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Demotivating the Doctors: The Double Demotivation Hypothesis in the Health Services of Less-developed Countries

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Introduction

There are different ways of helping poor countries to develop their health services. Developed nations often provide these less-developed nations with equipment, grants and personnel. Over the past 30 years, since the era of independence, many Southern African countries have received massive amounts of aid. Often health services have been a central focus and major recipient of such aid. Despite this, the health status of some African countries is worse today than it was 30 years ago[1]. The health sectors of many countries are in crisis and the sustainability of services is the overriding concern today[2]: having produced an improvement will it last?

The Doctor Solution

Many African countries have pursued a Western model of health education and health provision. Within this approach, doctors are seen as key personnel in the health system and so significant sums of money have been spent on the lengthy training which they receive in the more-developed world. However, whether medical doctors train in African countries or elsewhere (usually Europe, the USA or Australia) they do not always return to their own countries to practice.

The Doctor Problem

In Malawi, for instance, 50 per cent of the medical students who go abroad for training never come back[3]. The low salaries, in comparison both with other African countries and with the more developed world, are no doubt an important factor in this. Of Malawi's 120 doctors working at government institutions, only 30 are Malawian; the rest are expatriates[4].

The Doctor's Salary

These expatriate doctors are in Malawi under a number of different schemes, some linked to their own government's aid projects, such as the British Overseas Development Administration (ODA) and others as part of a non-government organization (NGO). A few, but very few, are working on "local contracts", in other

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words earning the same as a Malawian doctor earns. To illustrate the scale of difference in earnings between expatriate and local doctors, an ODA-funded doctor would be earning in the region of ten to 12 times what his Malawian colleague is earning, even though both of them may have graduated from the same medical school in the UK and at the same time.

While financial, material and professional aspects of aid have been closely reviewed, with the hope of identifying better ways to help health services to develop, the psychological conditions under which people work in health services have been given far less consideration. We believe that the huge differences in the earnings of some expatriate doctors and the earnings of local African doctors have the unintended, but negative, effects of demotivating those who work in health services in Africa.

A Double Demotivation

Change, and the sustainability of change, depend on human qualities rather than on the quality of equipment or the quantity of money available. Improvements in health services require a motivated workforce to implement them and to ensure their survival during difficult times. We suggest that the extant dichotomy in the salaries of local and some expatriate doctors results in demotivation. In fact, it is a double demotivation, where not only the lower-paid doctors are demotivated, but so too are the more highly paid ones.

The Demotivation of the Lower-paid Doctors

This is perhaps the more intuitively obvious claim. If money is seen as a motivator, then the more a person is paid, the more motivated he/she should be, and the harder he/she should work. This is, of course, the basis of many "pay for performance" schemes[5]. By implication, the less one is paid the less motivated one should be. Indeed, there is no doubt that some African doctors decide to work in more-developed countries because the material rewards are greater. But we are not simply suggesting that those African doctors who are "left behind" are demotivated because they are not earning as much as they could. The problem is more serious and more subtle than that.

We suggest that the inevitable comparison between yourself and another person, who in all meaningful respects (education, work duties, intelligence, ability etc.) is equivalent to you, except that he/she earns ten times as much is, in itself, psychologically irksome and ultimately demotivating. There is some evidence to support this notion. For instance, Adams and Rosenbaum[6] found that workers who were paid less than other workers, who were doing the same job, tended to work more slowly and to a lower standard than the more highly paid workers.

Equity theory[7] summarizes this notion by stating that people strive to achieve an equal ratio of their inputs to their output, in comparison with others. Translating this into the present argument, if two people are paid different rates to do the same job, then they will adjust their effort on the job, to reflect the pay which they are receiving. The doctors who are paid poorly will work less hard than those who are paid more. Perhaps then, Malawian doctors leave Malawi, not simply because of the absolute level of low pay, but also because of the relative difference and poor

comparison between themselves and expatriate doctors. Leaving the country could then also be seen as a means of salvaging one's dwindling motivation.

The Demotivation of the Higher-paid Doctors

We suspect that, to most people, our second claim that the higher-paid doctors may also be demotivated, appears to be counterintuitive and, by the rationale of our previous point, somewhat contradictory. So first of all we shall review some experimental studies which support our claim.

In a now classic experiment on cognitive dissonance, Festinger and Carlsmith[8] asked subjects to participate in an extremely boring psychology experiment. These subjects were then asked to tell participants that the experiment was very interesting. Half the subjects were paid $20 each to do this while the other half were paid only $1. Afterwards these subjects themselves rated how interesting the experiment had actually been.

