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Public Sector Health Worker Motivation and Health Sector Reform: A Conceptual Framework

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Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *better informed and more participatory policy processes in health sector reform;*
- ▲ *more equitable and sustainable health financing systems;*
- ▲ *improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- ▲ *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

This paper offers a conceptual framework for considering the many layers of influences upon health worker motivation. It suggests that worker motivation is influenced not only by specific incentive schemes targeted at workers, but also by the whole range of health sector reforms which potentially affect organizational culture, reporting structures, channels of accountability, etc. In addition, the impact of such organizational reforms will be further mediated by the social and cultural context. By drawing attention to the broad range of influences, the paper aims to help policymakers develop and implement health sector reform policies that promote worker motivation and understand better the potential of specific incentives to induce higher worker motivation. Two themes run persistently throughout the paper: (1) the need to broaden understanding of motivational determinants beyond simply financial incentives to other, often less tangible, non-financial instruments (such as organizational culture and feedback from community); and (2) the need for methods to increase alignment of individual, organizational, and reform goals.

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Foreword

Part of the mission of the Partnerships in Health Reform Project (PHR) is to advance "knowledge and methodologies to develop, implement, and monitor health reforms and their impact." This goal is addressed not only through PHR's technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The program comprises Major Applied Research studies and Small Applied Research grants.

The Major Applied Research topics that PHR is pursuing are those in which there is substantial interest on the part of policymakers, but only limited hard empirical evidence to guide policymakers and policy implementors. Currently researchers are investigating six main areas:

- ▲ Analysis of the process of health financing reform
- ▲ The impact of alternative provider payment systems
- ▲ Expanded coverage of priority services through the private sector
- ▲ Equity of health sector revenue generation and allocation patterns
- ▲ Impact of health sector reform on public sector health worker motivation
- ▲ Decentralization: local level priority setting and allocation

Each Major Applied Research Area yields working papers and technical papers. Working papers reflect the first phase of the research process. The papers are varied; they include literature reviews, conceptual papers, single country-case studies, and document reviews. None of the papers is a polished final product; rather, they are intended to further the research process—shedding further light on what seemed to be a promising avenue for research or exploring the literature around a particular issue. While they are written primarily to help guide the research team, they are also likely to be of interest to other researchers, or policymakers interested in particular issues or countries.

Ultimately, the working papers will contribute to more final and thorough pieces of research work, such as multi-country studies and reports presenting methodological developments or policy relevant conclusions. These more polished pieces will be published as technical papers.

All reports will be disseminated by the PHR Resource Center and via the PHR website.

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Acronyms

HR	Human Resources
HRM	Human Resources Management
PHR	Partnerships for Health Reform (project)
WHO	World Health Organization

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Charlotte Leighton (PHR, Technical Director) provided perceptive comments and ideas on earlier version of this paper and also undertook technical review of the final document. Nancy Pielemeier (PHR, Project Director) championed the cause of adopting a broader approach to considering incentives.

Executive Summary

Many health care reforms have sought to improve health system performance through changes that target resource availability and allocation, more efficient management, and rationalization of the government's role. Even though health care delivery is highly labor-intensive and service quality and efficiency is directly affected by worker motivation, worker motivation has rarely been an objective of reforms. 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 a transactional process reflecting the fit between the individual, the organizational context, and the broader societal context.

The purpose of this paper is to provide a comprehensive and systematic conceptual framework for thinking about worker motivation in the health sector, as a first step in assisting policymakers to design reform programs that improve worker motivation and ultimately health system performance. The focus of the paper is upon public sector workers directly engaged in health service delivery. Work motivation is a complex process. The framework set out in this paper describes and analyzes many levels of determinants of work motivation in the health sector including: the individual, the immediate organizational work context, the larger health sector context, and the socio-cultural and environmental context.

Workers' individual needs, self-concept, and expectations for outcomes and/or consequences are some of the more important *individual-level* determinants of work motivation. These determinants, coupled with the individual worker's technical and intellectual capacity and resource availability, lead to worker performance. Also affecting the level of motivation is a worker's actual experience of outcomes or consequences: observed effects of worker performance, direct feedback from supervisors or community, or rewards or punishments for work behavior.

As work motivation is a transactional process, a worker's motivation is contingent upon the *organizational context* in which the worker is situated. The organization must provide complementary inputs (such as drugs and medical supplies), as well as clear, efficient systems. Organizational structures and processes will affect workers' experience of outcomes and the nature of feedback that a worker receives from colleagues and supervisors within the health system. Human resource management systems affect workers' capability and their perception of that capability, through such mechanisms as training, supervision, and more concrete incentives such as remuneration, promotion, and performance review processes. Finally, organizational work culture contributes to the individual's level of commitment and motivation.

Outside of the immediate organizational environment, the broader *social and cultural context* also contributes to the individual's motivational processes. At the core of health service delivery is the interaction between the individual health care worker and the client. Community members have expectations for how services should be delivered, and they, too, provide feedback on health worker performance, both formally and informally.

All the above determinants operate whether the health sector environment is stable or changing through reform. While the primary focus of health sector reforms is system-wide changes in organizational structure and processes, these reforms have a very direct impact upon individuals' motivation. 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 among the workforce. Many of the reforms currently being

implemented attempt to change the role of the community and clients and to provide them with a more effective means of offering feedback on the performance of health care providers.

Design and implementation of health sector reform must take health worker motivation into account. Failure to do so has been a key missing ingredient of many reform efforts. On occasion, demotivation and confusion have slowed or blocked reforms. The conceptual framework presented in this paper, and review of current evidence from developing and industrialized countries, lead to the following considerations for design and implementation of health sector reform:

Importance of goal congruence between workers and the organization: The issues of goal congruence and fit suggest that there is no universal blueprint for how to design reforms which promote worker motivation. Each country must analyze its particular constellation of organizational structures, culture, and broader societal culture. However, efforts to ensure that organizational goals are clear and that workers see the benefits of working towards these goals, are universally important.

Multiple channels influencing motivation: Motivation is not created by a single incentive. Focusing solely on financial incentives is not likely to produce the desired results in the public- and private-sectors and in non-profit organizations as well. A holistic approach is needed to support goal congruence between the organization and the individuals working it.

Communication and leadership: Health sector reform often entails radical changes that may appear strange or threatening to workers. Clear communication of the objectives and rationale of the reform is important, both for overt goal alignment and for preventing demotivation and reducing levels of uncertainty.

Values: When health workers feel that the values associated with a reform program are not values to which they personally can subscribe, disaffection with the reform process and a concomitant lack of motivation and inadequate performance are likely outcomes.

Differential impacts: What motivates one level of worker may not motivate another. Design of reforms and communication strategies should recognize these differences.

Finally, not enough is currently known about which determinants of motivation are most important to workers in developing countries. This fundamental question requires further research.

