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Financial incentives and prosocial motivation among physicians in a faith-based society

How do healthcare professionals respond to financial incentive within mission-driven public hospitals in a faith-based society? This paper challenges previous research findings that healthcare professionals in mission-driven hospitals are prosocially motivated to serve the poor patients, and that performance-based financial incentives tend to crowd out such motivation. We used data from fifty-six interviews with healthcare professionals from three tertiary public teaching hospitals in Peshawar, Pakistan, to investigate the effect of a performance-related pay scheme. We found that the high professional standards and strong religious beliefs of the physicians were key to maintaining their prosocial motivation to serve the poor patients in their communities. We conclude that financial incentive does not always erode prosocial motivation in public-sector organizations, and that prosocial motivation itself may be determined by professional and social context.

Keywords: Performance-based financial incentives, extrinsic motivation, prosocial motivation, faith-based society, healthcare professionals

Introduction

Since the 1980s, the vast majority of countries in the Organization for Economic Co-

operation and Development (OECD) have introduced performance-based financial incentives in a variety of sectors that seek to enhance the motivation and performance of government employees. The introduction of performance-based financial incentive in the public sector has usually been adopted either as part of a New Public Management (NPM) initiative or as a sole innovative policy (Perry et al., 2009). The popularity of performance-based financial incentives in the public sector has been growing steadily and countries in emerging economies are now introducing performance-related pay (PRP) schemes in their public institutions to induce motivation and performance (Hasnain et al., 2014; Kim and Bak, 2020; Park, 2021). In Pakistan, a renewed interest in performance-based financial incentive stemmed from recent healthcare reforms introduced by the Medical Teaching Institution (MTI) Act of 2015. This Act was mandated to improve the performance of healthcare professionals, a long-standing issue in the national healthcare system of the country.

Performance-based financial incentives have long been a feature of public healthcare in developed countries (Kondo et al., 2016). Research into healthcare management and policy suggests that in the last few decades, many African countries have also adopted financial incentive schemes to achieve performance targets and New Millennium goals (Ireland et al., 2011). Many other developing countries are adopting pay-for-performance in public healthcare to improve employee efficiency and accountability (Bertone et al., 2018; Khan et al., 2020). However, this recent surge has led to concerns that a focus on earnings may crowd out the prosocial motivation of healthcare workers. This is even more of an issue in developing countries, where the majority of the population use public healthcare services (Lagomarsino et al., 2012).

The existing literature on PRP in public-sector organizations has some limitations. First, there is a persistent and longstanding debate in public management as well as in

economics and psychology on the use of financial incentives in social care and public-sector services (Georgellis et al., 2011). The public management view, which is shaped by Ryan Deci's self-determination theory and Bruno S. Frey's motivation-crowding theory, suggests that in the public sector, the strategy of financial incentive is counterproductive as it undermines intrinsic motivation, particularly in organizations such as healthcare and social services (Bellé, 2015; Ariely et al., 2009; Georgellis et al., 2011). In contrast, proponents of the financial incentive approach argue for its effectiveness using an economic model of human nature (Kim and Bak, 2020; Weibel et al., 2010). This view suggests that pay-for-performance has a positive effect on workers' motivation and performance. Confusingly, there is an abundance of empirical studies to support each of these theoretical standpoints (Duchoslav and Cecchi, 2019; Bellé, 2015; Bellé and Cantarelli, 2015; Kim and Bak, 2020).

A second limitation of the literature is that it often overlooks the ongoing debate on the relationship between financial incentive and the crowding out of motivation (Kim and Bak, 2020). Additionally, there is a paucity of research into whether prosocial motivation is influenced by other contextual factors such as social structure, professional identity, and the socially constructed logics of culture, norms, and rituals (Perry et al., 2009; Janus, 2014; Bellé, 2015; Ahmad et al., 2024).

Third, despite the global rise of interest in PRP in public healthcare, little research has taken place in developing countries, especially with regard to its effect on prosocial motivation (Bertone and Witter, 2015; Powell-Jackson et al., 2015; Singh et al., 2015; Ahmad et al., 2024). Calls for further research into PRP motivated us to conduct this study in the context of Pakistani public healthcare after the radical MIT reforms of 2015. One of the aims of the reforms was to improve employee performance using financial reward, an initiative which provided us with a novel context to broaden the geographical

and social context of the debate. The healthcare profession is an especially ideal ground for empirical analysis of motivation-crowding theory. Public-sector healthcare is a standard example of a professional work environment in which employees are expected to be highly prosocially motivated to help and care for patients, and the ethics of healthcare are also integral to their work (Andersen, 2009). The assumption that external incentives will crowd out prosocial behavior has led to a line of research devoted to investigating the relationship between performance-based incentives and prosocial motivation in healthcare professions (Bellé, 2015; Georgellis et al., 2011).

