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Giving and promising gifts: Experimental evidence on reciprocity from the field☆

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ABSTRACT

We test the value of unconditional non-monetary gifts as a way to improve health worker performance in a low income country health setting. We randomly assigned health workers to different gift treatments within a program that visited health workers, measured performance and encouraged them to provide high quality care for their patients. We show that unconditional non-monetary gifts improve performance by 20 percent over a six-week period, compared to the control group. We compare the impact of the unconditional gift to one in which a gift is offered conditional on meeting a performance target and show that only the unconditional gift results in a statistically significant improvement. This demonstrates that organizations can improve the performance of health workers in the medium term without using financial incentives.

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There is significant empirical evidence that unconditional payments can improve employee performance (Rigdon, 2002; Gneezy and List, 2006). As suggested by Akerlof (1982), gift exchange is one way to understand the relationship between wages and effort: employees may respond to a "gift" of unconditionally higher wages with a more than reciprocal level of effort. In addition, the gift exchange framework can be applied to non-monetary incentives that may also lead to significant improvements in performance, as has been shown in experimental studies. Importantly, non-monetary incentives might work better than money in signaling when effort should be independent of compensation (Heyman and Ariely, 2004; Gneezy and Rustichini, 2000). For example, subjects paid in candy (compared to cash) provide effort that is invariant to the rate (Heyman and Ariely, 2004) and subjects given a water bottle as a gift outperform those given cash of equal value (Kube et al., 2012). Even folding cash into origami outperforms pure cash in this setting. The fact that subjects in experimental settings might see non-monetary gifts as a signal that their effort is valued differently ties in with the literature on intrinsic motivation. Indeed, switching from non-monetary to monetary payments can decrease performance in some contexts (Gneezy and Rustichini, 2000) as compensation can crowd out intrinsic motivation.

In this paper we test the value of non-monetary unconditional gifts as a way to improve performance in a health care setting. We gave books to randomly selected clinicians working in outpatient settings in urban and peri-urban Tanzania and asked them to work harder. Their performance is compared to clinicians in the control group who were also asked to work harder, but were not given any compensation. Performance was evaluated over a period of approximately 10 weeks. We show significant improvements in performance for the clinicians who received the gift compared to

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clinicians who did not. Importantly, the gains we observe are still present after 10 weeks, demonstrating an important medium term effect from this simple intervention.

Our choice of health workers in a developing-country context was deliberate as this is a context in which gifts might serve a particularly important policy role. Health care in general is a setting in which effort is difficult for employers to observe (or for patients to evaluate) and almost impossible verify. In Tanzania, as in most developing country settings, a significant gap exists between effort provided by health workers and their capacity (Das et al., 2008; Maestad and Torsvik, 2008; Das and Hammer, 2007). Nonetheless, health workers in these settings are commonly described as being motivated by intrinsic rewards. The literature on health care is full of references to terms such as *professionalism*, *esteem*, and *caring* (Freidson, 1970; Mathauer and Imhoff, 2006; Lindelow and Serneels, 2006; Serra et al., 2011). Given that reliance on the prosocial instincts of health care workers has failed to assure quality and that most developing countries lack the institutional infrastructure to effectively regulate quality, attention has turned to other forms of motivation, particularly monetary incentives to provide specific inputs.[1] However, paying health workers to increase their workload is not the same thing as paying them to increase quality. Writing contracts based on quality is likely to be much more difficult. Thus, in such settings, gifts and bonuses may help to solve incentive problems that have otherwise proven difficult to address.

