Regulation by Incentives: Analytical Tools for a Very Local Approach. An Institutional Framework

Tommaso Vitale, T Emmeneger

Regulation by Incentives: Analytical Tools for a Very Local Approach. An Institutional Framework

Please quote as:
Vitale T., Emmeneger T., 2004, *Regulation by Incentives: Analytical Tools for a Very Local Approach. An Institutional Framework*. Report written for the Department of Health Service Provision – OSD, World Health Organization, Geneva.

Maybe you can be interested also in this paper:
Emmeneger T., Vitale T., 2005, *Effective Incentives in Critical Situations. Analysis and description of the functioning of the health care system, with a specific focus on how monetary and non-monetary incentives affect performance in two Eastern European countries (Serbia and Albania)*. Report wrote for The Department of Health Service Provision – OSD, World Health Organization, Geneva.

TO DOWNLOAD MY PAPERS: http://spire.sciences-po.fr
http://www.cee.sciences-po.fr/en/le-centre/research-team/258-tommaso-vitale.html

Contents

1. Main Debates about Regulation by Incentives

In this paper we introduce a theoretical and conceptual framework to analyse the role of monetary and non-monetary incentive schemes in the field of health services and their connections to human resources for health policies. The incentives that we will consider can be divided into four categories: (1) direct financial incentives; (2) indirect financial incentives; (3), non-financial incentives; (4) broader social incentives. Specifically, we stress the relevance of configurations that articulate different kinds of incentive conjointly from a bottom up and from a top down perspective.

The paper is divided into two main parts. In the first one we briefly analyse some of the main debates about regulation by incentives in local development policies. We focus on the relevance of a very local approach to configure incentives schemes. In the second part of the paper we introduce the Institutional Analysis and Development framework (IAD) to analyse the impact of a configuration of incentives on the functioning of the health care systems.

1.1 The Narrow View

It is interesting to note that the word "incentive" is never quoted in the monumental history of economic thought written by Schumpeter (1954). This may seem strange, especially in terms of the current economics debate where incentives play a central role. Schumpeter's omission is easily explained when you consider his statement that the main concern of economics' theorists was the theory of value in large economies. It can easily be argued that incentive theories emerge from the issue of division of labour and trade, and partly from distribution of work within the family (Laffont, Martimort, 2002: 1). The division of labour introduces the problem of delegation, hence the consideration about incentives, which can already be found in Adam Smith's (1776) famous thoughts about "sharecropping contracts" in agriculture. Sidgwick also dealt implicitly with the issue of incentives in 1883, examining the problems of redistribution. In firm theory, and management in particular, Chester Barnard in 1938 was the first to have a broad view of both monetary and non-monetary incentives.

In practice, however, the study of incentives developed explicitly and systematically from the second half of the 1950s. The initial concept was simple and assumed a high degree of *automatism*. The institution sets the framework for incentives and actors adapt their strategies to the institution's objectives. This can be defined as a narrow view of regulation by incentives. The "narrow" view of regulation by incentives assumes *rational actors* that are able to choose between alternative courses of action based on calculation. Therefore, it only considers pay incentives, without acknowledging even the potential role of non-pay incentives. Consequently, this narrow view considers one type with only three classes: (1) Financial Incentives; (2) Tax Incentives; (3) Real Incentives. Jorgenson was the economist who formalised this model using a well-known equation. This is a model that provides incentives for social investments. It was conceived in 1963, with a neoclassical framework. The expression shows the cost of using capital, whereby it would be advantageous for a company to invest until the increase in revenue equals the cost of additional investment.

This narrow view of regulation by incentives has several problems:

1. In the narrow view, the actor reacting to incentives is a Pavlovian actor with a behaviourist psychology, just like Pavlov's famous dog that salivated when subjected to a stimulus and reacted predictably, guided by the stimulus. Thus, the actor's behaviour is easily predictable and stereotyped.

2. In the narrow view, the context in which the actor operates is banal, where there is one or more incentives all having a consistent direction. This context does not provide the actor with more powerful or equal and contrasting stimuli. Therefore, the Pavlovian actor's calculations do not involve a check or deadlock situation due to contradictions.

3. The temporal context is not taken into account in the narrow view (there are long-term expectations not taken into account by the model).

These problems are closely connected with some assumptions of economic theory, namely that: (i) market problems are coordination problems and (ii) information is distributed symmetrically and is accessible to everyone. Given that coordination problems are information-related, point (ii) allows point (i) to be solved. Information is summarized as prices and the price system is the tool that allows coordination of individual expectations and interests.

1.2 The Agency Theory

Recently, the Agency Theory, or Principal/Agent Theory, has profoundly renewed the way in which regulation by incentives is considered. The Agency Theory is one of the most important theories in the current debate in economics. It has profoundly renewed microeconomics by placing information, and its role in the operation of a market economy, at the centre of its analytical framework, and in particular the *interests* of financial agents (Laffont, 2003). The Agency Theory has attracted some criticism, under points (i) and (ii), as a result of Akerlof's contributions (1984). As Barbera (forthcoming) clearly highlights, point (i) is modified based on the consideration that the problems a market economy must face include cooperation problems, namely that actors' interests do not converge and cannot be resolved by more information. That is, there are problems relating to motivation and to alignment of interests that are not attributable solely to information problems. As stated by Milgrom and Roberts (1994: 257): "(…) if individuals with significant information have different interests to those of decision-makers, they may not communicate their knowledge fully and accurately." The criticism of point (ii) also derives from this: information is not distributed symmetrically, at most each is better informed than the rest only about his/her own actual preferences, abilities and intentions. Consequently, this asymmetry has a decisive role in defining economic results.

Solutions proposed by the Agency Theory vary based on two different types of opportunism: the first is pre-contractual opportunism (*adverse selection*) and the second is post-contractual opportunism (*moral risk*).

1. Adverse selection is a problem of pre-contractual opportunism which arises on account of *private information* that clients have prior to stipulating a contract. In the case of adverse selection, therefore, the assumption is abandoned of an impersonal market – which is typical of a neoclassical model – whereby the characteristics of the population influence the result. In this case, the Agency Theory proposes two main solutions: signalling and auto-selection.

    a. In the case of signalling, the parties that have private information behave in such a way as to show the information they possess. As Filippo Barbera (2000) states, educational direction indicates individual productivity. It is assumed that productivity requires the same characteristics as good educational direction.

    b. Auto-selection relates instead to the activities undertaken by an informed party when they discover the other party's private information. For example, a company that wants a low turnover may select potential employees by offering a contract based on

a positive relationship between age and salary. Offering initially low salaries that increase with age will attract employees that intend or expect to remain in the company long-term (*ibidem*).

2. However, when facing a *moral risk* the basic problem would be: "(…) a form of post-contractual opportunism caused by the non-observability of certain actions, which allows the individuals charged with carrying them out to pursue their interests at the expense of the other party" (Milgrom and Roberts, 1994: 258).

    a. If *hidden information* was a problem in the case of adverse selection, here the problem is *hidden actions*.

    b. The Agency Theory suggests that hierarchical control is not a good solution for moral risk problems (too costly). It is often better to use *incentive contracts* that align the interests of the principal with those of the agent.

Therefore, the problem with the Agency Theory is balancing the benefits of incentives and the costs of the risk. However, the aim is always to have the principal's interests coincide with those of the agent by means of an appropriate incentive plan, using the agent's interest. Actors must be offered incentives to pursue a specific objective that would not otherwise be pursued without an incentive plan. But in order to achieve this, it would be sufficient to change the pay-off matrix so that the different interests can be aligned. The Agency Theory is applied primarily in the organizational field, in terms of designing efficient pay incentives, both in the relationship between owners and managers and managers and workers.

In keeping with a "natural" propensity to construct general analytical and deductive theories out of context, the Agency Theory was applied to the public regulation processes of the health service. In this case, the state is the Principal and the health service is the Agent. The objectives of the two actors are in opposition and, in the presence of the conditions described above, the Principal is exposed to the opportunism of the agent.

1.3 Is it Possible to Use Agency Theory in Health Sector Regulation?

The Agency Theory provides good heuristic tools in situations where the agent's opportunism is directed at a *private asset*, but the same does not apply when opportunism is directed at a *public asset*, the use of which cannot be denied. As Filippo Barbera (2000) rightly highlighted very clearly, public regulation of local development by means of incentives is almost always connected with the production of public goods (sometimes also of common pool resources), and this is certainly true in the case of health sector regulation. The state (Principal) has many Agents (healthcare organizations), the opportunism of which is the result of a collective action problem[1].

Therefore, many significant criticisms of the Agency Theory, principally by sociologists (Trigilia, 2002), do not relate solely to its *assumptions* (e.g. selfish and rational actors, Pavlovian actors, little consideration of the contradictory nature of the many incentives that are present in the situation, etc.), but also to its *scope conditions*. The Agency Theory may work where private assets are involved, but it is not very promising where public assets are concerned.

