

Incentives, Information, and Effective Governance in Healthcare Systems: The Role of Local Knowledge and Nonmonetary Incentives

Focus on the Primary Care Sector

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Healthcare systems worldwide face intensifying financial and operational pressures, compelling policymakers to enhance efficiency without undermining equity or quality. While reforms have traditionally emphasized financial incentives, market-based mechanisms and administrative controls, these approaches often overlook the crucial roles of intrinsic motivation, professional ethics, and local knowledge in shaping provider behavior and patient outcomes.

This thesis investigates how nonmonetary incentives and information dynamics influence governance and performance in healthcare, with a focus on the primary care sector. It adopts a conceptual, interdisciplinary approach that synthesises insights from economics, behavioral research, institutional and organizational theory, and health sciences to analyse how formal policies can better align with informal drivers of performance at the front lines of care.

A key contribution is the introduction of core healthcare services as 'tacit goods'—whose essential quality dimensions are difficult to observe and measure, and whose effective provision depends on trust, professional autonomy, and nonmonetary incentives such as intrinsic and prosocial motivation. The thesis also extends the concept of triple agency to examine how primary care providers navigate competing accountabilities to patients, payers, and provider organizations under resource constraints.

By integrating nonmonetary factors—such as intrinsic motivation, prosocial motivation, professional ethics, and social incentives—into the analysis of healthcare governance, the study offers a nuanced understanding of how to improve system efficiency and sustainability without over-reliance on financial incentives or top-down controls. The findings underscore that effective governance requires balancing monetary and nonmonetary incentives, empowering local knowledge and professional autonomy, and fostering trust within the system. By broadening the analysis of incentives in complex service environments, this perspective contributes to economic theory and offers policymakers practical insights for designing healthcare systems that are both efficient and resilient, grounded in motivation-sensitive and context-aware governance.

Key words: Healthcare governance, Primary care, Nonmonetary incentives, Tacit goods, Local knowledge, Institutional economics, Intrinsic motivation, Prosocial motivation

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1 Introduction

Healthcare systems worldwide face intensifying financial and operational pressures, driven by rising expenditures, constrained public budgets, and persistent workforce shortages—challenges further exacerbated by demographic shifts and the COVID-19 crisis. In developed countries, aging populations and commitments to universal health coverage place growing demands on public resources.¹ Policymakers must navigate increasingly complex trade-offs between fiscal sustainability, equitable access, service quality, and practitioner well-being—within tight fiscal, social, and political constraints. While expanding resources or reassessing public coverage remain important strategies, their long-term viability is limited. As a result, improving efficiency through more effective governance and incentive structures becomes an essential complementary strategy. (See e.g., OECD 2024a; 2024b)

Policy discourse and reform efforts have predominantly focused on financial levers—such as cost-control mechanisms—and market-based tools aimed at improving efficiency. Yet while these instruments remain important, they risk overlooking a critical set of drivers: intrinsic motivation, professional ethics, and social incentives. These nonmonetary factors profoundly shape provider behavior and patient outcomes, and—if harnessed effectively—can strengthen both quality and system efficiency. Their neglect, on the other hand, contributes to professional dissatisfaction, burnout, moral distress, and reduced autonomy—ultimately exacerbating workforce shortages and undermining care quality. Misaligned policies and excessive bureaucracy can erode clinicians’ ability to act in line with ethical commitments and local knowledge. In this light, a central question emerges: Could better integration of nonmonetary incentives enhance healthcare efficiency—without compromising equity, trust, or long-term sustainability?

Governments play a key role in ensuring equitable access, and maintaining public trust through oversight. Yet, fiscal constraints often hinder these efforts.² Many systems have responded with cost-control measures and market-based mechanisms to improve efficiency, but poorly designed economic incentives may prioritize cost-cutting over patient outcomes (see Goodair et al. 2024;

¹ On average, public funding through government schemes and mandatory health insurance account for 76% of health expenditures across OECD countries (OECD 2024a). The reliance on public funding stems from the presence of externalities (e.g., in public health and insurance market) and social goals (e.g. equal access), which also justify some form of universal health coverage provided by most OECD countries.

² While many governments are accountable to public for equitable access, they also maintain safety and competency of care through licensing, accreditation, and oversight. However, fiscal and political constraints can create inevitable trade-offs, as seen in some cost-containment or austerity policies.

Hart et al. 1997).³ Effective governance requires a balance between economic incentives, regulatory oversight, and institutional mechanisms that foster both efficiency and quality.

Beyond financial and regulatory mechanisms, intrinsic and prosocial motivations, professional ethics and social incentives influence provider behavior and the quality of care. Recent research highlights how nonmonetary incentives can shape healthcare efficiency and outcomes (Cassar & Meier 2018; Besley & Ghatak 2018; Ashraf & Bandiera 2018).⁴ Intrinsic motivation encompasses both self-regarding and other-regarding (social) aspects, and it is linked to job satisfaction. Prosocial motivations—which can be motivated both intrinsically and extrinsically—encourage providers to prioritize patient and societal well-being. Professional ethics are codified in formal self-regulatory frameworks but are also meant to be internalized by providers. Social incentives, arising from interactions with peers, patients and other actors, can reinforce ethical and efficient behavior through teamwork and reputational accountability. If harnessed effectively, these mechanisms can improve resource allocation, patient engagement, and service delivery.

Under fiscal constraints, universal health coverage increasingly functions as a common good—accessible to all, yet vulnerable to inefficiencies. Ostrom’s (1990) principles of commons governance, such as trust, cooperation and local monitoring, align well with the nonmonetary incentives. We could also say that these mechanisms aim to harness the ‘civil societal forces’. While the nonmonetary incentives is not analogous to civil society, it refers to the wide array of motivations and institutional mechanisms that can be seen as laying at the intersection between state, markets and civil society. Therefore, they can overlap and interact with government and market forces, sometimes complementing, substituting, or conflicting with them.⁵ Recognizing and strategically integrating these elements can enhance healthcare governance, while also reducing the unintended consequences of policy reforms.

Due to asymmetric and imperfect information, healthcare outcomes are difficult for patients to evaluate (Dulleck et al. 2011) and challenging to measure through standardized metrics (Propper &

³ Note that market-based mechanisms can be implemented both directly into public management practices and by incorporating private sector entities into the delivery of public services through forms of privatization or outsourcing. These practices are often broadly referred to as New Public Management (see, e.g., Ferlie 1996).

⁴ Nonmonetary incentives span a wide domain and overlap somewhat, but Cassar and Meier (2018) focus on intrinsic motivation, Besley and Ghatak (2018) on effects and sources of prosocial motivation, and Ashraf and Bandiera (2018) on social incentives. While intrinsic motivation can be relevant across sectors, social and ethical drivers are particularly critical in domains characterized by externalities and social objectives, such as in public services (e.g., health and education) and in green transition (on the latter, see Besley & Persson 2023a).

⁵ See Bowles and Carlin (2023) and Aghion et al. (2022, 303) for general discussion and presentation of some evidence.

Wilson 2012). Overreliance on market-based approaches may divert attention from qualitative aspects of care, leading to unintended consequences. Government oversight is necessary to maintain minimum standards, but when external demands clash with professional judgement, policies may undermine important incentives and knowledge that contribute to effective and high-quality care.

Moreover, important information is often scattered between patients and providers. Patients may hold experiential or hidden knowledge about their health risks, while providers bring clinical expertise needed to interpret and act on that information. This decentralized nature of local knowledge means that effective governance must support collaboration, trust, and professional autonomy at the point of care. Without such mechanisms, critical insights risk being underutilized—leading to inefficiencies and missed opportunities for better outcomes.

Furthermore, when governance fails to support such autonomy, the overuse of cost-control policies, financial incentives, and performance metrics can further erode provider morale. Recent evidence suggests that overreliance on these mechanisms diminishes professional autonomy and job satisfaction, contributing to burnout and moral distress (Buchbinder et al. 2024; Beadle et al. 2024), and ultimately exacerbating workforce shortages (Maunder et al. 2023).

Despite their importance, nonmonetary incentives remain underappreciated in policy design, often acknowledged only during wage negotiations or workforce crises. Yet growing evidence suggests that when effectively harnessed, these mechanisms can enhance system performance, support sustainability, and reinforce patient-centred care. Given the diverse effects of government, market, and social forces, identifying the optimal combination of motivations and institutional mechanisms is crucial for addressing health system pressures effectively.

1.1 Methodological Approach

This thesis adopts a conceptual and interdisciplinary approach to healthcare governance. It synthesizes insights from economics, health sciences, behavioral research, and institutional theory to analyse how nonmonetary incentives influence provider and patient behavior. Grounded in organizational and institutional economics, and informed by behavioral and informational theory, this approach offers a deeper understanding of the forces shaping care delivery. By rethinking governance not just as oversight and efficiency, but as the alignment of motivations, trust, and local expertise, the thesis provides an enriched perspective on how to strengthen healthcare systems without over-relying on financial incentives or administrative controls.

Given the complex, multi-layered nature of healthcare systems, this thesis adopts a structured, thematic approach to unpack how nonmonetary incentives and informational dynamics operate across different levels. Healthcare governance cannot be understood solely through top-down institutional design, nor through individual behavior alone; rather, it emerges from the interplay between the economic characteristics of healthcare services, the motivations of key actors, and the institutional contexts in which they operate. This structure enables exploration of how governance mechanisms can be better aligned with the social, ethical, and informational realities of healthcare.

The thesis proceeds thematically across three interconnected levels:

1. The nature of healthcare as a multidimensional economic good
2. The behavior, motivation and constraints of healthcare providers
3. The institutional design of governance structures in healthcare systems.

This layered framework supports a comprehensive examination of how formal and informal mechanisms—economic, ethical, and social—interact to shape outcomes related to efficiency, equity, and sustainability.

The analysis focuses particularly on primary care, a domain where health outcomes depend on the behavior and engagement of both providers and patients. Trust, local knowledge, prosocial motivation, and long-term relationships play a critical role in shaping decisions and outcomes. The quality of the patient–provider relationship is especially important, as it facilitates information sharing and deepens mutual understanding (Sabety 2023). These dynamics give rise to powerful—but often overlooked—incentives that, when effectively supported, can foster more resilient, sustainable, and patient-centred healthcare systems, shaped by the motivations of both providers and patients.

Parts of the drafting and editing process were supported by OpenAI’s ChatGPT, used to refine structure and language during the writing of this thesis. All ideas, interpretations, and conclusions remain the author’s own.

With this conceptual and methodological framework in place, the thesis makes three primary contributions.

1.2 Key Contributions of the Thesis

1. Conceptualizing healthcare as a “tacit good”: It introduces the notion of tacit goods to describe dimensions of healthcare quality that are inherently unmeasurable and rooted in trust, professional judgment, and contextual understanding—particularly in primary and mental healthcare.
2. Extending the framework of triple agency and moral distress: It develops the concept of triple agency to highlight the conflicting accountabilities healthcare providers face in fiscally constrained systems—and how these tensions can contribute to moral distress, inefficiency, and ethical strain in care delivery.
3. Integrating nonmonetary incentives into governance design: It synthesizes economic, behavioral, and institutional insights to propose a more nuanced governance model—one that values professional ethics, intrinsic motivation, and local knowledge as essential complements to financial incentives and performance metrics.

These contributions build on recent developments in institutional and behavioral economics, and frame a novel approach to understanding healthcare governance beyond traditional top-down or market-driven models. Together, these contributions provide a conceptual foundation for addressing the deeper motivational and informational challenges in healthcare governance.

As healthcare challenges intensify, policymakers should reconsider how to best support prosocial motivations, social incentives, and local expertise, and how to integrate them optimally into the effective governance of healthcare systems. As this thesis will demonstrate, the strategic recognition and integration of nonmonetary incentives may hold the key to more sustainable, efficient, and ethically grounded healthcare governance.

This inquiry is guided by two central research questions:

1. How do nonmonetary incentives and information influence healthcare efficiency, sustainability, and care quality?
2. How can these mechanisms be better integrated into the institutional design and governance of healthcare systems?

2 The Complex nature of Healthcare Systems: Goods, Institutions and Actors

To understand the complexities of healthcare organization, we must examine its peculiar characteristics and structural aspects. This chapter investigates the nature of healthcare goods and services, key players, and institutional frameworks, as well as the role of nonmonetary incentives in shaping healthcare outcomes.⁶

2.1 A Multidimensional Economic Good

Healthcare markets also depart from standard supply-and-demand models in fundamental ways. Inherent uncertainty, imperfect and asymmetric information, externalities, and social objectives all shape the behavior of market participants and necessitate the involvement of additional actors—such as governments, insurers, nonprofit organizations, and civil society. Unlike typical consumer markets, healthcare systems must address unpredictability in medical needs and costs, as well as the ethical imperative to provide equitable access.

