently.

Worker motivation is a critical component of health systems performance, and one that is largely understudied. In the context of health sector reform, there is a complex combination of factors which has individual, organizational, and societal components. Consequently, effective programs will depend, not only on country level analysis, but also on regional, local and facility level efforts. Clearly, further study is essential, and the conceptual framework presented in this paper offers a structure for future analysis and research on this vitally important topic.

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