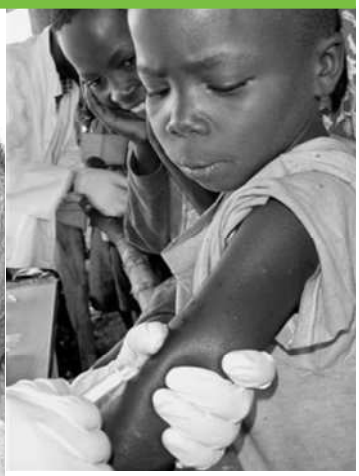
PAYING FOR PERFORMANCE IN HEALTH: A GUIDE TO DEVELOPING THE BLUEPRINT





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December 2008

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HEALTH SYSTEMS 20/20

Mission

The **Health Systems 20/20** cooperative agreement, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. HS 20/20 works to strengthen health systems through **integrated approaches** to **improving financing, governance,** and **operations,** and **building sustainable capacity** of local institutions.

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PAYING FOR PERFORMANCE IN HEALTH: A GUIDE TO DEVELOPING THE BLUEPRINT

CONTENTS

ACRONYMS

BSC	Balanced Score Card
BCG	French acronym for *Bacille Calmette-Guerin* (tuberculosis vaccine)
DHS	Demographic Health Survey
FFS	Fee-for-Service
GAVI	Global Alliance for Vaccines and Immunization
HIS	Health Information System(s)
IUD	Intrauterine Device
NHA	National Health Accounts
NHS	National Health Service
NGO	Nongovernmental Organization
OBA	Output-based Aid
P4P	Pay for Performance
PBC	Performance-based Contracting
PBF	Performance-based Financing
RBF	Results-based Financing
SP	Sulfadoxine Pyrimethamine
TB	Tuberculosis
USAID	United States Agency for International Development

FOREWORD

Are your health investments producing desired health outcomes, such as reduced maternal mortality and infant mortality, or is this link difficult to ascertain? All too often health systems pay for what is needed to produce health services and not for their "performance" or outcomes (i.e., if services are actually delivered or if the population's health improves). For example, payments to health centers and hospitals may be based on inputs, such as number of salaried personnel, fuel, and maintenance with no link to whether services are delivered. Workers whose pay is not linked to their performance may not be motivated to improve quality of care, productivity, or even show up regularly for work. Pay for performance (P4P) is an innovative approach that explicitly links financial investment in health to health results. In essence, it financially rewards providers or health care users for taking a measurable action (e.g., for having a facility-based antenatal care visit) or achieving a predetermined performance target (e.g., for ensuring that 85 percent of children under 1 year of age are fully immunized in a provider's catchment area).

This approach has produced positive results even in challenging country contexts. For instance, in Haiti, the P4P program yielded significant increases in immunization coverage and attended deliveries, because the payment approach pays nongovernmental organizations partly on whether health results are achieved. An evaluation found that an additional 15,000 children were immunized and an additional 18,000 women were provided a safer environment to deliver babies in each contract period – all happening against a complicated backdrop of violence, poverty, and limited government leadership.

While the P4P concept seems relatively straightforward, the mechanics of its implementation need to be planned very carefully to elicit the desired behavior change in a given country. To facilitate this planning, the U.S. Agency for International Development (USAID) through its Health Systems 20/20 project[1] has developed this P4P Blueprint Guide. Intended for country health program managers, including those representing government, nongovernment, and donor agencies, the Guide offers the reader a systematic framework to document and structure his/her thought process, rationale, and ultimate decisions made when designing a P4P initiative. In following each recommended step of the Guide (facilitated by technical support from experienced P4P implementers), the user is alerted to factors and issues that can influence the success of a P4P scheme. Upon completion of the Guide, the user will have produced a "blueprint" design for introducing P4P to his/her program area/country.

The suggested approach outlined in this Guide is based upon a successful tool used in Africa's first regional P4P workshop sponsored by USAID. Some of the participating countries that developed blueprints have gone on to implement their P4P designs, turning their ideas into reality. In addition, the Guide draws upon the lessons learned from P4P implementation in developing countries.

It is our hope that this Guide will facilitate the task of those interested in developing successful P4P initiatives so that they improve needed health outcomes in middle- and low-income countries.

Ann Lion
Director, USAID/Health Systems 20/20 project

[1] Health Systems 20/20, a five-year (2006-2011) cooperative agreement funded by USAID, offers USAID-supported countries help in solving problems in health governance, finance, operations, and capacity building.

PREFACE

Building upon the successful model developed in 2007 for the East and Southern Africa regional workshop on "Performance Based Financing" (PBF) (held in Kigali, Rwanda; May 2-4), this Guide offers a framework for thinking through and designing a PBF scheme. In addition, the Guide was piloted in two subsequent African regional workshops on results-based financing that were sponsored by the World Bank (also held in Rwanda; June and October 2008). The Guide draws heavily upon the review and lessons learned from P4P implementation in developing countries as described in *Performance Incentives for Global Health: Potentials and Pitfalls* (Eichler and Levine, eds., 2009).

We are grateful for additional comments provided by PBF experts, country PBF designers, and others including Amie Batson, Tania Dmytraczenko, Gyuri Fritsche Benjamin Loevinsohn, Bruno Meessen, Catherine Sanga, and Agnes Soucat. Finally, many thanks are extended to Linda Moll, Maria Claudia De Valdeneboro, and Ricky Merino for editing, formatting, and finalizing the document.

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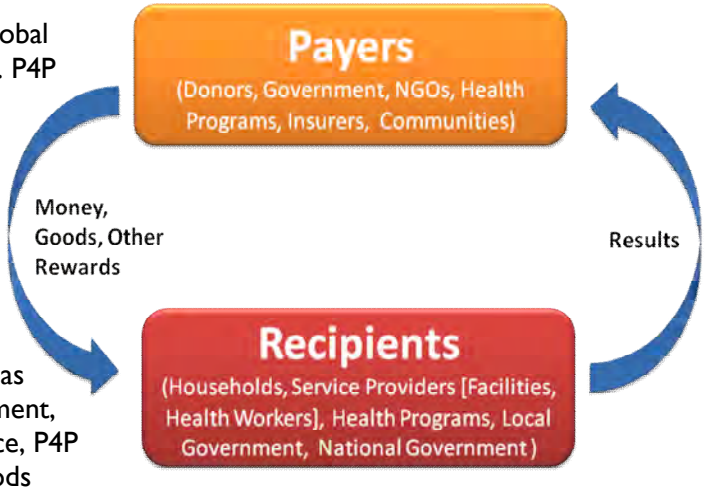
1. INTRODUCTION

1.1 WHAT IS P4P? CONCEPT AND RATIONALE



Pay for performance (P4P) is attracting much global attention as a strategy to achieve health results. P4P introduces incentives (generally financial) to reward attainment of positive health results. Recipients of performance incentives – which can be patients, service providers, or entities responsible for health in regions – receive performance payments only if specified results are achieved (no result, no performance payment). By doing so, P4P promotes hard work, innovation, and results – as opposed to simply paying for inputs, like equipment, training, fixed salaried staff, and drugs. In essence, P4P involves the "transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target" (Eichler and Levine, eds., 2009). This implies a financial risk – payment is received when (or withheld until) results (or actions) are verified.

Such schemes can be developed for both supply (health worker, facility, district health team, community) and the demand (patient) sides of the health system. A supply-side P4P scheme may tie health facility bonuses to the achievement of key performance targets such as an "increased number of women delivering babies with a skilled birth attendant" and/or an "increased number of fully immunized children." A demand-side P4P intervention may give households cash incentives to receive preventive care services or pay tuberculosis (TB) patients money or food to encourage completion of treatment. (See Annex A for more examples of P4P approaches.)

Most developing-country providers, however, are not rewarded for achieving health results. In contrast to P4P, incentives inherent in fixed salaries fail to stimulate sufficient attention to quality service delivery. For instance, fixed salaries with raises that are not tied to performance may lead providers to acquiesce to low productivity, absenteeism, poor quality, or lack of innovation. In addition, payment of fees by households (particularly when there is fee retention at the facility) results in a high volume of fee-generating services (typically curative care) and inadequate attention to preventive care and quality. At the facility level, fixed budgets focus on justifying expenditures on inputs and not on results; thus, there are weak incentives to expand coverage, promote preventive and primary care services, or solve systemic problems. At the patient level, limited incomes may cause households to prioritize urgent curative care services and neglect essential preventive care. This further reduces provider motivation to reach communities with essential public health services, resulting in limited accountability for or responsiveness to population needs.

The disconnect between what is rewarded and the reason for providing health services in the first place, i.e., to improve health, is a primary underlying cause of poor health outcomes in the vast majority of developing countries. By linking payment to actual results achieved (at the subnational, facility, individual

worker, and patient levels), the many individuals and institutions that together comprise a health system can be catalyzed to implement solutions that increase access to and use of priority services.

Many Names for P4P…

In entering the P4P milieu, one soon notices that global and national-level stakeholders use different terms and phrases to denote the P4P concept and related strategies. While these terms are similar, they may not be entirely synonymous and some distinctions do apply. Below are some popular P4P terms and an overview of their distinctions:

- **Pay for Performance (P4P):** Payment (monetary and/or nonmonetary) is issued based upon achievement of a predetermined performance target. Performance payments may target supply-side (e.g., health center, health worker) and/or demand-side (e.g., pregnant women) recipients.
- **Performance-based Financing (PBF):** Some consider PBF synonymous with P4P. Others also consider fee-for-service as part of PBF.
- **Results-based Financing (RBF):** Includes P4P and FFS.
- **Performance-based Incentives:** Synonymous with P4P.
- **Output-based Aid (OBA):** The use of development aid to support the delivery of services using targeted performance-related subsidies. Involves delegating service delivery to a third party (e.g., private firms, public utilities, nongovernmental organizations) that tie the disbursement of public funding to the services/outputs actually delivered (Global Partnership on Output-Based Aid, 2008). Distinctions with P4P are that OBA is largely supply-side oriented, focuses on external financing, and defines performance primarily in terms of outputs (i.e., goods and health services rendered) rather than outcomes (i.e., the consequences for the beneficiaries of those output, e.g., disease X prevalence reduced).
- **Fee-for-service (FFS):** Service provider is paid a fee for each rendered service/product. The distinction between P4P and FFS is that FFS strategies are supply-side oriented and do not have explicit performance targets, so payment is not based on achievement of a performance target.
- **Vouchers:** Target populations are given vouchers to access subsidized health services and/or products and/or other indirect benefits (e.g., transportation funds, financing for family member to accompany patient). The provider is then paid after remitting the vouchers to the payer**.** A voucher scheme can be an effective means for targeting specific population groups for health services and this constitutes one type of P4P approach.
- **Conditional Cash Payments:** Rendered for specific health services. Cash payments are given to patients when they use discrete health services, such as giving birth in a health facility with a skilled attendant (further discussion on this approach is provided in Step 2 of the Guide). This is an example of a demand side P4P approach.
- **Conditional Cash Transfer Programs:** Rendered as part of social safety-net programs. These are general welfare programs that target the poor for a variety of social services. Health conditions may be added to these programs (e.g., participants attend a health education session or obtain prenatal care visits).
- **Performance-based Contracting (PBC):** Refers to a legal or formal agreement to govern the terms of payment, which include a clear set of objectives and indicators, systematic efforts to collect data on the progress of selected indicators, and consequences, either rewards or sanctions for the contractor, that are based on performance (Loevinsohn, 2008). PBC is a type of P4P approach that specifically involves the development of a contract or formal agreement which may not always be the case for other P4P designs.

1.2 IS P4P RIGHT FOR YOUR COUNTRY?

While the concept sounds simple and logical, the challenge of designing and implementing a well-functioning scheme – including timely cash transfers, ensuring accountability, managing and monitoring performance etc. – can seem daunting, particularly in low-income countries that may already be grappling with inadequate infrastructure, shortages of human resources, weak information and financial management systems, competing priorities, high burden of disease, and limited funds. Nevertheless, it is because of the high health stakes that such countries should at least consider a P4P strategy[2] as one of the options for getting the most health out of limited funds. Moreover, through P4P introduction, many of the aforementioned systems issues, such as poor reporting information systems and low productivity, can start to be addressed. In this regard, P4P has been effectively implemented with good results in post-conflict countries or unstable environments and has shown to be part of an effective strategy to strengthen health systems while generating better health results. See Annex B for examples of country experiences with P4P.

Before deciding whether or not P4P is right for you, consider whether and under what circumstances using money to buy results generates a higher return than alternate strategies in your country. Also, do the benefits of performance-based incentive programs justify the costs incurred? In addition to the immediate term benefits of increased utilization of targeted services (e.g., immunizations), performance-based incentives may also provide benefits such as strengthening the capacity of delivery systems and alleviating poverty that will only be realized over decades. It is critical to note that not everything has to be "right" at the outset. P4P designers must be ready to assess and revise because successful implementation is an evolutionary process.