While uncertainty creates the need for risk pooling through insurance, health insurance markets are prone to inefficiencies—such as moral hazard, adverse selection, and cost escalation. These market failures, combined with concerns for equity and quality, justify further intervention. As a result, healthcare systems rely not only on pricing mechanisms but also on regulatory structures, professional self-governance, and social norms to ensure balance between efficiency and social welfare.

At its core, healthcare begins as a private good; it is excludable and rivalrous by nature, especially in its individualized, personal care dimensions. However, due to market failures, ethical considerations, and public policy goals, many healthcare services take on additional characteristics that blur or override this baseline classification, operate at the intersection of multiple economic classifications (see table 1).

⁶ This thesis owes great debt to the seminal article by Arrow (1963) and the concise presentations by Mankiw (2017) and Andersen et al. (2007, 134-156).

Table 1. Healthcare as a multidimensional economic good.

Includes the category of “tacit good,” a term introduced in this thesis, building on both Polanyi’s (1966) concept of tacit knowledge and Milgrom & Holmström’s (1991) model of incentive distortions.⁷

Type of Good	Key Characteristics	Example in Healthcare	Governance Implication
Private Good	Excludable, rivalrous	Private services, elective care	Market mechanisms may function
Public Good	Non-excludable, non-rivalrous; risk of free-riding	Public health: herd immunity, sanitation	Requires public subsidy and/or regulation
Common Good	Non-excludable but rivalrous resources; risk of overuse	Universal insurance pool, antimicrobial resistance	Requires collective governance: state, market and civil society.
Merit Good	Normative value exceeds the market demand	Emergency care, basic health care	Supports publicly ensured universal health coverage
Credence Good	Asymmetric information; quality hard for consumers to assess; risk of hazardous care	Most of the healthcare services	Requires trust, oversight, professional ethics, and social incentives
Tacit Good	Imperfect information across tasks; quality hard to externally observe and measure; risk of suboptimal care	Primary care, preventive services, mental health, chronic care	Requires trust, nonmonetary incentives, and professional autonomy

These largely overlapping characteristics create unique governance challenges. The definitions of private, public, and common good belong under the same conceptual framework of approaching goods based on their accessibility and rivalry, and are technically exclusive.⁸ The rest, however, can overlap. The merit good captures the ethical dimension, and emphasises the social motivation for basic healthcare. The credence good falls under the family of goods defining how easy it is for the consumer to obtain information about the quality.⁹ The tacit good can be seen as extending this opacity to the provider side. Each of these dimensions—excluding private goods—and their governance implications are covered in their own sections.

Moreover, as discussed in the introduction, the relevant information is often dispersed between patients and providers, making effective collaboration essential. Patients may hold contextual or hidden knowledge about their health risks, while practitioners contribute clinical expertise and

⁷ For detailed discussion and justification of the “tacit good” classification, see Section 2.5.4. The term extends the measurement and multitasking problem from Milgrom & Holmström (1991) into a category of goods where the tension between measurable and non-measurable performance dimensions is structurally embedded.

⁸ While these are technically exclusive, the basic primary care—consisting of preventive and curative services—can embody elements of both public and common goods. In addition, there is also a fourth category, that of club goods, but it is not relevant for the discussion here.

⁹ Unlike search goods (where quality is evident before purchase) or experience goods (where quality is revealed after use), medical services function largely as credence goods, where the quality is hard to assess even after the purchase (see e.g., Dulleck et al. 2011).

judgment. Facilitating trust and information-sharing at the point of care ensures that this local knowledge is used effectively to improve outcomes.

These distinct economic features help explain why healthcare systems are complex, highly regulated, and shaped by a mix of monetary and nonmonetary incentives. The following sections will explore these dynamics further—beginning with the key market failures that necessitate institutional involvement, and then examining how governance structures and incentive systems interact in healthcare.

2.2 Collective Dimension: Public Goods and Externalities

External effects, or externalities, arise when the actions of individuals or groups impose spillover costs or benefits on others who are not directly involved in the activity. Externalities, positive or negative, are often associated with goods, services, and resources that possess non-excludable characteristics, meaning individuals or firms cannot be prevented from using or consuming them, even if they do not contribute to their provision.

Both public goods and common goods share this non-excludability, but they differ in rivalry. A classic example of a public good is national defence. If privately financed, it would suffer from free-riding, as individuals would benefit from protection without contributing financially. This positive externality would lead to underprovision in purely market-based system. Common goods, however, face the opposite challenge. Being rivalrous but non-excludable, they are prone to overuse, depletion, and negative externalities. They risk leading to what Hardin (1968) famously termed the "Tragedy of the Commons", where individuals, acting in self-interest, overconsume shared resources at the expense of long-term sustainability.

Since both issues stem from collective action failures, addressing these externalities requires intervention—whether through government policies, social norms, or alternative governance mechanisms. Without such safeguards, goods with positive externalities tend to be underprovided, while those with negative externalities are often overused or excessive produced.¹⁰

In healthcare, externalities are evident in public health and medical research. First, consider the production and diffusion of medical knowledge. Medical research generates positive externalities,

¹⁰ However, positive and negative externalities are often two sides of the same coin. Consider clean air (a public good) and air pollution (a public bad)—one generates positive spillovers, while the other imposes societal costs.

as its advancements often spill over beyond those directly funding or conducting it, benefiting the broader public. Similarly, public health campaigns function as a public goods, since once information is shared, it remains available for everyone, potentially producing societal benefits.

Another clear example is infectious diseases, where individual health choices affect others. The spread of diseases like COVID-19, represents negative externalities, imposing societal costs through increased infections, economic disruptions, and healthcare burdens. Conversely, public health measures like vaccinations and social distancing create positive externalities by reducing transmission and protecting the broader population. While the act of getting vaccinated is excludable, its broader impacts, such as herd immunity, has characteristics of public good.

Some aspects of public health function more like a common good—notably antimicrobial resistance. The overuse and misuse of antibiotics diminishes their effectiveness, creating a negative externality that accumulates over time. This dynamic risks triggering a "race to the bottom", where individuals and healthcare providers prioritize short-term benefits over long-term sustainability, ultimately increasing societal vulnerability to drug-resistant infections (Roope et al. 2019).¹¹

When physical, technological or legal constraints prevent the exclusion of affected or affecting parties, addressing externalities can become challenging or even impossible for private actors, as they may be unable to internalize the social costs or benefits of their actions.¹² Consequently, achieving an efficient allocation of goods and services that have significant social returns not captured in private returns often necessitates government intervention. This can take the form of taxes, subsidies, regulations, intellectual property rights, or even direct provision.

However, governments do not always have an advantage in dealing with externalities. In some cases, private actors can—and do—effectively address them. Firms can internalize certain spillovers profitably—such as investing in corporate wellness to reduce employee healthcare costs, indirectly benefiting society. Additionally, other private actors, such as nonprofits, social enterprises, or professionals, can help correct externalities when driven by prosocial motivations and a clear understanding of how to generate societal benefits (see Ashraf et al. 2014). Social norms

¹¹ While this subsection focuses primarily on public health, externalities also arise in other settings, including markets with contractual imperfections—where informational asymmetries create enforcement challenges that resemble non-excludability, such as in health insurance. These topics will be explored further.

¹² With public goods, private providers are often unable to internalize the returns, whereas with public bads, they may either be unable or simply choose not to, as externalizing the costs can be more profitable. Individuals, organizations, or countries may also strategically refrain from taking action, assuming others will free-ride on their efforts.

are also important. During the COVID-19 pandemic, some countries successfully mobilized civil society to encourage vaccination and social distancing, demonstrating how non-governmental efforts can complement or even substitute state intervention (Hong 2024; Schmelz 2021).¹³

Externalities are further shaped by informational challenges, which complicate efforts to address them effectively. For example, uncertainty and imperfect information affect the management of public health issues. Uncertainty regarding healthcare risks, costs, and benefits—combined with incomplete data collection and diagnostic limitations—makes it difficult to identify, measure, and address externalities. For example, the long-term societal costs of antimicrobial resistance remain difficult to quantify, track, and mitigate due to gaps in surveillance, limited understanding, and misaligned incentives (see Roope et al. 2019).

While some public health measures and medical knowledge can be made excludable, the same does not apply to their effects, which inevitably generate positive externalities. As a result, many governments play a crucial role in ensuring their efficient allocation and provision.

In contrast, personal healthcare is inherently different—both its provision and, to a large extent, its impacts are private and excludable. Nevertheless, due to market failures and social objectives, interventions in healthcare systems often push personal healthcare into non-excludable domains.

The following sections explore:

- How asymmetric and imperfect information shape healthcare markets.
- How social goals, such as universal access, strengthen the case for government intervention.
- How market-based solutions, bureaucratic mechanisms, and nonmonetary incentives can jointly address healthcare inefficiencies.

The next section examines insurance market failures, where hidden information allows individuals or firms to shift risks onto others. This results in contractual inefficiencies, particularly adverse selection and moral hazard, which threaten the stability of insurance markets. While regulatory measures, such as mandatory insurance, aim to correct these distortions, they also push personal healthcare towards a common good, introducing new coordination challenges. As a result,

¹³ Another example of how nonmonetary motivations can drive positive externalities is their role in advancing scientific progress, as discussed by Besley and Persson (2023b). In healthcare, vaccination research provides a timely example, where such motivations may complement government subsidies and market incentives.

addressing these imperfections requires more than just government intervention—it demands a mix of market forces, policy mechanisms, and nonmonetary incentives.¹⁴

2.3 Risk and Uncertainty: Insurance Market Imperfections, and Common Good

Insurance markets exist due to two fundamental factors: uncertainty and individuals' aversion to it. While society as a whole faces broad uncertainty—such as the unpredictability of infectious disease outbreaks—individuals also face personal uncertainty regarding their future medical needs and costs. This unpredictability, combined with widespread risk aversion, generates demand for mechanisms to pool and distribute these risks, giving rise to health insurance markets.

However, while all parties face imperfect information about health risks, individuals often hold an informational advantage over insurers. This asymmetric information can create contractual externalities, distorting optimal insurance provision. Two key drivers of these distortions are adverse selection and moral hazard.

2.3.1 Adverse Selection

Health insurance markets are particularly vulnerable to adverse selection, a problem that arises when individuals have private information about their own health risks that insurers cannot fully observe. In competitive insurance market, individuals with higher, hidden health risks are more likely to purchase insurance, especially when insurers cannot accurately price risk at the individual level. In response, insurers increase premiums to cover expected costs, leading to lower-risk individuals to opt out, thereby further concentrating risk among insurers.

Several mechanisms exist to mitigate adverse selection.

- **Market-based solutions:** Insurers can require medical screenings before issuing contracts, allowing them to assess risk more accurately and adjust their pricing. However, this can lead to categorical exclusion of individuals perceived to be high-risk—even when some may actually be low-risk due to imperfect screening processes. Besides, individuals who are willing to pay higher premiums may still be excluded. This represents a contractual

¹⁴ Addressing governance failures in healthcare is further complicated by the fact that motivations vary across individuals—and may themselves be shaped by institutional context. This complexity is discussed in detail in later chapters.

externality, making it difficult for a competitive market to achieve an optimal insurance. (See e.g., Einav & Finkelstein 2011; Rothschild & Stiglitz 1976.)¹⁵

- Government interventions: To address this market failure and its ethical concerns, policymakers often introduce mandatory insurance requirements, ensuring participation from both low-risk and high-risk individuals. By preventing insurers from facing extreme risk concentration, this stabilizes premiums and promotes broader risk-sharing.

However, because not all individuals can afford private insurance, mandates alone are insufficient to achieve full coverage, typically requiring public subsidies or funding mechanisms. While personal healthcare is traditionally considered a private good (both rivalrous and excludable) mandatory insurance shifts it towards a common good by creating a shared financial risk pool that must be sustainably managed. This is further reinforced by the introduction of public funding and universal coverage. These dynamics will resurface at the end of this chapter.

2.3.2 Moral Hazard

A second major issue in health insurance markets—also driven by asymmetric information—is moral hazard. Once insured, individuals may reduce precautionary behaviours or overuse healthcare services, knowing that the financial burden is externalized to the insurer. Thus, insured individuals may visit doctors for minor ailments or opt for more expensive procedures than necessary.

While both adverse selection and moral hazard arise from asymmetric information, their effects differ:

- Adverse selection distorts who gets insured (sorting issue)
- Moral hazard distorts behavior after insurance is obtained (incentive issue).

Although market-mechanisms and government interventions can help mitigate adverse selection, moral hazard presents a more complex challenge. Several mechanisms are used to mitigate moral hazard, though each comes with trade-offs:

¹⁵ This dynamic resembles the externalities associated with public goods, where exclusion is either physically or legally impossible. In health insurance markets, the challenge is not strict non-excludability, but rather the difficulty of accurately identifying the risk levels, making insurers unable to optimally exclude those high-cost individuals who are unwilling to pay higher premiums.