1. Introduction

Many health reform activities are seeking to improve health system performance by improving the availability and allocation of resources, promoting more efficient management, and rationalizing the role of government. Yet experience with efforts to improve health system effectiveness has shown that the positive impact anticipated from such reform efforts has often been thwarted by the “unexpected” behavior patterns of health workers. Effective and efficient health care systems depend critically upon actions taken by individuals working in the system.

Motivation in the work context can be defined as an individual’s degree of willingness to exert and maintain an effort towards organizational goals. Motivation is an internal psychological process. Motivation is an internal psychological process. It is not possible to “motivate” people directly, only to create an environment conducive to high degrees of motivation. Further, motivation itself is not an observable phenomenon; it is only possible to observe either the results of the motivational process (such as improved performance) or perhaps, some of the determinants of motivation.

The results of the internal process of motivation reflect the specific individual’s situation and environment. Thus it is often said that motivation is a *transactional* process: it depends upon the fit between the individual and the organizational context within which they work, and the broader societal context.

Worker motivation is of critical importance in the health sector: health care delivery is highly labor-intensive and service quality, efficiency and equity is directly affected by worker motivation. Factors such as the availability of resources and the technical competence of the worker are not sufficient in themselves to always produce desired work behavior. Evidence has shown that motivated workers come to work more regularly, work more diligently, and are more flexible and willing. Increased motivation creates the conditions for a more effective workforce, but because work motivation is an interactive process between workers and their work environment, good management and supervision are still critical factors in reaching organizational goals (Hornby and Sidney, 1988).

While many aspects of health sector reform in the international context have been researched, there has been a surprising lack of attention to the human resource 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 and Martineau, 1996). This paper argues that a core component of the information necessary for policy making is still missing because there remains a dearth of studies about what motivates health workers in developing countries. As a consequence, many countries, and organizations within them, have implemented measures designed to improve health worker motivation without an empirical base to guide their choice of interventions.

In the face of this lack of information about the determinants of health worker work motivation, governments have often relied excessively on financial incentives to encourage more productive behavior. There are examples of the use of financial incentives as an explicit policy tool in Indonesia (Chernichovsky and Bayulken, 1995) and Thailand (Pannurunothai, et al., 1997). There is substantial discussion of the prospects for and effectiveness of performance-related pay in developing country public sector contexts (Nunberg, 1995). Even if financial incentives are not explicitly used to promote higher productivity, the underlying philosophy of health sector reform programs often suggests money as a key motivator in the work context.

While accepting the notion that financial incentives may be important determinants of work motivation, it seems equally evident that they alone are not able to resolve all work motivation problems. Moreover, an excessive focus upon financial incentives to motivate individuals in the public sector may have a number of negative consequences. For example, workers may come to see financial reward as more important than other types of reward such as praise from supervisors or appreciation by the community, or they may feel conflict between their own notion of public sector values and messages about working for financial gain (Giacomini, et al., 1996).

Work motivation is a complex process. This paper offers a conceptual framework for considering the many layers of influences upon health worker motivation. Health workers addressed in this paper are those providing direct public sector service delivery—from clinical officers and nurses working in remote rural settings to specialist physicians in urban hospitals.

The paper is specifically concerned with motivation to exert high levels of effort, rather than the more basic human resource issues concerning attraction and retention of staff. It suggests that worker motivation will be influenced not only by specific incentive schemes targeted at workers, 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, the paper aims to help policymakers view worker motivation in a more holistic manner and also to structure reform programs so that they more effectively promote worker motivation. A persistent theme throughout the paper is the need to broaden our understanding of motivational determinants beyond simply financial incentives to other, often less tangible, non-financial instruments (such as recognition, feedback from community, etc.).

Given the current lack of understanding about issues regarding health worker motivation in developing countries, this paper is a first step towards the ultimate aim of improving worker motivation and hence health system performance. Discussion here aims to help policymakers develop and implement health sector reform policies that promote worker motivation and better understand the potential of specific incentives to induce higher worker motivation. This paper also aims to identify priority areas for future research on this topic.

The paper is organized in the following manner. Section 2 below provides an overview of the conceptual framework used. Each of the three following sections then examines aspects of the conceptual framework in more depth—moving from the internal processes of motivation, to the potential effects of organizational and systems reform upon motivation, to the importance of considering the socio-cultural context for motivation. The paper concludes with a brief discussion of implications for policy and research.

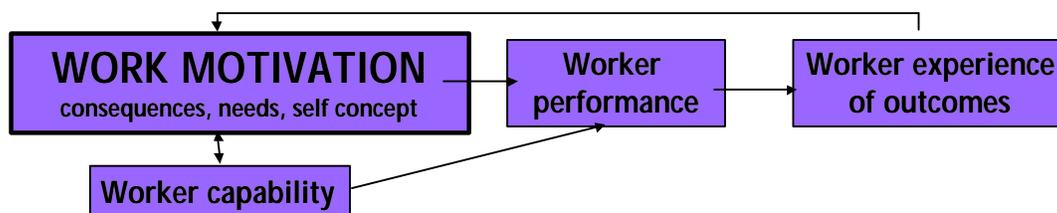
2. Overview of Conceptual Framework and Key Terms

Health worker motivation is an internal psychological process, operating at the level of an individual, while health sector reform seeks to modify entire systems. Determinants of work motivation originate at many levels: the individual, the immediate organizational work context, the larger health sector context, and the socio-cultural and environmental context. The following paragraphs categorize the many determinants of worker motivation according to the level at which they originate and briefly outline how health sector reform can impact on motivation of workers within the health care system.

2.1 Individual Determinants

Workers' individual needs, self-concept, and expectations for outcomes and/or consequences are some of the more important individual-level determinants of work motivation, shown in Figure 1. These determinants coupled with the individual worker's technical and intellectual capacity to perform and the physical resources at hand to carry out the task, lead to worker performance. Also affecting the level of motivation is a worker's actual experience of outcomes or consequences. These consequences can be observed effects of worker performance, direct feedback from supervisors or community, or rewards or punishments for work behavior.

Figure 1. The Internal Worker Motivation Process



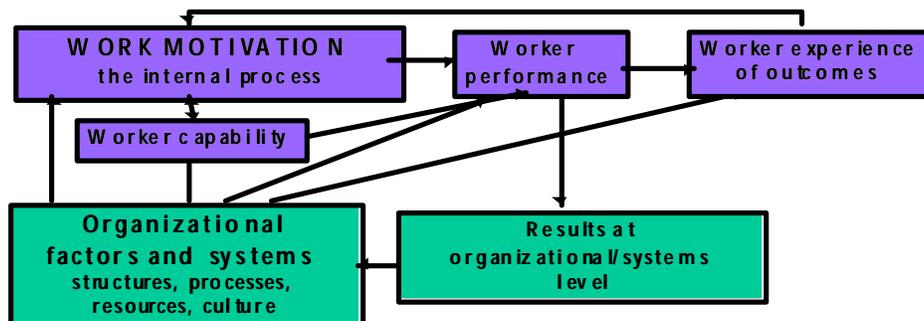
2.2 Organizational and System Level Determinants

As work motivation is a transactional process, a worker's motivation is contingent upon the organizational context in which the worker is situated. Figure 2 introduces organizational and system level determinants into the picture, illustrating that organizational structures, processes and culture, as well as information about organizational performance and results will contribute to the motivational processes occurring at the individual level.