[1] As Elinor Ostrom *et al.* (2002: xiii) say: "a collective-action situation occurs whenever two or more individuals associate to produce something of value together, when it would be difficult to produce it alone. Collective-action problems occur when a lack of motivation, and/or missing or asymmetric information, generates incentives that prevent individuals from satisfactorily resolving a collective-action situation".

Does this mean that incentives have no part to play in the regulation of the health sector? Given the criticisms of the Agency Theory, some believe that it is not possible to conceive a regulatory model based on incentives for the production of public goods (Barbera, 2000). The reasons for a lack of confidence in *regulation by means of incentives* are based on the significant "perverse" effects that are triggered by incentives. The main perverse effects identified by Carlo Trigilia (1998, 1999) are:

1) The *waste* effect, which indicates that the same assumption would have been made without assistance.

2) The *replacement* effect, whereby the incentivized assumption replaces a non-incentivized assumption in another company.

3) The *habit* effect, whereby assumptions are made only on the basis of incentives.

4) The *selective* effect (or "*cream skimming* effect"), whereby only the most competitive people are employed.

We would add a fifth criticism:

5) The *automatic nature* of incentives, as they are often implemented in the health sector, which according to many commentators (and analysts), has prevented the nature of selective and targeted interventions.

However, from our point of view, the criticisms described above should not be generalized to apply to *all* regulation by means of incentives, but rather to the *way* in which it is implemented. In other words, regulation by means of incentives as is often used – particularly in the health sector – does not affect the institutional context, it is only concerned with reducing costs and does not increase the actors' ability to cooperate. In this case, introducing incentives in the health sector would only satisfy short-term political requirements.

Based on a statement made by Barbera (2000, 2001, forthcoming), we would like to demonstrate how an appropriate incentive plan is able to take into account the issues raised by Trigilia, namely the relationship with the *institutional* context and the problem of *cooperation* between actors (the dilemmas of collective action). This involves considering the problem of incentives from a different viewpoint than that of the Principal/Agent theory.

1.4 Steps to an Institutional Approach

Using a slogan, we could say that if incentives are not sufficient to regulate economic actions, then an additional regulation of *incentives* is required instead (Barbera, 2001). In other terms, incentives can only work with appropriate institutional conditions, including trust, social capital, interpersonal relations, rules and regulatory and cognitive resources. This "regulationist" theory has two variations (Barbera, 2000): the first states that incentives work well with given institutional conditions. Here institutions take on a role regulating individual interest and define - but do not replace - the structure of constraints and resources with which actors interact (e.g. the relationship between institutions and economic development in North). In this sense, "institutions provide the incentive structure of an economy and therefore the way they evolve shapes long-run economic performance. Institutions, composed of rules, norms of behaviour, and the way they are enforced, provide the opportunity set in an economy which determine the kinds of purposeful activity embodied in organizations (firms, trade unions, political bodies, and so forth)" (North, 1993: 242).

The second version is more radical and states that institutions replace incentives in the actors' plan of action. Here institutions play a *constituent* role in individual interests (Streeck, 1992). For supporters of this second hypothesis, institutions intervene "within an actor's mind" and modify motivational and cognitive components (de Leonardis, 2001). In this sense, providing a collective asset (such as healthcare) is not only a function of relevant public incentives, but rather of the legislative constraints that exist between the actors. Streeck's theory highlights two important points: (1) as in Granovetter (1985, 2002) and in the *new economic sociology* in general, the *economic effects* of *non-economic* motivations and situations come to light; (2) social resources must complement economic action, they must be in addition to calculation and not replace it (Barbera, forthcoming). However, the main point of current interest in Streeck's theory is that incentives only work with appropriate institutional constraints.

1.5 Collective Incentives

A particularly fruitful way of reformulating the main questions relating to the relationship between incentives and the institutional context (social capital / trust / social norms, etc.) is to consider that even if incentives are provided to individuals, they are never provided to atomized individuals, but rather to individuals who operate in organized groups (such as healthcare organizations). This consideration allows questions to be formulated relating to incentive plans that are able to favour monitoring and reciprocal sanctioning within a group.

However, we need to introduce a further distinction. In addition to acknowledging that individual incentives are aimed at individuals within groups, the relevance of *collective incentives* should also be considered, namely incentives that are a function of the interdependencies within a given group and which are capable of sustaining such interdependencies.

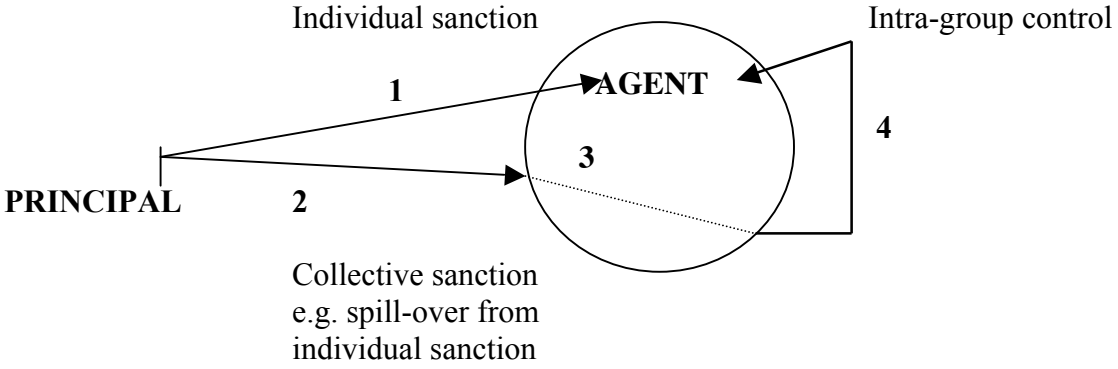
The main feature of collective incentives is that of internalizing the free-rider problem *within* the group, thus paving the way for effective solutions such as *peer monitoring* (Barbera 2002).

In order to examine the relationship between collective incentives and mechanisms that are internal to the free-rider control group (specifically social regulations), it should be underlined that *collective incentives* can have very different effects (Heckathorn, 1988):

1) They can encourage monitoring and reciprocal control, thus creating regulations internal to the group.

2) They can stimulate collusion, rebellion or deviations towards the external agent.

3) They can create resignation to punishment.



MULTI-AGENT GROUP

Figure 1. Adapted from Heckathorn, Broadhead, 1996, p. 239 and from Barbera, 2002, p. 239.

The arrow from the principal to the agent (1) shows the way in which the incentives issue is dealt with by the Agency theory. Individual incentives should align the interests of the agent with those of the principal, in the presence of information asymmetry. The broken line (3) stylises part of the sociological issues summarised above. Where there are strategic interaction problems (multi-agent group), \ and cognitive resources or institutional regulations provide a decisive contribution to processes that regulate the economy. The line that joins the principal to the group, favouring internal processes and control (2-3-4), summarises the theoretical direction proposed by Filippo Barbera (2002), namely that social resources are essential to initiate cooperative processes, but in turn can be stimulated by appropriate policies through collective incentives.

Filippo Barbera (2001) also highlights how the presence of a legitimate system of collective incentives produces within the group a regulatory interest in creating norms. Consequently, the regulatory/sanctioning system within the group is a "secondary dilemma". This is because the benefits of the system apply to the group as a whole, but creating and maintaining a system of regulations is an individual cost and therefore subject to free-riding (Barbera, forthcoming).

In concluding this first part, we believe that the considerations put forward justify maintaining the challenge of regulation by incentives. Indeed, using incentives makes the most of the actors in the context (they have the information about development possibilities and the local knowledge required to activate them) and reduces control costs top-down. At the same time, based on what has been discussed, the requirement to pay particular attention to the ways in which incentives are actually implemented emerges (Vitale, 2001). In order to do this a conceptual tool kit is required to support the analysis of incentive plan implementation processes. We will do this in the second part of the paper.

2. Rules and Incentives within Health Organizations

In the first part of this paper we established the need to find a framework capable of guiding the analysis of the empirical methods of *implementing* incentive plans in the health sector. From the conclusions in part I, we also saw the relevance of the collective dimension of healthcare organizations within which incentive programs are implemented. We stated that the incentive system within the group is a secondary problem (the appropriateness of opportunism) compared to the ways in which regulations are established within the collective. This results in an analytical problem: establishing the relevant classes of regulations to analyse the impact of incentives on groups.

2.1 Public Health and Local Development

In the first part of this paper, we witnessed how a significant part of the criticism expressed towards regulation by incentives is linked to the fact that such incentives are offered without regard to the specific context in which they would be given. In direct response to these criticisms, approaches to the problems of incentives have been specifically developed to take the individual contexts closely into account.