- **Cost-Sharing Mechanisms:** Insurers impose co-pays, deductibles, or coverage limits to encourage patients to encourage responsible healthcare consumption. However, these mechanisms also create another contractual externality, increasing out-of-pocket costs for all policyholders, including those who would not have engaged in opportunistic behavior.
- **Healthcare professionals as gatekeepers:** Professionals, such as primary care providers, often serve as decision-makers regarding treatment necessity, acting as controlling agents for insurers. However, this is neither without complications, as physicians may face conflicting incentives between patient advocacy, fiscal pressures, and organizational incentives.¹⁶

Beyond financial mechanisms, nonmonetary motivations and social incentives can play a role in reducing moral hazard.

- **Social norms:** Cultural expectations can influence health-seeking behavior, potentially discouraging unnecessary consumption of medical resources (Dufwenberg 2001).
- **Patient-provider relationships:** Healthcare practitioners can also reduce overuse by guiding patients toward necessary, rather than excessive, treatments and more responsible behaviours—effects which are reinforced by trusting, long term-relationships, and provider’s prosocial behavior.¹⁷

Nevertheless, informational asymmetries in healthcare extend beyond insurance markets. The difficulty of monitoring healthcare quality creates further distortions, potentially enabling providers to act opportunistically in the absence of oversight or accountability. This type of moral hazard occurs, when providers, such as physicians and hospitals, insulated from direct financial consequences, may overprescribe treatments, recommend unnecessary tests, or perform high-cost procedures that increase revenue without necessarily improving patient outcomes. However, before exploring these and other related issues (section 2.5), we focus on the universal health coverage.

¹⁶ This is further reinforced by the fact that practitioners may not be under adequate oversight—aspect which may be more pronounced in domains of primary care, as they are arguably less closely monitored than specialties like surgery. These elements are further explored in the coming sections.

¹⁷ This mechanism is likely most potential for the relationship between the patient and primary care provider, where the continuous relationships are the expected norm. Although implicative, Casalino et al. (2024) accounts how patients of physicians with greater social preferences, tend to be healthier and spend less resources.

2.3.3 Universal Insurance: Economic Rationales and Its Role as a Common Good

Universal health insurance emerges as a systemic solution to the challenge of adverse selection in voluntary insurance markets. While moral hazard becomes a central concern after coverage is in place, adverse selection is the primary market failure that universal insurance seeks to overcome. Economically, it functions by mandating broad participation, thereby stabilizing insurance risk pools and preventing market unravelling. By including low-risk individuals in the same pool as high-risk ones, universal insurance ensures financial sustainability through collective risk-sharing.

Conceptually, universal insurance can also be understood as a common good. It is intended to be accessible to all, yet—like other common-pool resources—it is vulnerable to overuse and inefficiency if poorly governed. Effective systems must be designed with mechanisms for equitable access, cost control, and quality assurance to avoid resource strain or service deterioration.

Although countries vary in how they implement universal insurance, the underlying rationale—managing collective risk through mandatory participation and redistribution—remains consistent among high-income nations. In many cases, this approach is not only grounded in economic reasoning, but also reflects a deeper societal commitment to healthcare as a basic right. This normative foundation helps explain the broad public support for universal systems, particularly in high-income countries. These aspects are explored further in the following section (2.4).

In addition to adverse selection, other economic considerations further justify extending the scope of coverage. Once a society commits to providing life-saving care regardless of ability to pay, there emerges a strong incentive to extend the insurance. Uninsured individuals may rely on emergency care or safety-net systems, which are costly and inefficient—an externality often described as the Samaritan's Dilemma (see Buchanan 1975). Individuals may also underuse valuable healthcare services due to cognitive biases, uncertainty, or poor information—a phenomenon known as behavioral hazard (Baicker et al. 2015). In this context, extended and effective insurance can improve efficiency not just by protecting against catastrophic costs, but also by encouraging the timely use of beneficial care, such as primary and preventive services. These additional considerations reinforce the economic logic for designing universal insurance systems that emphasize early access, broad participation, and institutional efficiency. (See also Baicker et al. 2023.)

Importantly, not all countries have pursued access through formal insurance schemes. While many rely on compulsory insurance, others ensure access through general taxation and public service

provision. These institutional differences reflect varied political ideologies, administrative traditions, and welfare state models.

To capture this broader landscape, this thesis adopts the term universal health coverage (UHC) as a more inclusive concept. UHC encompasses both insurance-based and tax-funded systems, unified by a common goal: to ensure equitable, comprehensive access to essential healthcare services without financial hardship. The normative dimensions of this commitment are examined in the following section, which also explores how different countries have institutionalized universal coverage through varied governance models.

2.4 Equity and obligation: Merit Good, and Universal Health Coverage

Beyond the technical justifications for universal health coverage lies a deeper normative commitment: the idea that healthcare is a basic human right. This section explores healthcare as a merit good and analyses how different countries have institutionalized UHC based on their values, histories, and political institutions.

Analysing the economic effects of healthcare is a complex task (see Weil 2014). While the positive externalities of public health interventions—such as vaccinations and infectious disease control—are well documented (see Bloom et al. 2022), the macroeconomic impact of the broader healthcare sector, including personal medical care, is far more difficult to assess (Bloom et al. 2012). This complexity likely arises because healthcare encompasses preventive, curative and palliative elements, each with different economic dynamics. While improved health can contribute to higher productivity and reduce long-term costs, empirical evidence on the direct economic spillovers of personal care remains inconclusive. Moreover, the extent to which universal access itself generates positive externalities remains an even more complex and contested question.

2.4.1 Healthcare as a Merit Good

Nonetheless, many argue that access to essential healthcare services should not be determined solely by the ability to pay. This perspective aligns with the concept of merit goods, which society deems necessary to provide regardless of an individual's financial means (Musgrave, 1959). Unlike ordinary consumer goods, which individuals purchase based on preferences and budget constraints, merit goods are considered essential for individual well-being and societal welfare.

While this discussion touches on political philosophy and ethics, two key arguments typically emerge. First, healthcare—particularly in its basic forms—is often viewed as a human right rather than a market commodity. In most markets, if consumers cannot afford a product, they go without it. But healthcare is different: financial barriers can result in preventable suffering and poor health outcomes. Second, the absence of universal access tends to reinforce broader social inequalities, including disparities in health status, economic opportunity, and life expectancy. While many nations agree on the need for universal access, there are important philosophical nuances in how the right to healthcare is interpreted, justified, and operationalized.

Even where positive externalities are difficult to quantify, the ethical rationale for universal access remains widely accepted. The widespread public support for ensuring access to essential care also reflects a societal motivation rooted in concern for others.¹⁸ Although the strongest economic justification for universal access stems from correcting insurance market failures such as adverse selection, the broader societal benefits of improved health—though often assumed—are harder to isolate at the level of individual medical care. As this thesis proceeds, it takes the normative foundation of universal access as given, while shifting focus to how healthcare systems can be designed to balance equity, efficiency, and quality in practice.

2.4.2 Institutional Models for Implementing Universal Coverage

While adverse selection provides a well-established economic justification for mandatory or universal health insurance, the merit good nature of healthcare reinforces the ethical imperative for universal access. Furthermore, once basic coverage for catastrophic care is established, additional economic arguments—such as behavioral hazard and the Samaritan’s Dilemma—strengthen the case for extending coverage to primary and preventive services. Together, these elements form the conceptual foundation of universal health coverage (UHC), which most high-income countries have adopted in some form. In practice, UHC is frequently implemented through universal health insurance, as comprehensive access typically requires pooled risk-sharing. Consequently, efforts to ensure UHC—while also addressing the positive externalities associated with public health—have

¹⁸ This commitment to shared responsibility—extending care to those in need regardless of personal benefit—suggests the presence of altruistic preferences within the population. Such preferences may be especially relevant among those who choose to work in health and care professions, where prosocial motivations often play a central role in shaping behavior. These themes will be explored further in subsequent chapters.

led to healthcare systems that rely predominantly on public funding, either through general taxation or compulsory health insurance contributions, depending on the financing model.¹⁹

While UHC is designed to function as a public good, practical constraints—such as budget limitations and service capacity—often introduce trade-offs. When the non-excludable services are overused, healthcare becomes rivalrous, creating a common-pool resource challenges. While some overuse is unintentional, moral hazard can also drive excessive consumption, as patients may overutilize services they are not directly paying for. As demand exceeds supply, publicly funded systems can become strained, leading to congestion, rising costs, and rationing mechanisms such as wait times or cost controls. These pressures have been evident in many healthcare systems and being further exacerbated by the Covid-19 crisis.

Therefore, ensuring universal health coverage requires balancing equity and efficiency. While UHC promotes fairness by ensuring access to care regardless of income, publicly funded systems must also manage limited resources efficiently. Striking this balance—ensuring universal access while maintaining affordability and sustainability—remains a key challenge in healthcare policy. The complexities of achieving efficiency gains will be examined in greater detail in the coming sections.

Beyond addressing insurance market failures, UHC reflects broader social objectives, prioritizing equitable access as a societal goal rather than purely an economic good. However, these social objectives extend beyond universal access; UHC also entails commitments to maintaining certain quality standards. While this represents the other important ingredient of merit goods, there is also an economic argument for providing effective care, if it can improve the overall efficiency.

While government mandates and public funding help secure access, accessibility alone does not guarantee quality care. A key challenge remains: how can systems measure and maintain care quality when outcomes are difficult to observe not only for patients, but also for actors that design the incentive structures?

¹⁹ In most developed nations, universal health coverage is predominantly financed either by government transfers (with the government acting as the de facto insurer) or health insurance entities (non-profit or for-profit). These two approaches broadly align with the *Beveridge* model (or single-payer system, e.g., UK, Ireland, Nordics), based on general taxation, and the *Bismarck* model (e.g., Germany, France, Belgium), often based on mandatory, subsidised social health insurance contributions typically collected via payroll taxes. Some countries in the latter group—such as Switzerland and the Netherlands—achieve universal coverage through subsidized, and highly regulated mandatory private insurance. The United States, by contrast, follows a mixed model combining of public programs (e.g., Medicare, Medicaid) and with “quasi-compulsory” private insurance. Regulatory incentives and mandates have historically encouraged insurance uptake, but these mechanisms have been weakened in recent years. As of 2023, the U.S. system covers only about 91% of the population. (OECD 2024a, 2023a; on the U.S., see also Baicker et al. 2023.)

2.5 Information, Trust and Quality: Credence Good, and Tacit Good

2.5.1 Second Informational Asymmetry: Healthcare as a Credence Good

Market efficiency relies on consumers making informed choices. However, patients typically lack the expertise to assess the extent of their medical needs or the quality of care they receive.

Healthcare services are thus often classified as credence goods (see Dulleck et al. 2006; 2011), meaning consumers cannot fully evaluate the utility or quality of services, even after consumption. Unlike search goods (where quality is evident before purchase) or experience goods (where quality is revealed after use), credence goods create persistent informational asymmetries between providers and consumers.²⁰

Therefore, while patients may have even advantageous knowledge of their health risks and behaviours, they face significant uncertainty regarding diagnosis and treatment effectiveness. In contrast, healthcare professionals—due to their medical expertise—have a clearer understanding of conditions and treatment options.²¹ This creates a power imbalance as patients must rely on physicians' recommendations without being able to verify their accuracy. While this imbalance persists in many healthcare domains, it is arguably most pertinent in long-term care and nursing homes, where vulnerable residents rely entirely on caregivers to act in their best interest. When incentives are misaligned, this can lead to both intentional and unintentional under- or overtreatment, complicating healthcare decision-making.

Moreover, because critical information is distributed between patients and providers, effective collaboration is essential to ensure that practitioners can access the most relevant knowledge when making care decisions, and sharing the essential knowledge to the patient to effectively improve his/hers health decisions and behaviours.

²⁰ Darby & Karni (1973), who introduced the concept of credence goods, gave three examples: repair services, taxicab rides, and medical treatments. Interestingly, only the latter still largely escapes collective evaluation in the internet era.

²¹ While the adverse selection suggests that patients may have advantageous knowledge regarding their health risks, the credence good aspect suggests that physicians may have advantage regarding the patients' medical needs. Therefore, as the patient's informational advantage is typically limited to symptoms, and that of physician's covers the underlying mechanisms of these symptoms and their treatments, collaborative effort would ensure best health outcomes.

2.5.2 The Role of Trust in Healthcare

Patients face uncertainty not only about treatment outcomes but also about provider behavior, exposing them to risks they cannot fully insure against. Since they must rely heavily on physicians' recommendations, trust becomes a fundamental component in healthcare markets (Arrow 1963).

Trust in healthcare can be defined as a patient's willingness to accept vulnerability, based on the belief that physicians and medical institutions will act in their best interest, demonstrating competence, honesty, and reliability (Hall et al. 2001).

