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PERFORMANCE-BASED INCENTIVES PRIMER FOR USAID MISSIONS

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ACRONYMS

| | |
|--------|--|
| ASHA | Accredited Social Health Activists |
| CCT | Conditional Cash Transfers |
| CHW | Community Health Worker |
| EC | European Community |
| FP | Family Planning |
| GAVI | GAVI Alliance |
| HPS | High Performing States (India) |
| IDB | Inter-American Development Bank |
| IFPS | Innovations in Family Planning Services (India) |
| JSY | Janani Suraksha Yojana (India) |
| KFW | German Development Bank |
| LPS | Low Performing States (India) |
| MOH | Ministry of Health |
| P4P | Pay for Performance |
| PBA | Performance-based Aid |
| PBD | Performance-based Disbursement |
| PBF | Performance-based Financing |
| PBI | Performance-based Incentives |
| RBF | Results-based Financing |
| SIFPSA | State Innovations in Family Planning Services Project Agency (India) |
| TA | Technical Assistance |
| USAID | United States Agency for International Development |

I. WHY PERFORMANCE-BASED INCENTIVES?

Performance-based Incentives (PBI), a strategy that links payment to results achieved, is a potentially powerful catalyst to strengthen health systems and achieve health targets. Numerous developing countries, many with USAID support, are piloting and scaling-up PBI programs to improve health outcomes and make progress towards achieving the health Millennium Development Goals.

However, PBI is not a solution for all problems in the health system and is not a substitute for investments in training, health facilities, and infrastructure. Each country context has to be assessed to understand the potential contribution of performance incentives to improving health outcomes.

This Primer provides information for USAID Missions on how to support a PBI program, be it through technical assistance (TA) to an existing program or directly funding a pilot or scaled-up national program. The Primer starts with a quick overview of PBI as one solution to strengthen health systems and improve health service delivery and health outcomes. The note also includes summaries of country experiences with PBI as well as sources for further information.

BOX 1: ALTERNATE TERMS USED FOR PBI

These terms are used to describe the same concept.

- Results-based financing (RBF)
- Performance-based financing (PBF)
- Pay for Performance (P4P)
- Conditional cash transfers (CCT)

1.1 WHAT IS PBI?

A formal definition of PBI is: “Transfer of money or material goods conditional on taking a measurable health related action or achieving a predetermined performance target.”¹ PBI programs provide incentives to recipients when desired results are achieved.

Performance indicators and targets are key to any PBI program and should be related as directly as possible to the objectives and priorities of the program. Payments are tied to the recipient achieving pre-determined results and thus, changes in these indicators have to be attributable to recipient actions.

Performance incentives are designed to encourage behaviors that both increase demand for and use of services and improve the quality and availability of those services. They may be paid to households or patients for adhering to a certain regimen or to service providers on the basis of the quantity and quality of their services. Performance payments to households contribute to overcoming financial and social access barriers and can support health improving behaviors. Providers paid on the basis of performance can decide how to spend the money – empowering them to think creatively about how to reward staff, improve facilities, and reach their community.

The benefits of performance incentives extend beyond the specific intervention to which they are applied – they can help strengthen entire health systems. Performance incentives require accurate monitoring and evaluation to be successful, and developing robust health information and management systems, even for performance incentives aimed at specific diseases, can help improve the overall capacity of a country’s health system. Much more than a system of financing, rewarding results can catalyze actions and innovations that enhance service delivery capacity, improve the effectiveness of the health workforce, increase accountability, and strengthen health information systems.

BOX 2: PBI AS ONE SOLUTION

One common problem: Staff at a rural health clinic in a poor country – one doctor, two nurses, and a few community health workers (CHWs) – make an effort to serve their clients. But medicines and equipment are in short supply, the building is in disrepair, and staff salaries are barely above subsistence levels. Those who fund the clinic are not present and not engaged and the district team tasked with providing technical support rarely makes an appearance. Staff members struggle to feel motivated, the poor clients who come to the clinic are not well served, and many community members rarely access the clinic. Add to this that the local population is poor and confronts many obstacles to obtaining care.

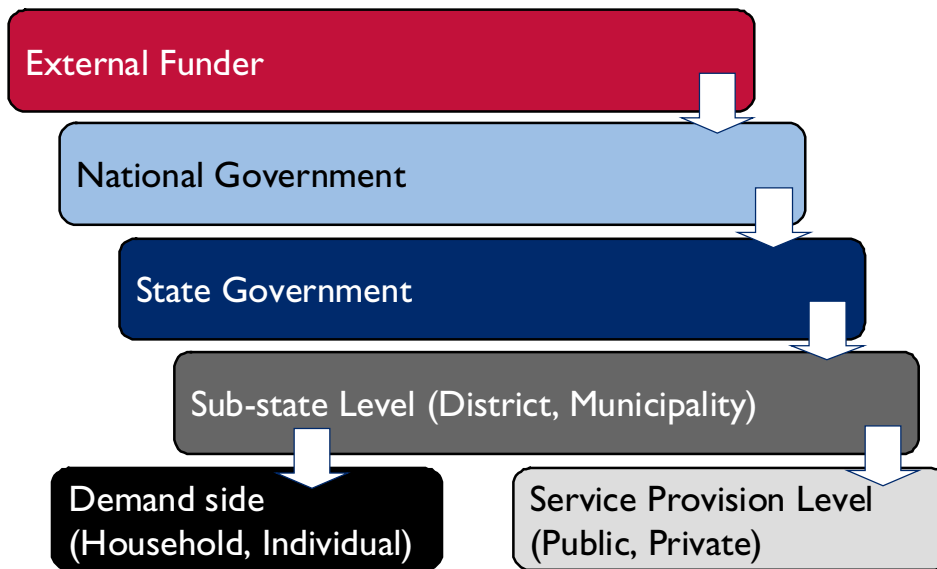
One promising solution: A PBI program provides additional funding to the clinic, on the condition that they achieve certain performance targets such as making sure that young children are fully immunized and women deliver babies with the assistance of trained health staff in the facility. Part of the funds are used to enhance clinic infrastructure and address periodic drug shortages. The remaining funds are given to clinic staff as performance awards. Staff are motivated to show results in order to receive the funding as the additional funding allows for improvements, which in turn makes it easier for the clinic staff to meet the next round of targets. Because incentives are at the facility level, clinic staff monitor and motivate each other and team work is inspired.