The choice of an approach which takes close account of the conditions in which incentive schemes are implemented *locally* is, nevertheless, fully coherent with the more general challenges

faced by health systems in Albania and Serbia-Montenegro. In both of these countries, the processes of democratic transition over the past 15 years (despite having come about in completely different forms) have provoked wide territorial disparities and inequalities in terms of access not only to health care, but also to other fundamental services. Albania, in particular, has experienced a polarisation of growth within a relatively narrow belt running between Tirana and Durres, together with the deterioration of significant parts of the rural areas (UNDP, 2002: 8). An analysis of the indices calculated at the national and regional levels demonstrates that there is a profound regional inequality in human development.

On the sanitary level, and despite indications of modest improvements since 1998 (including a fall in the infant mortality rate), Albania is still encountering many problems: a growing incidence of diseases, a deterioration in living conditions, the dilapidation of health structures, low quality of service delivery, and a lack of health specialists due to emigration UNDP, 2002: 25). However, the most fundamental problem faced by the health sector is the lack of financial resources. Although health spending has recently registered a slight increase, is still falls very much under the average European level (2.5% of GDP compared with 7.3% of GDP in 1999). In a chart of financial incentives for health professionals in countries of extreme poverty, Albania is shown to have 1.3 physicians for every 1,000 inhabitants, which is exiguous when compared to the 3 physicians per 1,000 inhabitants in the European Union, and to the 2.5 physicians per 1,000 in Eastern European countries.

Serbia and Albania are both shifting to new payment arrangements from a tradition of public-sector health delivery in which providers were paid by salary. The economic crises of these two countries and the consequent inflation have resulted in an erosion of the value of salaries. Under these circumstances, incentives are forced to collaborate or compete with the basic need for economic survival (Hicks, Adams 2000: 3).

The main problem in both countries is posed by the migration of competent health staff from the mountain areas to urban zones, and more generally, the emigration to other European countries. Moreover, the situation in Albania is exacerbated by the government's difficulty in initiating effective processes of decentralisation, thus rather favouring what the UNDP has come to define as "a centralised decentralisation" (UNDP 2002: 12-14).

Along with all of this, we are currently witnessing an uncontrolled growth of private practice in the health sector, mainly in Albania but to a lesser extent in Serbia. In recent years, macroeconomic restructuring has led to a greater role for the market allocation of resources, a greater role for the private sector in health care delivery, and also, a greater role for patient payments in health finance (Hicks, Adams 2000: 6). Private practice has often received impetus from a deterioration of public sector capacity, provoked in turn by low incomes in the health sector. Another phenomenon reported has been the formal or informal charging of patients for access to public facilities. The increasing privatisation of health care finance and delivery thus involves two different kinds of policy dilemmas: (1) the introduction of a market allocation mechanism (involving patient fees) often comes into conflict with the government's responsibility to guarantee access to medical services for the entire population; (2) the promotion of private sector delivery, which is usually concentrated in urban areas, may come into conflict with policies seeking to strengthen primary care and rural health systems.

Given this state of events, the local approach to health problems indeed becomes a vital necessity. In the specific case of Albania, several international organisations, and the UNDP in particular, continually insist on *local development*. Such insistence is made not only with regard to the health sector, but comprehensively as a new vision for the country's development. This vision

represents "first and foremost a novel mentality of government which is needed to meet this challenge, a mentality much more attune to local government and to the role of people in government than it has been in the past. Closely related to this is the need for a review of existing development strategies in order to accommodate the national objectives, together with work on selecting priorities for each region, calculating implementation costs and reorienting funding" (*ibidem*: 10). The overall problem therefore seems to be that of fostering autonomous processes of local health sector government, capable of mobilising all available resources be they local or provided by external donors, as a means to promote participative and purposeful intervention. In other words, in order for local health systems to work, a local and *participative* approach seems essential. Without such an approach, reducing territorial inequalities and encouraging innovative processes in the most disadvantaged areas remains an impossible task. Local development in these countries thus proves to be a fundamental necessity, and the only way to govern areas which are considered insignificant with respect to national dynamics and interests. In this sense, the term 'local development' is to be understood as it is often referred to in works on human development, that is to say, all the processes of integration between economic and social policies in a given territory with a view to improving social quality (Vitale, 2001).

2.2 The Social Quality of Public Health

It is worth dedicating a few words to the term 'social quality', a term which has come to acquire an ever more precise connotation in the European debate on local development processes. The basic definition of 'social quality' covers the following four conditions: (a) the existence of quality goods and services; (b) protection from social risks; (c) social cohesion; (d) the total commitment of one's capability to participate in society and in relevant public decisions, for the total population, that is, for each and every member of the community (Beck, van der Maesen, Walker, 1997; de Leonardis, Vitale, 2001). These four basic conditions immediately reveal the complexity of the concept of social quality. The concept regards the impact of politics, institutions and services on both individual and social welfare conditions, on both the availability of goods to meet the needs of individuals and the existence of power and resources for participation in public life, in discussions and debates concerning these goods and how they are to be allocated (Beck, van der Maesen, Walker, 1997: 297-309; de Leonardis, 2002). In other words, as in the case of health services, the parameter of social quality of local development suggests the maxim whereby "protection is effective if it means promotion" (de Leonardis, 2004). This implies that health policy is not intended to meet health *needs*, but rather to foster people's *capability* to choose and resolve to take care of their own well-being and in particular their health (*ibidem*).[2] This requires setting up mechanisms for health "co-production". What this means is that the social quality of local development is the result of processes of institutional change and institutional learning, wherein the interaction between the actors involved (health staff, but also patients) and the competent authorities becomes a continuous reciprocal exchange of top-down and bottom-up communication. This process of institutional learning may be defined as a 'sandwich', as a means to highlight the fact that social quality is the result of reciprocal convergence and feedback (de Leonardis, Vitale, 2001). Rather than basing itself on formal completed contracts, this 'sandwich' is built on the shared responsibility over common projects, a co-responsibility (or co-participation) leaving open the capacity for incremental learning (Vitale, 2004).

Therefore, social quality requires vital importance to be given to the analysis of how local development policies of health services are to be put into practice. Among the questions that need to be asked are which organisations and institutions will implement health policy, how the services are

[2] Following Amartya Sen (1992), the concept of "need" has acquired a passive connotation with respect to that of "capability". The prospect of positive freedom is closely linked to certain capabilities (e.g.: what a person can do) and not to the satisfaction of needs (i.e. what can be done for a person).

organised and act on a local level, what relations are established within and among the groups, what background habits and what practices are carried out by each one, and so on. Do these habits and practices play an active role in the encouragement of, for example, patronage, corruption and people's indifference towards their own health? Or, to the contrary, do they look towards generating 'empowerment', to redistributing and generalising capability of choice and action (Sen, 1988), participation and co-production of one's own health (de Leonardis, 2004)? In other words, in order to ascertain whether or not a given scheme of incentives could improve the actual quality of the outcomes (Hichs, Adams 2000: 13), it is necessary to look on the local level, that is, in the specifications of each individual health organisation (understood as a group with its own characteristics). At the same time, it is also at local level where innovations in the way of coordinating and mobilising actors can arise, with the additional effect of *multiplying* the resources and available capabilities.

The central position of the social quality of local development, with a view to addressing the problems of the Albanian and Serbian health systems, allows us to return to the primary thesis of this paper: in order to plan incentive schemes for health staff, health policy organisations and institutions need to be considered in their day to day activities, in the way they are organised and in the general practice that characterises them. Nevertheless, the consideration of the social quality of local development provides us with another point for reflection. The task of building generalised and impersonal trust together with forms of widespread responsibility is more than a mere problem of organisation for local health systems. Building a local context with widespread capabilities is not only an organisational problem, but is at the same time a form of incentive, capable in turn of motivating and of implicating health workers and officials in the significance and quality of their work. In other words, one of the main incentives, which can be offered to health staff, is to try to make local contexts work, rather than simply handing out financial incentives. As a matter of fact, making local contexts effective entails giving other health personnel a sense of belonging or participation. Furthermore, making local contexts work as discussed above implies a highly significant investment in the participation of the health workers: granting them an active role in risk management and decision making, as well as forming strategic objectives rather than mere opportunities, that is to say, involving the staff in the overall design of the dynamics of local development.

Given these preliminary indications, we have decided to outline an analytical framework with the following two capabilities: firstly, to take all observations of this paper into account and thus to focus attention on the local specifications, on the individual organisational contexts within which the incentive schemes are decided and implemented; and secondly, to value not only the financial incentives but also diverse types of non-monetary incentives, capable nonetheless of supporting the commitment of health staff to their particular area. In short, we may state that in order to define an analytical framework for our research, we have asked ourselves whether the knowledge of the context in which the incentives are implemented is as important as, if not more important than, the nature of the incentives themselves. As held by Hicks and Adams (2000: 12): "Incentives seldom exist in isolation, and the policy context in which they exist may be as important as the incentive itself in affecting behaviour".