[2] This is not to say that P4P is the only or best way to generate improvements, but rather that it should be featured prominently in the menu of options from which programmers and planners draw when determining how to best achieve their targets.

2. OVERVIEW OF THIS GUIDE

2.1 WHAT IS IT FOR?

To facilitate the P4P design process, this Guide offers country teams a systematic framework for creating a "blueprint" – a plan or outline that shows "what can be achieved and how it can be achieved."[3] In so doing, the Guide helps teams to organize their thinking processes and to document decisions. The framework takes teams through a series of key steps and tasks that guide decisions about the design of a P4P intervention either at the national or subnational level. At each step, the Guide also asks teams to consider a variety of factors and issues that affect the success of a P4P design. In short, the P4P blueprint contains the elements of the design and operations of a P4P scheme. This is presented in a series of tables (shown in the pages that follow) that are each associated with a step in the design process. It should be noted that while the Guide offers a general overview of the major design steps, it does not address every detail needed for an operational implementation plan. Annex C contains an illustrative country blueprint.

2.2 WHO SHOULD USE IT AND HOW?

This Guide is written with middle- and low-income countries in mind. It builds upon the successful model developed in 2007 for the "Performance Based Financing" (PBF) regional workshop for East and Southern Africa (held in Kigali, Rwanda; May 2-4); many participants from that workshop have used their blueprints to successfully introduce P4P schemes, turning P4P into a reality. The Guide has since been pilot-tested successfully in two regional workshops on P4P, also held in Rwanda. In addition to feedback obtained at these events, the Guide draws heavily from lessons learned when introducing P4P in middle- and low-income countries as described in *Performance Incentives for Global Health: Potentials and Pitfalls* (Eichler and Levine, eds., 2009), which offers a systematic review of developing country experiences to date.

Intended for a variety of health care stakeholders – including government officials, donor representatives, program managers, insurers, employees of nongovernmental organizations (NGOs), hospital administrators, and district-level officials – this Guide can be used:

- Within a P4P training workshop environment; the decisions made in workshops will serve as a "rough-cut" of the blueprint, which should be finalized following a consultative process in country.
- Outside of a workshop setting to guide interested country stakeholders to assess feasibility and design, and acquire stakeholder buy-in to P4P. In these cases, facilitated in-country technical assistance (from experienced P4P implementers) is recommended and the guide should not be

[3] Oxford Dictionary definition. http://www.oup.com/elt/catalogue/teachersites/oald7/?cc=global

used as a stand-alone tool.

2.3 HOW IS IT STRUCTURED?

The Guide offers a series of blueprint tables for P4P designers to fill in step-by-step. In so doing, the thought process, rationale, assumptions, and decisions are systematically documented. Prior to each table, the Guide offers a brief overview of the objectives, concepts, tasks, and considerations associated with each step.

In preparing a P4P blueprint, users of this Guide will carry out the following key steps:

- Step 1. Assess and identify the top five performance problems that P4P can address
- Step 2. Determine recipients and how to select them
- Step 3. Determine indicators and targets, and how to measure them
- Step 4. Determine payment mechanisms and sources of funding, and how funds will flow
- Step 5. Determine the entity(ies) that will manage P4P initiatives and how to make P4P operational
- Step 6. Develop an advocacy strategy and identify immediate next steps

In addition, the Guide offers a brief discussion on considering rigorous evaluations as a possible component to a P4P learning strategy. Finally, the Guide's annexes offer examples of P4P schemes (Annex A), country experiences with P4P (Annex B), examples of country blueprints (Annex C), and recommended readings (Annex D).

3. GETTING STARTED

3.1 POINTS TO KEEP IN MIND

When preparing a P4P blueprint, designers should remember that the process is iterative and will require returning to earlier steps for further revisions once decisions in later steps become clearer.

Before getting started, please take care to avoid common design and implementation mistakes.

COMMON MISTAKES IN PERFORMANCE-BASED INCENTIVE DESIGN

1. Failure to consult with stakeholders to gain input to design, maximize support, and minimize resistance
2. Failure to adequately explain rules (or rules that are too complex)
3. Too much or too little financial risk
4. Fuzzy definition of performance indicators and targets, too many performance indicators, and targets, and targets for improvement that are unreachable
5. Tying the hands of managers so that they are not able to fully respond to the new incentives
6. Insufficient attention to the systems and capacities needed to administer programs
7. Failure to monitor unintended consequences, evaluate, learn, and revise

Source: Eichler and Levine, eds., (2009)

3.2 MATERIALS AND RESOURCES NEEDED

Before undergoing each blueprint step and task, country teams should have a solid understanding of the major health issues and underlying problems in their health sectors. The table on the next page lists sources of data that will facilitate the blueprint process; teams should obtain the documents before beginning the process. Additional useful documents to have on hand are the following:

- Medium-term expenditure frameworks
- Operational plans
- Health sector strategic plans
- Program-specific strategic and financing plans

SOURCES OF BACKGROUND DATA USEFUL TO THE BLUEPRINT PROCESS

Data	Possible Data Sources (this will vary from country to country)
Top 5 causes of mortality	National health plans
Top 5 causes of morbidity	National health plans
Maternal mortality rate (per 100,000 live births)	World Health Statistics Report (www.who.int/whosis/en/)
Infant mortality rate (per 1,000 live births)	Demographic and Health Survey (DHS) (www.measuredhs.com/); World Health Statistics Report (www.who.int/whosis/en/)
Antenatal care coverage – at least 1 visit	DHS (www.measuredhs.com/)
Antenatal care coverage – at least 4 visits	DHS (www.measuredhs.com/)
Vaccination coverage:	Health information system (HIS), GAVI Alliance reports
Percentage 1 year olds with one dose measles	World Health Statistics Report (www.who.int/whosis/en/)
Percentage 1 year olds with 3 doses DPT3	World Health Statistics Report (www.who.int/whosis/en/)
Births attended by a skilled health professional	DHS (www.measuredhs.com/)
Contraceptive prevalence rate	DHS (www.measuredhs.com/)
Total fertility rate	DHS (www.measuredhs.com/)
HIV prevalence (adults 15–49)	DHS+, AIDS indicator survey, sentinel site surveys, official reports from national AIDS committees, UNAIDS annual reports
Government health expenditure as % of total government budget	Public expenditure review, National Health Accounts (NHA)
Malaria prevalence	Mapping Malaria Risk in Africa (MARA), Roll Back Malaria Reports
Total health expenditure as % of GDP	Official government publications, World Health Report
Total health expenditure per capita	NHA ,World Health Report
Utilization rates for key services (e.g., immunizations, prenatal care, assisted deliveries, antiretroviral therapies, TB case detection and treatment completion, growth monitoring)	HIS reports, DHS, AIDS indicator survey
Utilization of health services by targeted population groups (e.g., the poor, urban vs rural, male vs female, children, pregnant women)	DHS, welfare monitoring and indicator survey, household poverty-related surveys
Availability and distribution of health workers	Ministry of Health
Household out-of-pocket burden of financing for health	NHA, national household welfare and consumption surveys, world health surveys, core welfare indicator questionnaires, poverty studies
Financial contributors to providers (amounts and flows)	NHA

3.3 DIRECTIONS

For each step in the blueprint design process described in the following sections, review the underlying concepts, objectives, tasks, and considerations. Discuss your responses as a team and document your final decisions for each step in its associated table. Also, be sure to identify key stakeholders who would be critical in flushing out the details for each step. For example, identifying indicators and performance targets may require further discussion with monitoring and evaluation experts at the Ministry of Health, NGOs (if considering an NGO P4P design), and health information systems (HIS) experts (to provide input as to the feasibility of measuring proposed indicators). Should you wish to fill out the tables electronically, a Microsoft Excel version of the blueprint tables is available and can be downloaded from http://www.healthsystems2020.org.

4. STEP 1: ASSESS AND IDENTIFY THE TOP-FIVE PERFORMANCE PROBLEMS THAT P4P CAN ADDRESS

4.1 OBJECTIVE

To select the priority health results that will be addressed by your P4P intervention.

4.2 KEY CONCEPTS

Performance problems in this context refer to health outcomes in need of significant improvement, possibly through a P4P intervention. These outcomes may target the general population or a subset.

A health outcome refers to the "final result of a production process or activity, for example increased health" (Alban and Christiansen, 1995) (such as a decrease in infant mortality). In terms of health, it is a measurable change in health status, sometimes attributable to a risk factor or an earlier intervention (NHS Institute for Innovation and Improvement, 2008). This is distinct from a health output, which refers "to the immediate product or service from a production process or activity" (NHS Institute for Innovation and Improvement, 2008) (such as a fully immunized child).

Performance goal refers to the "general aim towards which to strive; a statement of a desired future state, condition, or purpose. A goal differs from an objective by having a broader deadline and usually by being long-range rather than short range" (European Observatory, 2008) For example, a performance goal may be "malaria incidence rate falls."

4.3 TASKS

1. Examine data on leading causes of mortality and morbidity
2. Identify underlying causes related to motivation, provider, and household action
3. Prioritize based on whether change is possible and the benefit would be significant
4. Choose top five
5. Identify broad performance goals

4.4 CONSIDERATIONS

While it may be tempting to address many performance-related goals, it is wise to limit program goals to a small number (fewer than 10) at the outset to ensure success of the P4P program. P4P program designers should prioritize goals based on the following considerations:

- What will be the goals' public health and other social impact?
- What is their likelihood to influence results? (Is poor performance a result of inadequate behaviors or actions of providers or patients?)
- What is feasible to implement at this time?

Also, consider the following questions:

- Where is the largest performance improvement needed? What specific results are desired? Illustrative areas for improvement are:
  - Infant and maternal mortality rates fall
  - Contraceptive prevalence rate rises
  - Patient self-care is improved
  - Chronic conditions are appropriately managed at the primary-care level
  - Quality of acute care is improved
  - Patient satisfaction has increased

  Make sure that your goals are specific. For example, if a goal like "increase utilization of essential health services" is proposed, consider specifying whether it applies to the general population or is focused on low-income groups.

  Another suggestion is to consider short- and long-term development goals. When there are many or competing goals, the team should identify trade-offs and assign a weighted value to each one.

- What are current incentives and how do they affect provider and patient actions? Understand the existing incentive environment, because new incentives (the result of P4P) will be introduced on top of existing ones; the interaction of the two will influence the overall result. To better understand this, ask yourself the following questions:
  - Is health worker pay currently linked to their performance?
  - Are salaries fixed and determined by seniority, with no link to results produced?
  - Are public health workers civil servants who are essentially guaranteed a job for life, regardless of their performance?
  - Do private providers such as traditional birth attendants and private drug dispensers have any incentive to refer people for care from trained health workers?
  - Does the population face barriers (financial, geographic, social such as stigma, or other) that prevent them from utilizing priority services?
- Where are large performance improvements possible?
- Are desired actions/behavior changes under the ***provider's*** control? under the ***patient's*** control?

Step 1: Performance problems and their underlying causes, in order of priority			
Performance problems	**Rationale for selection**	**Underlying causes**	**Performance goal**
1.			
2.			
3.			
4.			
5.			

Step 1: Performance problems and their underlying causes, in order of priority			
Performance problems	**Rationale for selection**	**Underlying causes**	**Performance goal**
E.g., TB patients drop out before completing treatment	TB prevalence rates have doubled in recent years and development of drug resistant strains is a concern; Measurement of TB cases is Not well-recorded at facilities.	Patient side: can't afford transportation and lost work, undervalue importance of completing treatment. Health worker side: not motivated to follow up on defaulters. Provider is paid a fixed salary, not tied to performance. Facility level: Funds for fuel not available to follow up on defaulters.	TB prevalence rate falls.
Country stakeholders to involve when defining Step 1:			

5. STEP 2: DETERMINE RECIPIENTS AND HOW TO SELECT THEM

5.1 OBJECTIVE

To identify ***whose*** behavior you want to change through the introduction of P4P and who would potentially receive performance payments.

5.2 KEY CONCEPTS

Recipients are institutions and/or individuals who can potentially receive incentive payments provided they meet performance targets. P4P initiatives can target a variety of potential recipients including district health teams, NGO networks, facilities, individual health workers, communities, households, and individuals.