It is necessary for the organization to provide complementary inputs (such as drugs and medical supplies), as well as clear, efficient systems, in order for workers to effectively carry out their tasks. Organizational structures and processes will affect workers' experience of outcomes and the nature of feedback that a worker receives from colleagues and supervisors within the health system. This

feedback loop, running from worker performance to worker experience of outcomes, and mediated by the organization and broader health care system is critical in affecting motivation. Consequences experienced by the worker can be positive, to reinforce good performance, or negative, to restrain inappropriate behavior. A particularly important organizational system is the human resource management system which is likely to affect both workers' perception of their own capability and their true capability, through such mechanisms as training, supervision, and more concrete incentives such as remuneration, promotion, and performance review processes. Finally, organizational work culture contributes to the individual's level of commitment and motivation.

Figure 2. Work Motivation in the Organizational Context

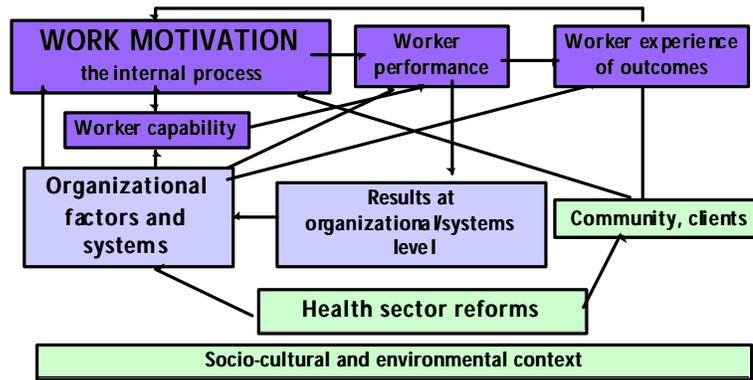


2.3 Socio-Cultural, Environmental, and Reform Context

Outside of the immediate organizational environment, the broader social and cultural context will also contribute to the individual's motivational processes (Figure 3). At the core of health service delivery is the interaction between the individual health care worker and the client. Community members will have expectations for how services should be delivered, (which may or may not correspond with organizational norms for services), and they too provide feedback on health worker performance, both formally and informally.

While the generic concepts of individual, organizational and community determinants of work motivation described above are relevant to all country situations, the socio-cultural context will affect the relative importance of the different determinants described 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. In societies that are accustomed to more hierarchical structures and give more legitimacy to unequal distribution of power, workers may ascribe less importance to these factors. Different cultural contexts will also shift the balance between a worker's competing needs. In some contexts, workers are deeply embedded in their communities and social context and thus need for social validation of their actions may be stronger than need for approval from supervisors.

Figure 3. Work Motivation in the Larger Societal/Health Reform Context



All the above determinants operate, whether the health sector environment is stable or changing. Health sector reform is a change process that seeks to improve national policies, programs and practices through alterations in health sector priorities, laws, regulations, organizational structure and financing arrangements. While the primary focus of health sector reforms is system-wide changes in organizational structure and processes, these reforms are likely to have a very direct impact upon individuals' motivation through the channels identified above. 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 among 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.

Health sector reform is essentially a change process, where both the change itself and the process of change can impact on health worker motivation. Reforms can be designed and communicated in a variety of ways: top policymakers can shape the reform with no input from health workers and communities, with limited 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 they are communicated will determine workers' perceptions (correct or incorrect) of how these changes might affect them.

Given the great variety of health sector reforms being implemented and the ways in which they are communicated, the nature of any health reform's impact upon health worker motivation will also vary. As an illustration Box 1 outlines possible effects of the reform program upon worker motivation in Zambia.

Box 1. Examples of Health Sector Reform in Zambia and Its Possible Effects on Worker Motivation

Zambia is currently pursuing a radical program of decentralization. Health workers have been removed from the civil service and are in the process of being brought into the employment of District Health Boards and Hospital Boards. This is likely to lead to future changes in human resource management policies as the local level should have greater control over basic conditions such as pay, benefits, and promotion. Such changes will affect worker perceptions of job security, ability to fulfill familial financial needs, possibilities for advancement, and professionalism. Budgetary decentralization has affected resource availability at the local level. Considerable training, particularly for District Health Management Team members, in planning and budgeting is likely to have affected worker's actual and self-perceived capabilities. The creation of District Health Boards, increased health worker accountability to communities, and greater attention to supervisory issues will provide different (and additional) feedback mechanisms. These feedback loops will mediate workers' experiences of outcomes and perception of their own self-efficacy. Finally the transformation from a centralized Ministry of Health during the period of President Kaunda's socialist/humanist regime to a series of decentralized organizations under the much more market-oriented, rule of the Mass Movement for Democracy (MMD) party has engendered a very radical transformation in organizational culture within the health care system.

While there are many opportunities for improving work motivation under the reforms, communication of reforms has often been "too little, too late." For example, during the initial phases of delinkage of health workers from the civil service, the Central Board of Health failed to communicate to health workers sufficiently clearly how the delinkage process would proceed, or what the benefits might be for the workers. Consequently resistance from health workers was encountered and the delinkage reforms became highly politically sensitive. On being appointed to office in, 1998 a new minister of health suspended these reforms prior to them being fully implemented.

3. The Internal Determinants of Work Motivation

Work motivation exists when there is alignment between individual and organizational goals and when workers perceive they can carry out their tasks. Work motivation is an internal process in which an individual receives certain stimulus from the environment (rewards, feedback, directives, and consequences of previous efforts) which combine with certain internal features (self-concept and needs). These internal and external factors, or determinants, together can engender a willingness to expend personal resources to perform a specific work behavior. Work motivation is not the same as job satisfaction, although the two are interdependent. Greater satisfaction in one's job will be one factor leading to greater motivation to continue to expend effort.

Because work motivation operates internally, the results of this motivation process will differ for every individual. In addition, an individual's motivation to work will change from one work situation to another, and even over time within the same work situation. However, there are common themes in motivation. Over the years, there have been numerous theories posited about the various components of motivation: human needs theory (Maslow, 1954), equity theory (Adams, 1965), intrinsic and extrinsic motivation theory (DeCharms, 1968), expectancy theory (Vroom, 1964), social cognitive (self-efficacy) theory (Bandura, 1986), self-concept theory (Leonard, Beauvais and Scholl, 1995), and goal-setting theory (Locke and Latham, 1984). The internal elements of motivation most commonly cited include:

- ▲ Expected Consequences or outcomes of behavior,
- ▲ Self Concept, including perceived self-efficacy and internalized values, and
- ▲ Needs.