This is a problem that obliges us to turn to the framework developed by the Workshop in Political Theory and Policy Analysis, under the direction of Elinor Ostrom and Michael McGinnis, i.e. the Institutional Analysis and Development framework (IAD). The IAD framework develops an extensive analytical vocabulary for the study of collective action dilemmas. In the IAD, collective action is central to the problem of incentive regulation. In institutional analysis, one uses the term "incentive" to refer to rewards and punishments that are perceived by individuals to be related to their actions and those of others: "the payments people receive or costs they have to pay, the respect

they earn from others, the acquisition of new skills or knowledge are all external stimuli that may induce more of some kinds of behaviour and less of other kinds" (Ostrom E. *et al.*, 2002: 6). The incentive structure that impacts a group is filtered by the set of regulations adopted by each group. The types of regulations are universal and their specification is infinitely varied, whereby it is only possible to study the differences between groups relationally, within a substantially structuralist approach.

2.3 The Institutional Analysis and Development Framework

The IAD was developed reflecting on two very different research programs: (1) common-pool resources, e.g. management of groundwater, irrigation systems, forestry resources and fisheries, typically by local groups (McGinnis 1999b); and (2) local public economies and public health services (McGinnis 1999a).

The research programs conducted by Workshop-affiliated scholars must be seen in the context of other studies of institutions as crucial links between political and economic phenomena. Institutional analysis initially began as a variant of public choice. In early works public choice was the preferred term used by the founders of the Workshop (e.g., Ostrom E., Ostrom V., 1971). Mitchell (1988) argues that the IAD framework differs from the other public choice tradition in its reliance on inductive empirical research rather than the development of formal models per se. Another major difference is that the work of Herbert Simon on public administration and on the cognitive limitations of human rationality had a major influence on institutional analysis. The following three points summarize aspects of institutional analysis that differentiate it from these other approaches to the study of institutions (McGinnis, 1999c).

1. No one institution or set of actors can be totally understood in isolation. Institutional analysts must consider the ways in which actor preferences are shaped by their institutional roles, which in turn result from processes in other arenas of choice. In this sense, all institutionalized interactions are instances of polycentric games (McGinnis, 2000). The essential defining characteristic of a polycentric policy system is one where "many officials and decision structures are assigned limited and relatively autonomous prerogatives to determine, enforce and alter legal relationships" (Ostrom V., 1999: 55). This implies the absence in a polycentric system of any simple one-to-one correspondence between categories of goods, property rights, and owner-bodies-organizational entities.

2. All successful organizations require effective procedures for monitoring and sanctioning. "This holds true even for small, homogeneous groups. Even groups with a strong sense of a shared community of understanding cannot neglect questions of monitoring the behaviour of individuals (both members and agents) and the sanctioning of rule violators" (McGinnis, 1999c: 5).

3. Co-production involves direct participation in the production of a collective good by those who will benefit from its production. This term denotes an alternative to the standard conceptualization of production and consumption as totally separate activities. In co-production, the quality of a good can be enhanced if consumers are directly involved in the production of that good. In regular production consumers and producers engage in simple exchange. This concept was originally developed in the study of neighbourhood security and other local public goods (Parks *et al.,* 1981; McGinnis, 1999b). It has subsequently been applied to sustainable development (Ostrom E., 1996; McGinnis, 1999a) and it has important implication in the health sector (Vitale, 2004).

The implications of institutions for individual behaviour and policy outcomes can best be understood by careful examination of particular empirical contexts, but such detailed analyses are most effective if they are informed by an overarching framework of analysis. The IAD framework provides a common set of concepts and analytical categories that can be applied to a broad array of empirical contexts. This framework elaborates upon the theoretical foundations of methodological individualism, and the components of this framework can be used to craft detailed models appropriate for different settings.

2.4 The Action Arena

The IAD framework highlights the importance of understanding the behaviour of actors as occurring within *action arena.* Whenever two or more individuals are faced with a set of potential actions that jointly produce outcomes, these individuals can be said to be in an action arena, as in team work within health organizations. The concept of action arena is currently used in different approach in social sciences to analyze and explain actions and mechanisms within both formal and informal institutional arrangements (Cefaï, 2002). In the IAD framework, apart from focusing only on one arena and taking the variables specifying the situation and the motivational and cognitive structure of an actor as given, this approach stresses two additional steps in the level of analysis (Ostrom, Gardner, Walker 1994). One step digs deeper and inquires into the factors that affect the structure of an action arena. From this vantage point, the action arena is viewed as a set of variables dependent upon other factors. These factors affecting the structure of an action arena include three clusters of variables: "(1) the rules used by participants to order their relationships, (2) the attributes of states of the world that are acted upon in these arenas, and (3) the structure of the more general community within which any particular arena is placed" (Ostrom E., Ostrom V., 2004: 116). The second step helps move outward from action arenas to consider methods for explaining complex structures that link sequential and simultaneous action arenas to one another (Ostrom, Walker, 1997). So, action situations are defined by different configurations of physical conditions, attributes of the community, and the rules-in-use, which are in turn differentiated among the operational, collective, and constitutional arenas of choice (typically referred to as levels of analysis). Institutional development refers to the ways institutional arrangements change, in interaction with changes in physical conditions, individual behaviour, and cultural understandings.

Figure 2. The IAD Framework

The IAD has allowed the explanation of various mechanisms that recur in diverse 'action situations', understood as dependent variables. The structure of all of these situations — and many more — can be described and analyzed by using a common set of variables or working parts: (1) the set of participants, (2) the specific positions to be filled by participants, (3) the potential outcomes, (4) the set of allowable actions and the function that maps actions into realized outcomes, (5) the control that an individual has in regard to this function, (6) the information available to participants about the structure of the action situation, and (7) the costs and benefits—which serve as incentives and deterrents—assigned to actions and outcomes (see Ostrom, Gardner, and Walker, 1994; Ostrom E., 1999a, forthcoming).

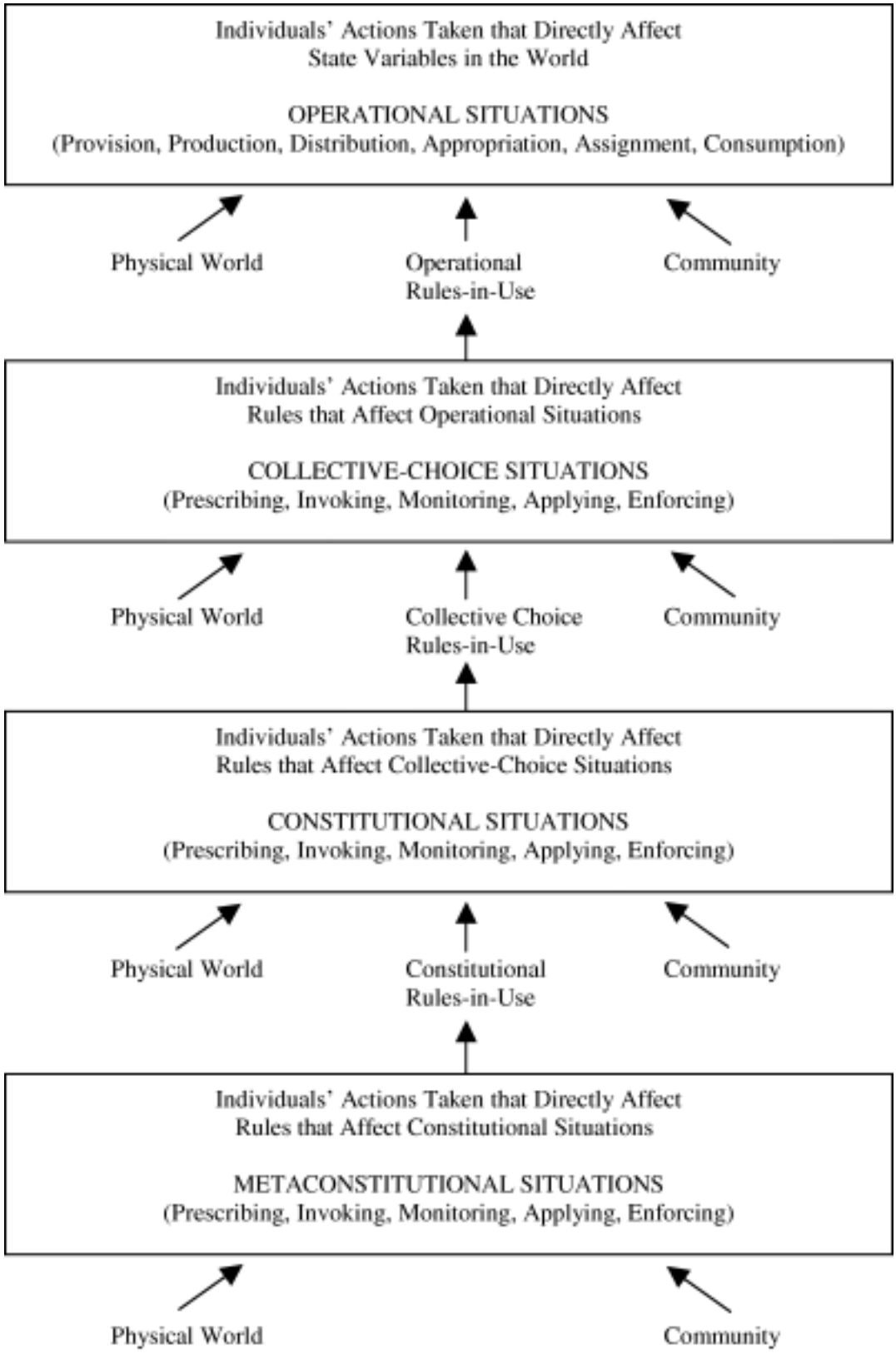
So, the IAD framework is an extensive body of political, social, and economic theory that focuses on the impact of diverse rules on the incentives, behaviour, and likely outcomes within different settings. It permits the undertaking of an analysis of how combinations of rules, the structure of the goods and technology involved, and culture interact to affect the incentives facing individuals and resulting patterns of interactions adopted by individuals. As Elinor Ostrom *et al.* (2002: xiii) say: "a successful approach to the problem of development must focus on how to generate appropriate