Interventions rewarding the producers of health care services are supply-side P4P schemes. Interventions rewarding the recipient/users of health care are demand-side P4P schemes. These interventions are outlined below[4]:

Supply side

Supply-side P4P interventions reward performance achieved by entities and workers involved in organizing and delivering health care, preventing illness, and promoting health. P4P initiatives can motivate providers to develop innovative strategies to improve outreach that will achieve health goals, as well as improve the volume and quality of services. Examples of rewards include the following:

- ***Financial bonuses*** to reward good performance and/or penalties for poor performance. This can motivate community outreach, in particular to underserved areas; encourage more convenient clinic hours; improve provider-patient interactions; and stimulate solutions that reduce financial barriers faced by households.
- ***Social, community-based, and private insurance*** that pays providers based on performance.
- ***National-to-local transfers based on results***, which can stimulate local solutions that improve provider performance and reduce financial barriers to access.

Demand side

Demand-side P4P interventions reward use of targeted services (such as vaccinations and antenatal care) or achievement of concrete health results (such as stopped tobacco use) by individual patients, specific population groups, or communities. Examples include the following:

[4] For more information on interventions, see Eichler and Levine, eds. (2009).

- ***Conditional cash payments*** to patients or households, based on whether they attend health education sessions, make prenatal care visits, or give birth in health facilities with the assistance of skilled attendants.
- ***Conditional cash transfer programs*** integrated into social safety-net programs. These are general welfare programs that target the poor for a variety of social services. In Latin America, health conditions have been added to social protection programs that provide income support to poor households (Glassman et al. 2007). These programs stimulate use of priority services by conditioning significant household income support on use of essential services. An additional benefit may be that they encourage households to use quality services and discourage them from purchasing low-cost substitutes.
- ***Transportation subsidies*** to reduce direct costs of obtaining care.
- ***Food support*** to free up income that would have been used to buy food. Reduces opportunity costs of seeking care, especially for treatment of chronic conditions.
- ***Direct payment for use*** provides incentives to access care by reducing direct costs (may make out-of-pocket costs negative).

5.3 TASKS

1. What possible P4P approach should be considered: supply side, demand side, or both?
2. Identify potential recipients
3. Determine how recipients will be selected, for example, a competitive process for providers, means-testing for households

5.4 CONSIDERATIONS

Selecting the type of recipient to pay

Selection of the recipients should be based on the behaviors that need to change (relating to the above-mentioned underlying causes of performance problems). In determining who should be rewarded for performance, review the underlying causes and consider the following:

Supply side

- It may be useful to target the ***individual health worker*** if individual action (i.e., working harder, doing more of what they are already doing) is all that is needed.
- It may be useful to choose the ***institution level*** if teamwork is warranted to improve performance or if systemic changes are needed. For example, an individual health worker may not be able to change clinic hours or implement community outreach strategies. Also consider whether incentives at the team level will motivate team members to pressure other members to increase productivity.
- It may also be useful to provide incentives to the ***district health team*** or ***umbrella organization*** that has the responsibility to supervise and support health facilities to reach the population they are responsible to serve with quality services.

- Consider also whether the benefits outweigh the costs of ***monitoring***. For example, it is more costly and complicated to monitor individual-level than facility-level performance.

Demand side

- Consider who needs to take action to use priority services. For children, the primary caregiver needs to take action. For women, it may be a complex combination of the woman and other decision makers in her family.
- Are there complementarities with other services that provide opportunities for positive spillover effects? For example, newborn care can be effectively linked with maternity services. Also, prenatal care can be linked to malaria prevention, prevention of mother-to-child transmission of HIV, and safe deliveries.

Selecting individual recipients

Once the type of participant/target population is identified, you will need to determine ***how*** to select the actual recipients. For example, on the supply side, you may decide that NGOs should be the recipients and then use a competitive process to select them. You may identify public facilities as the recipients but work only with the ones that meet specific criteria. On the demand side, if recipients will be poor women, you will need a process to identify who is eligible and a mechanism to operationalize this. Examples of approaches are given below:

Supply side

- Public providers:
  - All public providers in a certain ***category*** (example: all health centers)
  - Public providers that meet certain ***criteria*** (example: are able to report on information and have a functioning community committee)
  - Public providers of a specified type ***compete for the opportunity*** to be paid based on results and to operate with the associated autonomy. (Request proposals, evaluate them, and begin P4P with recipients that score well according to predetermined proposal evaluation criteria.)
- NGOs/ faith-based organizations (FBOs)/ private-for profit providers:
  - All existing payment arrangements are changed to ***performance-based payments***. For example, countries in Africa that currently finance FBOs with public funds could change the terms of payment, linking payment to results.
  - ***Precondition-based selection***: You may determine that all NGOs that meet specific conditions are eligible.
  - ***Competitive selection***: Manage a competitive process to select entities to provide health services for a specified population. This requires determining selection criteria, and designing a "request for proposal" document; it may benefit from holding a bidders conference to train potential bidders. An evaluation team needs to be assigned and evaluation criteria pre-determined. Refer to literature on contracting for various approaches (Loevinsohn, 2008).
  - ***Sole-source selection***: In some situations, it may make sense to go directly to NGOs that have long experience in a region.

Demand side

- ***All people with specified characteristics***: The demand incentive (e.g., a transport subsidy) could go to all pregnant women or, more narrowly, to all pregnant women who live in geographic areas where X percent of the population is designated as poor or extreme poor.
- ***All people with a particular condition or illness***: The demand incentive could go to, for example, all persons with TB or all HIV-positive pregnant women.

Step 2: P4P approach, its recipients and process for selection		
P4P approach	**Recipients**	**Process for selection**

Step 2: P4P approach, its recipients and process for selection		
P4P approach	**Recipients**	**Process for selection**
Example-side P4P: Pay performance awards to public ambulatory care facilities.	Public health posts, health centers, and outpatient services provided in district hospitals	All public facilities with a functioning HIS and minimal level of staffing according to norms.
Country stakeholders to involve when defining Step 2:		

6. STEP 3: DETERMINE INDICATORS, TARGETS, AND HOW TO MEASURE THEM

6.1 OBJECTIVES

To take initial steps towards defining measurements and specific targets of performance success that will determine payment.

To identify mechanisms for tracking and verifying performance progress, once targets and indicators are defined.

6.2 KEY CONCEPTS

Performance indicators: are measurements that aim to ***describe*** as much about performance as succinctly as possible. They help to ***understand*** a system, ***compare*** it, and ***improve*** it (NHIS Institute for Innovation and Improvement, 2008). Indicators used to reward performance should be quantitative variables that allow for the verification of change. Examples include:

Supply side

- Percentage of infants who are fully immunized, as a measure of primary health care delivery
- Score on standardized surveys/exit interviews, as a measure of consumer satisfaction
- Percentage of TB patients completing treatment, as a measure of health outcomes

Demand side:

- Children's growth is monitored (to ensure utilization of preventive care), as a measure of use of preventive care.
- Woman delivers with a skilled birth attendant, as a measure of utilization of a high-impact service.
- Random urine tests to confirm a substance user's use or no use of drugs, as a measure of health outcome.

Performance targets: While indicators specify what will be measured, targets imply the direction, speed, and destination, that is, how much of an improvement and how quickly it is achieved (NHIS Institute for Innovation and Improvement, 2008). They offer clarity to the potential recipient about what he/she should work towards. Examples include

Supply side:

- Increase percentage of fully immunized infants to 90 percent.
- Increase score on standardized surveys or exit interview to 80 percent.
- Increase percentage of TB patients completing treatment to 90 percent.

Demand side

- Children taken to have growth monitored in accordance with Ministry of Health norms
- Woman presents to facility to deliver with skilled attendant
- Biomarker to confirm no drug use by intravenous drug users

6.3 TASKS

1. Define indicators of performance
2. Determine targets for improvement
3. Describe how indicators will be measured and validated.

6.4 CONSIDERATIONS

Indicators

This step may seem daunting at first, particularly for countries where information systems are weak. When initiating a P4P intervention, use a small number (fewer than 10) of indicators. Limiting the number makes the scheme easier to understand and focuses recipients on making a few important changes that improve health results. As the P4P program evolves, increasingly complex performance measures may be both feasible and desirable. Furthermore, successful P4P schemes can in turn strengthen reporting and bolster HIS, because the information now more directly affects the producers and users of the health system.

Indicators must be directly related to the P4P goals of the payer. They should also be understandable, particularly to those whose behavior you seek to change – potential recipients will not be motivated unless they understand the evaluation process and how payment is linked to their performance. Indicators of key output measures must be attributable to the actions of potential recipients; that is, recipients should have direct influence over the indicators. For example, a supply-side indicator should not be so broad as a "reduction in child mortality rates" – there are many social determinants of health and providers cannot influence all of them. Rather, a good example would be "number of children who are fully immunized," because a provider can influence this aspect of child health. Finally, indicators should be measurable and verifiable; this process needs to be clearly articulated in a contract or performance-based payment agreement. Lack of specificity and clarity may lead to disputes between the recipient and payer at the end of the contract period.

Good candidates for indicators are those that (1) target a single intervention (e.g., immunization), (2) prevent or treat a single disease (e.g., TB), (3) determine the needed quantity/target (e.g., prenatal care visit), (4) have clear and standardized treatment guidelines (e.g., for TB and malaria), and (5) are needed

frequently by a target population (e.g., deliveries). As the P4P program evolves, more complex indicators can be introduced.

Targets

Ideally, targets should be population based. For example, at baseline 40 percent of infants are immunized and so a performance target may be to achieve 55 percent coverage. Another option is to establish a target quantity of rendered services, for example, the baseline is 400 immunized infants and so a performance target may be 500. Both types of performance targets encourage recipients to develop outreach strategies and strengthen delivery systems to achieve targets.

Determining targets for improved performance is an art as well as a skill, perfected as managers gain experience and programs evolve and mature. Care should be taken to develop informed, feasible, yet challenging targets. Targets should be neither achievable with very little effort nor, at the other extreme, impossible to meet even with extraordinary effort. Targets for improvement should be attainable within a contract period. Generally, bigger increases are possible when starting from a low baseline (as opposed to starting when already close to the maximum level of possible performance). In order to work effectively, there should be clear links between target setting and performance payment. It should be readily discernable that individual action can significantly influence achievement of performance targets; such targets are the most motivating.

In some settings, you may decide that paying for each additional rendered service will be more feasible to implement than approaches that reward attainment of targets. If your information system is weak, for example, you may not have the ability to establish the baseline levels of utilization needed to determine targeted increases. While paying a fee for each additional service will encourage increased production of services, it may not set in motion the same degree of system change and innovation that targets may encourage. In addition, blueprint designers should be advised that health economists agree that paying a fee for each additional service results in excessive numbers of services provided. While encouraging increased utilization of priority preventive care and high-impact services is desirable, you may place your health system on a long-term path to accommodate fees for other services that have a higher danger of leading to excessive utilization.

The team should also try to anticipate any unintended consequences of selected targets, both positive and negative. For example, a scheme that rewards only 100 percent treatment completion may have the adverse effect of causing TB providers to be unwilling to begin treating population groups that have been traditionally challenging, such as the homeless or substance abusers.

Two types of design options for setting targets have been shown to produce disappointing results: (1) a uniform threshold applicable for all P4P participants (for example, everyone must reach 90 percent full immunization coverage) and (2) following a "tournament model," where those in, say, the top 75th percentile of performance receive the bonus.

In most low- and middle-income countries, the goal should be to increase the performance of ***all*** providers, both those starting at a low baseline and already strong performers. Capacities and contexts differ, making it hard to establish an absolute level of performance that all need to reach. As discussed above, providers, especially those starting at a low baseline, will be more motivated to work toward a realistic target than toward one that appears to be an impossible challenge. For this reason, we recommend establishing targets for improvement that are set according to each recipient's own baseline.

A tournament model awards a performance bonus only to providers in the top X percentile. This tends to reward providers who are already top performers and fails to reward providers that have more ground to catch up. For this reason, a tournament approach should only be used if it is in addition to incentives that encourage the lower performers to improve.

Tracking and validating indicators

Success of any P4P scheme depends upon verification of its results. This is especially important because, once a program is in place to pay recipients based on results, they face incentives to report (correctly or incorrectly) that the results were achieved. The approach to verification needs to be designed carefully, as it can have both positive and negative effects on information tracking and how data are used. On the one hand, managers may be motivated to strengthen the quality of their HIS to better identify where interventions are needed to ensure progress toward meeting rewarded targets. On the other hand, P4P could lead to falsification of data, resulting in a weakened HIS unless care is taken to ensure the credibility of tracked data, complemented by clearly defined consequences for misreporting. Some examples of approaches to track and validate results are:

Supply side

- ***Provider-reported results, with random audits from an external agency*:** An external agency is contracted to evaluate the credibility of reported information that, most often, comes from service statistics: samples of recipients are identified, facility health records are audited, and a randomly selected sample of households are interviewed to verify that reported services were actually provided. The strength of this approach is that it stimulates providers to improve and use information for management decisions. Its weakness is that provider-reported data do not fully reflect population coverage.
- ***Population-based surveys by an independent entity*:** This approach surveys a sample of people living in a given geographic region to determine whether utilization has increased. Its strength is that information about population access and use can be estimated. Its drawbacks are that it is less apt to strengthen HIS and use of HIS data by facility managers, as well as its costs in terms of the human and financial resources needed to conduct surveys with a statistically significance sample.
- ***Verification by peers*:** Peer facilities or subnational teams can be used to validate the reported results of other facilities or teams at the same level. For example, a team from one hospital can be used to verify the reported results of a similar hospital in another region. The strength is that teams from peer facilities learn from each other through the assessment process. The drawbacks are that it takes often scarce health human resources away from their service delivery sites and that peers may be less willing than external entities to identify data discrepancies. Training peers to acquire the skills to audit peer entities imposes costs and time away from service delivery.