¹ From the Center for Global Development Performance Based Incentives Working Group.

1.2 TYPES OF PBI PROGRAMS

One way of categorizing PBI programs is based on the type of payer and recipient. These can range from an external funder as the payer with the government as a recipient to a government as a payer and patients and health care providers as recipients. Figure 1 depicts different levels from payer to recipient of performance-based payments. Section 3 below provides specific country examples of these different types of PBI programs.

FIGURE 1: LEVELS TO CONSIDER: FROM PAYER TO RECIPIENT



2. WHAT SHOULD USAID MISSIONS CONSIDER?

2.1 CHOOSING THE TYPE OF PBI PROGRAM

The PBI approach you might take partially depends on the realities of the health system and health priorities in your country:

1. If you are working in a context with stable government leadership, you may consider supporting pilots or a scaled-up national model that pays for results in public and private facilities (see Rwanda case summary in Section 3).
2. If you are working in a fragile state environment, you may choose an approach that contracts NGOs and pays them partly based on achieved results (see Haiti case summary in Section 3). Consider also enhancing the leadership of a nascent government by building capacity to manage performance-based contracts directly (see Afghanistan and Liberia in Table 1).
3. If the barrier to utilization is primarily on the demand side, consider approaches that provide payments to users based on health actions or results (see Pakistan and India JSY case summaries in Section 3).
4. If you are operating in a decentralized system where the national government wants to stimulate improved performance at sub-national levels of the country, consider supporting an approach that links federal to state level transfers to results (see Argentina case summary in Section 3).

BOX 3: ACTION STEPS FOR USAID MISSIONS TO CONSIDER

- Learn more about PBI by reading about other country experiences, attending workshops, and participating in study tours.
- Identify incentive schemes already underway in your country and consider providing TA to an existing program to improve impact.
- Review your portfolio of programs to identify opportunities where altering behavior by rewarding health results (through PBI) might be a valuable complement to the funding already provided to fund inputs and strengthen capacity.

2.2 CONSIDERING HEALTH PRIORITIES

PBI programs have been tried for specific priority health services including safe motherhood, maternal and neo-natal health, child health, family planning (FP) and reproductive health, tuberculosis, malaria, HIV/AIDS as well as for a broad package of essential services. Given the sensitive issue of incentives for FP services, special attention should be paid in supporting PBI programs for FP.

2.2.1 FP CAN BE INCORPORATED

Increasing access to FP can be integrated responsibly and effectively into PBI schemes in accordance with U.S. FP requirements. The opportunity to stimulate quality FP counseling and increase availability of a wide range of contraceptive methods to meet needs to delay, space, and limit births through performance-based incentives is considerable. At the same time, the challenge of introducing incentives that support informed choice requires careful design and ongoing monitoring. This tension should not cause USAID missions to shy away from incorporating FP into the list of rewarded services in PBI schemes, as this could greatly diminish access to these priority services. Developers and implementers of PBI programs should consider FP indicators that also promote quality provision of FP services, not just number of services, which could also support voluntarism and long term/consistent use of FP.

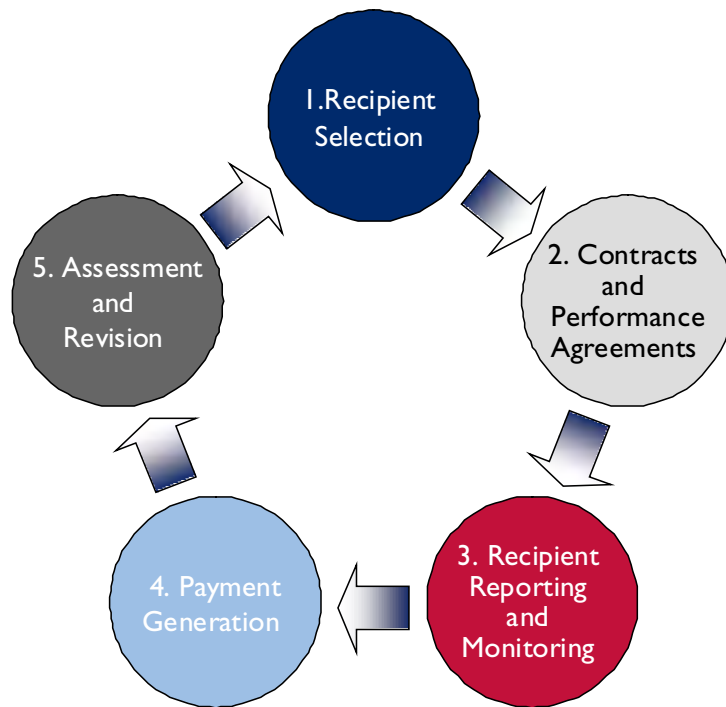
2.3 HOW LONG BEFORE RESULTS CAN BE EXPECTED?

Design and implementation of PBI programs takes time. In most cases, expect the design phase to last from 12-18 months. Once implementation starts, results can be achieved fairly quickly – within months in some cases – if the program is well-designed and well-implemented. It is thus very important to spend the time and effort on a strong design and the systems and capacities to administer PBI approaches.

During the design phase, assessments will be needed to examine issues such as: existing incentives, legal and regulatory realities and constraints, reliability of existing health information systems, and implementation capacity. After a preliminary assessment and draft approach is developed, consultations with stakeholders will be needed to refine and strengthen the approach and generate buy-in. It is also likely that investments will be needed up front in the systems and capacities to administer a PBI program. Figure 2 refers to the cycle of functions needed to administer a PBI approach.

In many settings it may make sense to begin with a pilot in order to refine the approach and “get the kinks” out. In settings where governments prefer going to scale, suggest a phased approach where the first phase can be implemented in a localized area to make sure that the systems and processes work as expected.

FIGURE 2: FUNCTIONS NEEDED TO ADMINISTER PBI



2.4 WAYS TO INCORPORATE PBI INTO USAID CONTRACTS

Support TA only (with performance incentives financed through other sources). USAID can support TA to help design and implement PBI approaches where the actual financial incentives are funded through other mechanisms (e.g., basket funds, government resources, other donors, social insurance). A high-impact strategy might be to support TA to help national governments incorporate performance-based incentives into the way they allocate funds. This can be done through buy-ins to global projects or through bilateral support.