incentives so that the time, skill, knowledge, and genuine effort of multiple individuals are channelled in ways that produce jointly valued outcomes".

In the IAD these "individuals" are *fallible learners* (Ostrom V., 1987) that can, and often do, make mistakes. "Whether incentives encourage people to learn from these mistakes, or to continue to make the same mistakes forever, depends on the particular institutional settings. And, whether incentives encourage the adoption of a reputation for being reliable and trustworthy or the seeking out of short-term benefits without taking into account the effect on longer –term patterns of interaction, also depend largely on the rules structuring particular situations" (Ostrom *et al.*, 2002: 279).

2.5 The Normative Dimension of an Action Arena

The IAD categorizes rules into three analytical levels to determine influential variables. The three levels are constitutional, collective, and operational (see Figure 3). The constitutional-choice level rules determine the overarching rule environment (i.e., who has the power to make rules about the rules). It is a stage of "epistemic choice" (Ostrom V., 1993, de Leonardis 2001: 127-9; Ostrom E., Ostrom V. 2004: 133), where actors discuss criteria, vocabularies, of analyzing and judging and discovering new possibilities. The constitutional-choice level connects to the second level of rules (collective-choice) through the implementation of the constitution and its enforcement. The collective-choice rules create the decision-making environment within the organization. The third level of rules, operational-choice, governs the day-to-day operations of a health agency. Outcomes of operational-choice level decisions are goods produced or services delivered. Since services are delivered and goods are produced at the operational-level, it is this level where quality is ultimately determined (Bushouse, 1999). In the IAD framework, the levels of rules are nested (Ostrom E., 1999a). Nesting means that the rule decisions determined at one level create the rules-in-use at the next level. Thus, the operational choice level rules are nested within the collective-choice level rules, which are nested within the constitutional-choice level. The implication of this is that constitutional rules do have an impact at the operational-choice level. But, the impact of a constitutional-choice rule must first be understood in relation to its impact on collective-choice level rules before any conclusions can be drawn about its impact on outcomes at the operational choice level (Bushouse, 1999; Ostrom E., Ostrom V., 2004).



Source: E. Ostrom (1999: 60).

Figure 3. Different Levels of Action Situations

One of the reasons why we find the IAD framework particularly interesting is connected with the ways in which the normative dimension is conceptualized by institutions (Crawford, Ostrom, 1995):

(a) *Rules* are shared understandings among those involved that refer to enforced prescriptions about what actions (or states of the world) are *required*, *prohibited*, or *permitted*. All rules are the result of implicit or explicit efforts to achieve order and predictability among humans by creating classes of persons (positions) who are then required, permitted, or forbidden to take classes of actions in relation to required, permitted, or forbidden states of the world (Crawford, Ostrom 1995; Ostrom V., 1991).

(b) *Norms* are shared and internalized understandings by those involved about the "do's and don'ts" involved in particular types of situations. "In contrast to rules that are generally enforced, norms are usually not enforced in a regular way by designated agents. Individuals involved in situations with participants who do not follow group norms may gossip about each other and refuse to engage in reciprocity with those who break norms. When rules are accepted as norms in a community, someone who breaks a rule faces a high likelihood of receiving both formal sanctions as well as various forms of disapproval extended to them by others in the group" (Ostrom E. *et al.*, 2002: 5).

(c) *Strategies* are the plans for action that individuals make within a structure of incentives produced by rules, physical goods, and attributes of a community; "the consequent expectations that an individual has of the likely behaviour of others; and the perceptions of likely benefits or costs they may receive or pay in light of actions and outcomes" (*ibidem*).

Obviously, the regulations that apply in one situation do not provide in themselves an acceptable explanation of the structure of the "situation". As we have seen, socio-economic factors (the "attributes of a community"), as well as physical and material conditions, are important variables too. *Within* a particular action situation, individuals can only attempt to choose in light of their beliefs about the opportunities and constraints of that situation.

In a longer-run view, "individuals may be able to affect the structure of operational action situations in which they repeatedly find themselves by changing the rule configurations affecting the structure of these situations. To do so, they move up an analytical level to a "collective-choice" or "constitutional-choice" action situation where the outcomes generated are changes in the rules of lower-level action situations. If one wants to change the behaviour of individuals interacting in a situation, one method is to change one or more of these working parts. One way of beginning to understand this process is to ask about the rules that affect each of the working parts of an action situation" (Ostrom E., 2004: 4-5). These are displayed around the outside of the circle of Figure 4. It is, of course, possible to generate a particular action situation using a variety of rules, goods, and community attributes.

Figure 4. Source: Ostrom E., forthcoming

The task is to try to understand who the actors are, how they came to be in this situation, and the characteristics that they share (or do not share) that affect their perceptions of the situation and each other. In addition to understanding the actions they can take and how these are linked to outcomes, it is important to pay particular attention to the information available to actors (in terms of completeness and distribution) and to the benefits and costs assigned to different actions.

2.6 Linking Rules and Incentives

The IAD considers relational, organizational and process interdependence of great importance, but it does not identify any process variables. Each local situation can be analyzed

using the process variables that a researcher chooses to select from the social theory that s/he considers appropriate. There are no general process variables, otherwise the approach would become one big structural / functionalist theory. The IAD is an analytical framework and not an explanatory one. It provides direction on how to observe the impact of incentives on action situations by the configuration of classes of rules. In other words, it basically says that there is no correlation between a rule and collective performance. There are only very local configurations (hyper-local approach)[3]. It is the *configuration* of each group's rules that allows the group to perceive incentives in a different way. The aim of this analytical conceptualization is trying to understand the structure of the situation as viewed by the participants. All the structural working parts of a configuration enter into the perception of incentives by actors. It is the identification of the perceived incentives that leads the analyst to generate hypotheses about expected patterns of interactions and resulting outcomes (Ostrom E. *et al.*, 2002: 299).

One recent fundamental theoretical development of the IAD is the identification of the working parts of rules (Ostrom E., 2004; forthcoming). As Elinor Ostrom wrote, "until we develop an analytical scheme for identifying rules we are stuck with the unsatisfactory language of broad general institutional types such as markets, governments, and private property" (Ostrom E., 2004: 5). Ostrom clusters generic types of rules according to which component of an action situation the rule directly affects (a rule may affect other working parts of an action situation as a secondary effect). This leads to the identification of seven broad groupings of rules: position rules, boundary rules, authority rules, aggregation rules, scope rules, information rules, and payoff rules.

> *"Boundary rules* affect how individuals are assigned to or leave positions and how one situation is linked to other situations. *Authority rules* affect the assignment of particular action sets to positions. *Aggregation rules* affect the level of control that individual participants exercise at a linkage within or across situations. *Scope rules* affect which outcomes may, must, or must not be affected within a domain. *Information rules* affect the level of information available in a situation about actions and the link between actions and outcome linkages. *Payoff rules* affect the benefits and costs assigned to outcomes given the actions chosen. If a prescription is a rule rather than being a norm that individuals in the situation share, some payoff rule must exist that adds sanctioning costs when a rule is broken and the action situation is linked to a second situation involving the monitoring of rule conformance in the initial situation" (*ibidem*, 2004: 6).