Demand side

- ***Provider-reported results of household actions*** (e.g., documented patient record of antenatal care visits) complemented by random spot checks of evidence from households. In programs where only households or individuals are rewarded (no performance payment to providers) when they receive services from the formal service delivery system, this approach makes sense. However, if providers also receive performance payments, they will have an incentive to over-report. (Advantages and disadvantages of provider validation approaches are discussed above.)

Step 3: P4P indicators of performance, targets, and process for measurement		
Indicators	**Targets**	**Process for measurement and verification**
1.		
2.		
3.		
4.		
5.		
E.g., % of children under receiving DPT3 in provider catchment area	85%	Provider reports with random household spot checks of immunization cards for validity
Country stakeholders to involve when defining Step 3:		

7. STEP 4: DETERMINE PAYMENT MECHANISMS

7.1 OBJECTIVE

To determine the mechanism that links reward (or penalty) to attainment of targets.

7.2 KEY CONCEPTS

Positive incentives: Reward individuals or teams directly for a desired behavior or outcome; they are affirmative enablers encouraging a desired behavior (Jochelson, 2007).

Negative incentive: focus on the failure of an individual or team to adopt a desired behavior, and discipline that individual/team by withdrawing the reward, believing that this will encourage adoption of the desired behavior (Jochelson, 2007). Examples include withholding funds or reducing fees if performance is not achieved.

Financial risk: Probability/likelihood of receiving or losing performance payment, i.e., payment occurs if the desired action is taken or behavior positively changed, but does not occur if conditions are not met.

7.3 TASKS

1. Determine how much payment will be linked to performance and how much is not exposed to financial risk.
2. Develop a formula that will determine performance payment.
3. Clarify where the funding for payments will come from and determine if it is sustainable.

7.4 CONSIDERATIONS

Designing a payment approach

P4P imposes financial risk. Payment is received when (or withheld until) results (or actions) are verified. In determining how much will be exposed to financial risk, country teams must assess how much risk is enough to motivate a positive behavior change and how much risk is too much to motivate actions to achieve the potential reward. In most supply-side cases, the majority of provider funding will be regular and reliable with only a small portion conditional on attaining performance targets.

Before choosing the most appropriate approach, you should review your assessment of the existing incentive environment. Consider that incentives are introduced on top of existing ones. This interaction is critical.

Included in this assessment is an estimate of other sources of funding and the associated terms. Consider the recipients' other resources: Will the potential performance payment be a small or large ***portion of total funds*** going to the recipient? For example, if an NGO receives only 10 percent of its funding from your P4P program and the rest in untied grants, you may need to increase the amount of funding that is linked to results (at risk) to make it worthwhile for the NGO to work toward achieving the results. In addition, spillover effects may be induced that may contribute to making the other grants more effective.

Supply level

In most cases, the performance payments are more effective when introduced at the level of teams such as for all people working in a health facility. Because improving utilization and quality of health services requires the combined efforts of a team of people, team based incentive programs are more likely to induce the desired results. When performance payments are made to teams, however, part or all of the funds should be shared with the individual members of the teams.

At the ***subnational, community,[5] and facility levels****, payers need to consider the following:*

- How often will you pay the performance award? There are trade-offs in making frequent payments linked to performance; they may be more motivating but have costs of reporting, measuring, validating, and paying.
- What portion of payment is at risk? Institutions may be able to absorb more risk than individual health workers. However, too much risk can be de-motivating. In the vast majority of cases, a relatively large portion of payment should be regular and reliable. Experience to date suggests that that the risk can be relatively small and still have an impact – for example, successful supply-side programs in developing countries have imposed a roughly 10 percent financial risk on providers.
- Is payment tied to attainment of all targets, or will payment be made for achievement of some targets? Similarly, will payment *per* target be "all or nothing"? Partial payments for partial attainment of the target(s) may be specified in a stepped approach. An "all or nothing "approach is clear, imposes fewer transaction costs on the payer, and encourages long-term planning and systems strengthening, but recipients that almost, but not quite, reach the target receive no payment. In contrast, a stepped approach may be perceived as more "fair," but it imposes increased transaction costs and weakens the incentives to attain the full target.
- Should you consider fee-for-service payment? Paying providers a fee for each service provided on a list is another way to increase production of services. This approach has the advantage of being easy to understand, making it motivating. However, there is unambiguous evidence that a fee-for-service system generates excessive provision of services (quantities beyond what is needed to ensure good health), which needlessly increases health spending. There are arguments for using a fee-for-service system to stimulate use of preventive services that are underutilized; this should be instituted with caution, however, as once the fee-for-service systems are in place, it usually is difficult to get rid of them.
- Should you consider adjusting payments to account for quality? In addition to rewarding increases in the quantity of services provided, it is possible to incorporate a payment that

[5] Here, "community" refers to community leaders and/or committees as "providers" that generate demand, not to the ultimate beneficiary.

rewards (or penalizes) quality. One example is to include an indicator of "patient responsiveness" that is measured by a short exit interview or population-based survey. An increase in the score that reached the pre-established target level could be rewarded with a performance payment. Another approach is to use an assessment tool that evaluates and scores quality across a range of domains. This approach is used in Rwanda and serves to deflate the fees a facility is eligible to receive (a quality score of 73 percent results in 73 percent of the earned fees). While these approaches have some merit, consider whether they would be feasible and cost effective to operationalize in your context. Another way to incorporate quality is to introduce indicators that include quality components. As your P4P system evolves, it will be possible to phase in adjustments for quality as part of more sophisticated measures. For example, instead of measuring whether four antenatal care visits are provided to pregnant women, you may specify that the four antenatal visits include services, such as iron supplementation and tetanus toxoid, that signify quality antenatal care. As programs become more sophisticated, you might want to construct indices of quality care and reward increases in overall scores. For example, some provider networks in the United States construct indices of quality care for chronic conditions and reward increases in the average score with performance payments.

- Should you consider some combination? It is possible to consider a combination of fee-for-service for underutilized preventive services, performance targets for other services, and a quality score? You may be able to combine capitation payments with performance payments. When considering these combinations, be sure to consider the feasibility of implementation and whether the recipients you hope to motivate will understand and act on incentives in complex payment approaches.

- For performance targets met by a health facility, community, or other team rather than by an individual, should the P4P program have rules for distribution of the award payment among team members or allow the team to allocate payment? In some settings, it may be necessary to establish rules for the distribution of group awards – including, perhaps, requiring that a portion of the award be set aside for investing in the facility, community outreach activities, or community health promotion. If the P4P program does not to establish rules, teams should be required to do so in advance, so that members are clear about how they will benefit financially if the team attains its targets.

- When considering payment for supervisors at the subnational level, how far up the administrative hierarchy should performance payments go? In settings where the actions of district health teams have a direct effect on the performance of health facilities, it would be a good idea to link a portion of the district health team pay to the performance of all the facilities in their district. This logic should continue "up the chain" to the level (regional? national?) where impact is potentially important. Note that it is critical to have system to validate performance information that is independent from those who directly benefit.

Demand side

Households and individual patients can be rewarded for a variety of goals:

- Performance payments for discrete health-related actions: An example of this is to pay a pregnant woman who delivers at a health facility. The rules should be clear and well publicized to the population and the system to transfer the funds to the recipient must be in place.

- Performance payments for long-term treatment of chronic conditions: To encourage adherence to long-term treatment regimens, performance payments or transfers of other material goods

(food) have been used. In most cases, patients are compensated when they present to take their medicine. The payer must decide whether to allow any missed treatments.

- Performance payments for evidence of behavior change: In developed countries, patients have been offered payments to change addictive behavior: remain drug free, quit smoking, lose weight. Payment is conditional on the results of verification techniques performed on the spot. Evidence of drug abuse or smoking can be measured with biomedical testing, weight loss with a scale.
- How frequently will households receive cash transfers? Demand side P4P programs must establish how frequently cash transfers will be made to households or individuals. For discrete health actions such as deliveries, the transfer may be one time or may include a subsequent transfer linked to postnatal care. For large-scale social protection programs that link payment of household income support to specified health (and often education) actions, transfers are periodic and regular. In the Mexican conditional cash transfer program, for example, households receive their income transfers every 2 months. These programs contain rules for number of health visits or days of school that can be missed before the income support is interrupted or terminated.[6]

Agreeing to a payment formula

There is no set approach to development of a payment formula. What is clear, however, is the importance of ***clearly specifying the terms of payment in a written contract or performance agreement that is signed by both recipient and payer***. Examples of payment formulas are the following:

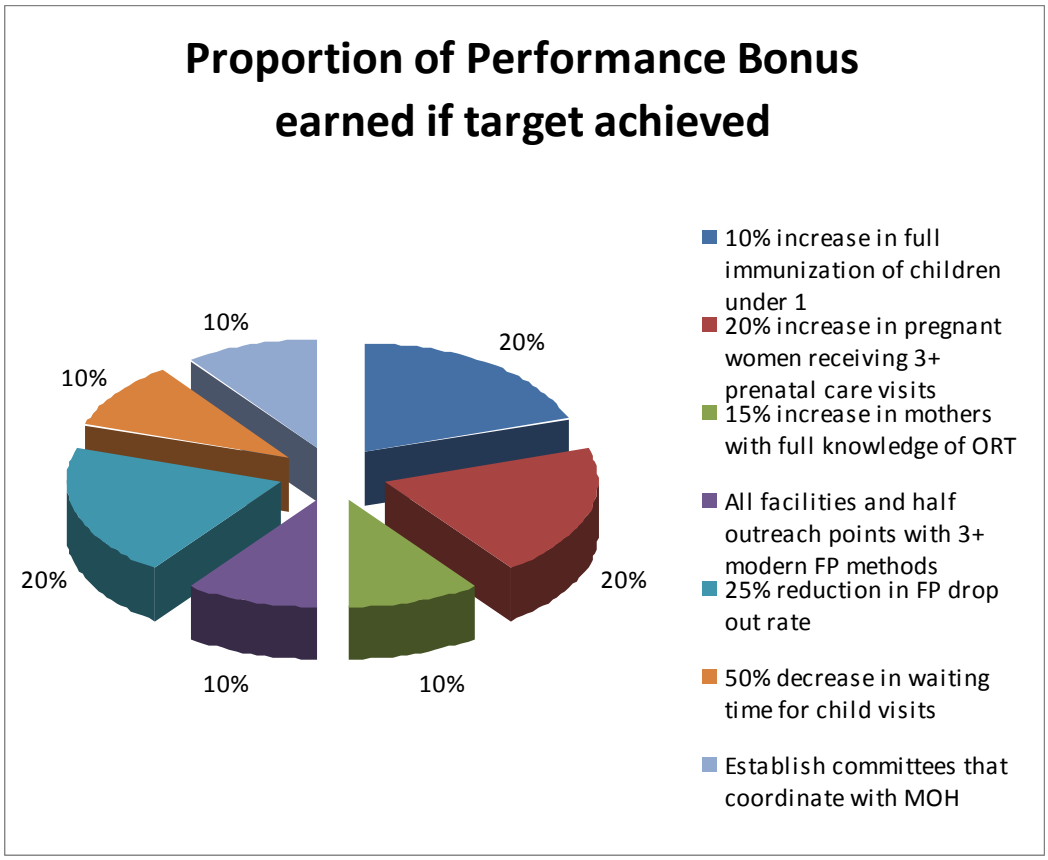
1. Payment formula: All or nothing population-based targets:

Total potential payment received by health facility = 95% of historical budget + performance bonus.

Maximum potential performance bonus = 10% of historical budget.

The following figure illustrates a performance award system that is apportioned among various targets.

[6] For information about conditional cash transfers, payment rules, and health conditions, see Glassman et al (2007).