Trust in healthcare operates at multiple levels. Both Hall (2001) and Williamson (1993) emphasize the distinction between interpersonal trust (confidence in individual providers) and institutional trust (faith in the healthcare system as a whole).²²

Trust is particularly critical in primary care and mental health, where the quality and continuity of patient-provider relationships affect health outcomes (Merenstein et al. 2023; Flückiger et al. 2018). The quality of these relationships can improve patient-provider communication, and allow physicians to accumulate a deeper understanding of patients' health over time (Hjortdahl 1992; see also Sabety 2023). This aligns with Polanyi's (1966) concept of tacit knowledge, which highlights the value of implicit, experience-based understanding.

Trust has been shown to:

- Be essential for continuity of care to be effective (Baker et al. 2003).
- Improve long-term health outcomes through accumulated knowledge (Safran et al. 1998), higher treatment adherence (Kerse et al. 2004; O'Malley et al. 2004) and the promotion of healthier lifestyles (Becker & Roblin 2008).
- Generate public health benefits, as both institutional and interpersonal trust has been shown to increase willingness to adopt preventive measures (Han et al. 2023; Perlis et al. 2024; Cairns et al. 2013).

While the interactions between trust, continuity, and health outcomes are complex (Birkhäuser et al. 2017; Baker et al. 2003), trust arguably contributes to healthcare quality and efficiency, at least in

²² While Williamson (1993) actually refers to these as institutional trust and personal trust, he also identifies a third category, that of calculative trust, which is based on structured incentives. While calculative trust plays a role in shaping provider behavior and system-level trust, its role in healthcare relationships should arguably be minimal.

primary care, mental health, and public health.²³ Therefore, beyond its ethical significance, trust has important economic consequences, as trust can enhance efficiency by improving healthcare effectiveness (e.g., treatment adherence) and reducing negative externalities (e.g., disease spread). Nevertheless, the ethical importance of trust in domains such as palliative care (i.e. nursing homes), is not to be undermined.

As trust is a structural necessity in credence-good markets like healthcare, systems rely on overlapping mechanisms to uphold it. The following section surveys how institutional, market-based, and professional forms of regulation contribute to—or at times, complicate—this goal.

2.5.3 Regulatory Responses to Maintaining Trust and Quality Care

To maintain trust, patients must believe that healthcare professionals are both competent and committed to prioritizing patients' interests over their own. Because patients cannot independently assess the quality of medical services—or could theoretically obtain this information, but doing so is often impractical and inefficient—various regulatory mechanisms exist to ensure safety, uphold quality, and maintain credibility in healthcare systems:

- **Institutional Oversight (Public & Non-profit):** Government agencies, medical associations, and accreditation bodies set standards, license professionals, regulate pharmaceuticals, and enforce ethical guidelines to ensure patient safety and system credibility.
- **Market-Based Regulation:** Private accreditation agencies, rating organizations, and competitive market forces can incentivise quality, though informational asymmetries and misaligned incentives may compromise credibility.
- **Professional Norms:** Healthcare practitioners uphold ethical standards, and promote best practices—fostering internalized accountability, care quality, and patient trust.²⁴

²³ While trust alone is not sufficient, some degree of trust is necessary for the efficient functioning of healthcare markets. This is perhaps most clearly represented in domains of preventive and curative care that both support economic productivity and rely on individual choice and behavior for treatment effectiveness, such as in many aspects of primary care, mental health, and public health.

²⁴ The Hippocratic Oath serves as a clear example of a professional code of conduct designed to preserve trust and quality in healthcare. By requiring providers to prioritize patient needs over their own, the medical profession establishes ethical commitments that foster trust. This also contributes to the professionalization of healthcare providers, as it encourages them to internalize the preferences of patients and society, and thus to become part of the professional norms. (See e.g., Besley & Ghatak 2018, 414-415; Williamson 1993, 478.)

While institutional oversight establishes compliance requirements and enforces minimum quality standards, professional ethics aim to align professional incentives with patient well-being. Thus, professional norms remain critical for sustaining trust and improving care quality.

In addition to these traditional mechanisms, social incentives, including peer expectations, teamwork, relational continuity, and reputational pressure—can reinforce ethical conduct and effective service delivery (see e.g., Ashraf & Bandiera 2018). For example, continuous patient-provider relationships can increase providers' sense of responsibility toward their patients, thereby reinforcing trust (Ward 2018; Tarrant et al. 2010; Hjortdahl 1992). Since primary healthcare and mental health services are often under less casual inspection of others than hospital settings (see also Arrow 1963, 961-962), the self-regulatory forces can become even more important in maintaining trust and quality care in these domains.

To echo Williamson (1993), we could say that institutional trust is reinforced by formal governance mechanisms, whereas interpersonal trust depends on direct patient-provider relationships and professional norms that guide ethical conduct. Williamson also discusses about calculative trust, which, although important, should only play at most a complementary role in healthcare settings.

Therefore, while market forces, such as competition, can, in theory, strengthen trust by holding providers accountable (Huck et al. 2012), and thereby could incentivise quality, asymmetric information limits their ability to do so. As patients cannot directly observe provider effort or expertise, it gives providers an informational advantage that markets alone struggle to correct.

Market forces also face challenges due to imperfect information on the provider side—the difficulty of externally measuring key aspects of care, such as diagnostic accuracy or patient rapport. Even carefully constructed incentives can misfire when tied to what is measurable but not necessarily meaningful. These tensions are explored in the next section, which examines healthcare as a tacit good.

At the same time, trust in healthcare depends not only on formal oversight, but also on professional integrity and social dynamics, particularly where asymmetric information persists and formal mechanisms—market or bureaucratic—cannot ensure meaningful accountability. These informal governance forces play a critical role in sustaining ethical, patient-centred care.

2.5.4 Measuring and Incentivising Quality: Healthcare as a Tacit Good

In competitive markets, quality is often ensured through consumer choice. However, because healthcare is a credence good, consumer-driven quality assurance alone is insufficient. Thus, the attempt to leverage market forces requires reliance on external metrics to incentivise performance. Yet, external measurement can be imperfect as well. While metrics like mortality and complication rates are measurable, key factors such as diagnostic accuracy and long-term health outcomes remain harder to quantify. Similarly, while trust plays a role in healthcare quality, it is equally difficult to measure (Merenstein et al. 2023; Kovacs et al. 2019).

This measurement problem can affect provider incentives, creating a risk that if performance incentives are used, providers prioritize what is quantifiable rather than what truly matters for patient health, as is highlighted in Holmström and Milgrom's (1991) multitasking model.

This thesis introduces the term “tacit good” as an extension of both Holmström and Milgrom's (1991) and Polanyi's (1966) work. While the Holmström and Milgrom's original model focused on how agents may skew effort between measurable and unmeasurable tasks, this thesis uses the concept of tacit goods to describe a class of goods or services where this tension is intrinsic to the nature of the product itself. In healthcare, particularly in primary care and mental health, critical aspects of quality—such as diagnostic accuracy, empathetic communication, and long-term relational continuity—are not easily captured by standard performance metrics. This makes healthcare not only a credence good but also a tacit good, where conventional incentive structures often fall short.

This challenge becomes particularly apparent when examining healthcare payment models. Because performance metrics are necessarily limited, different payment systems can unintentionally distort provider behavior by encouraging focus on what is easily measured rather than what is most important (see e.g. Mankiw 2017).

- Fee-for-service (FFS): Incentivises higher volumes of care, often rewarding overtreatment without necessarily improving outcomes.
- Capitation and bundled payments: Aim to control costs by setting fixed payments, but may under-incentivise appropriate care, particularly for complex or high-risk patients.
- Value-based payments: Attempt to tie compensation to patient outcomes, but their effectiveness depends on the measurability of those outcomes.

Therefore, while good performance should be incentivised, healthcare metrics—such as hospital wait times and readmission rates—if widely used, can distort behavior. One example is that of Medicare’s Hospital Readmissions Reduction Program (HRRP) in the US, which led some hospitals to reduce readmissions not by improving care but by shifting high-risk patients to observational stays, avoiding penalties without meaningfully improving patient outcomes (Gupta 2018).

Example from the primary care sector is provided by the Brosig-Koch et al. (2024), who find that while quality can be somewhat increased via performance payments, they risk providing suboptimal care. Moreover, they find that in high-profit practices, the quality actually decreases, and emphasize the important role of nonmonetary incentives in driving the quality care.

While alternative mechanisms can help bridge the measurement gap, they face limitations—especially given healthcare’s credence good nature (Hilger 2016):

- Reputation mechanisms (e.g., patient satisfaction ratings) reflect subjective experiences more than clinical effectiveness. and are often influenced by non-clinical factors such as bedside manner or wait times.
- Second opinions can offer safeguards, but are often costly, time-consuming, and may also be affected by the competing provider incentives.

These limitations underscore that even sophisticated incentive schemes and market-based mechanisms cannot fully govern provider behavior. Understanding how providers navigate overlapping pressures from patients, payers, and institutions requires examining the broader structure of conflicting incentives within healthcare systems.

2.5.5 Provider-Side Moral Hazard

The complexities of provider incentives are especially pronounced in insurance-based systems. The challenge of measuring and monitoring quality is further complicated by insurance structures, which may distort incentives and lead to provider-side moral hazard. This occurs when providers—such as physicians and hospitals—insulated from direct financial consequences, may overprescribe treatments, recommend unnecessary tests, or perform high-cost procedures that increase revenue without necessarily improving patient outcomes. Hilger (2016) also suggests that insurance can encourage overtreatment by reducing patients’ sensitivity to unnecessary services, while providers remain incentivised to maximize revenue under fee-for-service models.

To mitigate these issues, some insurers implement pre-authorization requirements or capitation payments to limit excessive provider-driven care. However, these interventions may risk undertreatment or introduce bureaucratic inefficiencies, further complicating the provider's role as a trustworthy agent of patient welfare. Hilger (2016) also emphasises the role of nonmonetary incentives in mitigating these adverse effects.

3 From Economic Pressures to Incentive Complexity

Rising healthcare expenditures are a central concern in most publicly funded systems. Demographic shifts increase demand while shrinking the tax base, and broader economic factors drive spending upward: (a) higher demand as incomes rise, (b) technological advancements expanding treatment options, and (c) the Baumol effect, where wage growth outpaces productivity gains in labour-intensive sectors like healthcare. These trends strain public budgets, especially in the context of competing fiscal demands—such as climate adaptation, defence, and cost-of-living measures. As a result, many governments pursue reforms aimed at improving efficiency and sustainability, including outsourcing, performance-based funding, and cost-sharing mechanisms.

3.1 Public–Private Systems and Incentive Fragmentation

In many publicly funded healthcare systems, the contracting of private providers is often introduced as a strategy to increase efficiency, foster innovation, or reduce public sector costs. However, while the policy intent is typically economic, the institutional consequences are deeply governance-relevant. Outsourcing introduces additional organizational actors into the care delivery chain, each with their own priorities, constraints, and accountability structures. As Andersen et al. (2007) and Hart et al. (1997) argue, such public-private arrangements can create governance tensions—particularly in healthcare—where the goals of equity, efficiency, and accountability are difficult to reconcile, and where service quality is hard to define and monitor.

In practice, outsourcing blurs traditional lines of accountability: while care is publicly financed, its delivery is shaped by privately governed institutions operating under contract. These arrangements require complex oversight structures to ensure compliance, manage performance, and align public objectives with private incentives. Yet these systems often lack clear mechanisms for reconciling conflicting objectives. For providers, this can result in competing pressures from patients, payers, and employers—raising new challenges for professional autonomy, transparency, and public trust. This institutional complexity is particularly pronounced in hybrid systems where the state retains funding responsibility but delegates provision to market-based actors.

In hybrid systems, where public funding supports both public and private providers, the institutional logic of care delivery may differ across ownership models. Public institutions may prioritize universal service provision and equity, while private organizations—especially for-profit entities—

may be more responsive to internal metrics or shareholder pressures. This divergence can complicate efforts to ensure consistent quality, transparency, and public accountability across providers operating under the same funding umbrella.

In a broader institutional context, recent studies show that efforts to incorporate market actors into healthcare provision can, in some cases, reduce care quality. Goodair and Reeves (2024), and Knutsson and Tyrefors (2022), for instance, document how outsourcing and privatization to for-profit organizations in health systems have been associated with unintended quality declines—highlighting the risks of aligning care delivery with organizational incentives not fully compatible with patient-centred outcomes.

It is important to note, however, that not all private providers operate on a for-profit basis. In many systems, non-profit hospitals, foundations, and social enterprises are key players in delivering publicly funded care. These organizational models often maintain a mission-driven ethos that aligns more closely with public values and professional norms. Additionally, many European countries have a long history of contracting primary care provision from locally organized groups of independent private practitioners—plausibly being less governed by profit motives than pure for-profit firms. In some cases, these models may help mitigate tensions between efficiency goals and ethical service delivery—particularly when supported by governance structures that preserve clinical autonomy and trust.