Support bilateral projects that subcontract service delivery NGOs and pay based on results. In fragile settings where the public sector is not the main service provider, USAID can contract with a firm to manage subcontracts with NGOs or private providers to deliver a defined package of services to a defined population with payment partially linked to results. The mechanism for these second tier subcontracts that has been used in USAID projects in Haiti, Liberia, and Southern Sudan is a fixed price contract with an award fee. The award fee can be linked to attainment of a list of targets and only paid to the NGO if results are achieved.

Fund pilots with evaluations: Many of the USAID projects began with pilots that aimed to work out the processes (to get the “kinks” out) and assess impact before expanding to scale.

2.5 USAID-FUNDED HEALTH ACTIVITIES THAT COULD BENEFIT FROM PERFORMANCE INCENTIVES

A wide range of health activities have the potential to benefit from responsible incorporation of performance incentives. Some examples include:

- Bolster human resources management: PBI can introduce incentives to increase productivity, inspire innovation, improve retention, and enhance team work.
- Improve leadership and management: PBI can enhance leadership at all levels and can strengthen management and supervision if rewards are linked to health results.
- Enhance public private partnerships: PBI can be incorporated into contracts between governments and NGOs/faith-based service delivery organizations or other providers of health services. By rewarding the results the public sector values, partnerships can be strengthened.
- Augment quality improvement programs: Linking rewards to improved quality may provide an added boost to quality improvement processes.
- Strengthen the supply chain: PBI can be incorporated into multiple levels in a supply chain – from central store to service delivery level – increasing accountability for availability of drugs, vaccines, commodities, and supplies at each level in the system.
- Increase effectiveness of social insurance: Including PBI in the payment system from social insurance entity as payer to service providers can increase accountability for results that include improved quality, increased equity, and better value for money.

2.6 IDENTIFY OPPORTUNITIES TO COLLABORATE, COMPLEMENT, AND LEVERAGE OTHER DONORS

A number of donors are supporting approaches that link payment to results on the demand side, supply side, or both. The Inter-American Development Bank (IDB) and the World Bank have supported CCT programs in a number of countries, primarily in the Latin America and the Caribbean (LAC) region. The World Bank supports PBI programs in a number of countries, including pilots in eight countries that will include rigorous impact evaluations funded by a trust fund. Norway has bilateral arrangements in a number of countries (India, Nigeria, Malawi, Tanzania, Pakistan) in addition to the funds provided through the World Bank trust fund. Department for International Development (DFID) also contributes to the World Bank trust fund and is considering a broader results-based financing strategy. KfW (German Development Bank) is supporting output-based aid (vouchers) and is beginning to support broader PBI programs with both supply- and demand-side incentives. Belgian Technical Cooperation has supported PBI in Burundi, Rwanda, and the Democratic Republic of Congo (DRC). AusAID has supported development of PBI designs in a number of Asian countries.

Currently, the GAVI Alliance (GAVI), the Global Fund, and the World Bank are working on operationalizing a joint platform for health systems strengthening that intends to incorporate results-based financing. Details are not fully determined, but TA has been identified as a priority.

USAID Missions can support these efforts using one of the options listed in Section 2.4.

2.7 POTENTIAL PITFALLS AND HOW TO AVOID THEM

Incentives to change behavior can be powerful, which is why it is critical to pay close attention to avoid unintended negative consequences such as misreporting, neglecting services that are not being rewarded, and undermining intrinsic motivations of health workers. Particular attention should be paid to making sure that potentially perverse incentives are avoided such as those that encourage women to have additional children because of the cash benefits in a poorly designed conditional cash transfer program, or payment schemes to providers that result in excessive provision of unnecessary or potentially harmful services. A strong system to monitor outputs that are not being rewarded with incentive payments should be part of any performance incentive intervention. Incentives matter, and thinking through and observing how they work and why is an essential part of the design and ongoing management of any performance incentive program.

BOX 4: BEST PRACTICES IN PBI DESIGN AND IMPLEMENTATION

The concept of incentives is easy to understand, but design and implementation can be complicated. Success depends on an intensive, collaborative, and flexible effort to design PBI, and then monitor and fix problems as they occur during implementation.

Remember that context (really) matters: All people live within dynamic systems that both enable and constrain their behavior and their repertoire of potential responses to any intervention. Designers of performance incentives must, therefore, consider real-world factors such as political and social realities, the timeliness and quality of information systems, the ability to transfer money securely through banks, and restrictions imposed by donors, governments, and NGO management. New incentives can catalyze innovative solutions in less-than-perfect environments, but programs must be flexible enough to adjust to realities on the ground.

Determine whose behavior needs to change: If the barrier to results is on the demand side, recipients of performance payments should be households, individuals, or communities. Remember, however, increasing supply is often the first priority. Be sure that once demand is stimulated, supply will be adequate to meet it. If the barrier is on the supply side, incentives to facilities or district teams may motivate the effort and teamwork needed to increase utilization and improve quality. If you are working with a national government on incorporating performance incentives into fiscal transfers, consider how incentives at higher levels will result in changing behaviors at the service delivery level.

Set goals that can be measured and achieved: Performance incentive systems need specific, measurable goals. Programs with vague or overly ambitious goals will not respond so well. Consider incentivizing improvements in quality as well as increases in utilization.

Determine indicators and set the targets: Performance indicators and targets are key to any PBI program and should be related as directly as possible to the objectives and priorities of the program. Indicators should be measurable and targets attainable within a contract period; in most contexts, progress should be measured against baseline performance data. Poor performers with low baselines can show big improvements relatively easily. Better performers can struggle to show big gains. It is often important therefore to measure the rate of change in an indicator instead of the absolute level.

Choose the incentive amount and type carefully: The type of incentives must be appropriate, and incentives must be the right size. On the demand side, food and income incentives are often more meaningful to poor consumers than to those with higher incomes. On the supply side, health workers and service providers may respond more positively to the possibility of additional payments for good performance than to the risk of losing payments for inadequate performance. Relatively small rewards or levels of risk are usually adequate to change behavior. Consult the recipients during the design phase to help predict their reaction to different funding arrangements.