Source: Adapted from Eichler et al. (2001)

2. Payment formula: Fee-for-Service with quality score deflator

Total potential award payments to a facility= (sum of E*F)* Quality score

A: Activities	B: Indicators	C: Quan-tity	D: Criteria for Validation	E: Validated Quantity	F: Fee	Monthly Amount (E*F)
Curative consultation	Number of new cases		Consultation register requires: name, gender, address, symptoms, exams completed, diagnosis, and treatment.		100	
New prenatal consultations	Number of new cases		Prenatal care consultation register requires: name, address, information from patient interviews, and information from physical and obstetric exams.		50	
Completed prenatal Consultations	Number of pregnant women with 4 prenatal care visits according to norms.		Registers document that 4 visits delivered according to Ministry of Health norms.		200	
Prenatal anti-tetanus	Number of pregnant women who		Registers validate that anti-tetanus vaccine delivered.		250	

	receive anti-tetanus vaccine					
Prenatal Sulfadoxine Pyrimethamine (SP)	Number of pregnant women who have completed the second dose of Sulfadoxine Pyrimethamine		Review of registers and copies of receipts.		250	
Prenatal referrals for complications	Number of pregnant women referred to the district hospital after the ninth month.		Receipts that document referrals that are signed by district hospital authorities		1000	
Well-child visits	Number of infants 12-59 months who receive well-child consultations.		Consultation register includes: record number, name, gender, address, age, weight, height		100	
New family planning acceptors	Number of new users of modern methods (IUD, pill, injectables, implant)		Family planning register shows: name, age, address, interview questions, preconditions, physical exam, and prescribed method.		1000	
Continuing family planning users	Number of users of modern methods (IUD, pill, injectables, implant)		Receipts showing continuation		100	
Fully immunized children	Number of children completing vaccinations		Immunization register shows: number, name, date of birth, gender, address, dates of: BCG 1,2,3, Pentavalents 1,2,3, and measles according to the vaccination calendar		500	
Deliveries in the health center	Number of assisted deliveries		Partograms show: name, required documentation of stages of labor, engagement.		2500	
Referred deliveries	Number of women referred for delivery		Receipts that document referral from health center signed by district hospital		2500	
Child referrals for severe malnutrition	Number of infants 0-59 months referred for severe malnutrition		Receipts that document referral from health center signed by district hospital		2000	
Other referrals	Number of referrals for interventions other than deliveries, prenatal complications,		Receipts that document referral from health center signed by district hospital		1000	

	or severe malnutrition					
Subtotal						
Quality score					X%	
TOTAL					Sub-total * quality score	

Source: Rwanda 2008 PBF fee schedule

Paying for P4P

Where will the money for performance payments come from – are the ***existing funds*** enough to cover the performance payments? There are several things that the team can consider in determining this:

- Change existing methods of paying (from government, NGOs, donors, etc.) providers from input-based to performance-based.
- Modify existing social safety-net programs that may be based on unconditional income transfers; make part of the transfers conditional upon a performance target.
- Modify payment of social insurance funds or community-based health insurance funds so that they are based on achieving performance targets.

The team can also advocate for ***new funding sources*** to cover the award fee amount. This is likely to be the most attractive to recipients. However, if these funds are only available for a short period of time, the long-run viability of the program may be threatened. It is possible, however, that demonstration of strong results from P4P using external funding may provide the evidence policymakers need to increase public spending for health.

- Lobby donor partners for funds – many donors are increasingly adopting a performance-based culture.
- Lobby the Ministry of Finance for additional funds.

Budget implications of P4P

Offering providers the chance to earn performance awards to change their behavior has budget implications. For example, if performance bonuses are designed as a fee for each additional service provided, the performance-incentive program will require funding for both the incentive and the incremental service provision. The total resources required are affected by the supply response. The maximum financial outlay can be more accurately projected if performance bonuses are determined by reaching a predetermined target level.

Another factor in determining the P4P budget is program administration costs. There will be new operational costs – of negotiating, managing, and monitoring performance agreements, and of building the capacity needed to carry out these duties – but also the elimination of some of the costs of running the existing reimbursement system. For example, the change from expenditure-based reimbursement to performance-based payment will increase the costs of monitoring results but also lower the costs of auditing financial reports (see Step 5).

Step 4: Payment mechanisms and sources of funding		
Recipient (e.g., subnational level, institution/facility level, individual health workers, teams, communities, households, patients)	**Payment mechanism and source of funding**	
Recipient Type A:		
1. Amount of payment linked to performance		
2. Amount of payment not exposed to risk		
3. Formula for performance payment if population based.	Performance Target	Associated Weight
4. Fee schedule if fee-for service is chosen.		
5. Added calculation that adjusts for quality?		
6. Frequency of performance payment		
7. Sources of funds		
8. Is this sustainable? Why?		
Recipient Type B:		
1. Amount of payment linked to performance		
2. Amount of payment not exposed to risk		

3. Formula for performance payment if population based.	Performance Target	Associated Weight
4. Fee schedule if fee-for service is chosen		
5. Added calculation that adjusts for quality?		
6. Frequency of performance payment		
7. Sources of funds		
8. Is this sustainable? Why?		

EXAMPLE: Name of recipient	Public health centers	
Amount of payment linked to performance	10% of historical budget to deliver target services (funded by a combination of withholding 5% of historical budget and an additional 5% of historical budget as potential additional funds)	
Amount of payment not exposed to risk	95% of historical budget to deliver target services	
Formula for performance payment	Performance Target	Associated Weight
	e.g., 10% increase in full immunization coverage	0.2
	e.g., 20% increase in # of pregnant women receiving at least 3 prenatal care visits	0.2
	e.g., 5% increase in the number of mothers with full knowledge of oral rehydration therapy	0.1
	e.g., 50% of outreach points with at least 3 modern family planning methods	0.1
	e.g., 25% reduction in the discontinuation of family planning	0.2

	e.g., 50% reduction in waiting times for child patients	0.1
	e.g., well-defined community committees with appropriate coordination with Ministry of Health	0.1
	Total	1.00
Fee schedule if fee-for-service is chosen	N/A	
Added calculation that adjusts for quality	No, but intention to refine indicators to incorporate quality service measures.)	
Frequency of performance payments	Quarterly	
Source of funds	Donor contributions at onset with increasing support from the Government.	
Is this sustainable? Why?	As performance indicators are reported, it is hoped that this will help the MoH advocate for increased funds from the Ministry of Finance	
Country stakeholders to involve when defining Step 4:		

8. STEP 5: DETERMINE THE ENTITY(IES) THAT WILL MANAGE P4P INITIATIVES, AND HOW TO MAKE P4P OPERATIONAL

8.1 OBJECTIVE

To determine how to operationalize the P4P initiative and its responsible entities.

8.2 KEY CONCEPTS

Previous steps took you through the overall design of your P4P program: you made decisions about your recipients, your indicators and targets, your monitoring system, and your approach to validating results. Guiding these decisions in part was the feasibility of implementing them given the realities of your health system. In this chapter, you will consider how each of these design elements will be implemented, again, in the context of your health system. You will determine how P4P will be administered and who will assume responsibility for each aspect of the program.

Possible management entities include the following:

- Government ministries (Health, Social Affairs)
- Agencies established explicitly to oversee elements of the P4P program
- Social insurance agencies
- Community-based health insurers
- Schools of public health
- Accounting firms for financial management
- Accounting firms for data audits
- NGOs
- Donor project management units

After you have determined this "how" and "who," you will consider what capacity building is needed so that providers and administrators are ready to carry out their new responsibilities. You will also need a plan to educate the many people who are stakeholders in your health system – public and private providers, government officials at all levels, payers, households, donors, etc. – about the new P4P approach. These steps may be part of your action plan.

P4P management functions: These functions are critical to the success of P4P and involve a number of implementation related issues associated with each of the design decisions associated with steps 2-4. Associated with the design elements below are examples of management functions.

Selecting or identifying recipients:

- Who will manage the bidding process if selection is competitive (supply side) and what procedures will be followed?
- Who will determine provider eligibility to participate if selection is based on criterion of "readiness" (supply side) and what procedures will be followed?
- Who will design and implement a targeting strategy to determine eligible households or individuals (demand side)?

Contracts and performance agreements:

- Who will be responsible for designing contract terms (broad template)?
- Who will negotiate contract terms with specific recipients?

Enabling Provision of Demand Driven Technical Assistance

- How will technical assistance be provided to help recipients achieve improved performance?

Reporting, monitoring, and validating results:

- How will information on results achieved be reported and by whom?
- Who will be responsible for verifying that reported results are accurate, and how will this be done?

Payment:

- How will information on results achieved be used to generate payments?
- How will funds flow and to where?
- How will recipients be required to account for how funds are used?

Evaluate and revise:

- Who will assess whether the P4P approach is working and revise it if needed?

8.3 TASKS

1. Identify your Management entity and the rationale for its selection (relevant capabilities for job)
2. What are the operational features for selecting recipients in your design?
3. What is the process for establishing and administering contracts?
4. How will you respond to demand-driven requests for technical support?

5. What is the process for results reporting, monitoring, and validation?

6. What is the process for generating payments?

7. What is the process for assessing and revising your P4P design and its implementation?

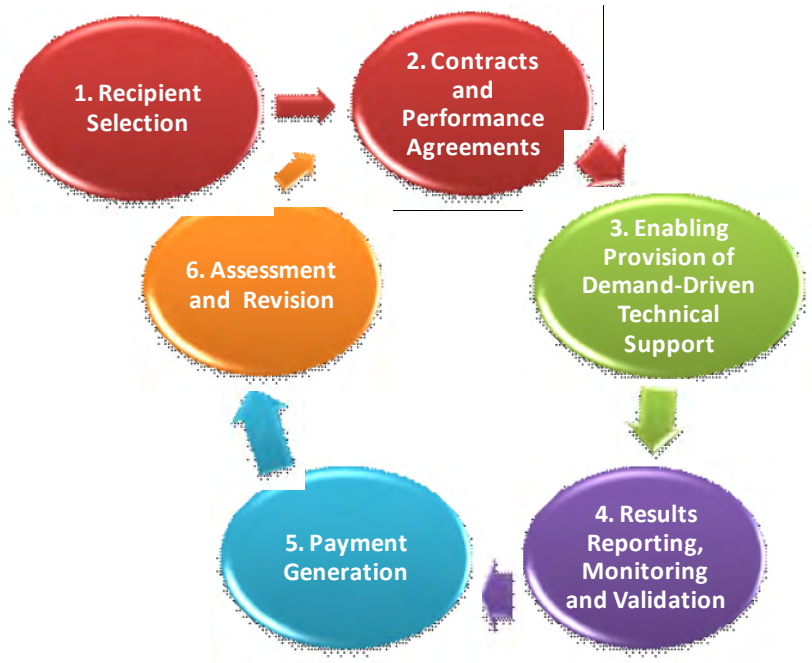
8.4 CONSIDERATIONS

Compared with more traditional input-based approaches, administration of performance-based incentives for providers requires a focus on monitoring and data quality assurance rather than on accounting for spending on every small item. Because payment is made based on results achieved, you will need a robust Health Information System (HIS) that links evidence of attained results to payment.

P4P can be implemented in public systems, as part of contracts with NGOs or FBOs, by health insurers (social, community-based, or private), or to incentivize households or individuals to utilize priority health services. Each scenario implies particular roles for administrators and recipients. This section presents broad categories to guide countries. It does not, however, cover every possible scenario. Within each functional category are many ways to operationalize. For example, many administrative functions can be contracted to a third party. If some functions are contracted, the lead entity will need to manage the contract.

It is important to consider whether entities responsible for particular roles face any conflicts of interest. For example, it would not make sense for supervisors who receive performance awards linked to facility performance to be responsible for validating the results facilities report. Because in this case supervisors have a financial interest in strong performance of the facilities they support, they would be less likely to catch over-reporting or outright cheating.

Functions Needed to Administer P4P



1. Selecting recipients

Step 2 helped you determine the profile of recipients and how you will select them. Now you will make a plan to operationalize the selection process.

Supply side

- ***Public sector***: When designing P4P in a public health care system, you first decide if (1) all providers (and administrators) can participate in performance-based payment or (2) participants must meet eligibility criteria. In implementing the latter, criteria need to be developed and applied to potential recipients at the facility and subnational levels of the public health care system. For example, you may require providers to have certain inputs in place and have basic capacities to deliver the rewarded services: subnational levels of health administration will need the ability to collect and monitor service statistics, manage data in Microsoft Excel or another software, open bank accounts for facilities, and provide technical support and oversight. These preconditions should be specified in a manual or guide that is disseminated to all participants in the P4P program. You will also need to determine who will have the responsibility to apply the criteria to determine eligibility and how the outcome of their assessment is communicated to those responsible for establishing contracts.

- ***NGO, FBO, or private sector*:** When contracting nonprofit or private for-profit service providers on a P4P basis, you need to determine procedures for selecting those recipient organizations. You may simply turn to NGOs or FBOs that have a track record of providing good health care services in your country or you may choose to select them through a

competitive process.[7] With a competitive process you will need to develop "request for proposal" documents, a strategy to disseminate them to potential bidders, evaluation criteria, and a process to evaluate proposals. You may want to hold a bidders conference to explain the terms of the procurement and to answer questions and address concerns. You will need to determine the entity and individuals who will manage this process.