This fragmentation of responsibility and oversight complicates the regulation of quality and trust, particularly when private firms operate under public funding but are incentivised by internal performance metrics or profit. Patients may remain unaware of these institutional layers, even as they shape the care they receive. As such, outsourcing becomes a site where efficiency goals directly intersect with the informational asymmetries and trust dynamics central to healthcare governance. Although efficiency concerns often drive reforms such as outsourcing, this chapter has shown that such institutional shifts carry significant implications for the governance of information, trust, and quality in healthcare.

3.2 Triple Agency and the Challenge of Incentive Alignment

This section focuses primarily practitioners operating in publicly funded but fiscally constrained healthcare systems that contract private providers—an institutional arrangement where incentive fragmentation is particularly pronounced. In these hybrid systems, clinicians are accountable to

multiple principals simultaneously: the public payer, the employing private firm, and the patient, who remains epistemically dependent due to informational asymmetry.

Unlike classical principal-agent models, where one principal delegates authority to one agent, real-world healthcare embeds providers in triangular accountability structures. Physicians must balance the interests of:

- Patients, who rely on their expertise but cannot directly evaluate care;
- Public payers, who seek cost containment and standardization through performance metrics;
- Private employers, who may prioritize revenue, cost-efficiency, or internal targets.

This makes physicians “triple agents,” navigating complex and often conflicting demands. When each principal emphasizes different outcomes—quality, cost control, throughput—it creates a tension between professional ethics, system-level efficiency, and organizational loyalty.

This complexity is further amplified by healthcare’s dual nature as both a credence good (where outcomes are difficult for patients to assess) and a tacit good (where essential aspects of care—like diagnostic accuracy or relational trust—are hard to measure externally). Consequently, market-based mechanism and bureaucratic oversight struggle to align with the realities of frontline care.

Adding to these institutional forces, clinicians bring their own internal motivations, which may align—or clash—with the demands of these principals. Evidence suggests that intrinsic and prosocial motivations can significantly contribute to provider effort, job satisfaction, and patient outcomes (Huang et al. 2025; Li et al. 2022; Kerschbamer et al. 2017; Cassar & Meier 2018).

3.3 Intrinsic Motivation, Autonomy, Moral Hazard and Moral Distress

Beyond structural and contractual tensions, conflicting incentives in healthcare also shape the psychological and ethical experiences of providers—especially their ability to act in line with intrinsic motivations and internalized professional values.

While traditional models have assumed physicians primarily respond to financial incentives, experimental evidence suggests that many exhibit substantial altruism, placing patient welfare above self-interest in allocation choices (Li et al. 2022). Cassar and Meier (2018) discuss how many, particularly public service, workers are driven by strong intrinsic and prosocial motivations. When properly supported, these motivations—together with carefully designed financial incentives—can enhance care quality, efficiency, and provider well-being. However, if governance

structures undermine these motivations, the result may be demoralization, disengagement, or distress.

The emotional and ethical effects of these pressures are visible in rising levels of burnout and moral distress among healthcare professionals (West et al. 2018; Day et al. 2022). Burnout and moral distress are closely linked to job dissatisfaction, but also to the erosion of professional autonomy, undermined intrinsic motivation, and compromised ethical agency (Pedersen et al. 2021; Lamiani et al. 2017).²⁵ Professionals require both clinical (professional) and operational autonomy to exercise ethical judgment and provide high-quality care. In firm-like or bureaucratic healthcare organizations, both forms of autonomy may be constrained—through rigid workflows, performance targets, or administrative controls—undermining motivation, relational care, and the effective use of tacit knowledge (Holmström 1999).²⁶ These conditions are often triggered by system-level constraints, such as staff shortages, time pressure, or rigid cost-control measures (Kherbache et al. 2022; Morley et al. 2019), which can create a vicious cycle where distress leads to workforce attrition, further intensifying pressures (Maunder et al. 2023).

Burnout and moral distress are also associated with heavier reliance on bureaucratic oversight and administrative metrics (Weisleder 2023; Sheikhabaei et al. 2022), as well as with performance incentives (Fuse Brown & Hall 2024; Dean & Talbot 2024; Beck et al. 2023).²⁷ While such tools aim to ensure accountability, they may inadvertently reduce clinical autonomy, and shift focus away from patient relationships. Moral distress is also correlated with worse collaboration among healthcare providers (Papathanassoglou et al. 2012). For example, Owens and Cribb (2019) describe how austerity-driven constraints—through increased workload, isolation, and organizational alienation—can undermine teamwork and erode the social conditions necessary for sustaining professional ethics. Increasing reliance on bureaucratic structures and standardized

²⁵ Moral distress arises when professionals are constrained from carrying out actions they believe to be ethically appropriate (Jameton 1984, 6). It is closely related to the more severe concept of moral injury—the harm caused by the violation of a deeply held moral beliefs (Day et al. 2022). For further reviews on these forms of moral suffering among healthcare professionals, see Buchbinder et al. (2024); Beadle et al. (2024), and Quek et al. (2022).

²⁶ See Holmström (1999) for a foundational treatment of firms as planned subeconomies, where internal coordination substitutes for market mechanisms—often at the cost of autonomy and flexibility.

²⁷ While most of the evidence for burnout and moral suffering linked with financial incentives comes from the US where private healthcare sector plays a larger role, the increasing corporatization in European healthcare markets makes the case for understanding this aspect in Europe timely as well.

performance targets may erode professional autonomy and undermine ethical agency, limiting healthcare workers' ability to act on local knowledge and prosocial motivation.

While financial incentives and performance targets are discussed as sources of provider dissatisfaction, this thesis argues that they are not inherently the cause. Rather, moral distress emerges when physicians are constrained in their ability to act in accordance with their professional judgment—due to resource scarcity, conflicting institutional demands, or governance mechanisms that emphasize measurable outputs over clinical discretion. In these situations, distress is not the result of incentives themselves, but of the structural misalignments embedded in the 'triple agency' role. When providers are caught between the conflicting expectations of patients, payers, and employing organizations—and lack the autonomy or flexibility to navigate these tensions—suboptimal care delivery and moral distress may result.

Beck et al. (2023), for example, document how performance-based reimbursement models in the UK NHS initially improved some outcome measures but ultimately contributed to clinician burnout—particularly as professional autonomy declined, and relational care was deprioritized. This illustrates a broader point: moral distress does not stem from incentives themselves, but from how they are embedded in governance structures that limit professional discretion.

These observations also suggest that moral hazard and moral distress may be closely connected. In cases where providers are constrained to act in ways they believe are ethically wrong—such as limiting care to meet fiscal targets—this could be described as “institutionalized moral hazard”. Unlike the classical form, where agents exploit information asymmetries, this version reflects a forced deviation from intrinsic or internalized moral standards, generating moral distress rather than opportunism.

These overlapping agency relationships reveal the limits of contract-based governance in healthcare. While payment mechanisms, regulation, and performance metrics play essential roles, they cannot fully substitute for professional integrity, prosocial motivation, and relational accountability. The persistence of moral distress suggests that provider behavior is not fully explained by self-interest or reputation; instead, it reflects deeper ethical commitments, shaped by context, purpose, and relationships..

Governance strategies that neglect the psychological and ethical dimensions of provider motivation risk not only workforce dissatisfaction, but also systemic inefficiency—by eroding the trust, tacit knowledge, and prosocial motivation on which effective, high-quality, patient-centred care depends.

Supporting provider autonomy, prosocial commitment, and ethical self-regulation is therefore not merely a human resources concern—it is central to system sustainability.

3.4 Fostering Sustainable and High-Quality Healthcare Systems

Ensuring sustainable and high-quality healthcare requires governance that transcends financial incentives and bureaucratic oversight. Given that no single metric can adequately capture healthcare quality—and that patients often cannot credibly evaluate the outcomes they receive—there is a constant risk that performance-based incentives may lead to unintended consequences. These include overtreatment, gaming of metrics, and neglect of unmeasurable but essential aspects of care such as trust, diagnostic accuracy, and continuity.

Governments can also attempt to ensure quality through oversight and regulation, particularly when care is delivered by market actors. However, excessive bureaucracy can crowd out professional judgment, and create administrative burdens (Zegers et al. 2022). In response to these challenges, many systems have opted for more direct involvement. These risks may explain why many governments, beyond merely financing care, have long history of directly providing services or maintain principal ownership over institutions (Hart et al. 1997). Public provision may allow greater space for professional autonomy and nonmonetary incentives to flourish (Andersen et al. 2007; Francois 2000; Tirole 1994), especially in contexts where trust is paramount, and quality is hard to observe. Moreover, when patients cannot assess quality, they may instinctively place more trust in institutions not guided by profit motives (Mankiw 2017).

3.4.1 The Role of Primary Care: Continuity and Teams

A robust body of evidence underscores the central role of primary care in improving health outcomes and containing system-wide costs (Starfield et al. 2005, 2012; OECD 2020). The proportion of primary care providers in a health system is also linked to lower overall utilization and improved system efficiency (Kravet et al. 2008). Key features—such as accessibility, continuity, coordination, and community orientation—are often linked with more equitable and effective care.

The quality of the patient–provider relationship, particularly in primary care, has long been highlighted in both economic theory (Arrow 1963) and clinical literature (McWhinney 1975, 1998).

As discussed in the section 2.5.2, continuity can also build trust, deepening providers' contextual understanding of patient needs, and reinforcing a sense of responsibility.

Recent studies further affirm the value of sustained patient–provider relationships. Continuity is associated with improved health outcomes (Sandvik et al. 2022; Baker et al. 2020; Barker et al. 2017) and reduced costs (Bazemore et al. 2023). This relational foundation may be even more critical in mental health, where trust and long-term therapeutic engagement are often prerequisites for effective care (Flückiger et al. 2018). Disruptions to continuity—such as provider exit or retirement—are also increasingly studied in economics. Research by Sabety et al. (2023), Staiger (2022), Zhang et al. (2022; 2018), and Simonsen et al. (2021) shows how provider turnover undermines care quality and patient outcomes.

However, as many countries have aimed to improve the efficiency in healthcare systems, the continuity of care has been declining (see above authors). In addition, healthcare systems face acute workforce shortages, particularly in primary care and nursing (State of Health in EU 2023). The reduction in continuity can be partly due to labor shortages. However, against the backdrop of what has been covered, it is also likely that increasing reliance on metrics that can be externally monitored and incentivised, has detracted from direct patient care and may have reduced morale, especially when the focus shifts to compliance rather than care. This may have further contributed by exacerbating the workforce shortages further.

One potential response is adopting team-based primary care models (see e.g., Jeffers & Baker 2016), that can support both quality, continuity and efficiency, and even reduce burnout (Willard-Grace et al. 2014). As many primary care providers are likely to retire in near future, team-based care may allow to maintain better relational continuity through another already familiar practitioner. Team-based provision can also reinforce the social incentives, enabling more efficient care. Furthermore, by making these team interprofessional, and giving them sufficient autonomy, when effectively managed, each member can contribute their personal expertise, and teams can act on their local knowledge, together ensuring efficient, high-quality care (Wei et al. 2022; Schmutz et al. 2019). One potential structural drawback is the risk of informational discontinuity, but it can be addressed through better implementation of technologies that enable information collecting and sharing.

Primary care practitioners—particularly in public services—arguably exhibit strong intrinsic and prosocial motivation. This reflects not only personal ethics, but also broader societal values tied to healthcare as a merit good—a service society believes should be accessible to all, regardless of

ability to pay. Such values of shared responsibility can be internalized by those in caring professions, and individuals with prosocial preferences are likely to self-select into healthcare roles, especially in public service settings. Supporting these motivations is essential for effective care and workforce wellbeing, and complementing them with carefully designed financial incentives can ensure the most efficient outcomes (Cassar & Meier 2018). The dynamics of motivation and selection are explored further in the next chapter.

3.4.2 Reflections on Efficiency and Sustainability

While team-based care can address many of the relational and motivational challenges described above, broader systemic constraints still shape how sustainable and efficient such approaches can be. Efficiency remains essential in publicly funded systems, particularly under fiscal constraint. However, when measurement limitations drive policy, there is a danger that easily quantifiable indicators—like wait times or readmission rates—displace more meaningful but less tangible outcomes. In primary care, this can lead to "checklist medicine," where the focus on compliance crowds out individualized care.

This challenge is especially relevant for preventive services in primary care. While preventive measures are key to long-term efficiency and improved population health, they are inherently difficult to measure and attribute. Consequently, they may be underprovided in systems overly reliant on quantifiable metrics. Incentive structures that neglect these services inadvertently undermine both health outcomes and sustainability.

While professional ethics and social incentives can significantly enhance trust and performance, they require institutional support. Overreliance on intrinsic motivation without adequate structural reinforcement risks burnout and moral distress—especially in under-resourced settings. As such, healthcare governance should integrate policies that sustain nonmonetary motivation without exploiting it.