In this framework, it is possible to see *how to affect the attributes of members* of an action situation through boundary rules, *how to affect the set of allowable actions* through creating position rules and through authority rules, while *outcomes are affected through* payoff rules and through changes in information, scope, and aggregation rules (Ostrom E., 1999b: 508-519). To better understand the classification of rules, we will follow the consideration of Ostrom E. *et al.* (2002: 291-293), as developed later by Elinor Ostrom (2004; forthcoming) to focus on a series of questions that are intended to help the analyst get at the rules-in-use that help structure a situation.

Boundary rules affect the number of actors, their attributes and resources, whether they can enter freely in the action situation, and the conditions they face for leaving. They are Entry and Exit rules and Positions rules. *Entry and Exit* rules affect the characteristics of the participants. Who are the users of the local health service? Are the users limited to local residents; to one group defined by ethnicity, race, caste, gender, or family structure; to those who win a lottery; to those who have obtained a permit; or in some other way limited to a class of individuals that is bounded? Is a new actor allowed to join a group by some kinds of entry fee or initiation? And what about the health

[3] The set of working rules is a configuration also in the sense that the effect of a change in one rule may depend upon the other rules-in-use (Ostrom, forthcoming).

workers (same kind of questions)? Position rules establish positions of participants in the action situation and differentially affect the capabilities and responsibilities of those participants in positions. A typical question is how does an actor move from being just a "member" of a group to someone who has a specialized task?

Authority rules assign sets of actions that actors in positions at particular nodes must, may, or may not take. Authority rules, combined with scientific cause and effect relationship of the world being acted upon, determine the shape of the decision tree – the action-outcome linkages. What understandings do users/workers have about mandatory, authorized, or forbidden health technologies? What choices do various types of monitors have related to the actions they can take?

Payoff rules affect the benefits and costs that will be assigned to particular combinations of actions and outcomes and establish the objective benefits and costs of action. These expected, objective benefits are perceived by actors as incentives or deterrents. Looking back at more than 30 years of research on common pool resources, three broad types of payoff rules are identified: (1) the imposition of a fine, (2) the loss of rights to access, and (3) incarceration. The severity of each of these types of sanctions can range from very low to very high and tends to start out on the low end of the scale. Boundary and authority rules also affect how easy or difficult it is to monitor activities and impose sanctions on rule infractions. How large are the sanctions that can be enforced for breaking any of the rules identified above? How is conformance to rules monitored? Who is responsible for sanctioning non-conformers? How reliably are sanctions enforced? Are there any positive rewards offered to appropriators for any actions they can take? (E.g., is someone who is an elected official relieved of labour duties?)

Information rules affect the knowledge-contingent information sets of actors, they affect the kind of information present or absent in a situation. Every health organization vary radically in regard to the mandatory information that they require. Many smaller and informal health unit rely entirely on a voluntary exchange of information and on mutual monitoring. Where the size of the health organization is larger, more and more requirements are added regarding the information that must be kept by health workers or their officials. A typical question is what information must be held secret and what information must be made public?

Scope rules delimit the potential outcomes that can be affected and working backwards, the actions linked to specific outcomes. In other words, scope rules affect the outcomes that are allowed, mandated, or forbidden. What understandings do the users and workers have about the authorized or forbidden functional domains? Do any maps exist showing who can do what? Are there understandings about interventions that are "off-limit"?

Aggregation rules affect the level of control that an actor in a position exercises in the selection of an action at a node. This means that aggregation rules affect how individual actions are transformed into final outcomes. Aggregation rules are used extensively in collective-choice processes and less extensively in operational settings, but one aggregation rule that is found in diverse systems is a requirement that health activities be done in teams. This increases the opportunity for mutual monitoring and affect the type of non-pay incentives that are relevant. What understandings exist concerning the rules affecting the choice of health activities? Must certain actions require permission from, or agreement of, others prior to taking the action?

AIM	Most General Verb	Type of Rule
Positions	To Hold	Position
Participants	To Enter or to Leave	Entry and exit

Actions	To Do	Authority
Control	To Jointly affect	Aggregation
Outcomes	To Occur	Scope
Information	To Send or to Receive	Information
Costs/Benefits	To Pay or to Receive	Payoff

Chart 1. Source: Ostrom E., forthcoming.

One problem is that many rules-in-use are not written down. Many of the rules-in-use are not even conceptualized by participants as rules. "In settings where the rules-in-use have evolved over long periods of time and are understood implicitly by participants, obtaining information about rules-in–use requires spending time in a site and learning how to ask non-threatening, context-specific questions about rule configurations" (Ostrom E. *et al.*, 2002: 293).

The direct relationships among rules and the components of an action situation is shown in Figure 4 as the set of arrows connecting rules to specific parts of an action situation. Obviously, the diagram in Figure 4 shows enormous complexity that cannot easily be supported in a single empirical study. However, at the same time, it seems to provide an overall view as to *how the incentive structure affects actors' strategies*.

Therefore, the essential point is that incentives do not align atomized and Pavlovian actors in a banal way. They work in directions that are similar (but never coincident) to those of the principal when they impact a collective where there is trust and reciprocity, and if the collective is able to intervene actively in its constituent rules. In addition, the incentives do not destroy the capacity for collective action, but rather they reinforce and support cooperation. Incentives will only produce results when all of these conditions have been met.

It is therefore possible to provide incentives using this approach, as long as there is a thorough understanding of the combination of rules being used in each specific context. One of the main messages of this approach is that it is not enough to shower money on an action situation.

2.7 Trust, Cooperation and Non-Pay Incentives

The approach we have described seems particularly useful and productive to analyze the regulation through incentives of healthcare organizations in countries having contradictory and paradoxical economic development. In this sense, the approach we chose for this paper is related to the types of countries in which the second stage of the research will be carried out: the empirical analysis of the healthcare systems in Serbia and Albania. The theoretical framework we have chosen shows the importance of closely analyzing the rules that are in force in each organization. Healthcare organizations are considered single action arena, each having its own specific rules. The IAD framework highlights how the cognitive method through which actors apply the incentive structure in an organization has a normative basis, that is a specific configuration of rules that govern the life of the group in question. The implementation of an incentive plan in a healthcare organization is perceived in different ways according to the configuration of rules that characterize the organization, as an action arena for individual workers. Before designing and implementing incentive plans from the top for a healthcare organization, the IAD framework reminds us that the regulations must be analyzed accurately, as individual incentives are not important in themselves, for their content, but rather for their configuration in relation to the structure of rules in the action situation that they will impact. In addition, the incentives of actors are shaped by institutional arrangements, and it is not always the case that the actors incorporate these incentives into their

goal structure in exactly the manner that the original designers intended. “Instead, individuals respond creatively to their changed circumstances, oftentimes creating consequences that may not have been foreseen by those involved in the design process” (McGinnis, 2003: 2).

In this sense, it is not possible to design incentive plans that are universally valid for all healthcare organizations, as each healthcare organization is a specific situation that reacts to incentives based on its specific structure of internal rules. This very local approach, far from discouraging investment in regulation through incentives, actually leads to attention being focused on individual beneficiary organizations and on the implementation process. At the same time, the connection between rules and incentives shows how it is not only financial incentives that allow the objectives of healthcare organizations to be directed. A basic requirement for healthcare organizations is to be characterized by a high level of trust, above all internally, but also in terms of the external context.

Particularly in contexts such as Eastern European countries, where healthcare operators are paid very low salaries and tend to emigrate to richer Western European countries, cooperation incentives are essential to enhance employee commitment through greater involvement at all levels. Therefore, it is important to understand how to be successful in creating an internal organizational environment that encourages cooperation among staff members to solve collective action problems.

It could be said that, instead of regulation by incentives, it would be sufficient to improve the control of governments, trying to oblige the commitment of health workers in a true Leviathan style. But we know that if the focus of government is too much on control, it crowds out investments in social capital and trust, it creates incentives to evade government regulations, and it is counter-productive in general (Ostrom V., 1997).

Similarly, it could be said that the preferable route is that of using financial incentives, both direct (with a higher level of pensions, or new insurances, or clothing / accommodation / travel / childcare allowance), or indirect (such as subsidized meals / clothing / accommodation / transport or childcare subsidies).

But neither of these options appears to be fully satisfactory. We are dealing with countries where health policies tend to be characterized by a marked difficulty in increasing health expenditure. Indeed, they tend to reduce health expenditure in favour of expanding a private market. In these contexts, rationalization and limiting waste and corruption are undoubtedly important and central, but they are typically not enough to find the necessary resources to provide substantial regulation through financial incentives. Therefore, in these contexts it is essential to involve the health operator in his/her organization. Regulation by non-financial incentives may encourage reciprocity and trust between colleagues, thus increasing cooperation. It may also encourage quality of work, by encouraging participation in the decision-making process within the organization and in some of the strategic objectives, but also by rotating functions and tasks, as well as flexibility of working hours and firmly rooting the healthcare institution within the territory (encouraging a closer link with local communities).