Demand side

Once demand-side eligibility criteria (e.g., health condition, geography, socioeconomic status, such as poor pregnant women as defined by X) are determined, you will need to develop a process to certify eligibility.[8] The process needs to determine the following:

- How will the population be certified (e.g., place of residence, means testing)?
- How will they be identified for participation?
- How will they be identified to providers and to the entity that will administer the payments or material goods transfer?
- How will the P4P program verify that services reach this priority population?

In Mexico, for example, recipient households receive an identification card that uses a hologram to uniquely identify them.

2. Administering contract and performance agreements

Once recipients are chosen, terms of contracts have to be specified, negotiated, and recorded in a contract document. (See Loevinsohn [2008] for necessary elements of strong contracts.)

Performance-based contracts with service providers must specify indicators, payment terms, and targets if a target-based model is chosen. In most contexts, indicators and payment terms will be standardized. However, in many models, target levels of improvement needed to receive performance awards will depend on individual recipient baselines. Collecting and validating baseline information and determining targets for improvement is a core function of P4P administration. For example, in national public models, this function may be delegated to subnational levels of government. Rules may need to be established to determine the expected increase relative to the current baseline. The table on the next page is from an initiative in Zambia that established rules about percentage-point increases in performance expected relative to existing baseline levels; note that higher increases are expected when starting from a low baseline than when starting from a higher level.

[7] An excellent guide for this process is Loevinsohn (2008).

[8] See Coady et al. (2004) and Maluccio (2005) for information on household targeting.

GEARING PERFORMANCE TARGETS TO THE PROVIDER BASELINE

Indicator	Baseline	Percentage Point Increase to Receive Incentive
Immunization	0-40%	20%
	41-65%	15%
	66-80%	10%
	81% and up	5%
IPT3	0-40%	15%
	41-65%	10%
	66-80%	5%
	81% and up	5%
Antenatal Care (4 visits)	0-40%	10%
	41-65%	10%
	66-80%	5%
	81% and up	5%
Institutional Deliveries	0-40%	15%
	41-65%	10%
	66-80%	5%
	81% and up	5%
Family Planning (New acceptors)	0-40%	10%
	41-65%	5%
	66-80%	5%
	81% and up	5%
Iron Supplementation	0-40%	15%
	41-65%	10%
	66-80%	5%
	81% and up	5%

Source: Zambia Health Results Based Financing Management Tool, September 2008.

Contracts should specify the roles and responsibilities of each party. They should cover issues such as results that need to be achieved, explicit payment rules, reporting and payment frequencies, mechanisms for verifying results, penalties for late reporting, penalties for discrepancies between what is reported and what is validated, and a process for resolving disputes.

The team that administers contracts or performance agreements needs clear links to the teams that monitor results and process payments. As just stated, contracts specify results that need to be achieved, monitoring and verification confirms that achievement, and payment is triggered when the monitoring team informs the payment team to process payments.

Demand-side agreements can also be formalized in writing with clearly specified payments or goods transfers when results are achieved. In some instances, demand-side programs have made formal verbal agreements that motivate continued TB drug regimen adherence, with transfers of food packages each week that a patient returns to take medicine.

3. Enabling Provision of Demand Driven Technical Assistance

Once contracts formalize performance expectations and associated rewards, recipients may want technical assistance to help achieve performance goals. Entities responsible for managing a P4P program can expect requests from recipients for help. An important difference between technical support provided in P4P contexts and the typical approach to technical assistance in developing countries is that requests are demand driven. Recipients ask for assistance because they are motivated to achieve performance targets and associated rewards.

Administrators of P4P programs are advised to consider how to provide the forms of technical assistance that recipients may request. For example, they may want help developing strategies to reach hard-to-reach populations, or to attract women to deliver in facilities, or to improve health care processes that lead to better quality outcomes. Arranging to make health system performance enhancing technical assistance available by enhancing the capacities of national and subnational teams, through contracts with technical assistance providers or through collaboration with donor funded programs will add to the effectiveness of the P4P program.

4. Reporting, monitoring and validating results

You will need to establish systems to track results, transfer information on results, aggregate and analyze results, and verify that what is reported really occurred. The flow of how information is reported will depend on the recipients you choose and the indicators of results you reward.

For example, community-level P4P may provide rewards to community leaders or community health workers for increasing the number of households with latrines and properly installed insecticide-treated bednets. Someone (e.g., community health worker or community health committee) will have the responsibility for collecting and reporting this information to the next level in the health system, say, a health center. This level may aggregate the community-level results into combined results for its full catchment area. Additional indicators may be added that capture health priorities for which the health center team is accountable. Health centers then report this combination of indicators to the next level, for instance, the district health team.

For demand-side programs, you will need to determine how to verify that individuals or households actually received the rewarded services. For facility-based services, provider reporting is the likely mechanism, with checks that validate that services were provided to entitled people. If providers also receive payment (as is the case in most voucher programs), there is an incentive to report more

services than were actually delivered, to generate more payment. This calls for a system to detect and deter false claims and false reporting.

To deter data falsification and ensure that what is reported is reliable and true, an independent entity should do data validation to complement routine reporting. If random audits will be used to control data quality, you will need to determine the process and the entities that will carry this out. This includes specifying the frequency of audits and the process that will be followed. If you choose a peer validation approach, you will need to detail the procedures to be followed, the roles and tasks, and the frequency. Some training may also be needed to begin peer evaluation.

5. Transferring award payments to recipients

Once the data reporting and monitoring system verifies that the indicators specified in contracts are reached, you will need to determine how the rewards will be transferred to the intended recipient.

Supply side

For supply-side initiatives, ensuring reliable transfer of funds according to the rules established in contracts is critical to the ongoing credibility of the program. One way to do this is to open bank accounts for each facility and community that can receive performance award payments electronically. Procedures to open accounts and to account for funds may need to be detailed; local-level P4P representatives may need to assist facilities and community entities to open accounts and ensure funds are used according to rules. Other options are for the district health management team (or subnational level of government) to manage accounts for each facility and community entity, or for performance awards to be transferred to the district, which would then allocate the funds to recipient accounts.

Demand side

Demand-side P4P initiatives require particular attention (more so than supply-side initiatives) to the administrative and management processes due to the large number of transactions involved with paying individual or households.

The logistics of transferring cash and transporting, storing, and distributing food and other goods are considerable. Transferring payments to individuals who do not have bank accounts requires a system to provide cash payments. In Mexico, for example, the conditional cash transfer program contracts the telephone company to use armored trucks to distribute cash to recipients in poor communities on a set schedule. Recipients hold a coupon book stamped with unique holograms. The distributors of cash match the coupons with holograms on a list of approved recipients provided by the central office that administers the cash transfer program. Providing in-kind awards, such food and other material goods, poses the additional challenges of procuring goods, managing stocks, minimizing spoilage, and controlling leakage.

6. Assessing and revising the P4P program

The design and implementation of your P4P approach can be modified if it does not work as expected. Refinements will be needed as your system evolves and matures. To this end, an entity will have to be assigned the responsibility to assess whether the program is being implemented as planned and achieving the desired impact and to introduce refinements. Data from the routine monitoring system will contribute information that informs whether performance is improving on key indicators. In addition, countries may want to track progress on a list of indicators that are not being rewarded to identify unintended consequences of the P4P scheme. In national schemes introduced into public systems, the

responsibility to determine refinements is likely to be held by the national government or a national social insurance program. Evaluation of progress and suggestions for refinements, however, may be contracted to a third party.

You may want to complement information from the routine monitoring system with "process monitoring" that determines what is working and how recipients are responding. Process monitoring identifies how the many recipients in your P4P program are responding to new incentives and enables a program of learning that documents lessons. Please refer to the section of the Blueprint on your learning agenda and consider how this will be managed and operationalized.

Step 5: Management entity (ies) and process for management (complete one form for each entity with management or administrative roles)		
Management entity	**Rationale for selection and process for management**	**Example:**
Name of entity:		Ministry of Public Health: Unit established in the Department of Planning
1. Rationale for selection (relevant capabilities for job)		Has steering role for health system.
2. Process for selecting recipients.		Will design and issue "request for proposal." manage bidding conferences, form selection committee, assess proposals, and negotiate with top bidders.
3. Process for establishing and administering contracts.		Will use geographic targeting to identify areas where more than 70% of the population is considered "poor" or "extreme poor."
4. Process of responding to demand-driven requests for technical support		Will propose sponsorship of tech support through SWAp basket funding mechanism. Application requests will be reviewed by Ministry in consultation with partners to identify possible consultants
5. Process for reporting, monitoring, and validating results		Baselines established through routine information systems, targets set based on standardized guidelines for improvement, targets for improvement established through norms plus negotiation.
6. Process for generating payments.		NGOs report performance on rewarded indicators to district health teams quarterly. MOH unit compares reported results to contract terms and transfers earned performance payments to NGO bank accounts quarterly
7. Process for assessing and revising operationalization and design.		District teams assess performance against targets and provide supportive assistance to weak performers.
Country stakeholders to involve when defining Step 5:		

9. STEP 6: DEVELOP AN ADVOCACY STRATEGY AND IDENTIFY IMMEDIATE NEXT STEPS

9.1 OBJECTIVES

- To determine a strategy for obtaining national buy-in, ownership, and mitigate potential opposition.
- To identify immediate next steps – a program of action – for blueprint developers to ensure that design will be considered and discussed by country stakeholders.

9.2 KEY CONCEPTS

Stakeholders: Groups that have an interest in the organization and delivery of health care, and who either conduct, sponsor, or are consumers of health care services, such as patients, payers, and health care practitioners. Examples include representatives from the government, community groups, physician associations, donors, and NGOs (European Observatory, 2008).

9.3 TASKS

1. List potential stakeholders essential for obtaining national buy-in for P4P
2. Assess degree of potential support
3. Identify potential P4P champion(s)
4. Identify approaches to generate buy-in
5. Determine the immediate next steps or program of action needed to turn this blueprint into reality.

    a) Who are the key individuals that should be briefed? What key messages should be conveyed?

    b) What additional resources/support (financial and technical) will you need to follow up on your plans?

    c) What will your team do to continue work towards building P4P?

9.4 CONSIDERATIONS

P4P initiatives affect numerous players in health care: especially those who receive rewards and those who oversee and administer the programs. Involvement of these stakeholders is critical to maximizing the effectiveness of P4P and to minimizing potential resistance that may interfere with implementation (e.g., health worker unions, political representatives, and community-based organizations). Moreover, stakeholder consultation can be very useful for identifying the incentive approach that can lead to desired behavior changes. For example, in Russia, it helped to consult with prisoners first to understand what would motivate them to complete TB treatment after their release; this led to the identification of rewards associated with assistance in obtaining identity cards, which were critical to obtaining jobs and housing (Beith et al. 2007). In Latin America, design of conditional cash transfer programs was informed by surveys and interviews with key informants knowledgeable about the obstacles to health care use. One issue that was examined in the program planning stage was whether it is possible and culturally acceptable for women to be primary beneficiaries in indigenous communities. Consultations and focus groups complemented information from quantitative data to help determine whether supply or demand constraints or both inhibit use of essential health services.

Consulting with stakeholders helps understand their intrinsic motivations (e.g., professional pride, altruism of providers), the extrinsic incentives (money, recognition, awards) that can inspire desired actions, and the potential effects of newly introduced extrinsic incentives. In short, stakeholder input (public, private, and donor) is critical for two reasons:

- To solicit stakeholder contribution to the P4P design
    - Stakeholders will know the underlying causes of poor performance
    - Stakeholders will know what would be most motivating to them
- To solicit stakeholder buy-in and ownership
    - Critical to engage those affected early and often to create trust and develop a sense of partnership
    - Perfectly sound approaches have been derailed when doctors go on strike because of mistrust
    - Assess relevant stakeholder positions and develop strategies to generate their support

As with any major health initiative, policy advocates/champions are critical to moving the process forward. Champions are individuals/leaders who understand the context of the country and are well connected to key stakeholders (both the potential supporters as well as possible detractors). Champions are able to "speak the language" of these stakeholders and can thus effectively communicate the value of P4P. Given their important role, policy advocates should also be savvy about the technical nuances of P4P initiatives.

Consider whether you need additional information before moving from design into implementation. Some next steps might include assessments of your existing system to determine whether it can support P4P.

- Does the existing HIS produce reliable service statistics that can be used in the initial stages of your P4P program?