Strike clear contracts so that all players know what is expected: Contracts and performance agreements specify target results, how they will be measured, and how payment will be linked to their attainment. Contracts should specify the responsibilities of the recipient and purchaser, reasons for termination of the contract, payment formula, and how to resolve disputes.

Monitor and validate performance: Verifying whether targets are met, tracking what is working or what needs to be changed, and evaluating the effects of the chosen approach are essential for any performance incentive program. Monitoring requirements may motivate managers to improve their information systems, but they may also encourage falsification. To ensure that information is accurate, programs can rely on a combination of independent evaluations and provider self-assessments with random audits and penalties for discrepancies.

Evaluate, learn and share: For performance incentive programs to realize their potential, practitioners need to know more about what works across different settings. Programs therefore need to be rigorously evaluated and documented, and effectively shared. Some of the most important lessons will be learned through the trial and error of implementing programs and captured by those who are undertaking that challenging job.

3. COUNTRY EXPERIENCES WITH PERFORMANCE-BASED INCENTIVES

The following table (Table I) and brief case descriptions below were chosen to provide a taste of the various forms PBI may take to guide thinking about potential USAID support. You will read summaries of cases of external donors funding countries (GAVI), subnational levels of government (India), and NGOs (Haiti). You will read about Argentina where the federal government conditions fiscal transfers to subnational levels on results. You will read about the Janani Suraksha Yojana (JSY) program in India that pays CHWs to accompany poor women to deliver in health facilities and pays the women as well. Many examples from USAID-supported PBI schemes are included as well as a few other schemes that may be relevant to USAID Missions.

Table I presents a snapshot of PBI programs in developing countries, by the categories described above, and shown in Figure 1 in section 1.2. Country programs listed in bold are further described in the sections following Table I.

TABLE I: COUNTRY EXAMPLES BY PBI LEVELS²

| PBI LEVELS | COUNTRY EXAMPLES |
|--|--|
| External donor to national/subnational | <p>Innovations in FP Services Project (IFPS), India: Since 1994, USAID has provided funds linked to attainment of a series of FP performance benchmarks to a parastatal entity established in the state of Uttar Pradesh.</p> <p><u>GAVI immunisation services support (ISS):</u> Since 2000, GAVI has provided three years of fixed and reliable funding to countries to strengthen their routine immunization systems followed by performance payments of \$20 for each fully immunized child (DTP3) over the level in the previous year.-</p> <p><u>Meso-American Initiative:</u> A new regional initiative will provide payments to all countries in Central America and eight states in Mexico based on performance on indicators related to immunization, maternal health (prenatal care, deliveries, FP), infectious diseases (malaria, dengue) and nutrition (vitamin A, iron, zinc). (To be funded by the Gates Foundation, Fundación Slim, IDB)</p> |
| National to subnational | <p>Plan Nacer, Argentina: Since 2004, funds are transferred from the federal government to provinces based partly on the number of poor women and children enrolled in a maternal and child health insurance program and partly on how provinces perform on ten tracer indicators. (GOA and World Bank)</p> <p><u>Brazil:</u> The federal government in Brazil transfers funds to states and municipalities based on increased access to family health practices and on attainment of performance targets. (GOB)</p> |
| Government or donor to public facilities | <p>Rwanda: Health facilities receive payments for delivering a list of priority services (maternal and child health, FP, TB, and HIV) in this fully scaled-up national approach. Scores on quality assessments discount fee amount, providing incentives to improve quality as well as quantity. (USAID support and others)</p> <p><u>Burundi:</u> Health facilities receive payments for delivering a list of priority services (maternal and child health, FP, TB, and HIV). Scores on quality assessments provide potential increases of up to 15 percent of total fees received. (Multiple donors)</p> <p><u>Egypt:</u> Since 2001, Egyptian family health model facilities in five directorates receive financial incentives when they reach certain targets. This financial incentive is then distributed to the health care staff within the facility. (USAID support and GOE)</p> <p><u>Honduras:</u> Monetary payments are given to hospitals based on implementation of quality improvement plans. The level of funding received depends upon the extent to which quality indicators are met: for example, if the quality assurance team uses a partograph in 70 percent of cases, the team receives 70 percent of the funds for this indicator. (USAID support and GOH)</p> <p><u>Zambia:</u> A forthcoming pilot, funded by a World Bank trust fund, which will assess the impact of PBI in nine districts in each of nine provinces. Fees will be paid to health facilities, district teams, and regional teams for assuring delivery of priority services. (World Bank support)</p> |

² Country programs listed in bold in Table I are further described in sections 3.1-3.6.

| | |
|---|---|
| <p>Contracting NGOs in fragile/post-conflict states</p> | <p>Haiti: Since 1999, USAID has progressively changed the terms of contracts with NGOs from payment for spending on inputs to payment for results. By 2007, NGOs providing services in more than one-third of the country were supported with performance-based contracts.</p> <p>Liberia: USAID began supporting contracts with NGOs that pay partly based on results in 2009. Contracts support developing the capacity of county health teams as well as service delivery.</p> <p>Afghanistan: In addition to support for contracts with NGOs to deliver services, three dominant donors (European Community [EC], USAID, World Bank) are supporting capacity to manage contracts in the Afghan Ministry of Health (MOH). The World Bank contracting approach is performance-based while the EC and USAID specify that payment is not conditional upon attainment of results.</p> |
| <p>Voucher schemes</p> | <p>Pakistan Greenstar: To overcome financial and social barriers to comprehensive maternal health care, USAID-supported enhancement of a social franchise of private providers combined with vouchers that entitle poor women, who had not previously delivered in health facilities, access to a comprehensive package of services, including FP.</p> <p>Bangladesh: To increase access to safe deliveries, donors (through pooled funding) have supported a pilot since 2007 that provides payment to poor women for ante-natal care (ANC), post-natal care (PNC), delivering with skilled birth attendants at home or in health facilities, and transportation. Evidence suggests that all services including safe deliveries increased significantly. In addition, providers receive payments for registering voucher recipients and for providing services covered by the voucher. Some portion of the payments go directly to individual providers, while the rest goes to a facility fund for quality improvement.</p> <p>Kenya: The GOK, with support from KFW, has implemented a reproductive health voucher program that provides poor women access to a network of approved private and public providers for safe motherhood and FP services.</p> |
| <p>Community health workers (CHWs) as recipients</p> | <p>JSY Program, India: To reduce maternal mortality, the GOI has implemented a nationwide program that pays poor women to deliver in health facilities and pays the accompanying CHW. Institutional deliveries have increased substantially, resulting in a strain on the delivery system to meet this enhanced demand. (GOI funded)</p> <p>Philippines: To increase institutional deliveries among poor women, women health teams, which include a midwife, “barangay” health worker, and a traditional birth attendant, receive payment for every poor mother referred and for women who deliver in a health institution. (PhilHealth, GOP, and World Bank)</p> |
| <p>Conditional cash payments to users</p> | <p>JSY Program, India (see above)</p> <p>CCT programs in Mexico, Nicaragua, Bolivia, and Honduras: The programs link income transfers to poor households based on whether children are immunized and receive regular health check-ups.</p> <p>Malawi: Malawi tested providing discrete payments to individuals for getting tested for HIV/AIDS and to reward those who remained HIV negative for a year.</p> |