The main treatment in our study is giving subjects an unconditional gift. In this treatment, the gift was given at the same time as they were asked to work harder. In order to better understand the way the gift was received we used two additional types of gifts, randomly assigned among two additional treatment groups. A second group was told that they would be given a "gift" later, if their performance on the mentioned tasks improved. This treatment (which we call the prize) was not designed to test whether conditional prizes can work (there is significant literature to show that they can) but rather to see if the exact same "gift" worked better in a conditional or an unconditional setting. Because a conditional prize implies a follow up visit (to award the prize) and some feedback on performance (receipt of the prize would signal improved performance) we also used a follow up visit for the unconditional gift treatment. Thus the only differences between these two treatments were the timing of the gift (immediate or follow-up) and the conditionality of the gift. To further explore the role of timing, we also introduced a treatment in which the gift was given at the same time as the follow-up visit. This treatment did not include any feedback at the follow-up visit to avoid making the gift appear as if it was awarded as a prize. This treatment allows us to see if gifts are valuable because they are immediate, or if they are valuable because they are gifts. Importantly, we measured performance after the follow-up visit, which allows us to measure the impact on the delayed treatment category of having received the gift. In contrast, no explicit incentives were offered to the control group. Importantly, our study could still affect the control group as all subjects in the research study were enrolled, visited once by a clinician who observed their practice, visited later by a doctor who encouraged them to improve their performance and specifically asked to improve performance on a particular list of tasks. Each clinician was told that the research team would interview their patients over an extended period of time.[2]

Our results show significant improvements in performance compared to the control after receiving a gift, but no significant improvement in this first period when the gift was offered as a prize or when the clinician was told they would later receive the gift. For the delayed gift treatment, a significant improvement in performance occurs after the gift is finally awarded and is essentially identical in size to the improvement seen in the first period for the immediate gift treatment. By comparing performance on tasks that were part of the encouragement script (primed tasks) to performance on other tasks which were measured but never mentioned (un-primed tasks), we can show that there was no task shifting in any of the treatments: we observed improvements in both specified and unspecified tasks. Importantly, by using patient exit interviews to measure adherence—a measure we explicitly validate—we are able to observe clinician performance when the clinician does not know he or she is being observed.

Our work builds on the strands of literature that combine gift exchange, non-monetary incentives and duration effects. There are a few other studies that test the effectiveness of non-monetary incentives for motivating performance in the field. Kosfeld and Neckermann (2011) and Bradler et al. (2013) look at whether students hired to do a one-time data entry job perform better when put in a tournament situation, where winners get a non-pecuniary, publicly announced award (a card of recognition signed by a prestigious figure). Their work is based on the idea that awards are valuable to workers because they contribute to increased self-esteem and they distinguish the winner's status among his or her peers. In this one-shot setting, they do find positive and significant effects from symbolic awards. Bradler et al. (2013) even find increases in effort from an unconditional prize, though the response is less substantial. In both studies, the public nature of the award matters. However, these results are short term and it is not clear that this kind of incentive structure is sustainable or repeatable in a real workplace.

Ashraf et al. (2012) also study awards as non-monetary incentives in the health setting. Their field experiment in Zambia compares trainees' sales of condoms under monetary and non-monetary incentives. As in Kosfeld and Neckermann (2011) and Bradler et al. (2013), the non-monetary incentive used is an award that is publicly given out according to a tournament and conditional on performance. They find that only the subjects in the award treatment group perform significantly better than the baseline (where trainees are not paid). But while they can juxtapose the impact of monetary and non-monetary incentives between subjects, the non-monetary incentive involves at least 3 levels of potential motivation: social comparison and status value, the satisfaction of winning itself, and utility from competition. In our work, we attempt to more precisely identify the value of a gift by removing the social recognition and competition dimensions, which we do by offering an unconditional gift in two of the treatments, and awarding each participant's gift in private.

In a setting similar to ours, Currie et al. (2013) test whether a patient receives better care after giving a token (non-monetary) gift to a medical clinician. They also find that gifts increase effort and, interestingly, show that gifts can have implications for both the giver and for others as well. In their setting, gifts from one patient decreased the quality of care provided to other patients if the two patients were perceived by the clinician as unrelated. In our setting,

[1] There is evidence that direct incentives (pay for performance) and organizational incentives (supervision combined with institutionalized rewards or punishments) do lead to improved quantity of care. See Eichler and Levine (2009), for an extended discussion of pay for performance; and Meessen et al. (2006), Basinga et al. (2011), for early evidence of success.

[2] These activities are similar to activities carried out in hundreds of research projects that have been conducted in health care (Jamtvedt et al., 2003, 2006, 2013; Rowe et al., 2005). These meta-studies examine interventions that provide information to clinicians about better practices as well as varying degrees of follow-up, feedback and contact. They find that information alone does not improve performance, but that information combined with subsequent attention—similar to the intervention received by the control group—does improve performance in many studies.

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