- Do existing fiscal flows allow paying for results? Will modifications be needed to your system of transferring public funds from national to local, facility, community, and individual levels?
- Does the capacity to manage and administer P4P exist in national entities? Where? Where are the gaps? What strategies might be considered to enhance capacity and address gaps?
- Do recipients have the ability to receive payments and the autonomy to manage funds? What changes are needed to accommodate P4P? For example, do communities need to be registered in some formal way to be able to receive fund transfers? Can facilities manage bank accounts?
- Are the essential inputs in place that are needed to achieve performance targets or do recipients have the means to solve input problems "from the bottom up"? What is needed to ensure that essential inputs are in place?

In determining your team's immediate next steps, consider this program of action as a "pledge" among team members to turn the blueprint into a reality. It is critical that the steps and timeframe for their implementation be realistic and that team members commit to their completion.

Step 6: Key stakeholders, positions, and approaches			
Stakeholder (institution)	**Stakeholder contact person and position**	**Degree of potential support**	**Approach to generate buy-in**
	(Place * next to P4P champion)		
Program of action-IMMEDIATE next steps			
Tasks	**Way forward**		**Deadline for completing tasks**
Immediate actions	1		
	2		
	3		
Key individuals who should be briefed and message that should be conveyed to each person	Name:	Message:	
	Name:	Message:	

	Name:	Message:	
	Name:	Message:	
Additional resources/support (financial and technical) needed to follow-up on plans			
Continued work by blueprint authors to support P4P development process			

10. CONSIDERING RIGOROUS EVALUATIONS

10.1 OBJECTIVE

To consider the inclusion of evaluations in your P4P design to determine "what worked and what did not work"

10.2 KEY CONCEPTS

Monitoring: regular observation, surveillance, or checking of changes in a condition or situation, or changes in activities (World Health Organization, 2008).

Evaluation: The systematic assessment of the relevance, adequacy, progress, efficiency, effectiveness and impact of a course of action (European Observatory, 2008)

10.3 CONSIDERATIONS

While evaluations are not critical when designing a P4P *Blueprint,* they can significantly augment your learning strategy. P4P initiatives are not a one-time design, but an evolutionary process. The program must evolve as more is learned, capacity is developed, and performance requirements change. Indicators, targets, and incentives need to be monitored and revised regularly. Remember to also look for unintended consequences, both positive and negative.

Routine monitoring is part of the ongoing operationalization of your P4P program (Step 5). Your routine monitoring system should track utilization of a key list of services that are not rewarded, as well as those that are. Examining performance trends on non-rewarded services will help you detect services that are being neglected as well as positive spillover effects.

Some "process monitoring" that examines whether the program is being implemented as planned and identifies challenges would be a helpful complement to evaluation of impact. For example, you might like to know whether results are faltering because of a problem with implementation or a problem with the design.

Consider complementing routine monitoring with more intensive study in focal areas. You may want to identify a handful of locations that have characteristics of interest (rural, urban, ethnic, extremely poor, other) and complement routine monitoring with intensive quantitative and qualitative study. For example, you may want to implement household and facility surveys to determine whether impact reported through routine service statistics are supported as household-level impact. You may also want to conduct focus groups of patients and/or providers to understand views. Information from these focal areas could inform future design and contribute to learning.

However, routine monitoring is not sufficient to provide rigorous evidence that the performance trends are driven by P4P. It can be challenging to isolate the impact of the performance incentive on results

because P4P is often part of a package of interventions implemented simultaneously. Ideally, to measure the impact of a new program, researchers need to observe the same individuals or providers in parallel situations – with and without (counterfactual) the program and at the same moments in time. In social research however, such a controlled "laboratory"-type environment is difficult to mimic. As a proxy, social scientists choose to compare (pre- and post-implementation time points) those receiving the program with a comparison group that is similar to the recipients in observable and unobservable dimensions with the "sole" exception of not having received the program. Selection of the "control" group can be created through a range of techniques such as the following:

- Random program assignment: most likely to avoid biased results (but can be difficult to implement in developing country settings)
- Statistical matching
- Use of program eligibility criteria

These evaluations can respond to broad policy questions that ask, for example:

- Of a range of policy choices, which approaches to P4P have the greatest impact, and when is P4P more effective than other approaches?
- What elements of performance-based incentive programs lead to success?
- What pitfalls can be avoided?
- When are performance-based incentive programs more cost effective than other approaches?

Addressing these questions can be used to generate political support for continuing programs after governments change. Moreover, such evaluations are tremendously useful for sharing lessons learned with other countries and contributing to the global knowledge on what works and does not work when it comes to P4P implementation.

ANNEX A: EXAMPLES OF P4P APPROACHES THAT ADDRESS PERFORMANCE BARRIERS

Performance Barrier*	P4P SOLUTION	How does it address the issue?
1. Financial and physical barriers, 2. Information and social norms inhibit utilization 3. Staffing and management challenges	**Conditional cash transfer programs**	1. Directly increases household income and reduces price of essential services. Also inhibits household decisions to purchase low-cost services. 2. Payment conditional on actions can counteract social norms that may drive households to invest less on females. By conditioning payment on receipt of specified services, household decisions to choose low-cost and low-quality substitutes may be altered. 3. Can stimulate providers to be more responsive and accountable to households, in the process catalyzing a process of management strengthening that leads to increased utilization
1. Financial and physical barriers 2. Staffing and management challenges	**Transportation subsidies**	1. Reduces direct cost of obtaining care 2. Can stimulate providers to be more responsive and accountable to households, in the process catalyzing a process of management strengthening that leads to increased utilization
1. Financial and physical barriers 2. Information and social norms hat inhibit utilization 3. Staffing and management challenges	**Food support**	1. Frees up income that would have been used to buy food. Reduces opportunity costs for seeking care – especially for treatment of chronic conditions 2. May help overcome social barriers to obtaining care 3. Can stimulate providers to be more responsive and accountable to households, in the process catalyzing a process of management strengthening that leads to increased utilization
1. Financial and physical barriers 2. Staffing and management challenges	**Direct payment to households/patients (demand side) for use**	1. Provides incentives to access care by reducing direct costs (may make costs negative) 2. Can stimulate providers to be more responsive and accountable to households, in the process catalyzing a process of management strengthening that leads to increased utilization.
1. Financial and physical barriers 2. Information and social norms inhibit	**Financial rewards to providers for results (and/or penalties for poor performance)**	1. Motivates outreach, encourages more convenient clinic hours, and stimulates solutions to reduce financial barriers faced by households 2. Can stimulate improved communication and health education that may enhance care seeking by increasing understanding and reducing social obstacles.

Performance Barrier*	P4P SOLUTION	How does it address the issue?
utilization 3. Staffing challenges 4. Management challenges 5. Resource allocation inequities and inefficiencies		3. Can motivate effort and result in innovative changes to the way services are delivered through strategies that may include improved outreach to underserved areas, altered mix of health care workers, and performance awards. Incentives can be structured so it is in the provider's interest to adhere to quality standards. 4. Can strengthen management by causing service-providing institutions to examine the range of constraints they face to achieving results, and the systems, capabilities, and strategies they need to introduce to achieve them. 5. When payments are conditional on services to the poor: can improve access and equity as part of a social insurance program, a contracting process with the private sector, a system to reward public sector providers – or a combination.
1. Financial and physical barriers	**Provision of per diems and vehicles to enable providers to reach remote areas**	1. Can be an incentive if per diems exceed incurred travel costs and vehicles are also used for personal use
1. Financial and physical barriers 2. Information and social norms hat inhibit utilization 3. Staffing challenges 4. Management challenges 5. Resource allocation inequities and inefficiencies 6. Weak and overly centralized systems for planning and management	**National to local transfers based on results**	1. Can stimulate local solutions to reduce financial barriers to access 2. Can stimulate local solutions to increasing knowledge of the value of health interventions and counteract social norms that inhibit appropriate care seeking by stimulating increased consumer education and implementation of demand-side incentives. 3. Can motivate effort and result in innovative changes to the way services are delivered. Incentives can be structured so it is in provider interest to adhere to quality standards. 4. Can stimulate strengthened management through dynamics similar to those described in the first bullet. 5. Can result in innovative solutions to (a) increase access and use among the poor and improve equity and (b) improve efficiency by stimulating local-level solutions. 6. Can contribute to strengthening planning and management at local levels.
1. Financial and physical barriers 2. Management challenges	**Social insurance that provides universal coverage and pays providers based on performance.**	1. Can be part of a P4P intervention if payment is based on results. Will also minimize household decisions to consume low-cost substitutes 2. Can stimulate strengthened management through dynamics similar to those described in the first bullet.
1. Information and social norms that inhibit utilization	**Regulations that require health screening or evidence of good health as a condition of participation in other valued programs**	1. Can stimulate changed behaviors. A common example is regulations that require full immunization as condition of enrolling in school.
1. Stock-outs of drug and supplies	**Contract out drug procurement, storage, and distribution.**	1. Reward contracted entity(ies) based on results
1. Stock-outs of drug	**Performance-based incentives in**	1. Can increase responsiveness by improving management from central to regional to

Performance Barrier*	P4P SOLUTION	How does it address the issue?
and supplies	**inventory management and distribution**	facility levels.
1. Stock-outs of drug and supplies	**Financial penalties for substandard quality**	1. Include severe penalties for substandard quality in procurement contracts.

Source: Adapted from Eichler and Levine (2009): Table 3.1

*Performance Issue addressed:

1. Financial and physical barriers: Households can't afford to obtain quality care and/or health services are hard to reach
2. Information and social norms that inhibit utilization: Lack of information and social norms inhibit seeking recommended services
3. Staffing challenges: Inadequate supply, misdistribution, poor motivation, and poor quality of care delivered by health workers
4. Management challenges: Weak technical guidance, program management, and supervision.
5. Drugs and supplies: Drugs and supplies not available, of variable quality.
6. Resource allocation: Inequitable and inefficient distribution of resources for health
7. Planning and management: Weak and overly centralized systems for planning and management.

ANNEX B: COUNTRY EXPERIENCES WITH P4P

AFGHANISTAN: Three donors are contracting NGOs to deliver health services: USAID, the World Bank, and the European Union. Until recently, only the World Bank approach tied payment explicitly to achievement of performance targets. Other donors now intend to adopt this approach because of the superior results it appears to have generated. The capacity of the Afghan Ministry of Health has been developed to manage the contract process and to oversee some elements of performance monitoring and transfer of funds. As each donor has distinct accountability requirements, the ability to transfer this responsibility to local governments differs.

In Afghanistan, NGOs were chosen to provide a basic package of services to people living in an entire province through a competitive process that followed World Bank Quality and Cost Based Selection (QCBS) procurement guidelines. Winning NGOs received a contract that pays them the budget they proposed plus the opportunity to earn up to an additional 10 percent if performance targets are reached. Performance bonuses are earned if scores improve on the "Balanced Score Card (BSC)" mechanism that assigns scores for performance in a range of priority areas. Because BSC scores are computed for all provinces in Afghanistan, it is possible to compare performance of provinces with NGOs that are paid for performance to other provinces with cost-based reimbursement. Overall performance is better in these World Bank provinces, causing other donors to consider PBF. It is also important to emphasize that factors other than payment incentives contribute to differences in performance in a complicated context like Afghanistan, making it hard to fully attribute the better performance in PBF provinces to the incentive approach. (1)

HAITI: Starting in 1999, the USAID mechanism used to pay contracted NGOs changed from reimbursement for documented expenditures to a fixed price subcontract plus an award fee linked to attainment of predetermined performance targets. Some examples include: "increase in the percentage of children under 1 who are fully immunized to a specified percent" and "increase in the percentage of pregnant women who receive at least three prenatal care visits according to Ministry of Health norms." For each indicator, a baseline measure is determined at the beginning of a contract period and a target for improvement is established. Subcontracts clearly establish these targets, describe how performance will be measured, and determine the award fee associated with attainment of each target.

Remarkable improvements in key health indicators have been achieved over the six years that payment for performance has been phased in. Now covering 2.7 million people, NGOs provide essential services to the Haitian population in the complicated context of violence, poverty, and limited government leadership. A series of regression analyses that adjust for other factors that might determine performance suggest that being paid based on results is associated with highly significant increases in both immunization coverage and attended deliveries. Regressions suggest that payment for performance was responsible for increasing immunization coverage as much as 24 percentage points, implying that as many as 15,000 additional children were immunized in Haiti because of the changed payment regime. Attended deliveries increased as much as 27 percentage points, implying that up to an additional 18,000 women were provided a safer environment in which to deliver their babies (2).