3.1 DONOR TO SUBNATIONAL PBI – INDIA

“Performance-based aid” (PBA) provides funding from an external donor to a national or subnational level of government, embodies assumptions that incentives at this “higher” level will catalyze changes in leadership, planning, management, and systems that will result in improved health. The evidence on the effectiveness of PBA, however, is far from clear, partly because incentives provided at this higher level do not appear to trickle down to affect behaviors of providers and clients. Rigorous evaluation results are not available.

PBI IN INDIA DONOR TO SUBNATIONAL³

In India, USAID has used a form of PBA termed “performance-based disbursement” (PBD). In 1992, USAID and the GOI signed a 10-year \$325 million agreement for the Innovations in Family Planning Services (IFPS) project to reduce fertility in the state of Uttar Pradesh by expanding access and improving quality of FP services. The program was later expanded with three phases: Phase I: 1994-2002; Phase II: 2004-2009; and Phase III: 2009-2012. USAID defined this PBD approach as “... AID periodically pays the grantee (GOI) upon verifiable achievements of mutually agreeable project outcomes. Achievements are defined under PBD as “benchmarks” and they are verified by means of “indicators of achievement.” Payments are made to the grantee when benchmarks are attained. The level of payment is agreed to in advance by AID and the grantee.”

The program officially started after an Indian registered “society,” the State Innovations in FP Services Project Agency (SIFPSA), was formed to oversee implementation of state-level activities. SIFPSA’s responsibility was to develop implementation plans to increase FP access, use, and quality, and to contract a range of public and private entities to implement activities. Although SIFPSA receives funding through the PBD mechanism, the actual implementers of activities – NGOs and public sector departments – are paid on a cost-based reimbursement with no element of PBD (although the IFPS Technical Assistance Project (ITAP) contract of 2007 is one example of PBD).

Key activities under Phase I of IFPS included: strengthening government hospitals, district action plans, clinical trainings, IEC activities, and contraceptive social marketing. Phase II emphasized reproductive health services in addition to FP. Phase III focuses on strengthening health systems, evaluating public-private partnerships, training and human capacity building, and behavior change communication.

Objective: The IFPS project was originally designed to test a number of innovative approaches to expanding FP services in UP, replicate successful approaches throughout the state, and make a major impact on contraceptive use and fertility.

Payer: USAID disburses funds to SIFPSA. SIFPSA in turn pays implementing organizations.

Recipients: SIFPSA.

Payment approach: Disbursements are based on achievement of defined benchmarks.

Performance indicators: A large number of benchmarks have been used, based on which SIFPSA receives funding from USAID. Early benchmarks were related to priorities such as development of management systems and procedures, planning, and staffing. Later benchmarks relate to process measures including: number of people trained; NGO contracted and funds disbursed; development of a media campaign; and introduction of quality improvement systems and were used to measure FP use through mechanisms such as social franchising. Each benchmark in the annual plan is costed and associated funds are disbursed after the benchmark is achieved. The majority of the measures are process-oriented.

³ Rowan, Margaret. October 2009. “Performance-Based Disbursement: Innovations in FP Project.” Futures Group International, New Delhi, India.

Reporting and validation: An annual report of the proceedings of SIFPSA and all work undertaken was to be prepared by the governing body of SIFPSA for the National Steering Committee. Program audits are done once a year.

Evidence of impact: There does not appear to have been any systematic, rigorous evaluation done to measure health impact and to what extent the program contributed to improved contraceptive use and access to quality FP services.

Lessons learned: There are lessons learned related to management, accountability, and operational issues, based on SIFPSA's experience.

- Given the PBD agreement, there appeared to be strong ownership of the program and accountability. This involved donor, national, subnational, and local commitment.
- Development/agreement/approval of the benchmarks was time consuming. Once approved, repeated time extensions to achieve the benchmarks were common, which likely undermined the PBD approach. Selection of relevant performance indicators is critical with reasonable timeliness of completion, tied to funds disbursement.
- Benchmarks/indicators were primarily related to management and operations rather than health outputs or outcomes, which limited understanding of the program's impact.
- PBD to a local entity such as SIFPSA is considered by many to be an effective and sustainable approach that strengthens an indigenous organization. Concerns expressed, however, are that SIFPSA is bureaucratic and slow in disbursing funds to project implementers.

3.2 NATIONAL TO SUBNATIONAL PBI – ARGENTINA

National governments can incorporate performance-based incentives into the methods used to determine transfers of federal funds to states and municipalities. This may be especially useful in settings where top-down approaches to health are not feasible due to factors such as sheer size of countries (e.g., India) or decentralization that transfers responsibility for health to subnational levels of government. By linking federal-to-state transfers to results, national governments can exert influence by providing incentives to hold lower levels of government accountable while preserving the principle of direct management of health at the state level. Effective performance-based transfers can stimulate state health leaders to identify and fix systemic weaknesses and bottlenecks. One word of caution is that if the incentives do not translate into health-improving actions at the interface between providers and clients, performance-based transfers will have little impact.

PBI IN ARGENTINA AN EXAMPLE OF NATIONAL TO SUBNATIONAL PBI ARRANGEMENT⁴

In **Argentina**, the federal government transfers funds to provinces partly based on enrollment in the maternal and child health insurance program *Plan Nacer* and partly based on achievement of 10 tracer indicators that include services delivered to women and children. Provinces negotiate quarterly targets, expressed as a proportion of the total eligible population, with the national MOH. Each province sets up a “provincial purchasing unit” to oversee implementation of *Plan Nacer* at the provincial level. *Plan Nacer* covers a benefits package that includes 80 health services that improve maternal and child health.