Expected Consequences or outcomes workers experience from their behavior become intrinsic or extrinsic incentives for continuing certain behaviors. Feedback from supervisors, peers and clients, financial incentives, and promotions can stimulate motivation. Some individuals will be motivated by the knowledge they are achieving something, regardless of whether they are recognized by others for the achievement. Others may need more external reinforcement to motivate continuing good performance. How individuals perceive consequences is critical, and is linked to their expectations: if workers' behavior leads to what they consider an inadequate reward (e.g., a bonus less than expected), they may interpret this as a negative outcome, even if the organization meant otherwise.

Self Concept, which includes values and self-efficacy, is an important determinant of motivation in a number of different respects. Linked to perceptions of outcomes is the workers' perception of their abilities to perform the required work. The sense of competency is an internal motivator, which can be reinforced by external positive consequences (e.g., feedback) for work performed correctly. An individual's self concept (Leonard, et al., 1995) will mediate how much an individual needs external reinforcement for his or her behavior. Also, values internalized through the socialization process will guide behavior by putting boundaries on whether an individual can accept or be stimulated by specific organizational goals.

Every individual has certain psychological **Needs** that must be met either in the workplace or outside. Maslow (1954) developed a hierarchical model of these psychological needs: physiological, safety, social, self-esteem, and self-realization. Although empirical evidence does not support the specific hierarchical nature of these needs, the notion of a range of needs is useful for understanding certain work behaviors. When an individual's needs are not met, she experiences a tension that leads her to try to satisfy these needs, inside or outside the workplace. For example, if salaries are not paid in a timely fashion, health workers will be less willing to exert effort at work as they seek alternative means to gain an income and support their families. Differences among individuals imply that health workers will not all have the same balance of needs, nor will it be necessary to meet each need in the work context. Furthermore the relative importance of various needs will change over time.

These three components, Expected Consequences, Self Concept, and Needs, mediate the internalization of organizational or specific work goals, which in turn determine the effort one puts into the task at hand. Goal-setting theory states that performance is a positive function of goal difficulty, and that specific, difficult goals induce better performance than easier or vague goals (Locke and Latham, 1990). Research findings on goal-setting theory have consistently shown that those who try to achieve specific challenging goals perform better than those working with moderate goals, vague goals or no goals at all (Locke and Latham, 1990b). Specificity of quality and quantity components of goals is also important for effort expended, and those with higher perceptions of self-efficacy expend more energy and develop better strategies for task performance than those who were less confident. (Erez, 1990; Terborg and Miller, 1978). Regardless of the effect of specific work goals, congruence between individual goals and organizational goals is critical for stimulating motivation.

Because a variety of factors influence an individual's willingness to exert efforts, many have attempted to examine which factors have the most influence on motivation and performance. A distinction is commonly made between motivation and demotivation. Herzberg's work (1959) indicated two types of factors affecting work behavior: *hygiene factors* which, by their presence or absence, determine levels of worker *dissatisfaction* (e.g., supervision, interpersonal relations, work conditions, salary, and job security); and *motivating factors* which determine the level of worker satisfaction and motivation (e.g., achievement, the work itself, recognition, responsibility, advancement, and growth). Herzberg's theory suggested that it is difficult to produce positive motivation if hygiene factors are absent. Studies among nurses in the United States seemed to support Herzberg's model (Rantz, et al., 1996), but little is known about the relative importance of these various determinants of motivation in developing country contexts. However, a distinction between hygiene and motivational factors is useful for understanding worker behavior, even if the distribution of factors between motivation and hygiene may vary in different settings.

Herzberg also predicted that hygiene factors would escalate their zero point (as expectations are met, new higher expectations take their place). Experience seems to bear out this hypothesis, as salary and benefits expectations continue to rise, in both developing and industrialized country settings.

4. Organizational Factors and their Influence upon Worker Motivation

Figure 2 above highlights several channels by which organizational factors affect worker motivation: through the organization's efforts to improve worker capability, through the provision of resources and processes, and through feedback or consequences related to worker performance. This section briefly summarizes the manner in which organizational structures, human resource management policies, and organizational culture impact on health worker motivation, and how they are likely to be affected by health sector reform.

4.1 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 (and also how different organizations relate to each other) reflect reporting hierarchies, level of worker autonomy, clarity of organizational goals, relative status of different workers and delegation of responsibility and authority. Organizational processes include:

- ▲ service delivery (treatment protocols, referral),
- ▲ support (supervision, logistics, training), and
- ▲ management (planning, budgeting, monitoring and evaluation).

These processes may be specifically outlined in norms, standards, guidelines, standard operating procedures, or they may be undocumented processes transmitted verbally or not at all. The way processes and organizational structures are laid out helps determine the kinds of resources needed to complete the work of the organization.

There is no single, most appropriate organizational structure for generating or sustaining worker motivation. How well any organizational structure will stimulate worker motivation depends on how well it articulates and communicates organizational goals and how well its structures facilitate the workers' ability to meet those goals. The various aspects of organizational structures and processes impact upon worker motivation to work towards organizational goals via a number of different routes:

Organizational Management Structures and Processes will influence whether the organization has clearly articulated goals as well as norms and standards for provider behavior. If norms and standards are clear and have processes to go with them, then goal clarity is possible and goal alignment is facilitated.

Communication Processes within the organization will determine how information about the organization, its goals, norms, and standards is communicated to workers. Communication processes that facilitate frequent, transmission of appropriate information can increase the likelihood of congruence between health workers' own goals and those of the organization, and in turn affect the worker's motivation.

Organizational Support Structures and Processes shape workers' perception about the possibility of doing good work. Ability to perform is not dependent only upon the worker's own skills but also upon the system wide support: Has the worker been given sufficient authority and autonomy to complete the task? Is there clarity about the roles and responsibilities of the different individuals involved? Are service delivery, support and management processes spelled out, clear, and efficient? Are the resources available (such as drugs, supplies and equipment) to carry out these processes?

The organizational work context helps define the status of the worker, the extent of social contact they encounter in the workplace, and their opportunities for self-development and self-realization. These factors will determine the extent to which some of worker's individual needs can be met through the workplace. The greater the extent to which these needs are met, the more positive will be the effects on worker motivation.

Organizational systems of feedback determine the type of feedback received by the worker, and who provides this feedback. Differing organizational structures give more or less emphasis to the importance of feedback. Feedback may also be received from different individuals/groups within the organization. How a worker relates to the individual or group providing feedback will influence the value they place upon this feedback.