In addition to the contribution of the performance-based payment strategy to increasing coverage and the quality of health services, field assessments strongly suggest that this strategy has catalyzed the development of the institutions involved. This is reflected in the changed behavior of managers and service providers at all levels; they are observed to be more proactive, innovative, and focused on being more accountable for results. These behavior changes have resulted in improved information systems and the effective use of data for decision making; strategic use of technical assistance; improvements in human capacity development and management; strengthened financial management; and increased cost effectiveness. All of these changes will contribute to the likelihood of the viability of the service providing organizations making this a long-term development strategy as well as an effective strategy to "buy" results. Recent enhancements include engaging the Ministry of Health to introduce PBF in public facilities. (3)

RWANDA: The Government of Rwanda has taken bold steps to pioneer the institutionalization of PBF. In 2005, PBF was adopted as a national policy. This effort draws upon experience with three pilot schemes, known as the Cyangugu model, Butare model, and Belgian Technical Corporation model (for Kigali Ville, Ngali, and Kabgayi regions). While the schemes differed in their execution (e.g., in terms of their means for verifying performance, listing of target indicators, and the institutions serving as fund-holders), all three had the overriding goal to improve the utilization (and more recently quality) of health services through supply-side mechanisms.

	Contracting provinces 2001	**Contracting provinces 2004**	**Non-contracting provinces 2001**	**Non-contracting provinces 2004**
Curative care/ inhabitant/ year	.22	.55	.20	.30
Institutional deliveries	12.2%	23.1%	6.7%	9.7%
New FP acceptors	1.1%	3.9%	.3%	.5%
Measles	70.7%	81.5%	77.9%	78.9%

Results from the Cyangagu and Butare models compared with provinces with similar characteristics that did not implement PBF suggest that the strategy holds promise. Large increases in the number of curative consultations and institutional deliveries have been seen with a smaller increase in measles and new family planning acceptors. (4,5,6) A planned impact evaluation will improve the evidence base by adjusting for "other" determinants of performance that simple comparisons do not capture.

The national model for PBF draws from these pilot experiences. It works through local government (in accordance with recent decentralization efforts) and involves broad stakeholder participation through the formation of steering committees. Payment is determined by fees for priority services multiplied by the volume delivered and adjusted by a quality score. While this is an ambitious plan, PBF in Rwanda benefits from strong government leadership and efforts to work with other stakeholders as partners towards common goals.

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ANNEX C: COUNTRY EXAMPLE OF BLUEPRINT

The following "blueprint" is adapted from one drafted by a country team in the first East and Southern Africa regional workshop on "Performance Based Financing," held in Rwanda. The format of the blueprint has since been revised.

Step #1: Assess and identify the top five performance problems that P4P can address.					
	Data on top causes of mortality and morbidity	**Identify underlying causes – related to motivation, and provider and household action**	**Prioritize based on whether change is possible and the benefit would be significant**	**Feasibility (Choose top five)**	**Also consider current national focus/ effort**
1	Malaria	Underestimated households, (IRS/ITNs)	Yes, 2 [Both Demand and Supply sides]	**5**	
2	RTI/non-pneumonia				
3	Diarrhoea (non-blood)				
4	RTI/pneumonia	Case management,	Yes, 3 (IMCI) [Both]	**3**	
5	Eye infections				
6	Trauma				
7	Skin infections				
8	ENT infections				
9	Intestinal worms				
10	Anaemia				
11	HIV/AIDS (mortality, prevalence, etc)	Stigma, Food supplementation, Access to ART	Yes, 2	7	
12	TB	Cure rates	Yes, 3 [Both]	**2**	
13	Maternal mortality (neonatal mortality)	Supervised delivery, ANC attendance	Yes, 3 [Both]	**1**	
14	Under-5 mortality	Immunization rates	Yes, 2 (especially to maintain with ART scale-up) [Both]	**4**	
15	Malnutrition	Nutrition programmes	Yes, 2	6	

Step	Tasks	Group Consensus
Assess and identify top five performance problems that performance-based incentives can address.	Examine data on top causes of mortality and morbidity. Identify underlying causes- related to motivation, provider and household action. Prioritize based on whether change is possible and the benefit would be significant. Choose top five	Top five performance problems: 1. Maternal mortality (neonatal mortality) 2. TB cure rate 3. RTI/Pneumonia morbidity & mortality 4. Under-5 mortality 5. Malaria incidence Approach: Demand side or supply side or both?
Determine recipients and how to select them.	Identify potential recipients Determine how recipients will be selected (ex: competitive process for providers/ means testing for households)	Recipients: 1. Maternal mortality (neonatal mortality) – Mothers / Health provider [All pregnant women + MCH staff] 2. TB (Clients – H/facility + Community volunteers) [TB patients + DOTS staff + selected facilities] 3. RTI/Pneumonia [HF / Care givers] [Health facility staff + care givers] 4. Under-5 mortality [HF / Care takers] [Health facility staff + care takers] 5. Malaria [HF / Care takers of <5 children] [Health facility staff + care takers] Process to select recipients: Consultative and consensus approaches
Determine indicators, targets, and how to measure them.	Define indicators of performance Determine targets for improvement Describe how indicators will be measured and validated	Indicators: 1.

Step	Tasks	Group Consensus
See indicators attached below		2. 3. 4. 5. Targets: 1. 2. 3. 4. 5. Process to measure and validate indicators:
Determine payment mechanism and sources of funding	Determine how much payment will be linked to performance and how much is not exposed to financial risk? Develop the formula that will determine performance payment. Clarify where will the money come from and is this a sustainable funding solution?	Detailed payment mechanism: Proposed sources of funding are Annual District Budget and additional Donor funding of 10% from each for the cost of Reproductive Health (RH) for the year. From Planned Annual District Budget for Reproductive Health for all HCs: 10% to be linked to performance for SUPPLY SIDE 90% not exposed as already funding is insufficient Formula: Based on appropriately documented deliveries (using standard criteria) per month as funding is done monthly. X % of expected deliveries = Y% of award Eg 50% of expected deliveries = 40% of Award Funds will come from: a. External sources through collaborations and MOUs b. 10% annual district grant (Policy decision needs to be made) c. Future prospective source is Social Health Insurance scheme

Step	Tasks	Group Consensus
5. Determine the entity that will manage and oversee the performance-based incentives process and how to operationalize the system.	Identify capacities needed Select management entity Define organizational structure, staffing, and systems	The management entity is: a. External sources through collaborations and MOUs DHO will manage the PBF funds on behalf of health facility. b. 10% annual district grant (Policy decision needs to be made) DHO will manage the PBF funds on behalf of health facility. c. Future prospective source is Social Health Insurance scheme The DHO itself will manage the PBF on behalf of health facility. How will you: a. Manage the bidding process if selection is competitive (supply side) Not applicable for our proposed model as DHO are the sole eligible entity, however contracts will be signed based on performance targets for districts for the respective performance problem. b. Design and implement targeting strategy (demand side) c. To begin with we will only deal with the supply side Design contracts: a. Contracts with donors will be done in consultation with key stakeholders ie the donor, DHMT and MoH. b. For funds from government grants, the contracts will be done by MoH with input from DHMT. c. For Social Insurance funds, the contracts will be done by MoH with input from DHMT and the Fund. Negotiate contract terms: a. Contracts with donors will be done in consultation with key stakeholders, i.e., the donor, DHMT and MoH.

Step	Tasks	Group Consensus
		b. For funds from government grants, the contracts will be done by MoH with input from DHMT. c. For Social Insurance funds, the contracts will be done by MoH with input from DHMT and the Fund. Establish reporting procedures: a. Through stakeholders discussions and consensus meetings. Monitor performance (routine): a. Use existing internal performance monitoring tools by health facility, DHO and PHO. b. Peer reviews by other DHMTs. c. Spot checks to health facility level by upper levels. d. Donors to have access to health facilities to monitor performance as per contract. e. Community feedback through Health Committees; exit interviews; community surveys Audit and verify performance: a. Strengthen existing independent auditing bodies for quality assurance eg; "hospital committee" like Rwanda model etc. b. Establish independent body monitoring and verifying the data from facilities c. Community household surveys Generate payments a. Verified performance attained will generate payment accordingly every month. Evaluate and revise contract terms Periodic stakeholder review meetings. As provided for in the contract. The structure, systems, and staff needed to operationalize the system is: Existing district health structures & systems.

Step	Tasks	Group Consensus
		Existing staff with option to contract for specific services as need arises.
Identify key stakeholders, positions, and approaches.	List all potential stakeholders. Assess degree of potential support. Identify approaches to generate buy-in.	Key stakeholders: Government through MOH & MoFNP; cooperating partners; NGOs; professional bodies; Health Unions; health workers; patients; community volunteers & general members of the public. Government is currently rethinking approaches to address the human resource crisis in the country and therefore the PBF strategy maybe a possible input into this process; This implies that potential to support this initiative is good. Develop a PBF proposal as per road map from Kigali. Disseminate PBF approach proposal to MoH senior management and then to other stakeholders through routine meetings Approaches to win them over: Promote consensus discussions; through one to one meetings, evidence-based information sessions; if necessary *coercion!*
Develop evaluation and learning strategy	Determine how interventions will be monitored and evaluated to determine evidence for scale up, revision, and detect unintended consequences to revise.	Systems to assess impact and inform modification and scale up: Research questions:
Country Team Performance-based Incentives Program Action Planning See attached Plan below	Review and refine the road map developed over the past few days. Develop a plan of action to take the process forward when you return to your country.	What are 2-3 immediate actions you plan to take to introduce performance-based incentives when you return to your country? Who are the key individuals you plan to brief about the results of this workshop when you return home? Permanent Secretary Ministry of Health Director of Planning and Development Director Public Health Director Technical support Director Clinical Care and Diagnostics Director Human Resources and Administration The Lead Donor Health Sector Programme officers Ministry of Health Senior Managers What are the key messages you want to convey to each person

Step	Tasks	Group Consensus
		Pay for performance can certainly improve the supply and demand side in terms of scaling up health care interventions. For instance it increases efficiency by health workers through performance audits as well as push and pull factors in terms of motivation. What additional resources / support (financial and technical) will you need in order to follow-up on your plans? What will your team do to continue your work towards developing a performance-based incentives program in your country?

MILESTONES

Item	Timeframe	Responsibility	Estimated cost
Action plan developed in Rwanda	4th May 2007	PBF Team	Nil
Presentation of Action Plan to Director planning MoH	9th May 2007	Team	Nil
Develop an **MoU** for the three team members and their institutions	By end May	Team	
Action plan revised in line with comments from DPD/Senior MGT MoH	Early June	Team	
Revised plan presented at a stakeholder consultative meeting	July	Team	
Incorporate stakeholders comments and link the PBF action plan to the MBB(and Health systems strengthening)	July-August	Team	
Seek funding for feasibility study of the final action plan	July-August	Team	
Implementation of the feasibility study	August	Team	
A) Formation of a PBF TWG	August	MoH planning	
B) Developing of indicators (BHCP + MDG)	August/Sept	TWG	
C) Assess incentive structures at institution and community level	August/Sept	TWG	
D) Desk study of previous ongoing PBF initiatives	August/Sept	TWG	
E) Develop PBF Protocol(including orientation W/shop)	August/Sept	TWG	
F) Implement a feasibility study	August/Sept	TWG	
Evaluation of the study outcomes	December	TWG	
Dissemination and lessons learnt	December 2007/ January 2008	TWG	
11 Interim report to ECSA SECRETARIAT	February 2008	Team	
10. Scale up positive lessons to other districts	March 2008	MoH Planning Directorate	

INDICATORS (Road map item No.3)

Area for motivation	Define indicators of performance	Determine targets for improvement	Describe how indicators will be measured and validated
1. Maternal mortality (Neonatal mortality) – Mothers / Health provider	**% of skilled supervised deliveries at health facilities**	Baseline = 62% Year 1 = -10% Year 2 = -8% Year 3 = -7%	HMIS data, Validated by Community-based data surveys [post natal mothers delivered by skilled personnel]
2. TB (Clients – H/facility + Community volunteers)	**% TB cure rates**	Baseline = 71% Year 1 = +5% Year 2 = +6% Year 3 = +7%	HMIS data, Lab data [Smear negatives]
3. RTI/Pneumonia [HF / Care takers]	**Incidence of RTI/ pneumonia among children <5**	Baseline = 71% Year 1 = -15% Year 2 = -9% Year 3 = -6%	HMIS data, Community data [Community mapping of priority diseases among <5 children, KII; incidence of coughing/ fever + fast breathing, dyspoenea]
4. Under-5 mortality [HF / Care takers]	**% children under 5 immunized**	Baseline = 81% Year 1 = +8% Year 2 = +7% Year 3 = +4%	HMIS data, Community-based data [Immunization scars, sites, client knowledge, <5 cards]
5. Malaria [HF / Care takers of <5 children]	**Malaria attendance [HF]/ Fever prevalence [Com] among <5 children; ITN / IRS coverage**	Baseline = X% Year 1 = ±18% Year 2 = ±10% Year 3 = ±8%	HMIS data, Community-based data Incidence of fever among children <5 children, Proportion of households with at least 1 ITN or Sprayed

ANNEX D: RECOMMENDED READING

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