This study contributes to our knowledge of the relationship between performance-based pay and prosocial motivation in the public sector in three ways. First, it empirically examines motivation-crowding theory using a sample of public healthcare professionals in three Pakistani public hospitals. In the last decade, many developing countries have introduced pay-for-performance schemes, either as a part of new public management reforms or as stand-alone policies, to improve work performance and to encourage higher standards and efficiency in healthcare. To the best of our knowledge, our study is the first to investigate the effects of financial incentive on prosocial motivation in a mission-based organization in a faith-based society, in our case, Pakistan (Qadri, 2022).

Second, we investigate the "dark side" of performance-based pay, asking whether it crowds out the prosocial motivation deemed necessary for vocational work. To date, most proponents of performance-based financial incentives have focused on the mechanical aspects of performance and motivation i.e., improved performance, job accomplishment and target achievement. However, this one-sided focus tends to ignore the prosocial aspects of motivation. Scholars repeatedly remind us that prosocial motivation is an essential attribute of employees in mission-driven organizations such as social services and public healthcare (Georgellis et al., 2011; Rollnick et al., 2008; Steijn

and Van der Voet, 2019). Healthcare employees are traditionally characterized by high levels of prosocial motivation, which in this field has been defined as a "willingness to sacrifice one's own gains for a stranger's benefits and willingness to exert costly effort on behalf of one's patients" (Brock et al., 2016, p. 135), and as "supportive behavior, and helping and feeling empathic concerns for others" (Biagioli et al., 2016, p. 293).

Third, our study deepens the still limited knowledge of how the type of profession (with its norms, ethics and identity) combines with socially-constructed logics (e.g., culture, religion and values) to alter the effect of financial incentive on prosocial motivation (Janus, 2014, Bellé, 2015). In their review of PRP in the public sector, Perry and colleagues (2009) conclude that research should investigate the moderating effects of socially constructed logics in relation to financial incentive and intrinsic motivation. We answer this call by investigating the social and cultural factors that influence the effect of pay-for-performance on prosocial motivation in a public healthcare context.

This paper begins with a description of the theoretical foundations followed by a section on the research context. Next, we describe our research design and explain the data collection and analysis techniques. Following this, we present the findings and discuss them with reference to the literature, and then identify the limitations of the study with ideas for future research. The final section sets out the conclusions drawn from the findings.

Theoretical background

Prosocial motivation as an important work characteristic in healthcare professionals

Public healthcare professionals are committed to caring for patients and the wider community; this type of commitment is generally known as public service motivation (PSM) or prosocial motivation. These two concepts are closely related and are sometimes used interchangeably (Perry et al., 2010, Perry and Hondeghem, 2008), although many scholars stress the need to differentiate between them in order to advance PSM theory as a separate area of study (Bozeman and Su, 2015; Steijn and Van der Voet, 2019; Schott et al., 2019). PSM can be defined as involving commitment to a particular community or group, whereas prosocial motivation is a more general motivational driver towards helping others (Wright et al., 2013; Moynihan et al., 2015) and is "the desire to positively affect the beneficiaries of one's work" (Grant, 2007, p. 403). For example, it can be argued that PSM is a quality that drives developers of public policy, while prosocial motivation is present in workers carrying out those policies (Steijn and Van der Voet, 2019).

Prosocial motivation is seen as an essential personal requirement for many types of healthcare work, especially where the aim is to help and improve the lives of the wider community (Rollnick et al., 2008). The sociology of healthcare reminds us that as well as the ethics and processes of healthcare, it is the employees themselves who convey the strong sense of altruistic and selfless behavior we associate with these services (Andersen, 2009). Research suggests that healthcare professionals are more likely to be motivated by altruism than their counterparts in other industries (Brock et al., 2016).

Theories vary as to the origins of prosocial motivation. Earle and Letherby (2008) point out that healthcare professionals may not be aware of possessing greater altruism

or generosity than employees in other fields, and suggest that the impetus to serve others is a common and unselfconscious trait in people attracted to vocational work. The authors also consider the role of modern medical training in shaping professional attitudes and contend that the social awareness components of medical education programmes may be an important generator of prosocial motivation. Thus, the desire to help patients even to the point of sacrificing their own well-being becomes part of healthcare professionals' behavior (Caldas et al., 2021). Certain practices and norms encourage healthcare workers to pursue prosocial behavior (Andersen, 2009); for instance, they are obliged to take care of the wider community and take decisions in the best interests of their patients (Currie et al., 2019). These institutionalized norms exist within the healthcare community as part of its professional culture (Janus, 2014), and since they are considered imperatives, any deviation may result in loss of authority, reputation, and withdrawal of public trust (Andersen, 2009; Hagstrom, 1975).