4.1.1 Relation to Health Sector Reform

There is not an homogeneous package of health sector reforms, but there are several key ways in which reforms appear likely to impact upon organizational structure, processes and resources, and hence affect health worker motivation.

First, organizational reform in the context of health sector reform often aims at creating a narrower and clearer organizational mission. For example, the establishment of the Central Board of Health in Zambia separated policy making, coordination, and regulatory functions (which continued to be the territory of the MOH) from implementation functions. Similarly purchaser-provider splits in the U.K. removed the District Health Authority from responsibility for the organization and delivery of services and re-focused its mission on defining needs and purchasing care. Such reforms may filter down to individual workers in a number of ways. A strong sense of organizational mission appears to be one of the key factors motivating workers and explaining organizational effectiveness (Grindle, 1997). Furthermore if a clearer definition of the aims of the organization leads in turn to clearer definition of the goals of individuals within the organization, then this is likely to contribute to improved motivation (if there is goal congruence).

Second, reforms often endow specific health care organizations with greater autonomy. Many public sector organizations are embedded in centralized bureaucracies that control human resource management systems and set norms (implicit and explicit) for organizational structure, processes etc. The establishment of autonomous organizations (such as autonomous hospitals) is aimed at freeing organizations from such structures and giving these organizations responsibility to adopt more rational structures making the work environment more conducive to task achievement and workers more likely to think that they can achieve specified goals.

Third, many health sector reforms try to transfer authority for providing feedback to agents situated closer to the health worker. For example, decentralization transfers more authority for human resource decisions to local administrative units which should be better informed (than distant public service commissions or such-like) about the performance of the worker. Similarly encouragement of hospital boards, district health boards and health center committees etc try to place more authority for providing feedback in the hands of local communities (this is discussed further in section 5).

Fourth, reforms affect the availability of complementary resources at different points in the health care system. Schemes to raise extra resources (such as health insurance schemes) may be initiated. Reforms may attempt to improve efficiency with which existing resources are managed (e.g., overhaul of drug supply systems) and they may redistribute resources between different parts of the health care system so as to more closely match priorities. While an overall increase in resource availability is likely to enhance working conditions and improve motivation, redistribution of resources will benefit some, while adversely affecting others.

While on paper there are several opportunities for health sector reform to create organizational structures more conducive to worker motivation, the transition process itself may have significant, and possibly negative effects upon worker motivation. For individuals to continue to be motivated it is imperative that the reforms taking place are transparent, not only in terms of the changes occurring but also the purpose of those changes. Individual workers need to understand the new organizational goals in order for there to be any chance of alignment between their own personal goals and those of the organization.

Reforms frequently redistribute power, authority and autonomy between individuals within the public health care system. For example, health care reforms in the U.K. have granted greater authority to managers (commonly referred to as managerialization) at the expense of other professionals (Ferlie, et al., 1996). Organizational reform which entails the “professionalization” of a small elite group who are given the opportunity to supervise, control, and conceptualize the work of others frequently leads to the down-grading of work among another groups (Ginsburg and Chaturvedi, 1988). In the U.K., for example, professional managers in many Trust hospitals have shifted nursing staff mix to a core of well-qualified permanent salaried staff, backed up by agreements with private sector nurse “banks” which meet hospital needs for much of routine nursing (Corby, 1996). The process of this type of transition will inevitably affect the motivation of the workers concerned.

Finally, reforms may be based upon values contrary to those held by health workers. For example, reforms that promote competition between providers, or which introduce fees for health care services, might conflict with individual workers’ beliefs, and hence make it difficult for workers to commit to new organizational goals. Communication of organizational objectives (e.g., how revenues for fees might be used to improve quality) may mitigate this problem but there may still be an uneasy transition process.

4.1.2 Empirical Evidence

There is a substantial body of empirical work within the health sector that explores the organizational determinants of motivation; however, it relates primarily to industrialized country contexts, and tends to be focused in the nursing profession. Some studies have examined how concepts such as empowerment, leadership and commitment affect worker motivation (Beaulieu et al., 1997; Morrison et al., 1997). Other studies have explored the relative importance of different factors (such as salary, promotion prospects, and work autonomy) on motivation through examining motivation of health workers in different work contexts (Blankertz and Robinson, 1997; Vinokur-Kaplan et al., 1994; and Rantz et al., 1997).

Empirical analysis of the nursing profession in the United States appears to support Herzberg’s notion that primary motivators tend to be intrinsic factors (such as job satisfaction, recognition) rather than extrinsic factors such as pay. Tumulty et al. (1995) classified more than 50% of the nurses they surveyed as being “morally committed” to the job compared to 12% who were committed to their employer only because of the material benefits they gained from the relationship.

In a study of social workers Vinokur-Kaplan, et al., found that:

“Among workers in public and non-profit agencies, perceived opportunities for promotion and job challenge are pre-eminent in influencing their job satisfaction.”

Application of Herzberg’s framework to health workers in the, 1990s indicated a few changes in the original hypothesis, but did not put into question its value in the current U.S. context: recognition, the work itself, and responsibility have remained as major motivating factors (Rantz, et al., 1996).

4.2 Human Resource Management

Worker motivation is a core goal of human resources management (HRM). A World Health Organization (WHO) expert committee on management of human resources for health stated that health personnel management involves:

“... 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 in which human resources (HR) departments are typically involved include: recruitment, structure and organization, reward and recognition, management, training, participation, and termination of employment (Farnham and Horton, 1996). Human resource management has a number of tools at its disposal which may contribute to worker motivation:

- ▲ Job definition and job descriptions which help ensure that the worker is aware of organizational goals and of the role which they are expected to play in achieving these goals;
- ▲ Effective recruitment procedures which help identify individuals who will fit in well within the organization in terms of their preferences for how they work, and that ensure there is a fit between the tasks required of individuals and the skills and knowledge which they bring to bear on these tasks;
- ▲ Incentives such as salaries, bonuses, promotions, which link performance to reward;
- ▲ Staff development which enhances worker knowledge and skills, making the worker better able to perform the tasks expected of them; and
- ▲ Supervision and performance assessment which provide feedback to workers on performance.

It has been argued that with the exception of “establishment work”¹ and other aspects of manpower planning, many lower- and middle-income countries have ignored (or paid little attention to) the human resource management functions in health care (WHO, 1989). As a consequence, the basic conditions for the effective functioning of the bureaucracy are often not in place. For example, regular procedures for recruitment and promotion may not be established, job descriptions may not be available, and dismissal procedures may be overwhelmingly cumbersome. Without such basic systems in place, scope to use more sophisticated incentive schemes to motivate workers appears

¹ Establishment work is normally taken to include establishment of staff levels, staff mix, and remuneration

limited (Moore, 1996). In this context the recent growth of interest and work in HRM (Dussault, 1998; Martinez and Martineau, 1996) appears very pertinent.