In addition, non-financial incentives include forms of support and incentives for teamwork, which are very important to maintain good levels of commitment and loyalty. And as Keser (2002) shows, voluntary teaming increases team effort with respect to enforced teaming. Axelrod (1984) defined reciprocity in terms of behaviour without reference to preferences: cooperation is reciprocated with cooperation and defection is reciprocated with defection. This implies that it is not only important to change the order of preferences of people within an organization, but to change the style of work to obtain trust. And this is a typical role for non-financial incentives. Non-

financial incentives could also sustain new management control strategies seek to involve the workers. Also task discretion does appear to be a significant factor for employees (Gallie, 2003). Finally, non-monetary incentives may support individual agencies, cooperation between operators (Tendler, 1997: 21-45), redefining roles and providing symbolic recognition (social status, social respect and self-respect), more intense trade and training activities.

Non-pay incentives are essential incentives, as they allow the creation of *non-consequentialist motivations* (Granovetter, 2002) and a kind of "serial equity" (Ouchi, 1980) that allows actors to continue cooperating, remaining in their positions even though it would be in their immediate interests not to do this and leave. As Filippo Barbera (2001: 447) reminds us, "In order to undertake cooperative processes, actors must have consideration as well as a lengthy orientation period. Actors must be able to *stop* rational calculation and act *as if* incentives were aligned and cooperation were always advantageous: "Trust begins (...) by acting *as if* we are trusting, at least until more stable convictions are formed on a more solid base" (Gambetta, 1989: 305)". It is this very connection between the normative aspect of health organizations and regulation through incentives, as we have seen, which is central to the IAD framework.

2.8 Regulation by Incentives and Outcomes Changing

In our judgement this is really a major analytical result. It permits to understand better if and how incentives could change health sector outcomes. The structural connection between normative aspect of health organizations and regulation by incentives help us to analyse feasible changing in health agencies. It is obviously rather difficult for change to come about, especially in critical situations where obstacles and habitual inertia make the problems impossible to solve and exacerbate the already chronic effects. In this sense, the desire for change is not enough: in fact, the framework we have chosen strongly reminds us that the *intention* of a single actor is not enough, nor even his or her *rationality* or *capability*. Just as change cannot come about by means of a pre-designed plan, well-defined objectives together with an appropriate calculation of the relationship between means and ends are not enough. As the IAD framework emphasizes above all else, it is necessary to be aware of the different set of rules, which characterises the context of local organisation. Resistance to change, linked to the rules that characterise the particular health authority, needs to be fully explored. Such resistance to change forms an integral part of collected and shared ways of understanding and of working. Moreover, these practices indeed enjoy a strong normative power: what is thought and done matches what must in fact be thought and done. This situation, which rests on a long-settled body of rules, often seems to be the only possible option, whereby resources always appear to be dramatically scarce, and one finds himself thinking only in terms of *what lacks* and not in terms of *potential actions* to bring change, improvement and learning (Hirschman, 1971). In this sense, change in health organisations is only possible where the situation and the common feeling with respect to the situation, rules and preferences are successfully turned around.

This is a very important hypothesis for National Regulative Health Agencies (especially for Health Ministers), but also for external donors offering pay and non-pay incentives to health organizations in Albania and in Yugoslavia. Also it is very important for donors to take into account the particular structure of rules of each health organization, before deciding how recurring to an incentives schema. Research literature using the IAD framework to analyse development cooperation (e. g.: Gibson *et al.*, forthcoming) clearly underlines the relevance for donors to provide incentives for organizational learning about the long term sustainability of workers commitment. Much of the literature on incentives in development assistance focuses on conditionality – that is, how aid can be used as a carrot and stick to modify recipient behaviour. This literature deals mainly with the relationship between the donor and recipient governments. Gibson *et al.* underline that

incentives in the context of aid are based more broadly and deeply. Against the underpinnings of this well-explored interpretation of aid as an incentive, they sustain the idea that the characteristics and modality of aid carry rule properties that, within specific configurations, take on particular institutional significance. They stress the main rule implications of different modalities of aid (grants, credits, and guarantees as well as tied-aid). And they note that "these rule properties interact with institutional realities faced by beneficiaries. Sustainable benefits from development assistance can emerge only when the structure of aid helps align incentives to extant problems of collective action" (Ostrom E. *et al.,* 2002: 89). So, a more explicit and systematic understanding of rules' configuration and the incentives that emerge within particular health organizational structures, "as well as mechanisms for transmitting this knowledge" (*ibidem*: 240), are therefore crucial to improve donor's mission effectiveness.

From the IAD framework, we understand that it is important to investigate if and how incentives are able to direct the inertia, which characterises and oppresses the health organisations in a different manner. Thanks to the IAD framework, we make the hypothesis that directing inertia can only be made possible through this joint work on the normative and cognitive structure of each single organisation. Strategic reasoning and intention is thus far from enough (Boltanski, 2002), and it is very necessary to give weight to the capacity to reflect and learn throughout the work (De Leonardis, 2002). To achieve this objective, again there are no recipes, but the preferences of the actors involved and their changes could be used as a means to spur the work. Integrating, relocating, and creating a plurality of contrasting experiences and viewpoints would also be extremely useful, without losing track of the need to produce tangible, visible results which can be shared by all, and which can provoke a change in perspective (both the situation and the way it is seen) by virtue of their very existence.

To briefly conclude we can summarize saying that the IAD framework directs our attention not only on the contents of an incentive scheme for health workers (e. g.: financial or non-financial motives), and not generically on the context where this scheme has to be implemented. It allows us "to put beneficiaries first": the tools of the IAD framework focus the analysis "on the institutional change that will be required to allow beneficiaries to overcome their collective-action problems and realize their own developmental potential" (Ostrom E. *et al.*, 2002: 250).

References:

Akerlof G. A., 1984, *An Economic Theorists Book of Tales: Essays that Entertain the Consequences of New Assumptions in Economic Theory*, Cambridge: Cambridge University Press.

Axelrod R., 1984, *The Evolution of Cooperation*, New York: Basic Books.

Barbera F., 2000, *Incentives, Institutions and the Regulation of the Economy*, paper presented at the ECSR Summer School "Integrating Sociological Theory and Research", Nuffield College, Oxford, September 2000.

Barbera F., 2001, "Le politiche della fiducia. Incentivi e risorse sociali nei Patti Territoriali", *Stato e mercato*, 3: 413-450.

Barbera F., 2002, "Così vicini, così lontani: una replica alla svolta culturale nello studio delle mafie", *Polis*, 1: 229-244.

Barbera F., Forthcoming, "Social Networks, Collective Action And Public Policy: The Embeddedness Idea Revisited", in S. Koniordos (ed.), *Networks, Social Capital and Trust: Theoretical and Empirical Application from Europe*, London: Ashgate.

Barnard C. I., 1938, *The Functions of the Executive*, Cambridge Mass.: Harvard University Press.

Beck W., van der Maesen L. J. G., Walker A. (eds), 1997, *The Social Quality of Europe*, The Hague: Kluwer Law.