Motivation-crowding theory suggests that offering financial incentive as a way of improving healthcare employees' performance is likely to conflict with their prosocial motivation (Frey et al., 2013). It recommends therefore, that performance-based financial incentives should be discussed with due consideration given to the possibility of unintended negative effects (Lohmann et al., 2018).

However, despite these concerns about prosocial motivation, the use of monetary incentives in the public sector seems to be rising steadily, especially in developing countries (Bellé, 2015). Several countries in Africa and Asia, for example, have adopted performance-based financial incentives to improve work motivation and performance in public healthcare (Bertone et al., 2018; Singh et al., 2020; Ridde et al., 2018).

The impact of financial incentives on prosocial motivation

Motivation-crowding theory challenges the NPM philosophy of incentivizing public-sector employees with high-powered financial incentives, particularly in the healthcare industry (Frey et al., 2013; Weibel et al., 2010; Georgellis et al., 2011). It argues that financial incentives can be counterproductive and erode the prosocial motivation of public employees (Perry et al., 2009; Bellé, 2015). The theory proposes that extrinsic reward has two aspects, supportive and controlling, which determine outcomes. If workers perceive extrinsic reward as a form of control by the management, intrinsic motivation is crowded out as an unwanted side effect, while if they perceive it as a supportive move, intrinsic motivation is crowded in (Frey, 1997; Weibel et al., 2010; Frey et al., 2013; Fang et al., 2013).

Crowding out can negatively affect performance even though the economic theories do not predict it. For example, Ariely et al. (2009) argue that financial incentives do not work in charitable organizations because employees are not encouraged to think of money as a priority in charitable work. The introduction of performance-based financial incentives or paying volunteers in charities may signal that the personal relationship has been transformed into an economic arrangement and this could be counterproductive for such motivation. However, James (2005) notes that this observation is not relevant in the public and private sectors, where earnings and extrinsic reward are an inherent part of the employment structure.

Current research into the influence of performance-based pay on prosocial motivation is inconclusive (Gerhart and Fang, 2014; Lohmann et al., 2018; Shen et al., 2017). Some empirical studies move towards a more positive view of extrinsic reward, reporting the crowding-in effect of financial incentives in public administration jobs. Stazyk (2013), for example, found that PRP had a positive effect on public service

motivation in US local government. Drawing on cross-sectional data from a sample of managers, assistant managers and heads, he observed that performance-based financial incentives increased employees' existing feelings of job satisfaction. Stazyk further noted that financial incentives were particularly important for employees whose public service motivation was low to start with, and acknowledged that his findings differed from most of the previous research because of differences in research context and study design.

Liu and Tang (2011), researching in China, asked whether love of money moderates the relationship between motivation and job satisfaction among public employees, finding that individuals with a strong "love of money" enjoy a significantly better relationship between public service motivation and job satisfaction, thus supporting the crowding-in effect. However, they attribute this finding to the *steel rice bowl* mentality, which is rooted in the Chinese employment structure. Likewise, Duchoslav and Cecchi's (2019) recent study examines the response of healthcare employees to extrinsic rewards in healthcare organizations in Uganda. Using a unique panel of output and expenditure data from a small nonprofit healthcare facility, the authors found that employees responded positively to extrinsic reward, without any crowding out of their motivation to serve vulnerable patients.

In sum, the importance of prosocial behavior in public healthcare provision is clear (Brock et al., 2016; Caldas et al., 2021; Earle and Letherby, 2008), and the theory behind the crowding in or out of intrinsic motivation is well established (Frey and Jegen, 2001). However, the effects of financial incentive on employee motivation in public healthcare is open to debate, and recent empirical evidence of performance-based pay on prosocial motivation remains inconclusive (Duchoslav and Cecchi, 2019; Shen et al., 2017; Lohmann et al., 2018). Recently, public scholarship has begun to focus on the variables that alter the effect of financial incentives on prosocial behavior (Perry et al.,

2009; Bellé, 2015). Our study goes in this direction by providing one of the first empirical tests of this in the context of public administration research and theory. Thus, in this study, we develop an initial answer to the following research question: What effect do the perceptions of performance-based financial incentives have on the prosocial motivation of public healthcare professionals?