4.2.1 Relation to Health Sector Reform

Health sector reform and human resource management have a symbiotic relationship (Martineau and Martinez, 1996). On the one hand, reforms in the human resource management system (such as an improved staff mix and the 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, establishment of autonomous facilities) may transfer responsibility for the human resource management system, or conversely be constrained by rigidities in the HRM system.

Attempts to advance quality and efficiency of the overall health care system through human resource management approaches have very evident links to health worker motivation. Typical efforts in this area include attempts to improve education and training (both as a means to create incentives for employees and to improve capacity to perform); to restructure salary scales so as to provide a living wage and hence reduce “moonlighting;” and to create a closer link between performance and reward through such mechanisms as performance appraisal and performance related pay. Human resource management systems, through performance assessment and reward, and through disciplinary procedures, should form a key part of the feedback loop, affecting how workers experience the consequences of their behavior.

Several of the strategies pursued by HRM specialists in the health care sector bear a close relationship to civil service reform strategies promoted by the World Bank, among others. The two common core elements used in developing country civil service reform programs to create stronger incentives for efficiency and productivity are: downsizing, and reform of pay and employment policies.

4.2.2 Empirical Evidence

The World Bank’s own appraisal of civil service reform programs was, at best, mixed. Dia (1993) notes that, of fifteen countries in, 1990 with World Bank supported Civil Service Reform programs:

“None of the cases reviewed so far have revealed any empirical evidence that the Civil Service Reform and related Technical Assistance Loans have succeeded in fostering the needed change in work attitudes, ethics and organization culture that could lead to greater efficiency/productivity in the civil service.”

Evidence from industrialized countries on the same issues indicates that linking performance to promotion prospects is likely to have beneficial effects in terms of productivity and motivation. However, the evidence is considerably more mixed about the benefits of performance-related pay and Nunberg (1995) concludes that this method for motivating public sector workers is unproven and not a priority for developing countries to explore.

Other case studies have highlighted how HRM may be adversely affected by health sector reform, particularly decentralization (Perez, 1998 and Dovlo, 1998). Reforms, particularly during the transition period, may create uncertainty about employment conditions (Kohlemainen-Aitken, 1998) and introduce what workers perceive to be unfair treatment of different groups of employees.

4.3 Organizational Culture

Organizational culture can be defined as “a shared set of norms and behavioral expectations characterizing a corporate identity” (Grindle, 1997). These norms and values may be reinforced through organizational “rituals”. An organizational culture may be a positive culture created through specific and concerted efforts of management aimed at motivating individuals within the organization to pursue organizational goals. But every organization will have its own specific organizational culture, even where management has not made a concerted effort.

Public health care systems are made up of multiple organizations. When there are strong and charismatic leaders, an overall organizational culture might permeate throughout a health care system. However, it is more likely that organizational culture will vary considerably between different organizational units (such as different hospitals and health centers). As a consequence it is common to find that the performance of one particular health care unit is considerably better and staff motivation considerably higher than another health care unit which operates with similar structures and levels of resources. One explanation of these differences lies in organizational culture. Some organizations might value independent decision making and entrepreneurial spirit which will most likely lead to greater innovation. Similarly some organizations might value more collaborative approaches over individual action and decision making. Such rituals as frequent staff meetings and extra-curricular social bonding activities may reinforce these values.

Organizational culture may not necessarily promote the achievement of organizational goals. Like other elements of the conceptual framework discussed, the issue of congruence between different dimensions of the organizational culture and societal and individual values is paramount.

Organizational culture is formed through the interaction of broader societal culture, organizational structures, and the personal characteristics of individuals and sub-groups that make up the organization. Section 4.2 discussed aspects of organizational structure that are likely to influence organizational culture and vice versa, such as the clarity of organizational mission, the extent of autonomy given to decision makers, and the organization of work. Two additional important contributors to organizational culture discussed here are the characteristics of leadership styles and the presence of sub-cultures within an organization related to particular associations of workers, such as professional groupings. The next section (5.1-5.2) discusses in more detail different dimensions of societal culture and how these might interact with organizational culture and structure.

Charismatic leadership within an organization can communicate both a vision and goals for the organization which inspire workers to devote greater effort to achievement of these goals. Such leadership can also help develop loyalty to an organization. While people in formal positions of power have sanctions and incentives at their disposal, there are often also informal leaders within an organization who derive power solely from their charisma or societal status. Often such informal leaders may come to represent and articulate the interests of sub-groups within the organization. Gaining the support of such informal leaders for reforms may be key to communicating successfully the objectives of the reform program and motivating workers.

Individuals bring with them into the organization not only the values that they have learned from society, but also their experiences within specific parts of society. A group of individuals that have a common set of specific experiences (such as professional training or prolonged service in rural areas or overseas training) may form a sub-culture within the organization.

In the public health care sector one of the most prevalent sub-cultures may be that associated with professionals. Professionalism is generally considered to entail (1) a certain autonomy in one’s job due to the technical nature of the work and the difficulty of supervision (2) adherence to

professional norms and standards and (3) enforcement of norms and standards through peer group pressure (Leonard, 1993, Ginsburg and Chaturvedi, 1988). Often both physicians and nurses have quite distinct cultures based around their profession. Their notion of what it is to be a professional will influence organizational values. If professionalism is valued by the organization, and incentives encourage professional behavior, workers will be stimulated to behave according to professional norms.

In some countries, the very fact of being a public sector worker (or civil servant), particularly at 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 service (Farnham and Horton, 1996). A similar sense of public sector work ethos is reported in many East Asian countries.

4.3.1 Relation to Health Sector Reform

Health sector reform can disrupt 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 the organizational goals and the inherent values with which they are associated. For example, reform programs that place an excessive emphasis on financial incentives may diminish the sense of public sector ethos among workers, which could in turn lower overall performance and motivation. 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. Even a single reform may bring about widespread changes (positive or negative) in motivation and performance if it succeeds in changing organizational culture.

4.3.2 Empirical Evidence

Very few studies have explored the impact of organizational culture upon worker motivation. Grindle (1997) examined the links between organizational culture and broad organizational performance in a number of developing country case studies. These case studies showed a positive link between performance and (1) clear mission that created a mystique about the organization; (2) clear performance expectations; and (3) value placed on teamwork, participation, flexibility and problem-solving. This last component however, is not universally supported in the literature. Substantial problems may be associated with implementing organizational structures and mechanisms which reflect common industrialized countries' organizational values (such as openness or worker participation), but which are incompatible with local cultural traditions (Blunt, 1990; Mendonca and Kanungo, 1994).