Objectives: Reduce the infant and maternal mortality rate; strengthen the incentive framework for efficiency; enhance focus on results between the national level and participating provinces and between provinces and service providers; and strengthen the stewardship capacity of national and provincial ministries of health.

Payer: There are two levels of payer in *Plan Nacer*: 1) national MOH transfers funds to provinces linked to the number of poor women and children enrolled in *Plan Nacer* and performance on ten tracer indicators and 2) provinces purchase services from providers for this covered population.

Recipients: Provinces are first-level recipients and service providers are second-level recipients.

Payment approach: Of the per capita payment of roughly \$10 per person/per month (the average cost of providing the defined package of benefits), 60 percent is transferred based on submission of enrollment lists that show numbers of poor women and children enrolled in the scheme and the remaining 40 percent is linked to evidence of achievement on 10 performance targets.

Performance indicators:

1. Proportion of pregnant women with first antenatal care visit before 20th week of pregnancy.
2. Proportion of pregnant women who get VRDL test and antitetanic vaccine during pregnancy.
3. Proportion of children less than 18 months old with coverage of measles vaccine or triple viral.
4. Proportion of puerperal women that receive sexual and reproductive care consultations.
5. Proportion of children one-year-old or less, with all normal child development consultations up to date.

⁴ Eichler, Rena and Amanda Glassman. September 2008. “Health Systems Strengthening via Performance-Based Aid: Creating Incentives to Perform and Measure Results.” Brookings Institution Global Economy and Development Working Paper: Global Health Financing Initiative. Working Paper 3.

6. Proportion of newborns weighing more than 2,500 g.
7. Proportion of newborns with APGAR score higher than “6” at minute 5.
8. Percentage of MSN-MSP annual performance agreements successfully implemented.
9. Percentage of authorized providers under annual performance agreements.
10. Percentage of *trazadora* targets achieved by the provinces in the last billing period.

Reporting and validation: Enrollment of the target population is crosschecked by examining enrollment registers of other social insurance schemes. Provinces are accountable to assure the quality of enrollment information. Provinces collect output information for each tracer, following explicit guidelines from the national program. An external auditor examines a sample of registrations (enrollment and tracers) for verification. Penalties for misreporting enrollment = 100% of the per capita transfer given to cover the unauthorized person plus an additional 20% penalty.

Evidence of impact: For six out of the 10 indicators, goals were achieved (based on 2009 data).

Lessons learned: There are many details in the design and implementation and much attention is needed at each step if this approach is to be replicated in another setting. Requests for TA became demand-driven as provinces demanded help to improve information systems, expand enrollment, and contract and pay providers, especially when it became clear that they were not fully on track. This changed the dynamic between provinces and the central ministry – before the TA was not valued and after was highly sought after. This approach profoundly changes the roles of key actors and shifts the focus on results. It is viewed as a strategy to catalyze enduring changes in the health system.

3.3 PAYMENT FROM GOVERNMENT/DONORS TO FACILITIES – RWANDA

One obvious approach for PBI is for the government or donors to directly pay a facility (and thus motivate staff) based on achievement against pre-determined performance indicators. Table I provides examples of this type of PBI programs.

PBI IN RWANDA GOVERNMENT/DONORS PAYING FACILITIES⁵

Rwanda is one of the pioneers of PBI, with a national-level program that evolved from three pilots. Two pilot schemes were launched in 2002 by Dutch NGOs and a third one in 2005 by the Belgian Technical Cooperation. The programs paid providers based partly on services delivered and empowered them to find creative ways to increase the quantity of those services. Each pilot had slightly different payment structures and performance indicators. Initial results showed improvements in coverage, quality, and impact on patients. Based on the experience of these pilots, performance-based financing was adopted as a national policy in 2005 and as part of the 2005-2009 Health Strategic Plan. It was subsequently incorporated in the National Finance Law. The program was scaled up over 2006-2008. Key development partners, Belgium, United States (PEPFAR), and the World Bank, were instrumental in supporting the scale-up. The summary below focuses on the national program and not the pilots.

Objective: Motivate and empower providers in order to improve services and produce better health outcomes.

Payer: Government with multiple donor support, including USAID providing TA.

Recipients: Public and private health facilities.

Payment approach: Health centers are reimbursed for the quantity of services provided according to a standardized fee structure for a list of services, discounted by a composite quality score.

Performance indicators: Focus on quantity and quality of curative, maternal and child health, and HIV/AIDS services.

Reporting and validation: The program has a rigorous data verification and validation system. There is an internet-based data entry and retrieval system. District steering committees validate invoices quarterly, while district hospital teams check quality on a quarterly basis.

Evidence of impact: A rigorous impact evaluation was recently conducted – key findings include:

- Statistically significant increase of institutional deliveries, and quality of prenatal care; in particular, institutional deliveries increased by 7.3 percentage points due to the PBI program (compared to control areas), which corresponds to a 21 percent increase from baseline.
- Statistically significant increase in preventive health care for children. Visits by children 0-23 months increased 64 percent over baseline and by children 24-59 months the increase was 133 percent. There was no significant effect on immunization for children 12-23 months.
- Larger impact on services with higher incentives and for services that are more in the control of the provider and depend less on patients' decisions.

Lessons learned: The Rwandan experience has shown that national scale-up is feasible and rapid results on a large scale can be achieved.

- A results-oriented culture promoted managerial autonomy and empowered providers to find creative solutions, such as subcontracting birth attendants.
- Providers understand their local conditions and have the skills and knowledge to deliver desired results, given the right incentives.

⁵ Rusa, Loius, Miriam Schneidman, Gyuri Fritsche, and Laurent Musango. 2009. "Rwanda: Performance-Based Financing in the Public Sector." In Rena Eichler and Ruth Levine. *Performance Incentives for Global Health – Potentials and Pitfalls*. Center for Global Development. Baltimore: Brookings Institution Press.