Incentives for physicians in the context of the Pakistani healthcare sector

Recent healthcare reform in Khyber Pakhtunkhwa (KP) province in Pakistan provided an ideal context for our inquiry. In 2013, the newly-elected provincial government embarked on a program of public reform, inspired by New Public Management, in which healthcare was prioritized. Changes to the employment structure were embodied in the Medical Teaching Institutions (MTI) Act of 2015 and were initially applied in the three major teaching hospitals in Peshawar (Lady Reading Hospital, Khyber Teaching Hospital and Hayatabad Medical Complex). The reforms were then to be rolled out to all hospitals in the province over a five-year period. One of the main changes was the introduction of a PRP scheme for physicians, a measure which arose out of the government's tendencies towards isomorphism, i.e. mimicking successful schemes from other countries, and was intended to improve performance. Along with PRP, there were fundamental changes to HR policies. including a radically revised performance management system for greater transparency and objectivity. The ward managers were actively involved in drafting the performance indicators, which became more transparent and objective and were broadly divided into clinical and general auditing. Clinical auditing included numbers of surgeries, methods, success rates and innovative techniques, while general auditing indicators included physician-patient relationships, absenteeism and continuing professional development. Although these measurements were undoubtedly valuable from a management point of view, there was some concern among the senior physicians

that the new auditing system would compromise their professional autonomy. No more than 30% of the staff could be included in the highest category, with 50% of the annual salary being the highest pay reward for exceptional performance. These evaluations translated into lump sum payments which were to be paid on top of the annual base pay.

Methods

Research design and data sources

This study is rooted in the phenomenological tradition of qualitative research that seeks to interpret phenomena in terms of the meanings that people attach to them in their local context and to learn the reasons why they feel as they do (Denzin and Lincoln, 2011). Our aim was to explore the perceptions and experiences of physicians on the introduction of a performance-based pay structure in the local hospitals. To this end, we drew on three different sources of qualitative data that provided detailed information about perceptions of new pay scheme (see Table 1).

Table 1 about here

The main data was gathered from a total of fifty-six interviews carried out in the three public teaching hospitals where the reforms were introduced. The interviewees were sixteen junior physicians, twenty-six senior physicians, eight ward managers and six private patients. The junior physicians we interviewed had no specialization. Senior physicians hold assistant, associate and full professorship roles in our case hospitals. Some of the senior professors also serve as ward managers and are in charge of their own 'unit'. All of the senior physicians we interviewed also ran their own separate private

medical practices outside of their public hospital work. All physicians, at junior and senior level, were asked generic questions about the MTI reforms followed by an invitation to give their perceptions of the performance-based pay scheme. Probing questions centered on specific topics such as the objectives of pay-for-performance in the hospitals, the importance of extrinsic reward, changes to work routines, what the healthcare profession meant to them, and perceptions of prosocial behavior, such as importance of doing good for their patients, desire to help patients, self-sacrifice for patients, commitment to caring for patients, positive impact on patients through work, relationship with patients and changes to routine medical practices (see Appendix for interview questions). Fifty-one of the interviewees were male and five were female. On average, the interviews lasted 60–90 minutes. A detailed breakdown of the sample is summarized in Table 2.

Table 2 about here

The second set of data was gathered from interviews with six private patients. These were carried out in the later stages of the research, in order to compare their views with those of the physicians on patient care and patient satisfaction within public and private healthcare. These discussions were intended to provide us with independent consumer views to counteract the possibility that we had obtained socially desirable responses from the healthcare professionals and strengthen validity. On average, the interviews with the private patients lasted half an hour.

Finally, we drew upon a range of secondary data sources. These comprised three different versions of MTI reform documents and the official government website. Gathering secondary data was very helpful to generate initial understanding of the

functioning of the performance-based incentive scheme. These secondary data sources also provided a richer context in which to understand and interpret the responses of the individual physicians.

The data from the physicians was collected January-March 2017. All of the interviews were semi-structured and administered by the first author. The interviews were conducted in wards, hospital cafes and the Dubgari Garden (an establishment where senior physicians conduct their private practices). Informed consent was obtained for all interviews, which were voice-recorded and later transcribed. In addition to the interviews, field notes were taken that were cross-checked with the informants immediately after their interviews.

Data analysis

The first author translated and transcribed all of the interviews. Our qualitative data analysis used the Straus and Corbin (1998) technique of open coding to identify concepts in the data and cluster them into categories. Specifically, we were looking for fragments of data with similar characteristics which could be grouped in such a way as to facilitate answering the research question. In the first stage we began to identify first-order codes in the transcript relating to how physicians see the performance pay scheme in the context of the hospitals and their prosocial attitude towards patients. In the next stage we clustered the first-order codes into theoretical categories through the process of axial coding (Strauss and Corbin, 1998). In this process we moved beyond descriptive statements, aiming to create conceptual connections between first-order codes. Then we connected the second-order themes with the literature, further refining the themes which began to emerge (Gioia et al., 2013). We let the categories and themes refine themselves until the relationship between them became clearer. The process was continued until we reached

a point of saturation where the process yielded no further insights.