5. Socio-Cultural and Environmental Influences on Worker Motivation

Much of the research on health worker motivation has been undertaken in the health systems of industrialized countries. There are serious obstacles in transferring findings from this context to those of developing countries: not only are there significant differences in organizational structure, processes, and culture, but there are also differences in broader societal culture. This section explores the importance of cultural differences upon motivation, and to a limited degree discusses other environmental influences.

A consideration of culture is relevant to assessing the impact of health sector reform upon health worker motivation in at least two dimensions. First, the effectiveness of a particular constellation of organizational structure, processes, and culture in achieving worker motivation will depend to a considerable extent on how well the characteristics of the organization mesh with the local culture that frames an individual's values and goals. Second, the broader societal culture forms the backdrop in which an individual health provider interacts with his/her patients and makes choices about appropriate provider behavior.

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 are unlikely to support merit-based systems of promotion and may jeopardize the credibility of leaders. If workers believe reforms are being imposed by external agencies (such as international financial institutions or donors), and there is little local ownership of the reform process, then worker commitment to the reforms is likely to be weak. While acknowledging the critical importance of these broader environmental factors, there is insufficient space here to address them in any depth.

5.1 Characterizations of Culture

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 (ethnic, religious, national, and so on)” (Schwartz, 1997). Culture has at its heart shared values, which contribute to a type of “mental programming” carried out by the 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). Shared values provide the context in which individuals operate both in the social and work aspects of their lives.

“These shared values provide broad goals of varying importance, render available action alternatives more or less attractive according to the likelihood that these alternatives will promote goal attainment. Hence, values can account for both initiation and direction of action.” (Schwartz, 1997)

Table 1. Dimensions of Culture

Dimensions	Description
Conservatism vs. autonomy: the relationship between individual and group	The degree to which individuals are embedded in the collectivity, find meaning largely through social relationships, or whether individuals find meaning in their own uniqueness and individual action.
Hierarchy vs. egalitarianism: assuring responsible social behavior	The degree to which individuals are socialized and sanctioned to comply with obligations and rules attached to their roles, as ascribed by a hierarchical system. Or a more egalitarian view, where individuals are portrayed as moral equals and people are socialized to internalize a commitment to voluntary cooperation and concern for others.
Mastery vs. harmony: the role of humankind in the natural and social world	The degree to which people see their roles as one of submitting, fitting in or exploiting the natural and social world in which they live.

Source: Schwartz, "Values and Culture."

Several analysts have suggested that there are key differences between developing country and industrialized country cultures. Pioneering work in this area was conducted by Hofstede (1980), based on a multi-country study of IBM employees in the 1960-70s. Recent work has led to a simpler categorization (Schwartz, 1994), shown in Table 1 below. Each dimension is a continuum. The specific combination of the various dimensions together characterizes the cultural environment of a particular society.

Cultural dimensions reflect beliefs, values and assumptions that workers carry with them to the workplace. Culture is the composite of individuals, but each individual may have his/her own values that correspond or conflict with those of the general society. The degree of congruence affects how well a given individual will function in that society.

5.2 Culture and Organizational Functioning

Just like individuals, organizations do not function in a cultural vacuum; they are embedded in a larger society. Thus, societal characteristics will influence how organizations are structured, how decisions are made, acceptable levels of autonomy, and organizational culture. Organizations with internal cultures not in alignment with the broader societal culture will encounter difficulties both within and without. Individual workers whose values do not correspond to those of the organization may be less willing to devote their personal resources towards organizational goals.

The broader cultural values translate into specific types of work behaviors and prescriptions for appropriate behavior. Kanungo and Mendunca (1994) posit that in developing countries where cultural values emphasize the collectivistic, hierarchical, and harmonious, workers are more likely to believe that:

- ▲ Fate is outside of one's control,
- ▲ Humans have fixed capabilities,

- ▲ The past and present is more important than the future, and
- ▲ Short-term goals are more appropriate.

In turn, workers may tend to find it desirable to be passive, moralistic rather than pragmatic, and authoritarian. Such beliefs will affect workplace behavior and the ability of certain types of organizational structures and processes to function well.

Aitken's study of health service workers in Nepal (1994) demonstrates the need to understand "values in use" or the implicit cultural values in order to make sense of health worker behavior in Nepal. The "values in use" are not necessarily the same as those officially espoused by the bureaucracy, but are part and parcel of the organizational culture. Aitken proposes that the following statement accurately describes an 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.*"

The effects of culture on the relative importance of various determinants of work motivation have been studied quite extensively in Asian countries in attempts to understand the performance of the Asian "tiger" economies. These studies emphasize the collectivist orientation of East Asian workers and the moral commitment to their employer organizations: workers are commonly willing to exert and maintain a high level of effort towards organizational goals, even if they do not find their work satisfying. Thus, organizational performance is supported by certain cultural dimensions.

The effect of culture on organizational function argues for a fit between cultural values "programmed" by socialization, and organizational structures and the values they embody. Some of the difficulties encountered in many reform programs result from importation of structures and processes that function best when supported by certain types of organizational 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 organizations is not part of broader American culture.

5.3 Culture and Provider-Patient Relationships

In service organizations, societal culture affects workers not only through their interactions within the organizational context, but also their interactions with their clients who are themselves embedded in the societal context with its values and beliefs. The culture of clients also affects workers' motivation through two main channels: the workers' links to the community served, and the degree of congruence about what is perceived to constitute good service.

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 be motivated 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. In considering the motivation of a worker to provide high quality service to patients, issues such as whether or not the worker comes from that community, or how embedded they are within that community, will be critical. As many developing country societies are less individualistic than Western societies and place greater emphasis upon the collectivist whole, the issue of social relations between provider and patient may be of particular importance.

Tendler and Freedheim (1994) note that 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)

A second issue is the effect of client expectations on worker behavior. If clients expect and value certain types of treatment, such as multiple drug therapy or injections of vitamins, public sector health workers experience a conflict between these expectations and organizational goals of cost-effective treatment that is affordable for the government.

5.4 Culture and Health Sector Reform

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

The various studies which have examined the effect of culture upon motivation suggest such a diverse and complex set of local cultural contexts that it is difficult to draw specific conclusions for the design of health sector reform. The main lesson emerging is that, to be effective, reforms should be embedded in a sound understanding of local values, and culture. Unfortunately there is a very limited body of health sector-specific analysis that explores these issues, and most of this work is anecdotal in nature. A few examples of how health sector reform might interact with societal context are provided here.

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. For example, 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, as employees 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 engendering 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 reinvigorated) organizational structures create an alternative and potentially effective feedback loop. Part of the success of a highly acclaimed project in Northeast Brazil (Tendler and Freedheim, 1994) appeared to stem from a conscious strategy to “embed” health workers in their community.