Boltanski L., 2002, "Nécessité et justification", *Revue économique*, 53: 275-90.
Bushouse B. K., 1999, *The Missing Link: Collective-Choice Policymaking in Nonprofit, For-Profit, and Public Child Care Centers*, paper presented at the Workshop on the Workshop, June 10-12, 1999, Indiana University, Bloomington, Indiana.
Cefaï D., 2002, "Qu'est-ce qu'une arène publique? Quelques pistes dans une perspective pragmatiste", in D. Cefaï and I. Joseph (eds), *L'héritage du pragmatisme. Conflits d'urbanité et épreuves de civisme*, La Tour d'Aigues: Editions de l'Aube, 51-81.
Crawford S., Ostrom E., 1995, "A Grammar of Institutions", *American Political Science Review,* 89 (3): 582-600.
de Leonardis O., 2001, *Le istituzioni. Come e perché parlarne*, Roma: Carocci.
de Leonardis O., 2002, "Social Markets, Social Quality and the Quality of Social Institutions", in W. Beck *et al.* (eds), *Social Quality. A Vision for Europe*, The Hague: Kluwer Law, 178-204.
de Leonardis O., 2004, *Social Capital, Sociability and Health,* Position Paper, Rockfeller Foundation, Joint Learning Initiative on Human Resources for Health.
de Leonardis O., Vitale T., 2001, "Forme organizzative del terzo settore e qualità sociale", in M. La Rosa (ed.), *Le organizzazioni nel nuovo Welfare: l'approccio sociologico. Pubblico, privato sociale, cooperazione e non profit*, Rimini: Maggioli, 113-130 .
Gallie D., 2003, "The Quality of Working Life: Is Scandinavia Different?", *European Sociological Review*, 19 (1): 61-79.
Gambetta D. (ed.), 1989, *Trust: Making and Breaking Co-operative Relations*, Oxford: Basil Blackwell.
Gibson C., Ostrom E., Shivakumar S., Andersson K., Forthcoming, *The Samaritans' Dilemma: The Political Economy of Development Aid,* Oxford: Oxford University Press.
Granovetter M., 1985, "Economic Action and Social Structure: The Problem of Embeddedness", *American Journal of Sociology*, 91(3): 481-510.
Granovetter M., 2002, "A Theoretical Agenda for Economic Sociology", in M. Guillen *et al.* (eds.), *The New Economic Sociology*, New York: Russell Sage Foundation, 35-60.
Heckathorn D., 1988, "Collective Sanctions and the Creation of Prisoner's Dilemma Norms", *American Journal of Sociology*, 94 (3): 535-562.
Heckathorn D. D., Broadhead R. S., 1996, "Rational Choice, Public Policy and AIDS", *Rationality and Society*, 8 (3): 235-260.
Hicks V., Adams O., 2000, *The Effects of Economic and Policy Incentives on Provider Practice*, Issues in Health Services Delivery, Discussion Paper n. 5, Geneva: World Health Organization.
Hirshman A., 1971, *A Bias for Hope. Essays on Development and Latin America.* New Haven: Yale University Press.
Jorgenson D. W., 1963, "Capital Theory and Investment Behavior", *American Economic Review Proceedings*, 53: 247-259.
Keser C., 2002, "Cooperation in Public Goods Experiments", in F. Bolle and M. LehmannWaffenschmidt (eds), *Surveys in Experimental Economics: Bargaining, Cooperation, and Election Stock Markets*, Heidelberg: Physica-Verlag.
Laffont J.-J. (ed.), 2003, *The Principal Agent Model: the Economic Theory of Incentives*, Cheltenham; Northampton: Edward Elgar.
Laffont J.-J., Martimort D., 2002, *The Theory of Incentives : the Principal-Agent Model,* Princeton (N.J.) ; Princeton: Princeton University Press.
McGinnis M. D. (ed.), 1999a, *Polycentric Governance and Development: Readings from the Workshop in Political Theory and Policy Analysis,* Ann Arbor: University of Michigan Press.
McGinnis M. D. (ed.), 1999b, *Polycentricity and Local Public Economies*: *Readings from the Workshop in Political Theory and Policy Analysis,* Ann Arbor: University of Michigan Press.
McGinnis M. D., 1999c, *Institutional Analysis and the Future of the Workshop: Toward a Tocquevillean Synthesis of the Policy Sciences?*, paper presented at the Workshop on the

Workshop, June 10-12, 1999, Indiana University, Bloomington, Indiana.
McGinnis M. (ed.), 2000, *Polycentric Games and Institutions: Readings from the Workshop in Political Theory and Policy Analysis,* Ann Arbor: University of Michigan Press.
McGinnis M. D., 2003, *Varieties of Institutional Analysis: The DECIDERS Framework*, Working Paper, Workshop in Political Theory and Policy Analysis, Indiana University, http://mypage.iu.edu/~mcginnis/cider.doc
Milgrom P., Roberts J., *Economics, Organization and Management*, Englewood Cliffs, NJ : Prentice-Hall international (it. ed.: 1994, *Economia, Organizzazione e Management,* Bologna: il Mulino).
Mitchell W. C., 1988, "Virginia, Rochester, and Bloomington: Twenty-Five Years of Public Choice and Political Science", *Public Choice*, 56: 101-119.
North D. C., 1990, *Institutions, institutional change and economic performance*, Cambridge: Cambridge University Press (it. ed.: 1994, *Istituzioni, cambiamento istituzionale, evoluzione dell'economia,* Bologna: il Mulino).
Ostrom E., 1996, "Crossing the Great Divide: Coproduction, Synergy, and Development", *World Development*, 24: 73-87.
Ostrom E., 1999a, "Institutional Rational Choice: An Assessment of the Institutional Analysis and Development Framework", in P. Sabatier (ed.), *Theories of the Policy Process*, Boulder, CO: Westview Press, 35-71.
Ostrom E., 1999b, "Coping with Tragedies of the Commons", *Annual Review of Political Sciente,* 2: 493-535.
Ostrom E., 2004, *The Working Parts of Rules and How They May Evolve Over Time*, Papers on Economics and Evolution, n. 04/2004, Max Planck Institute for Research into Economic Systems, Evolutionary Economics Group.
Ostrom E., Forthcoming, *Understanding Institutional Diversity*, Princeton: Princeton University Press.
Ostrom E., Gardner R., Walker J., 1994, *Rules, Games, and Common-Pool Resources*, Ann Arbor: University of Michigan Press.
Ostrom E., Gibson C., Shivakumar S., Andersson K., 2002, *Aid, Incentives, and Sustainability. An Institutional Analysis of Development Cooperation,* Stockholm: SIDA.
Ostrom E., Ostrom V., 1971, "Public Choice: A Different Approach to the Study of Public Administration", *Public Administration Review*, 13: 203-16. Reprinted in M. McGinnis (ed.), 2000, *Polycentric Games and Institutions: Readings from the Workshop in Political Theory and Policy Analysis,* Ann Arbor: University of Michigan Press.
Ostrom E., Ostrom V., 2004, "The Quest for Meaning in Public Choice", *The American Journal of Economics and Sociology,* 63: 105-147.
Ostrom E., Walker J., 1997, "Neither Markets Nor States: Linking Transformation Processes in Collective Action Arenas", in D. Mueller (ed.), *Perspectives on Public Choice: A Handbook,* Cambridge: Cambridge University Press, 35-72.
Ostrom V., 1987, *The Political Theory of a Compound Republic: Designing the American Experiment*, Lincoln: University of Nebraska Press.
Ostrom V., 1991, The *Meaning of American Federalism: Constituting a Self-Governing Society,* San Francisco: Ics Press.
Ostrom V., 1993, "Epistemic Choice and Public Choice", *Public Choice,* 77: 163-76.
Ostrom V., 1997, *The Meaning of Democracy and the Vulnerability of Democracies: A Response to Tocqueville's Challenge*, Ann Arbor: University of Michigan Press.
Ostrom V., 1999, "Polycentricity", in M. McGinnis (ed.), *Polycentricity and Local Public Economies: Readings from the Workshop in Political Theory and Policy Analysis,* Ann Arbor: University of Michigan Press: 52-74/119-138.
Ouchi W., 1980, "Markets, Bureaucracies and Clans", *Administrative Science Quarterly*, 25: 129-41.

Parks R. B., Baker P., Kiser L., Oakerson R., Ostrom E., Ostrom V., Percy S., Vandivort M., Whitaker G., Wilson R., 1981, "Consumers as Coproducers of Public Services: Some Economic and Institutional Considerations", *Policy Studies Journal,* 9: 1001-11. Reprinted in M. McGinnis (ed.), 1999, *Polycentricity and Local Public Economies*: *Readings from the Workshop in Political Theory and Policy Analysis,* Ann Arbor: University of Michigan Press.

Schumpeter J. A., 1954, *History of economic analysis,* Oxford: Oxford University Press.

Sen A. K., 1988, "Freedom of Choice: Concept and Content", *European Economic Review*, 32: 269-294.

Sen A. K., 1992, *Inequality Reexamined*, Oxford: Oxford University Press.

Sidgwick H., 1883, *The Principles of Political Economy,* London: Macmillan.

Smith A., 1776, *An Inquiry into the Nature and Causes of the Wealth of Nations,* London: Strahan and Cadell.

Streeck W., 1992, "Productive Constraints: On the Institutional Conditions of Diversified Quality Production", in Id., *Social Institutions and Economic Performance*, London: Sage.

Tendler J., 1997, *Good Government in the Tropics*, Baltimore: The John Hopkins University Press.

Trigilia C., 1998, *Sociologia economica: Stato, mercato e società nel capitalismo moderno,* Bologna: il Mulino.

Trigilia C., 1999, "Capitale sociale e sviluppo locale", *Stato e mercato*, 57: 419-440.

Trigilia C., 2002, *Economic Sociology: State, Market, and Society in Modern Capitalism*, Oxford: Blackwell Publishers.

UNDP, 2002, *Challenges of Local Governance and Regional Development: The Albania National Human Development Report*, New York: UNDP.

Vitale T., 2001, "Politiche attive del lavoro e sviluppo dei mercati sociali: i dilemmi locali della regolazione pubblica", in C. Ranci (ed.) *Il mercato sociale dei servizi alla persona*, Roma: Carocci, 119-143.

Vitale T., 2004, *How Do You Build a Shared Interest? A Case of Social Innovation between Strategy and Organizational Learning*, paper at the session "Policy and Policy Outcomes", at the "Spring Conference", organised by the Workshop in Political Theory and Policy Analysis – Indiana University, Bloomington, May 1st – 3rd.