Findings

In this study, we explored physicians' perceptions of a new performance-based pay scheme in three public tertiary hospitals in Peshawar, Pakistan. More specifically, we look at what the interviews revealed about pay-for-performance in relation to their prosocial motivation. Our findings indicate that the physicians in our study were highly prosocially motivated and that this motivation did not appear to be in danger of erosion by the introduction of a performance-based financial incentive. Our analysis indicates that the reasons for this were the ethical and vocational demands of the medical profession as well as the research participants' strong religious values. In this section, we discuss each of the factors that serve to maintain strong prosocial attitudes and behavior in the presence of financial incentive in our study. Figure 1 shows how we explored each of the main themes to substantiate the overall findings.

Figure 1 about here

The role of professional identity

During the interviews, the majority of the informants (46 out of 56) were very clear that their professional identities i.e., the nature of their professional belonging, was key to their motivation to help patients. Our data revealed that the physicians felt strong commitment to their professional code and, for this reason, a shift in pay structure towards pay-for-performance did not appear to undermine their prosocial attitudes towards work. The healthcare profession is characterized by the spirit of vocational work, as well as commitment to serving patients and the wider community. Medical codes of conduct and

professional ethics were found to be dominant motives for physicians to serve patients to the best of their ability.

Codes of conduct

Our analysis revealed that the informants behave according to two codes that influence and shape their motivation to help patients. The first code embodies the strict demands of professional and ethical conduct which is deeply rooted in the principles of healthcare and sets the standards of physician's implicit contract with society. These standards are deeply rooted in commitment, conditionality and relationships and demand that the interests of patients are placed above those of the physician in order to establish and meet high levels of competence and integrity. Physicians are committed not only to caring for patients, but also to improving their work performance and to accountability for their actions in all practices. These sentiments were illustrated by a young physician:

> "This field is all about motivation. We agree to strict ethical standards before entering the medical profession and we work under a certain code of conduct. We treat patients regardless of race and economic status...We have a specific and strict code of conduct to which we must adhere." (Junior physician, LRH)

Similarly, according to a senior gynecologist,

> "You see our profession is very different from others, there are rules and regulations under which we operate…the code of conduct is the spirit of this field and it helps us to make the best decisions on behalf of patients for their best interests" (Junior physician, KTH)

Second, many respondents emphasized that the medical field is itself intrinsically motivating. These physicians have developed their own "code of conduct" which goes beyond that required by the profession. In other words, physicians impose personal *ethical standards* on themselves in addition to their professional code of

practice. A general view was that they had joined the healthcare profession not solely to make a living, but to serve humanity; crucially, their own code of conduct also guided them to serve patients without focusing on financial or material return. One of the junior physicians illustrates this point:

> "Code of conduct is very important to our profession, but in addition to our professional code of conduct every physician has their own code of conduct as well…for example some physicians suggest there should not be any private practices while other suggest it's a legal practice." (Junior physician, LRH)

Similarly, a ward manager noted,

> "As far as professionalism is concerned, everyone has their own level. We have a professor who sees only twenty patients a day in his private clinic, since he feels that it would be unfair to them to squeeze in more than that. He could easily earn more money by seeing more patients, but it's about professionalism and our code of conduct" (Ward manager, KTH).

In sum, the medical profession works under a specific code of conduct which makes it different to other professions. The code is deeply rooted in the professionalism demanded by the healthcare context and guides physicians to carry out duties without compromising on quality and standards in patient healthcare.

Professional ethics

Our analysis revealed that the physicians are given comprehensive training in medical ethics, starting from the day they join medical school and lasting their entire professional career. Professional ethics is, thus, a foundational part of medical training. As well as ethics and conduct, there is an emphasis on altruism and obligation to society. In addition, during practical training on the wards, medical students learn how the code of conduct works by observing the senior physicians. One of the important points they are taught is

to treat all patients equally, whether rich or poor. These sentiments are illustrated in the following quotation by one informant of our study:

> "We are taught in medical college and trained in the ward about our professional attitude, how should we carry out our work professionally." (Junior physician, LRH)

Additionally, after medical students begin working, they continue to study moral philosophy and medical ethics as a part of continuing professional development (CPD) and postgraduate training. This further education helps them to understand that professionalism is not an inherent but rather an acquired quality. One of the senior ward managers highlighted the importance of professional ethics:

> "Further training is so important for our medical career, not only to keep up to date with recent developments in medicine, but also to learn about best medical practice to maintain high standards of healthcare for our patients." (Ward manager, LRH)

Similarly, a senior cardiologist noted,

> "We have been taught and trained about professionalism which guide us to conduct our professional duties. We have to engage in personal career development trainings that guides us throughout medical career." (Senior physician, KTH)