However, excessive autonomy can also pose risks, potentially undermining efficient allocation and resource use. Some practitioners might be excessively financially motivated, and others might want to focus too much on individual care quality at the expense of allocational and productive efficiency. The latter aspect is further underlined by the fact that trust and reciprocity are likely to interact.

Governance strategies must therefore strike a balance: enabling professional autonomy while ensuring accountability, fostering trust while guarding against opportunism, and supporting

prosocial motivation without imposing unsustainable burdens. As Kerschbamer et al. (2017) and Gaynor et al. (2004) argue, aligning performance incentives with the realities of care delivery is central to sustainable reform.

Ultimately, neither patients nor regulators can fully assess healthcare quality. Providers hold informational advantages, and whether these translate into ethical care or opportunistic behavior depends on the surrounding institutional context. When profit motives misalign with broader societal goals, alternative models—such as direct public provision, non-profit delivery, and social enterprises—may offer more resilient solutions (Besley & Ghatak 2017).

These models tend to better align organizational missions with public values, reinforcing professional ethics and intrinsic motivation. In doing so, they foster the trust-based, relationship-driven care that is foundational to high-performing health systems. True sustainability in healthcare governance will depend not only on how resources are allocated, but on how systems recognize the value of local knowledge, support nonmonetary motivation, and manage the complex accountabilities faced by providers.

4 The Many Faces of Healthcare: Reflections on Governance

Unlike typical consumer markets, healthcare encompasses multiple overlapping economic classifications. Public goods arise in healthcare through public health measures and medical research, which benefit society beyond individual patients. Credence goods emerge because consumers cannot reliably assess the quality or utility of medical services, even after consumption (Dulleck et al. 2011). Tacit goods reflect the challenges of governing services with both measurable and immeasurable components, as standard incentives risk skewing provider behavior. Additionally, basic healthcare is widely regarded as a merit good, essential to individual well-being and a fundamental human right (Musgrave 1959).

While personal healthcare is inherently a private good, the merit good nature of basic services—combined with insurance market imperfections—has led to the development of universal health coverage (UHC), which functions largely as a common good. Moreover, primary care, which includes preventive services, outcomes of which (such as herd immunity) are prone to positive externalities if privately financed, has public good characteristics as well.

Besides, while institutional actors (governments, insurers) hold the broadest system-level knowledge about available resources, crucial local knowledge is more scattered. Patients often have hidden information about their health risks, while practitioners possess the best knowledge regarding treatment needs and effectiveness. Therefore, effective collaboration between patients and providers should be encouraged to ensure that practitioners have access to the most relevant information. At the same time, practitioners must have sufficient autonomy to act on that knowledge—otherwise, excessive bureaucracy or misaligned incentives may compromise system efficiency. These aspects are also particularly crucial in primary care.

Because this thesis focuses on the role of primary care in efficient healthcare systems, and the impact of nonmonetary incentives, the complexity of healthcare governance becomes especially apparent. Healthcare systems must continuously balance efficiency, equity, and quality—while managing diverse incentives, actors, and institutional frameworks. (See e.g. Cassel & Brennan 2007.)

To better conceptualize these governance dynamics, we can turn to a triangle model representing the interplay between three major forces in healthcare (see figure 1):

- The state (regulation, funding, oversight)

- The market (competition, pricing, performance incentives)
- Civil society (social norms and social preferences)

The nonmonetary incentives—*intrinsic and prosocial motivations, professional ethics, and social incentives*—can be seen as harnessing the civil societal forces and lying at the intersection of these domains, complementing or substituting the government and market forces. Together, the plausibly underutilized but essential civil societal forces are forces can play a critical role in sustaining patient-centred care and institutional resilience, particularly in complex and informationally opaque settings like primary care.

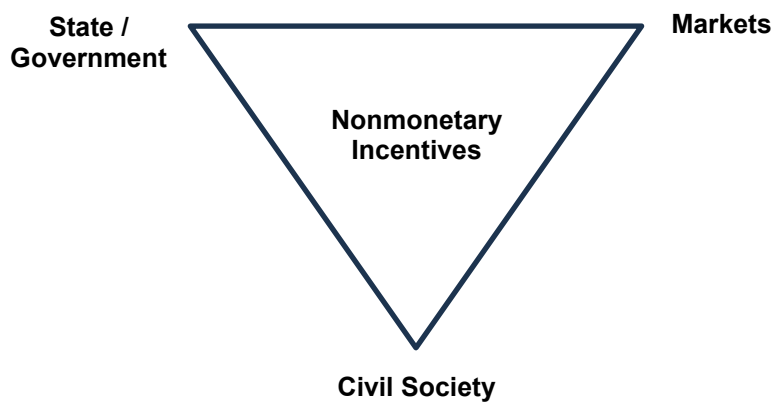


Figure 1. Triangle with three poles: Government (or State), Markets, and Civil Society, with Nonmonetary Incentives operating at the intersection. Adapted from Bowles and Carlin (2020)

While Bowles and Carlin (2023; 2020) call this the “synergy simplex”, Aghion et al. (2023, 303) refer to it as the “golden triangle”.

4.1 Key players in the healthcare sector

The multidimensional nature of healthcare—as a merit good, credence good, tacit good, common good, and public good—necessitates governance mechanisms that ensure financial sustainability, access, quality, and efficiency. Unlike standard markets, where buyers and sellers engage in direct transactions, healthcare relies on multiple intermediaries that shape decision-making, financing, and service delivery.

At the core of healthcare governance are four key actors, each playing a distinct role in shaping the system:

- Insurers: Manage risk pooling and financial sustainability.
- Governments and Non-Profits: Regulate, finance and often provide core services.
- Providers (clinicians and organizations): Deliver care, navigating complex incentives
- Society and Patients: Contribute through health behaviours, social norms, and trust-relationships.

Governance emerges not from one institution but from interactions between them. Many of these roles—especially within governments, public providers, and non-profit organizations—are filled by clinicians and public servants, whose motivations and ethical commitments play a crucial role in how governance functions in practice. (Li et al. 2022; Ritz et al. 2016)

4.2 Financing and Risk Pooling: Governance for Optimal and Equal Insurance

Healthcare is unpredictable and expensive. Risk pooling through insurance is essential. Yet, due to problems like adverse selection and unaffordability, insurance alone cannot ensure equitable access. As a merit good, healthcare requires public intervention to ensure everyone can access a minimum standard of care. Most high-income nations provide universal coverage, but the mechanisms differ.

Governance solutions:

- Insurers design coverage schemes but require regulation to avoid exclusion
- Governments act as financial backstops and equity guarantors.

Comparative models used to expand coverage²⁸:

- Beveridge (UK, Nordics): Tax-funded, government-run systems.
- Bismarck:
 - Germany: Mandatory, subsidised social insurance provided by non-profit sickness funds.

²⁸ While many countries combine elements of both the Beveridge and Bismarck models, systems are predominantly financed and organized as presented. For a more detailed explanation of these models—including systems such as Switzerland and the U.S.—see footnote 18 in Section 2.4.2.

- Switzerland: Mandatory, subsidised and heavily regulated insurance provided by for-profit insurers.
- Mixed (U.S.): Public programs, quasi compulsory private insurance. However, the U.S. does not guarantee universal coverage; approximately 10% of the population remains uninsured.

4.3 Service Provision: Institutional Governance for Safety and Quality

Even with universal coverage, service delivery remains prone to market failures. While healthcare services often function as credence goods, primary care and mental health also exhibit characteristics of tacit goods—where essential dimensions like prevention, continuity, trust, and holistic care are difficult to measure and incentivise. As a result, markets often struggle to deliver consistent quality in these domains.

Governments (and in some contexts, non-profits) often step in to:

- Set standards for safety, quality, and competence
- Provide essential infrastructure
- Ensure service provision in low-profit or high-need areas
- Select and regulate providers of public services, sometimes opting for direct provision:
 - Public hospitals in Beveridge countries
 - Non-profit hospitals in many Bismarck countries
 - Publicly funded but privately delivered primary care (common in Europe)²⁹
 - For-profit hospitals contracted for specialist and acute care

These hybrid arrangements reflect the limitations of pure market delivery and the need for institutional trust to ensure both safety, quality, and fairness.

²⁹ In many countries, governments or health insurance entities remain the main organizer of publicly funded health services, but have long history of contracting services from private actors. In many European countries, primary care is contracted from privately operating general practitioners organized in small local groups. However, these do not function specifically as for-profit firms. Yet, outsourcing to for-profit organizations has grown in recent decades.

In recent years, however, governments—facing fiscal constraints—have increasingly turned to market-based mechanisms to pursue efficiency gains. This shift has amplified the role of contract design, performance monitoring, and incentive alignment in the governance of service delivery. Yet, as Holmström (1999) notes, firms often operate as subeconomies that rely on internal control systems rather than market coordination. In healthcare, these internalized mechanisms—such as administrative protocols, reporting obligations, and standardized workflows—can constrain professional autonomy and ethical judgment.

This is not to suggest that healthcare should not be provided by public, private, or hybrid entities. Rather, the concern is that over-reliance on rigid control structures—regardless of ownership—can constrain the kinds of professional discretion and relational care that tacit services require. This dynamic reveals how seemingly different governance models—market-based and bureaucratic alike—can generate similar constraints, particularly in domains where trust, intrinsic motivation, and contextual knowledge are essential for quality.

4.4 Aligning Provider Behavior: Incentives, Motivations and Ethics

How healthcare providers are paid directly shapes their behavior. Yet no payment model fully captures the complexity of healthcare delivery:

- Fee-for-service (FFS): Rewards volume, but risks overtreatment.
- Capitation & bundled payments: Controls costs but may disincentivise needed care.
- Value-based payments: Aim to reward outcomes but depend on measurement accuracy.

These mechanisms are limited in service that exhibit both tacit good and credence good characteristics, where key quality-related dimensions are difficult to observe and effectively measure—for both patients and provider organizations. While informational asymmetries introduce a risk of opportunism, other forms of imperfect information constrain the effectiveness of top-down monitoring and financial incentives.

Lazear (2018) emphasizes that incentive systems must match the nature of the work. In healthcare, where outcomes are difficult to measure and teamwork is essential, overreliance on individualized performance-based pay can lead to misaligned behavior and demotivation.

This complexity is further amplified in publicly funded but privately delivered systems, where practitioners increasingly act as triple agents:

1. For patients, as care providers and advocates;
2. For payers, as stewards of public resources and policy compliance;
3. For employers or their own business models, as productivity-driven workers or entrepreneurs.

As introduced in Chapter 3, this triple-agency framework captures the institutional tensions that shape frontline behavior and complicate incentive alignment—a core governance challenge addressed throughout this chapter. These roles often carry conflicting incentives, and practitioners must constantly navigate between professional ethics, financial logic, and bureaucratic accountability. These tensions not only complicate incentive alignment but can also place providers in ethically conflicting roles—contributing to what Chapter 3 described as ‘institutionalized moral hazard’. These three principals also broadly correspond to the institutional forces explored in this thesis: civil society (patients), state (payers and regulators), and market (employers or business models).

In such an environment, the alignment of practitioner behavior requires more than financial incentives. It depends also on a robust set of nonmonetary motivators::

- Professional ethics help maintain interpersonal trust and quality, while discouraging distortions like overtreatment.
- Social incentives—such as continuity of care and peer accountability—can foster effective care where financial measures fall short.
- Intrinsic and prosocial motivation enhance quality, efficiency and resilience, especially when external incentives are weak or misaligned. However, in latter case there arises the risk of moral distress.

Healthcare providers exhibit significant, though heterogeneous, intrinsic and prosocial motivations (Li et al. 2022; Cassar & Meier 2018; Kerschbamer et al. 2017). While some of these are linked to reputational concerns or social signalling (Bénabou & Tirole 2006), the persistence of moral distress even in protected institutional settings suggests a deeper ethical commitment. As Kreps

(1997) argues, poorly designed incentives may crowd out such motivations by undermining trust—especially in professions where autonomy and mission alignment are central.

This raises a key question: how should governance systems respond to this motivational complexity?

Besley and Ghatak (2018; see also 2005), together with abovementioned authors, argue that systems should focus on selecting mission-aligned individuals—those with strong intrinsic or ethical motivations—and then design institutions that allow them to act on these motivations effectively. This approach emphasizes the importance of maintaining professional autonomy, minimizing the crowding out of motivated individuals, and reinforcing meaning at work, complemented by carefully designed financial incentives.

While motivation plays a role in selection, it is also shaped by institutional context. Li et al. (2022) emphasize how workplace culture and ethical education can influence prosocial preferences. Similarly, Attema et al. (2023) argue that governance can play a broader role—not only in preserving motivation but actively cultivating it. Unlike the classical crowding-out hypothesis (Titmuss 1970), they suggest a more dynamic view, where institutional design and daily practice shape the ethical landscape. Kreps (2023) supports this perspective, highlighting how preferences evolve in response to environment and experience.