6. Implications for Policy and Research

6.1 Implications for Health Reform Policies

6.1.1 Goal Congruence

At the core of the motivation question is the extent to which the goals of individual health care workers are in alignment with the goals of the employing organization. It is most unlikely that the individual workers and the organization will have the same goals, but it is highly desirable that individuals' own goals lead them to strive to achieve the goals of the organization; i.e., there should be goal congruence.

Probably the most important factor for health policymakers to consider when endeavoring to promote goal congruence is the immediate organizational context. Policymakers should assess to what extent organizational structures and processes clearly communicate organizational goals, provide timely feedback on performance to health care workers, and ensure that higher levels of performance are met with greater reward. However, as the multiple levels included in the conceptual framework suggest, there are other dimensions of congruence that may be critical. Good fit between the needs and self-concept of individual health workers on the one hand, and organizational structures and processes on the other, will strengthen worker motivation. Congruence between organizational culture and broader societal culture will make it easier for health care workers to pursue organizational goals. When the goals of health care organizations are congruent with the needs articulated by communities, this should reinforce positive behavior on the part of health care workers.

The issues of congruence and fit suggest that there is no universal blueprint for how to design reforms that promote worker motivation. Each country must analyze its particular constellation of organizational culture, structure, and the broader societal culture to determine how best to approach the design and implementation of health sector reform. The following sections suggest strategies for achieving better goal congruence and improved worker motivation.

6.1.2 Multiple Channels Influencing Motivation

Health sector reform will influence worker motivation via a number of channels. Well-designed reform policies can promote goal congruence. Frequently however, reform policies focus only on a very limited number of channels affecting worker motivation. If only a few determinants of motivation are targeted by reform programs, it is highly likely that motivation will not improve, or that it even be completely reversed by unanticipated influences. For example, as part of Senegal's recent reforms, competition between facilities was promoted to stimulate performance. However, some facilities became demotivated by competition because workers there did not feel able to perform at the same level as other groups for reasons that were entirely outside of their control (such as lack of resources). Some policy instruments may indeed be more effective than others, but it is critical that all incentives work in the same direction and that balancing measures are put into place, as needed, to counteract potential negative effects of new incentives.

This paper argued that reform programs commonly place greater emphasis upon financial incentives than on less tangible non-financial ones, such as achievement, the work itself, and recognition. Herzberg argued that the more concrete *hygiene factors* could only avoid dissatisfaction while the more intangible factors engendered positive motivation. In reality, this distinction is often difficult to maintain. Salary increases and bonuses may be valued not only for financial reasons but also for prestige and status which they endow.

Focussing solely upon financial incentives as a means to improve worker motivation is likely to be problematic. At a practical level, the fact that most hygiene factors have “escalating zero levels” means that such a strategy will, in the long run, be prohibitively expensive. High cost is not the only problem:

“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

Reforms emphasizing the importance of financial or material rewards may be the victim of their own success: financial incentives may displace other determinants of motivation such as achievement and the work itself. At the same time workers’ commitment to the organization may shift from an affective commitment or loyalty to one based more upon the potential for personal gain.

6.1.3 Communication and Leadership

Health sector reform sometimes entails quite radical reforms of organizational structures, processes and culture. To health workers accustomed to a particular way of working, reforms may 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 demotivation by reassuring and reducing levels of uncertainty.

A consultative process that involves workers in the development of reforms is likely to imbue a greater sense of ownership among health workers and thus provide an even better chance of securing their support. As Tumulty, et al., (1995) note in the U.S. context:

“These nurses have made a large psychological investment in the organization and a sudden change in the organization’s goals or direction would be very distressing to them. They should have meaningful input into work unit or department changes and they must perceive administrative support for their practice.”

Strong and charismatic 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 lacking credibility is unlikely to gain worker commitment or willingness to exert effort in order to implement reforms.

6.1.4 Values

Health sector reforms are rarely confined to changing organizational structures. Sometimes the thrust of the reform may be 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. Health workers, like other individuals, have a set of values acquired through the socialization process and partially determined by their own psychological

make-up. When health workers feel that the values associated with a reform program are not values to which they can personally subscribe there is likely to be a disaffection with the reform process and a concomitant lack of motivation. Even reform policies with more limited ambitions may be rejected by health workers, if they conflict with the dominant values held by individuals within the organization.

In some instances it is highly desirable to change prevailing values; however, this is unlikely to be achieved within a short period of time. The magnitude of the task should be recognized and strong communication strategies need to be developed to support change of values among the workforce.

6.1.5 Differential Impacts

The motivation of public sector health workers is likely to be affected by reform programs in different ways. First, different cadres of health worker might be motivated by different factors. This is certainly supported by studies in the US which showed determinants of motivation among physicians to be very different from the determinants of motivation among nurse aides.

Second, different cadres of workers are likely to experience the effects of health sector reform in different ways. Civil service reform in developing countries, for example, tends to decompress salary structures, and retrenchment policies are often focussed on less skilled workers (Dia, 1993). Similarly, health sector reform programs, depending on their design, are likely to benefit some health workers and disadvantage others.

Third, the organizational context in which the worker is situated will mediate the impact of reforms. Reforms will affect hospital workers and workers in primary care settings differently. Even among the same type of organization (e.g., hospitals) the effect of reforms upon the worker is likely to vary.

These differential impacts need to be borne in mind when designing and implementing reform policies. Communication strategies should be adapted to reflect differential impacts and reform programs phased so as to ensure appropriate timing to the more and less controversial elements of the reform.

6.2 Implications for Research

This paper has described relevant empirical evidence about both the determinants and effects of motivation, where such information has been available. It is striking how little empirical information about this key topic is available. Virtually all of the evidence on health worker motivation originates from industrialized countries and it would appear very problematic to transfer the findings from such contexts to developing countries with widely differing organizational structures and broader societal cultures.

For example, while empirical evidence from industrialized countries for the nursing profession confirmed Herzberg's original list of motivators and hygiene factors, there is no systematic evidence from the health sector of developing countries. In many low income countries and some middle income countries, public sector health workers do not receive a living wage, and salary payment is often late. Under such circumstances one might expect that basic needs are key motivators. However, there are many anecdotal examples of health workers continuing to provide services despite late payment or non-payment of salaries. It is not clearly understood what role more positive motivating factors such as recognition, responsibility and career advancement can play.

The priority for future research, therefore, is to explore basic questions about the determinants of worker motivation in different developing country contexts. The relative importance of different determinants, such as worker relationships with the community, status, prestige, salary, and financial incentives, could be explored. It would also be important to consider how motivational determinants differ by cadre of health worker and by organizational setting (public/private organization, urban/rural setting, and hospital or health center workers). Such basic empirical information appears a necessary next step before engaging in a more elaborate analysis of the relationship between health sector reform and health worker motivation. Furthermore, it could provide policymakers with insights about which sorts of motivational determinants to which they need to pay close attention in order to achieve better goal congruence and better health worker and health system performance for achieving reform goals.

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