3.4 CONTRACTING NGOS IN FRAGILE, LOW-RESOURCE SETTINGS – HAITI

In low-resource settings with limited public health service delivery capacity, contracting NGOs to deliver services may be one of the most effective strategies to reduce maternal and child mortality and prevent and treat infectious diseases. In Afghanistan (with World Bank support), DRC (World Bank), Haiti (USAID), Liberia (USAID), and Southern Sudan (USAID and World Bank), NGOs are contracted to directly deliver services and/or oversee service delivery in a geographic area. This sometimes includes paying incentives and providing support to public health teams and public facilities as well as second-tier contracts to service delivery NGOs. These settings have in common a relatively weak public service delivery system and a history of relatively strong NGOs delivering services in the context of fragility from conflict or lack of government leadership. Contracting NGOs and paying based on results has proven to be an effective strategy to ensure that services reach the population in fragile contexts. In some settings (Afghanistan and Liberia), NGO contracting has also been effectively used to bolster the steering role of the national MOH.

PBI IN HAITI CONTRACTING NGOS AND PAYING BASED ON RESULTS⁶

In 1999, USAID changed how it contracted NGOs in Haiti from paying for documented spending on inputs to paying for achievement of output and performance results. Beginning with a pilot with three NGOs that provided services to roughly 500,000 people, more NGOs were progressively graduated into a PBI payment regime until 2005, when all health service delivery NGOs supported by USAID were paid based on results. This approach continued and PBI with the public sector was planned. However, the devastation brought by the 2010 earthquake disrupted the existing program. Evolution of the approach in Haiti contains many lessons, as the model was refined and revised.

Objective: Increase access to a comprehensive package of maternal, child, and infectious disease services and to strengthen institutional capacity of service delivery NGOs.

Payer: The USAID project HS-2004 sub-contracted NGOs.

Recipients: Service delivery NGOs with networks of CHWs, health centers, laboratories, and hospitals.

Payment approach: Since 2005, NGOs received 94 percent of the estimated budget needed to deliver a defined package of services to a catchment population in fixed, reliable, quarterly payments. In addition, NGOs could earn the 6 percent “withheld” plus another 6 percent if they achieved predetermined performance targets.

Performance indicators: Indicators evolved during the ten-year period. They cover child health (e.g., fully immunized children under one) and maternal health (proportion of pregnant women receiving at least four prenatal care visits and proportion of women with institutional deliveries). HIV and tuberculosis indicators were added in recent years. Indicators of sound financial management and on-time reporting are also rewarded.

Reporting and validation: NGOs reported results are validated through random administrative audits at the facility level and random household visits to verify that services were received.

Evidence of impact: Strong performance seen quickly on services such as immunizations and institutional deliveries. Other indicators take longer to show results.

Lessons learned: PBI is a powerful approach to strengthen capacity and to achieve results. NGOs made changes to how they structure and deliver services, motivate staff, and reach out to communities so they could achieve the results.

⁶ Eichler, Rena, Paul Auxila, Uder Antoine, and Bernateau Desmangles. 2009. “Haiti: Going to Scale with a Performance Incentive Model.” In Rena Eichler and Ruth Levine. Performance Incentives for Global Health – Potentials and Pitfalls. Center for Global Development. Baltimore: Brookings Institution Press.

3.5 VOUCHER SCHEME FOR MATERNAL HEALTH – PAKISTAN

Vouchers are coupons that are given for free or sold to eligible participants, entitling them to specific health services from participating providers. They are designed to overcome access barriers, including financial barriers to access priority health services. Vouchers can be used to target priority groups (such as poor pregnant women) and areas for subsidization (for example, maternal health services). They have the potential to increase consumers' choice of providers and improve quality of care. In addition to the obvious demand-side incentive, voucher programs have a supply-side component given that providers receive payment for services covered by the voucher. In some voucher programs, providers or facilities receive additional incentives based on specific performance indicators. Vouchers cover maternal health services in Bangladesh, Cambodia, Pakistan, Kenya, and elsewhere. Schemes in Nicaragua, Uganda, and elsewhere covered FP services.

PBI IN PAKISTAN GREENSTAR VOUCHER SCHEME⁷

Over one year from October 2008-2009, the Greenstar Social Marketing network piloted a voucher scheme in six union councils of one district in Punjab. Poor pregnant women were sold vouchers for maternal health and FP services. Greenstar network providers who met certain criteria were selected to participate in the scheme. The pilot is being repeated in a second district based on results of the first pilot.

Objective: Reduce maternal and infant mortality by increasing utilization of antenatal care, skilled delivery, postnatal care, and FP services.

Payer: USAID-financed under the PAIMAN project. Greenstar Social Marketing network manages payment to providers and voucher distributors.

Recipients: Poor pregnant women purchased vouchers (at subsidized rates) for services as well as for transportation cost. Providers received payments for services provided to voucher holders.

Payment approach: Providers paid voucher holders transport cost and provided the covered services for no fee. Greenstar reimbursed providers the transport payments that providers gave voucher patients and paid for the services provided to voucher holders, based on claims submitted by the providers.

Performance indicators: Number of vouchers sold; number of vouchers redeemed for specified maternal health and FP services.

Reporting and validation: All voucher claims from providers were verified against client names. In addition, a random sample of voucher claims were verified monthly to ensure services were provided and went to eligible voucher holders. The Greenstar office also conducted quarterly audits.

Evidence of impact: The voucher scheme is considered a success – more than 98 percent of the voucher holders delivered at facilities, while more than 78 percent returned for FP counseling after delivery.

Lessons learned: There were many lessons learned from pilot scheme – a few are highlighted here:

- Baseline data was not collected for the pilot, which would have been important for measuring impact.
- The voucher scheme used various communications strategies with pregnant women, their families, communities, and traditional birth attendants in order to change the social and cultural norm of home deliveries – this multi-faceted strategy likely contributed to the high rate of facility-based deliveries.
- Contracting transport services to reduce costs and respond quickly to clients is being considered.

⁷ Bashir, Hamid, Sarfaraz Kazmi, Rena Eichler, Alix Beith, and Ellie Brown. January 2010. "Pay for Performance: Improving Maternal Health Services in Pakistan" (Working title of draft). Maternal and child health P4P case studies. Bethesda, MD: Health Systems 20/20, Abt Associates Inc.