Surprisingly, those subjects who had been paid only $1 rated the experiment to be significantly more interesting than those who had been paid $20. It seems that the smaller subsequent reward produced greater liking for the task than did the larger reward. One interpretation of this is that those people who were paid the larger sum justified their involvement in the experiment purely in terms of being paid for it – "it was boring, but at least I got well paid for it" – whereas those paid the lower sum felt a greater intrinsic interest in the experiment – "it wasn't too bad, and we certainly didn't do it for the money!" Thus, there seems to have been a difference in how people saw their involvement in the experiment, and this was dependent on how much they were paid to do it. (It is now recognized that this effect also depends on perceiving a choice in performing this activity. Hence, workers who were obliged to work for low pay, like the lower-paid local doctors, would not be expected to show an intrinsic interest in their work.)

One difficulty with Festinger and Carlsmith's classic experiment, however, is that subjects were involved in an objectively boring task. While any kind of work has a degree of boredom in it, we would hope that most doctors would be interested in and committed to their medical practice. In other words, they would believe in what they were doing. The influence of pay on personally held beliefs would therefore be of greater relevance.

Benware and Deci[9] paid subjects to argue in support of their own beliefs. For example, one of these arguments was that education should be partly determined by the consumers of education themselves. What they found, rather surprisingly, was that the more they paid subjects to argue for their own beliefs, the less these subjects came to believe in the arguments which they had been making. It seems that, for these highly paid subjects, the money which they received became the justification for their argument, even to the extent of undermining already-held beliefs.

This finding might suggest that doctors who perceived themselves to be very well paid – certainly relative to their local colleagues – may start to see the justification for their work as being the money, rather than the intrinsic features of the job. If this were so, then one could talk of the qualitative shift in the motivation

of these highly paid doctors, possibly from a desire to help the needy, to a desire to earn the money. This qualitative shift may or may not go hand in hand with a qualitative reduction in overall motivation.

But does it really matter what motivates people as long as the work gets done? Well, from a sustainability point of view, yes, it does. In another experiment reported by Deci[10] he found that the more people were paid to work on intrinsically interesting problems, the less willing they were to continue working on the problem when given the choice to stop or continue, but without pay. The important point here is that motivation was shifted from intrinsic aspects of the task to extrinsic rewards. Again the justification for doing the work became the money. For a high effort to be maintained in situations of staff shortages, staff must be motivated beyond earning their salary and towards maintaining a sufficient service. This may mean covering for others without pay. Projects which draw attention to pay differentials and focus employees on the unfairness of their renumeration are intrinsically less sustainable than those which focus employees' attention on the intrinsic aspects of their job. Perhaps this can be achieved only through equitable pay rewards.

While a qualitative shift in motivation is one problem an equally significant problem from the point of view of sustainability is that to maintain motivation under such conditions of renumeration, similar extrinsic rewards must be maintained. If the intrinsic rewards are withdrawn then one can expect a quantitative demotivation (see Deci[11,12]). In essence, foreign doctors would be unwilling to switch to local terms of renumeration if their "overseas" funding was withdrawn.

When Foreign Doctors Leave

When an expatriate doctor on an international salary leaves, he or she usually also leaves a gap, at least for some time. Ideally, others would step into his or her shoes and take on the responsibility which the foreign doctor had while there. But we wonder: is that really what we would do? In terms of equity theory, it would be difficult to be fully committed to doing the job which someone else had been doing, but for only one-tenth of the pay.

Costing the Crisis

If we are right, then what we may find in the hospitals of developing countries where foreign (expatriate) doctors are on international salaries, working side-by-side with local doctors on local salaries, is a double demotivation. Those who are paid less are demotivated by the comparison of their "inputs" and "outputs" with those of their expatriate colleagues; and those who are paid more are demotivated because their awareness of the pay differential may insidiously shift their motivation from intrinsic aspects of their work to extrinsic rewards – money. This double demotivation has the effect of making the sustainability of health services an even greater weight to be borne by local doctors. Such psychological dis-ease, together with the poor working conditions and the opportunities to earn more elsewhere, may cause doctors from less-developed countries to leave these countries, where they are most needed.

Policy Implications

It is rare for a problem in the development of health services to be identified where possible solutions do not necessarily require the spending of more money and may even entail the saving of money. A most obvious solution would be to reduce the pay differentials between expatriate doctors on international salaries and "Third World" doctors on local salaries. This might entail the sponsors of expatriate doctors paying them less, and the local doctors more. Sponsors could shift their focus from supporting an individual doctor (often of their own nationality) to supporting a group of doctors, of whatever nationality, working in a particular hospital.

Would foreign (expatriate) doctors still want to work, if they were paid, say, half as much? Some of them already work for the local salary. One justification for high salaries is, however, that they keep pace with the amount which the doctors would be earning "at home". However, those who have such a keen eye on the money are, we would suggest, more likely to fall foul of this qualitative (and possibly quantitative) demotivation away from the intrinsic nature of their work. It seems to us that many doctors, earning ten times what their local colleagues earn, would be prepared to work for less. How much less is an empirical question which aid agencies and foreign governments might profitably address.

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