Moreover, the persistence of moral distress in constrained environments suggests that intrinsic and prosocial motivations often endure despite misaligned incentives—indicating that such motivations are not easily extinguished but can be undermined or suppressed. Importantly, those with the strongest prosocial motivation—and potentially the most efficient and committed care providers—may be the most vulnerable to moral distress. If governance structures fail to support these values, they risk driving the most prosocially motivated actors out of the profession altogether. These motivational dynamics have direct implications for workforce sustainability and wellbeing.

These insights help reinterpret provider burnout and moral distress. As Greep, Woolhandler, and Himmelstein (2021) argue, physician burnout is often mischaracterized as a personal weakness, when in fact it reflects deeper systemic dysfunctions in healthcare delivery—especially excessive administrative burden, loss of autonomy, and misaligned incentives. Addressing burnout, therefore, requires governance reform rather than resilience training.

Building on Becker's (1962) foundational model, investments in human capital—such as training, education, and supportive workplace design—are not only economically rational, but can also

enhance motivation, professional growth, and long-term system performance. In healthcare, these investments can support ethical behavior, relational continuity, and skill accumulation—factors central to both productivity and professional integrity.

This insight deepens the case for governance that enables, rather than overrides, professional judgment. Environments that support ethical reflection, collaboration, relational continuity, and a sense of purpose are more likely to reinforce the motivations on which sustainable care depends. Conversely, systems that ignore or mismanage these dynamics risk not only inefficiency and job dissatisfaction, but also greater attrition and workforce shortages.

4.5 Governing for Sustainability: The Proper Scope of Government, Markets, and Civil Society

As the preceding reflections have shown, effective and equitable healthcare provision is shaped by a range of interdependent elements. Yet healthcare systems are not simply delivery mechanisms for services; they are complex, shared institutions that manage collectively important resources, and depend on public trust, social cooperation, and collective stewardship.

In important part, healthcare functions as a common-pool resource—non-excludable yet rivalrous—where overuse or misuse, such as avoidable emergency visits or the overprescription of antibiotics, can strain capacity and impose costs on others. Simultaneously, many public health interventions—including sanitation, vaccination, and education—generate positive externalities that benefit society at large.

Governing such systems effectively requires more than cost-efficiency or hierarchical oversight. It demands a clear understanding of the proper scope of government, markets, and civil society, and a nuanced integration of nonmonetary incentives—including intrinsic motivation, public service ethos, professional ethics, and social norms—into the institutional design of healthcare systems.

Each of the three institutional domains brings distinctive tools, logics, and risks to healthcare governance. Drawing on Williamson's (1993) typology of trust, we might associate institutional trust with the state, calculative trust with market actors, and interpersonal trust with civil society. However, as these domains often operate under conflicting assumptions about behavior, responsibility, and control.

This gives rise to what Furton and Martin (2019) call an institutional mismatch: a situation where governance systems rely on incentive structures or policy tools that are suboptimally aligned with the motivational and informational realities they seek to manage.³⁰ In healthcare, this might mean using market incentives in settings where trust and professional ethics matter more, or relying on bureaucratic compliance in contexts that require local judgment and adaptive problem-solving.

Sustainability, then, depends not only on institutional capacity, but also on achieving optimal alignment across domains—so that governance structures support, rather than undermine, the motivations and capabilities of healthcare actors. This requires an understanding of the complex incentive structures that lie at the intersection of the state, markets and civil society—and how they can improve system performance and long-term sustainability.

Finally, the integration of new technologies, while offering considerable promise, also introduces new governance challenges—particularly if digital systems are deployed in ways that reinforce measurement problems, administrative burden, or professional dissatisfaction and burnout.

4.5.1 The State and Bureaucratic Tools for Stewardship

Governments play a foundational role in healthcare governance: financing services, allocating scarce resources, managing public health risks, and maintaining system legitimacy. In domains where outcomes are hard to measure and incentives are difficult to calibrate—particularly in primary care and public health—bureaucratic controls, like line-item budgeting, often substitute for market mechanisms. While seemingly rigid, such tools can act as second-best solutions under informational opacity, gradually revealing where resources are needed most (Andersen et al. 2007).³¹

State actors also bear responsibility for rationing mechanisms—wait lists, triage protocols, or prioritization guidelines—that seek to distribute services equitably under fiscal and capacity

³⁰ Furton and Martin (2019, 198) define it as follows, "Institutional mismatch occurs when the rules governing an economic problem are inferior to a feasible alternative set of rules." This term aims to capture the nuances that are missed by focusing solely on correcting either market or government failures—and also what might be called "civil societal failures".

³¹ Andersen et al. (2007) argue that when performance is difficult to measure, line-item budgeting—often paired with incremental adjustments—is a second-best governance tool. While zero-based budgeting would, in theory, offer more precise resource alignment, it is often too burdensome in complex, information-poor environments like healthcare.

constraints. These are most legitimate when implemented transparently and in collaboration with clinicians who possess tacit and contextual knowledge.

Yet excessive bureaucracy can increase the administrative burden (Zegers et al. 2022), and undermine provider autonomy and professional ethics. To be sustainable, state-led governance must avoid over-centralization, and instead enable ethically grounded discretion.

4.5.2 Markets and Innovation: The Role of Regulated Competition

Markets can bring valuable efficiency and responsiveness to certain domains—particularly where consumer choice is feasible, and outcomes are observable. Competitive contracting, for instance, may work well in elective services, logistics, or health IT. Performance-linked payments can incentivise innovation, especially when outcomes are well-specified and unintended consequences are mitigated.

That said, the governance of core services requires caution. In areas characterized by credence and tacit goods—where quality is difficult to observe, both for patients and providers—market mechanisms can distort provider behavior, promote gaming of metrics, and undermine intrinsic motivation. Empirical evidence supports this concern. A meta-analysis by Comondore et al. (2009) found that for-profit nursing homes tend to provide lower-quality care than not-for-profit facilities. In hospital settings, outsourcing has been linked to fragmented accountability and reduced care quality (Goodair & Reeves 2024). Similarly, Brosig-Koch et al. (2024) find that high-profit primary care providers deliver lower quality care and highlight the role of prosocial motivation in maintaining service standards.³²

These risks are not only operational but structural. Gilmore et al. (2023) argue that commercial actors can exert significant influence over health systems through political lobbying, profit-driven service models, and regulatory capture—factors that complicate governance efforts and may undermine health equity and system legitimacy.

When well-designed, regulated markets can complement public goals, but they must be bounded by strong oversight and embedded within mission-aligned institutions such as social enterprises or non-profits. Besley and Malcomson (2018) argue that not-for-profit status can serve as a commitment

³² These reflect a broader problem in public service contracting under asymmetric information; see Laffont & Tirole (1993) for the canonical treatment.

mechanism to signal intrinsic motivation in settings where quality is hard to observe, making them particularly well-suited for public service provision under incomplete contracts.

4.5.3 Civil Society and the Power of Social Norms

Civil society contributes essential, often underappreciated, forms of governance. Social norms around preventive behaviours—like vaccination, smoking cessation, and responsible antibiotic use—can reduce unnecessary demand and reinforce public health goals. Social norms may also help to mitigate the patient-side moral hazard (Dufwenberg 2001). Voluntary organizations often step in where neither state nor markets suffice, organizing care, supporting vulnerable groups, or advocating for neglected needs.

Moreover, civil society provides a channel for feedback and local knowledge, helping public and private actors correct blind spots. In times of crisis, such as during pandemics, the collective uptake of behavioral norms can be more decisive than formal policies alone (Schmelz 2021; Hong 2024).

Informal governance—through peer pressure, reputational accountability, and community identity—can reinforce ethical behavior in ways that are difficult to replicate through contracts or regulation.

4.5.4 Prosocial and Public Service Motivation: Incentives at the Intersection

The interplay between institutional context and professional motivation is especially visible at the intersection of state, market, and civil society. Effective governance of public services requires more than financial incentives—it depends on selecting and supporting individuals with mission-aligned or prosocial motivations. As Finan et al. (2017) argue, the interaction between personnel selection, incentive structures, and intrinsic motivation is central to state performance, particularly in complex or resource-constrained environments.

As has been covered, healthcare practitioners are often driven not only by compensation but also by intrinsic and prosocial motivations. But this extends more broadly to public servants in general, such as bureaucrats, who are often guided by what could be called public service motivation (Ritz et al. 2016; Delfgaauw & Dur 2008; Perry & Wise 1990).³³ These forms of motivation can play a

³³ While there are multiple definitions and models of prosocial motivation and thus behavior (see e.g., Besley & Ghatak 2018), we can conceptualise the prosocial motivation being connected to interpersonal altruism and public service motivation being related to societal altruism (Schott et al. 2019, 1203).

central role in maintaining efficient and sustainable healthcare systems, especially when financial incentives or institutional oversight might lead to misalignments, and public funds are increasingly scarce.

Francois (2000) argues that when intrinsic or public service motivation plays a significant role in performance, government provision may be preferable to outsourcing, as it better preserves these motivations and avoids the distortions that private-sector incentives may introduce. Social enterprises and non-profits illustrate alternative governance models that support work driven by prosocial motivations while avoiding the pitfalls of profit-maximization. Actors in these settings may be more responsive to ethical obligations and community values, particularly when supported by peer relationships and social incentives such as reputation and team-based care.

Bureaucrats overseeing healthcare policy and resource allocation may also exhibit intrinsic or public service motivation. Like practitioners, they are guided by professional norms and social incentives, and require sufficient autonomy to act on those nonmonetary drivers (Tukiainen et al. 2024; Wilson 1989). Yet austerity, performance pressures, and bureaucratic overload often erode these motivations, weakening morale and governance effectiveness (Yu 2023).

While selection mechanisms are important among both healthcare providers and bureaucrats, the motivations—particularly that of practitioners—are neither guaranteed nor immutable (Attema et al. 2023). This suggests that governance structures must do more than “not interfere” with motivation—they must actively cultivate it. For example, as discussed in Section 3.4, governance structures that support interdisciplinary team-based care, allow for discretion within ethical bounds, and can maintain relational continuity, alongside generating social incentives and workplace meaning that can reinforce professional identity and improve efficiency. Peer dynamics, shared accountability, and a sense of purpose can act as powerful governance forces, especially in contexts where performance measures are crude or misleading.

As emphasized by the Lancet Global Health Commission on Financing Primary Health Care (Hanson et al. 2022), strengthening primary care requires not only adequate funding but also governance reforms that enable provider autonomy, foster motivation, and support team-based, people-centred care. These reforms align with the argument that institutional design plays a central role in sustaining ethical and efficient care delivery.

Because core healthcare services function as tacit goods, governance structures should avoid over-reliance on externally imposed metrics and instead support professional judgment, continuity, and experience-based quality — aspects that are critical but difficult to measure.

Importantly, these arrangements reflect not only an ethos of professionalism, but also Ostrom's (1990; 2010) principles of commons governance. When motivation is embedded in peer relationships, and responsibility is shared through transparent, self-managed systems, formal oversight becomes less burdensome—and more effective. Such models offer a credible alternative to purely financial or hierarchical mechanisms, and suggest that relational and ethical incentives can be institutionalized as part of a robust governance design.

In complex, fiscally constrained systems, such governance arrangements may be the most viable path to aligning the realities of frontline care with the institutional goals of efficiency, equity, and ethical integrity.

4.5.5 Technology: Enabler, Amplifier, or Burden?

Technology and data systems offer enormous potential to improve healthcare governance, but also introduce new risks. When used thoughtfully, digital tools can enhance triage, coordination, and resource allocation, especially in data-rich contexts. Predictive analytics can support early intervention; telemedicine may increase access and reduce systemic strain; and information systems can improve transparency and reduce duplication.

Yet technology is not a neutral enabler. If implemented primarily for oversight or surveillance, or if systems are not carefully designed, it may increase administrative burdens, exacerbate provider burnout, and undermine relational care (Shanafelt et al. 2016).³⁴

To avoid these pitfalls, technology must be designed and governed in ways that support professional judgment, enhance autonomy, and facilitate trust-based care—rather than replacing them.

4.5.6 Conclusion: Governance as Complementarity

No single institutional domain—state, market, or civil society—can govern healthcare sustainably on its own. Likewise, financial incentives alone are insufficient to sustain trust, equity, and

³⁴ While technological advancements can improve efficiency, they have also introduced new administrative burdens and, in some cases, exacerbated existing inefficiencies, particularly in documentation and compliance.

professional commitment. Effective governance requires complementarity, where each domain reinforces the strengths and mitigates the weaknesses of the others.

Recognizing the motivational diversity of healthcare actors—especially their intrinsic and ethical commitments—is essential. Equally important is ensuring that governance structures, technology, and policy tools align with these motivations, rather than eroding them.