3.6 PERFORMANCE INCENTIVES FOR CHWS AND WOMEN – INDIA

CHWs respond well to incentives and can contribute to changing behaviors and increasing access to formal health services by providing information and support to community members. What follows is a summary of the JSY program in India that provides incentives to CHWs and to women for deliveries.⁸ Incentives to consumers to use services can be a powerful strategy to increase utilization. Offering payments at the point of service use or linked to health improving behaviors can overcome financial and social barriers and incentivize action. Offering payments when women come to a health facility to give birth has proven to be an effective way to increase institutional deliveries by the poor.

PBI IN INDIA JSY PROGRAM

The JSY program, introduced in 2005 and funded by the GOI, is both a demand- and a supply-side PBI scheme. JSY covers all 28 states in India – indeed, it is mandatory for states to implement the scheme, though they have the authority to modify central guidelines to better shape the program to their local contexts. In 2008-2009 the JSY program covered nearly 8.4 million people.

Objective: To reduce maternal and infant mortality through increasing institutional deliveries, especially by poor women and members of traditionally underserved communities⁹. JSY also seeks to increase access to quality antenatal and postpartum health care, especially for poor women.

Payer: The central government initially provided all JSY support. States are now required to contribute to supporting JSY in order to receive central funding.

Recipients: There are two types of PBI recipients:

- On the demand side, women accessing a continuum of maternal and newborn health services at government or accredited private institutions and who deliver in one of these institutions, and
- On the supply side, individual community-level health workers (primarily accredited social health activists [ASHA]¹⁰) who support community members' health needs and serve as liaisons between the community and the government health system.

Payment approach:

- On the demand-side: in low performing states (LPS¹¹), all pregnant women of any caste, age, or income group that deliver in a government or accredited private facility qualify for the JSY program and receive payments specified in the table below. In high performing states (HPS¹²), all pregnant women who are members of scheduled caste/scheduled tribe communities and pregnant women who are below the poverty line and older than 19 years qualify for incentives.
- On the supply-side, ASHAs and other CHWs receive a financial incentive when they accompany a woman to deliver, but only in LPS, not in HPS.

⁸ Dagur, Vikas, Katherine Senauer, Rena Eichler, and Alix Beith. January 2010. "Pay for Performance: The Janani Suraksha Yojana Program in India" (Working title of draft). Maternal and child health P4P case studies. Bethesda, MD: Health Systems 20/20, Abt Associates Inc.

⁹ Called "scheduled caste/scheduled tribe communities" and recognized by the Constitution of India as having traditionally been underserved.

¹⁰ Other local level health workers can also qualify to be "CHWs." Like ASHAs these individuals serve as links to the community and are eligible to qualify for JSY benefits if they fulfill the appropriate JSY responsibilities.

¹¹ The LPS are Assam, Bihar, Chattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar.

¹² The HPS are Andhra Pradesh, Arunachal Pradesh, Goa, Gujarat, Haryana, Himachal Pradesh, Karnataka, Kerala, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Punjab, Sikkim, Tamil Nadu, Tripura, West Bengal.

Performance indicators: Women receive payment after they have given birth in a public or accredited private institution. AHSAs and other CHWs receive payment only if they escort the pregnant woman to the institution for delivery and stay with her until delivery is complete. The GOI recommends that payments to ASHAs and other CHWs be made in two installments. The first payment is given at the health facility upon delivery of the child, while the second is paid approximately one month after delivery when the ASHA or other CHWs have helped with postnatal care, registration of birth, and BCG immunization of the newborn.

Evidence of impact: Institutional deliveries have substantially increased in many states during recent years and it is likely that the JSY program contributed to this increase, especially as JSY beneficiaries have reported that the payments received through JSY have helped motivate them to deliver in health facilities. Specific studies have also provided evidence that the JSY program contributed to increased access to antenatal and postpartum services as well as an increase in institutional deliveries.

- A study conducted in 2007 in Rajasthan State (a LPS) by the Centre for Operations Research and Training on behalf of UNFPA, compared the change in number of deliveries in public sector facilities before and after the JSY program began. The number of institutional deliveries in the public sector increased by 36 percent pre-JSY compared to one year after JSY initiation.
- In 2007-2008, the Population Research Center at Mohanlal Sukhadia University conducted a study sampling two districts in Rajasthan State.¹³ Of the two districts sampled, one had a high performance record of institutional deliveries (Banswara District) and one had a low performance of institutional deliveries (Barma District). The study found that overall the JSY program contributed to increased access to antenatal and postpartum care as well as increased institutional deliveries. The majority of beneficiaries interviewed had access to a trained ASHA in their village and received the full package of JSY services including: three ANC visits, use of iron folic acid tablets, a postpartum visit, an appropriate payment package; and they delivered with the presence of an ASHA or other CHW.

Lessons learned: Key lessons include:

- The importance of conducting studies to monitor program implementation and of sharing findings from these studies across states.
- The need to create payment mechanisms/systems that allow for timely payment of beneficiaries and that are not overly cumbersome in terms of document submission and reporting requirements.
- The importance of incorporating strategies to strengthen both human resource and infrastructure requirements ideally prior to program implementation/scale-up.

¹³ Sharma, Ramakant. Janani Suraksha Yojana: A Study of the Implementation Status in Selected Districts of Rajasthan, 2007-08. Population Research Centre Mohanlal Sukhadia University.

4. SOURCES OF INFORMATION

Content for this Primer comes primarily from the following sources:

Eichler, Rena and Ruth Levine. May 2009. *Performance Incentives for Global Health*. Center for Global Development Brief.

Eichler, Rena, Barbara Seligman, Alix Beith and Jenna Wright. March 2010. *Pay-for-Performance in Family Planning: Lessons for Developing Countries*. Bethesda, MD: Health Systems 20/20, Abt Associates Inc.

Eichler, Rena and Ruth Levine. *Performance Incentives for Global Health – Potentials and Pitfalls*. Center for Global Development. Brookings Institution Press: Baltimore, MD. 2009.

Further information on PBI programs can be found at the following websites:

Health Systems 20/20: <http://www.healthsystems2020.org/section/topics/P4P>

Center for Global Development:

http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/performance

World Bank: <http://www.rbfhealth.org>

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U.S. Agency for International Development

1300 Pennsylvania Avenue, NW

Washington, DC 20523

Tel: (202) 712-0000

Fax: (202) 216-3524

www.usaid.gov