Our analysis further reveals that a number of the informants who ran private practices often waived the fee for those patients who really could not afford it, and in some cases, they also provided free medicines. The respondents saw this kind of action as representing their commitment to professional standards and norms. These norms develop over time via experience as well as through medical training and guide physicians to serve their patients without expecting in return. Consider, for example the comments of a senior

pediatrician who owned a private practice:

> "I conduct my private practice in Dubgari Garden, and sometimes I come across poor patients who cannot afford my fee. In such cases I ask them how much they can pay, then I charge accordingly. In some cases, I see them for free. I have been taught in my professional training not to reject patients simply because they are poor." (Senior physician, HMC)

This custom of charging according to income was corroborated by a private patient we interviewed:

> "I came to this private clinic because the quality of public healthcare isn't very good… I borrowed money from my cousin and travelled here from my village, and I have to stay in a hotel here with my son for at least few days. When I told the doctor that I'm a poor farmer on a low income, he waived the medical fees."

In our analysis of perceptions, we found that many of the senior physicians were confident that PRP did not affect their attitude to their patients. They attributed this to their professional ethics, which safeguard their altruistic motivation. One of the senior physicians expressed it like this:

> "No, I don't think that being paid for good performance kills either my inspiration or the motivation to help patients…the pay scheme rewards my work if I do it well or work hard, but it doesn't affect my attitude to my patients… for example, even if my colleagues earn more than me, I still do my job well, that's how I have been trained – to follow my work ethic." (Senior physician, LRH)

Similarly, an ENT specialist noted,

> "I don't see that my being paid for good performance has a negative effect on my motivation to help patients…We are professionals and are trained in the ethics of medical profession…This is a public hospital and mostly poor patients visit here, and to be honest, sometimes they can't afford a prescription charge so we help them out to best of our ability and provide them with free medicines that are supplied by medical representatives for promotional purposes." (Senior physician, LRH)

The physicians in our study had all been trained to treat patients equally, whatever their social or financial circumstances, and in some cases, those who worked in private practice did not charge the poorer patients. In sum, financially rewarding the physicians according to their performance did not necessarily undermine their existing prosocial attitudes towards patients. Instead, the values underlying their professional medical training and codes of conduct provided a very powerful motivation for physicians to maintain these attitudes and behaviors.

The role of religion

The second major theme that motivated the physicians to behave generously towards patients is the socially constructed logic of religion. Many respondents (39 out of 56) found religion a strong source of motivation to help their patients, especially the poorer ones, and the introduction of PRP in their employment structure was found to have no effect on their altruistic behavior. In analyzing the interviews, we identified the two key constructs of religious belief that encouraged prosocial motivation towards individuals and the wider community.

Inspiration from the teaching of Islam

The first construct is the Islamic ethics on the treatment of the poor. In the interviews, many of the participants said that Islamic teachings inspired and motivated them to help patients in need, and they said that they try to help the poor for the sake of God. They gave examples from the Quran and other Islamic teachings in which God and the Prophet Muhammad (peace be upon him) exhort us help our fellow human beings and promise that God will reward selfless behavior. Many of the participants said that they don't charge patients if it is clear that they are unable to afford the prescription fees and they were clear that religious as well as medical ethics were the reason for this practice. Consider for example, a quotation one of the juniors said:

> "Apart from our professional duty I try to help these people (especially poor patients), because our religion encourages us to help the poor…If somebody comes from my village, I always try to get them free medicines for the sake of God, and for that, God will reward me" (Junior physician, HMC).

The public hospitals in KP province charge nominal fees for prescriptions and tests, as might be expected. However, we found that one of the crucial differences between our study context and a western-based one is that here, it is normal for physicians to set up a collection among the staff to pay these charges for impoverished patients. In return, grateful patients offer their prayers. Physicians felt that this response to the needs of others reaches beyond the boundaries of professional duty and is stimulated by their firmly-rooted religious convictions. This is illustrated in the following quotation by one of participants:

> "To be honest there are many patients coming to the hospital who even cannot pay for their prescriptions and essential tests. In these situations,

> we and other staff members collect money for them and help them out as much as we can." (Senior physician, KTH)

The same spirit was also observed among other physicians working in private practice who did not charge patients with little means to pay the fees. They affirmed that aside from professional demands, their religion forbids them to refuse treatment to patients who struggle to pay. They pointed out that Islam teaches the importance of looking after the poor, and quoted verses from the Quran and Ahadith which promise that this behavior will be rewarded by God. One of the informants told us:

> "Sometimes I see patients who can't afford the fees, and I take them on for the sake of Allah…We get a lot of representatives from pharmaceutical companies coming to the ward to promote new drugs. They leave us a lot of free samples which I distribute to poorer patients" (Senior physician, LRH).

Similarly, according to a private patient whom we interviewed:

> "I am a poor man and work in a grocery store in the village. I know someone from the village who works as a technician in a private clinic, and he asked the physician there to see me free of charge…In the end, he not only waived the fee but he gave me some free medicine samples from the pharmaceutical company, and in return he asked me to pray for him."