Sustainability, in this view, is not just about efficiency—but about institutional design that respects complexity, supports cooperation, and reinforces shared purpose.

5 Conclusion

This thesis set out to explore two central questions:

1. How do nonmonetary incentives and information influence healthcare efficiency, sustainability, and care quality?
2. How can these mechanisms be better integrated into the institutional design and governance of healthcare systems?

These questions stem from the observation that healthcare, particularly in primary care and mental health, operates in domains where quality is difficult to observe, outcomes are often intangible, and relationships matter as much as results. In such environments, traditional governance tools—be they market competition, performance-based pay, or hierarchical oversight—face serious limitations. This is especially the case for services that function as both credence goods and tacit goods, where neither patients, payers, nor providing organizations can easily assess performance. The thesis has argued that in these contexts, governance must look beyond financial incentives to understand how motivation, trust, and institutional structures interact.

This thesis contributes to this inquiry in three key aspects. First, it conceptualizes healthcare as a “tacit good” to better capture the complexity of unmeasurable quality in care. Second, it extends the idea of triple agency to examine how misaligned institutional roles contribute to inefficiency and moral distress. Third, it proposes an integrated governance perspective that incorporates nonmonetary incentives—professional ethics, intrinsic motivation, and local knowledge—as essential complements to financial and regulatory tools.

By introducing the idea of tacit goods, this thesis to describe services where quality cannot be fully standardized, codified, or externally verified. Drawing on Polanyi’s concept of tacit knowledge and Holmström and Milgrom’s work on multitasking, the thesis argues that such services—particularly in frontline healthcare—require governance mechanisms that support discretion, judgment, and trust rather than control.

Second, the thesis develops the notion of triple agency to describe the multiple, and often conflicting, expectations placed on healthcare providers. Providers are accountable simultaneously to patients (ethical care), to payers (efficient use of public resources), and to employers or their own businesses (productivity or profitability). These three principals correspond to the institutional logics of civil society, the state, and the market. The resulting tensions—between care quality,

efficiency, and compliance—are shaped by how governance systems structure incentives and allocate decision-making authority.

This leads to the idea of institutional mismatch, as defined by Furton and Martin (2019): a situation where the rules and incentives applied to a governance problem are inferior to feasible alternatives. In healthcare, this might mean applying market-based incentives in domains where trust and professional judgment are more effective, or enforcing rigid compliance mechanisms where adaptive learning is needed. Institutional mismatch is not just a theoretical construct—it helps explain moral distress, inefficiencies, and provider burnout that arise when the system's structure conflicts with the realities of care work.

A key insight of this thesis is that nonmonetary incentives—such as intrinsic motivation, public service ethos, professional ethics, and social norms—are not merely secondary to financial ones. In many healthcare settings, they are the principal drivers of effort, quality, and continuity. Moreover, as research by Besley and Ghatak and by Cassar and Meier shows, these motivations can be enhanced by selecting individuals with prosocial dispositions and aligning institutions to allow them to act accordingly. Yet more recent work by Attema et al. (2023) deepens this insight by showing that preferences themselves are endogenous—they evolve in response to institutional context. This means that governance structures do not just filter for motivation; they can also foster or erode it.³⁵

This understanding reframes governance as a tool not merely for compliance or performance monitoring, but as a platform for enabling ethical, cooperative, and purpose-driven action. Supporting professional autonomy, reinforcing meaning at work, and embedding accountability in peer relationships are not soft ideals—they are essential strategies for achieving resilient, high-performing health systems. In this light, Elinor Ostrom's principles of commons governance offer a useful parallel: effective healthcare governance depends on shared rules, peer monitoring, and nested governance structures that respect local knowledge and relational trust. These principles suggest that care systems are sustained not through tighter control, but through cooperation—grounded in shared purpose and local knowledge. Governance must recognize and foster this tacit expertise—not only in clinical judgment but in managing the relational dimensions of care. Long-term provider–patient continuity is key to accumulating and applying this knowledge effectively.

³⁵ However, as was discussed in 4.4. this erosion does not refer to the crowding out effect of financial incentives, but more to institutional constraints. Nevertheless, this does not exclude another possibility.

The practical implications of these findings are considerable. Faced with fiscal constraints, workforce shortages, and rising administrative complexity, health systems must leverage nonmonetary incentives more effectively—not as symbolic gestures, but as structural design features. This includes building interdisciplinary teams, preserving relational continuity, reducing bureaucratic overload, and designing digital tools that support rather than control providers.

Ultimately, sustainable healthcare governance depends on institutional complementarity: the alignment of state, market, and civil society in ways that recognize the complexity of care and the diversity of motivation. Financial incentives, performance metrics, and regulation all have their place—but they are insufficient on their own. The core of resilient systems lies in institutions that enable trust, foster ethical judgment, and reinforce shared purpose.

As Kreps (1997) observed, poorly designed incentive systems can erode intrinsic motivation by sending the wrong signals about trust, purpose, and autonomy. More recently, Kreps (2023) extends this insight by showing that preferences themselves are shaped by institutional experience and context. These findings reinforce a central claim of the thesis: governance is not merely about managing agents, but about cultivating the conditions under which ethical and prosocial motivations can flourish.

6 Discussion

This thesis has argued that sustainable healthcare governance requires alignment not only between institutions and incentives, but also between governance structures and the underlying motivational and informational dynamics of care. By focusing on the role of tacit goods, triple agency, and institutional mismatch, it has shown how current governance models—often rooted in financial measures and performance incentives—fail to address the core complexity of healthcare systems. However, these insights raise further questions about the limits of governance, the risks of instrumentalizing motivation, and the path ahead for both theory and practice.

A key argument in the thesis is that prosocial motivation—particularly intrinsic, ethical, or mission-driven forms—is central to sustainable care. Yet the concept of prosocial motivation itself is multifaceted. As Besley and Ghatak (2018) have noted, such motivation can stem from several sources: mission alignment with the cause, personal identity, altruism, status and reputation, or a desire to see one's effort produce meaningful results. These are not mutually exclusive, but their presence and salience likely vary across settings and individuals. Importantly, the governance implications differ: systems relying on identity or effort-based motivation require different forms of support than those engaging with altruism or status. Furthermore, there is a difference between interpersonal altruism and societal altruism, roughly aligned with prosocial and public service motivation, respectively.

A particularly important insight emerging from this thesis concerns moral distress. While burnout is often taken as a signal of poor work conditions or misaligned incentives, moral distress may be even more telling. If providers experience distress even in situations where institutions formally shield them from responsibility—such as budget-driven resource constraints—it suggests that their ethical standards exceed the expectations embedded in the system. This challenges the idea that provider behavior is purely instrumental or reputationally motivated. If motivation were driven only by compliance or image, moral distress would be alleviated once blame was removed. That it persists suggests a deeper internalization of ethical commitments, and raises questions about how institutions respond to, support, or suppress such motivations.

This relates to the broader issue of preference endogeneity. As recent work by Attema et al. (2023) emphasizes, preferences are not fixed. They are shaped by institutional environments, peer cultures, and incentive structures. While earlier models focused on selecting intrinsically motivated individuals into mission-driven roles (e.g., Besley & Ghatak 2005; Cassar & Meier 2018), newer

approaches recognize that motivation can evolve—or erode—over time, depending on how institutions reward, frustrate, or ignore ethical effort (see also Besley & Ghatak 2023). If governance systems impose repeated constraints that prevent providers from acting on their moral commitments, it is plausible that they may either exit the system or adjust their values as a coping mechanism. Over time, this could reduce the presence of strongly ethical actors in the workforce—not because markets directly crowd out morality, as Titmuss (1970) once argued, but because constrained moral agency leads to attrition or adaptation.

While concerns about markets crowding out moral behavior have a long tradition (see also Gneezy & Rustichini 2000a; 2000b), more recent scholarship suggests that this relationship is contingent rather than inherent. Choi and Storr (2023) argue that markets can either support or undermine moral behavior depending on the surrounding institutional norms, governance structures, and incentive alignments. Kreps (2023) further highlights that preferences themselves are shaped by experience and institutional context—supporting the broader case for governance systems that not only preserve motivation but actively cultivate it. Yu (2023) shows that autonomy is a key moderator of public service motivation's effect on performance—reinforcing the argument that governance design must empower intrinsically motivated actors to act effectively.

While market-based governance tools do not necessarily crowd out morality in a deterministic way, intensified competition and performance pressure may alter the motivational composition of the workforce over time. As Dewatripont and Tirole (2024) argue, in competitive settings where moral behavior is costly or non-instrumental, selection dynamics can drive out more ethically committed professionals. Even if market mechanisms do not erode individual morality directly, they can shift the incentive environment such that morally motivated agents either exit or are discouraged from entering. These dynamics may be especially acute in sectors with imperfect competition, where perverse incentives are reinforced—exemplified by the opioid crisis in the United States. In such contexts, market failure is compounded by ethical failure, not because individuals act immorally, but because the institutional conditions make moral behavior less viable.

This raises a deeper question: even if healthcare systems can rely on prosocial motivation in principle, under what institutional conditions can such motivation survive and scale? Selection effects, preference adaptation, and organizational norms all interact. Therefore, designing systems that preserve a space for ethical agency—and reward it appropriately—is a key challenge for future governance research. Recent empirical evidence reinforces this perspective: Casalino et al. (2024) find that physicians with stronger altruistic preferences are associated with lower healthcare

spending, fewer hospital admissions, and reduced emergency department utilization—suggesting that prosocial motivation can enhance not only ethical commitment but also system efficiency.

This dynamic further complicates the relationship between prosocial motivation and system goals. Even if ethical motivation supports care quality, it does not necessarily align with efficiency. In fact, if provider motivations reflect more interpersonal altruism (focused on patients) than societal altruism (focused on broader resource stewardship), there is a risk that providers will resist policies that aim to ration care or control costs. This creates a normative dilemma: how much should health systems rely on, and attempt to cultivate, prosocial motivation? If motivation is heterogeneous and endogenous—as recent work (Attema et al. 2023; Besley & Ghatak 2023) suggests—how large system-wide effects we can expect?

As Li et al. (2022) also point out, there are open questions about how norms and preferences interact. Do strong prosocial preferences make it easier to adopt ethical norms? Or do institutional norms shape the salience of altruistic behavior? As Cassar and Meier (2018) argue, we still know too little about how different dimensions of meaning, purpose, and motivation interact—whether they act as substitutes, complements, or conditional supports depending on governance context.

However, as Greep et al. (2021) argue, physician burnout is often mischaracterized as a personal weakness, when in fact it reflects deeper systemic dysfunctions in healthcare delivery, including excessive administrative burdens, loss of autonomy, and incentive misalignment. Addressing burnout, therefore, requires governance reform rather than resilience training.

As discussed in the section 3.3, this thesis suggested that moral hazard and moral distress may be closely connected. Institutional constraints that force providers to act against their ethical judgment may create what this thesis calls ‘institutionalized moral hazard’. This dynamic blurs the line between systemic failure and moral distress. This further illustrates the importance of aligning governance structures with professional ethics (see also Day et al. 2022).

This discussion also points toward a promising—if still underdeveloped—interdisciplinary research agenda. Network science and game theory could help illuminate how peer dynamics, reputation systems, and institutional trust shape behavior in decentralized systems—insights that resonate strongly with Ostrom’s work on commons governance. Her principles of shared rule-making, peer monitoring, and nested institutions provide a compelling foundation for understanding how health systems might move beyond command-and-control logic toward cooperative, adaptive governance.

One potential mechanism for integrating local knowledge into system governance is through community-based advisory boards, where primary care teams offer structured feedback on policy implementation. Such mechanisms could enhance responsiveness while preserving the relational and experiential knowledge that guides effective, high-quality care.

Finally, the thesis suggests several directions for future empirical research. Most notably, there is a need for comparative case studies or policy evaluations that examine how different health systems have attempted to harness nonmonetary incentives—and with what consequences. Which models of interdisciplinary team care have supported ethical alignment and efficient healthcare systems? Where have digital governance tools undermined motivation? What happens when mission-driven providers are exposed to highly competitive or privatized environments? In addition, studies should explore whether and how systems have institutionalized support for professional meaning—through peer relationships, patient continuity, or organizational culture—and what effect this has had on performance and retention.

While this thesis draws on existing empirical studies to support key claims—particularly regarding provider motivation and care outcomes—it adopts a primarily conceptual approach. As such, it does not offer empirical validation of the proposed governance mechanisms at a system-wide level. Future research could explore the broader effects of local knowledge integration and prosocial incentives in primary care settings through case studies, comparative system analyses, or longitudinal evaluations.

In conclusion, this thesis has argued for a new governance paradigm: one that sees motivation not as a constraint to manage, but as a resource to cultivate. While the risks of instrumentalizing ethics must not be ignored, the potential benefits of designing institutions that support trust, cooperation, and moral purpose are too great to dismiss.

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