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Improving healthcare quality without financial incentives: peer effects in South Africa

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Low quality health care remains a significant issue in many low- and middle-income countries (LMICs) where health systems often lack incentives to improve. Many countries have experimented with results-based financing and pay-for-performance schemes, where healthcare providers receive financial rewards for better quality. But high costs and mixed effectiveness have limited the widespread use of these schemes. In high-income countries, provider competition for patients has been used to improve quality but this relies on having financial incentives for providers to attract more patients, on patients having access to information about quality, and on the costs of switching to be low - conditions that are rarely met in most LMICs.

However, evidence increasingly suggests that 'social incentives', including reputational concerns, can influence provider behaviour. Our research investigated whether healthcare facilities respond to changes in the quality of 'peer' facilities, even when there are no direct financial rewards for doing so.

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With data from over 2,300 primary health care (PHC) facilities in South Africa and using the phased implementation of a quality improvement programme, we examined whether facilities responded to quality improvements of 'peer' facilities i.e., those located nearby or within the same administrative district. We measured quality using indicators covering management practises, staffing, infrastructure, and service delivery processes. We found that PHC facilities do respond to the performance of their peers. On average, a 10-point increase in the quality score of peer facilities was associated with a 3.6-point improvement in a facility's own score.

So why do facilities improve if there's no money on the line? The quality scores were not publicly available but were visible to facilities and health authorities, allowing facilities to compare themselves against peers. Social incentives – such as intrinsic motivation to do a good job, or reputational concerns about how they are perceived by others – may be driving this behaviour.

These findings have important policy implications. They suggest that simply measuring and sharing performance information between providers could improve health care quality. Where financial resources are constrained, low-cost interventions such as public reporting of quality scores or peer benchmarking may offer a promising alternative to more complex and costly payment reforms. Additionally, if peer effects spread improvements, then traditional policy evaluations may underestimate the total benefit of quality improvement programmes.

Read the full paper, funding sources and disclaimers in Regional Science and Urban Economics.

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