To summarize, our study informants were motivated to help less affluent patients through the teachings of their religion. Islamic scripture clearly promises that those who help humanity are specially rewarded, and the physicians interviewed were all committed to following the requirements of their religion. These deep religious values render it unlikely that financial incentive would erode physicians' prosocial behavior.

Sadaqah (Charity)

The second aspect of Islamic practice which inspired our informants is *sadaqah*. *Sadaqah* is an important concept in Islam and means to give charity to the less affluent out of the goodness of one's heart. The goal is to help people in need, and to give *sadaqah* is highly preached and encouraged in Islam; for example, "Give *sadaqah* without delay, for it stands in the way of calamity" (Tirmidhi: 1887). Many verses in the Quran and Ahadith are devoted to the importance of *sadaqah*, which could be in the form a charitable act, charitable giving or donating money with an intention to please Allah. Our study informants highlighted the role of charity and reward in Islam and gave examples from Islamic scriptures. They indicate that *sadaqah* is the gateway to Jannah (paradise) and if one gives *sadaqah* to others, Allah will respond with rewards both in this world and on the Day of Judgment. A few of the respondents suggested that *sadaqah* guards against hell fire, and backed this up with references from the Quran and Ahadith. One of the informants noted:

> "There are many verses in the Quran about *sadaqah*, suggesting how much God loves those who regularly give it. For example, *sadaqah* will guard you against the fire (of hell), even if it be only with half a date-fruit given in charity, and if you cannot afford even that, you should at least say a good word" (Al-Bukhari and Muslim via a senior physician, LRH).

Our analysis revealed that most of the informants practiced *sadqah*. The senior physicians give it by attending poor patients in the private clinics without charge, treating them for the sake of Allah. Some of them even dedicate a full day to the poor in their private clinics because they consider it their obligation as *sadaqah*. Consider a quotation for example which illustrate how informants help the poor patients by practicing *sadaqah*:

> "I spare one day (Friday) in my clinic to see poor patients only for free. This is my practice of *sadaqah* and I do it for the sake of God" (Senior physician, HMC).

Similarly, according to a senior ENT specialist:

> "Professionally I can't refuse a patient because he is poor and can't afford my clinical charges, so I see him for the sake of God and consider it as *sadaqah*… One way or other the basic philosophy is helping others, especially the poor and needy" (Senior physician, KTH).

Islamic scripture plays an important role in shaping the prosocial attitudes of the healthcare professionals we interviewed, and the respondents regularly mentioned the Quran and Ahadith with regard to the practice of *sadaqah*. They were very clear that financial incentive would not undermine their motivation to act altruistically towards their patients because it was based on faith and strong religious values. In sum, strong religious values played an important part in encouraging physicians to maintain their prosocial motivation, despite the introduction of PRP into the employment structure.

Discussion

Healthcare organizations worldwide have often focused on manipulating extrinsic motivation in the form of performance-based financial incentives as a way of incentivizing better work performance, but without considering the crowding-out effect it might have on employees' prosocial behavior. However, in the context of Pakistani healthcare, our findings demonstrate that such crowding out is outweighed by the positive effects of professional ethics and religion on professional practice. According to Frey's motivation crowding theory, under certain conditions financial incentives do not always crowd out prosocial motivation (Frey, 1997). Our research indicates that in the presence of high professional standards and strong religious beliefs, performance-based financial

incentives did not crowd out the prosocial motivation of the physicians; instead, these conditions were key to supporting rather than diminishing such motivation. Our research participants were prosocially motivated to help poor patients by providing free medicines and collecting money for them, while the senior physicians in private practice often waived fees for patients who were struggling financially. In our study, *high professional standards* and *strong religious beliefs* were crucial to the maintenance of prosocial motivation. We can therefore contend that the physicians' high professional standards and strong religious beliefs did not allow the introduction of performance-based financial incentive to crows out their prosocial motivation.

Our findings are especially interesting because they conflict with much of the broader research on PRP in the public sector (Perry et al, 2009; Bellé, 2015), which concludes that PRP may harm prosocial motivation in public-sector organizations. We can offer two reasons why, in our case, financial incentive did not undermine prosocial behavior. First, the study participants' prosocial motivation was reinforced by their professional medical training and the norms and ethics of the medical profession, and second, it was further strengthened by their social, cultural, and religious commitment to the beliefs of Islam (c.f. Nalbandian and Edwards, 1983; Perry 1997; Houston and Cartwright 2007), in which helping the marginalized and poor is highly valued and respected. Together, these professional ethical and religious reasons for helping the vulnerable form an imperative part of physicians' work motivation, and they are trained both professionally and through religious teachings to serve patients regardless of faith, race or economic circumstances. It is interesting that our findings contradict Bellé's (2015) experimental study, which concluded that financial incentives crowd out intrinsic motivation in public employees. Bellé called for real-life qualitative research to validate his findings; however, our research demonstrates the emergence of a rather more complex

picture, in which financial incentive does not necessarily diminish prosocial motivation because the context is more powerful.

It is also interesting to note that there were no significant differences between the views expressed by the senior physicians and those of the junior staff, and that the research findings held true for the participants as a whole group, with no observable differences between them in terms of seniority or professional role. It is important to mention that in general, we found that the physicians welcomed the scheme, and found it supportive, as it provided the opportunity to increase earnings in the generally lower-paid public healthcare field. In feeling positive about having more control over their income, they were free to focus on patient welfare and in contributing to the organization making healthcare available to all individuals, rich or poor.

It is worth mentioning that from a methodological standpoint, to the best of our knowledge this is the first qualitative analysis that investigates the effect of financial-based incentives on prosocial motivation. Our contribution is particularly relevant in helping to fill the gap in public administration scholarship on PRP in public-sector organizations, which currently lacks substantive qualitative work. Indeed, the most recent systematic literature review of PRP in public-sector organizations shows that only 14% of studies adopt a qualitative methodology (Ahmad et al., 2024). We perceive a great need for robust qualitative research that yields clear theoretical and practical understanding of the motivational forces behind prosocial behaviour in public organizations.

The current study has some limitations, which suggest directions for future research. First, our study is limited to qualitative data from healthcare professionals and may be view as selection bias, and it could be argued that healthcare professionals are more motivated to serve their community than the average public-sector employee. Future

research could adopt a comparative approach in studying the effects of performance-based pay in other professions. Another future avenue is to test the research hypotheses on the effects of ethical standards in the medical profession and the role of religion as well as the PRP schemes on the work motivation and prosocial behavior in the similar context. Second, our data is confined to a limited sample within Pakistani public healthcare, which could be seen as preventing the generalization of our findings; on the other hand, we can argue that a naturalistic study such as ours should be judged more in terms of how usefully it can be replicated and developed in comparable contexts (Denzin and Lincoln, 2011). Thus, our findings can be generalized to other countries which share similar social structures and institutional dynamics. Third, the PRP scheme was introduced in 2015, and this study was conducted only two years later, in 2017. Such a short gap may not have allowed enough time for the full effects of the scheme to become apparent, and any attempt to claim definitive findings would be premature. With this in mind, it would be useful to conduct further research on work motivation and prosocial attitudes once the PRP system is more firmly embedded in the healthcare system. A comparison of the findings may then prove interesting. Fourth, our study is based on physicians own statements, which may have resulted in a high number of socially desirable responses (Jakobsen and Jensen, 2015). However, the trustworthiness of the findings has been tested by cross checking data from the physicians against data from a number of patients, in order to triangulate the findings.

It is important to note that this research into pay-for-performance was specifically designed to analyze its effect on prosocial motivation, rather than performance. However, we acknowledge that further research could usefully be carried out to explore in more detail the relationship between financial incentive, strong prosocial motivation (backed by contextual factors such as professional ethics and religious beliefs) and measurable

effects on work performance, with the goal of revealing useful theoretical and practical implications for public-sector policy.

Conclusions

Despite public administration scholars denouncing the use of financial incentive in the public sector on the grounds that it conflicts with the spirit of public service and erodes employees' sense of vocation, healthcare organizations across the globe continue to adopt performance-based financial incentive as part of New Public Management reforms or as independent policy aimed at inducing positive change in work performance. This study began with the research question: How do public healthcare professionals perceive pay-for-performance, and does it affect their prosocial motivation? Our research found that PRP had an overall crowding-in effect on the prosocial motivation of the physicians. Within our study context, the combination of high professional identity and ethical standards, along with a staunch faith-based approach allowed prosocial motivation to thrive. This finding by no means refutes or denies motivation-crowding theory, however, because the fundamentals of that theory lie in its discussion of the conditions of crowding out and crowding in. The argument that prosocial motivation is crowded out by external reward very much depends on employees' personal perceptions of their motivation, and this is central to Bruno S. Frey's motivation-crowding theory.

We suggest that, instead of debating whether monetary incentives are effective or whether crowding out exists, future research could refocus and pay greater attention to exploring how an effective incentive system could be formulated and implemented in healthcare. It would be particularly interesting to support the inclusion of contextual factors such as professional identity and socially constructed logics that may have a positive effect on prosocial behavior. Thus, more research in different contexts and

professions would help us to have a more nuanced understanding of the positive (supporting) effect of financial incentives on prosocial motivation.

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