T17P09 / Public Policy and Payment for Performance Programs (P4P/PBF) in Health: in High-, Middle- and Low-Income Countries

Topic : T17 / HEALTH POLICY

Chair : Fabiana SADDI (Universidade de Brasília)

Second Chair : Stephen Peckham (Centre for Health Services Studies, University of Kent)

Third Chair : Lara Gautier (Université de Montréal)

GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

Co-organized with Dr. Nick Turnbull (University of Manchester)

GENERAL OBJECTIVES: The objective of this panel is to discuss studies applying Public Policy theories and related theories and concepts in Health System Research to study the design/formulation and/or implementation processes of pay for performance programs (P4P) – also known as performance-based financing (PBF) - in health policy in high-, middle- and low-income countries, focused either on theoretical or empirical approaches, as case or comparative study.

RESEARCH QUESTIONS: In what ways diverse Public Policy elements/ aspects/ dynamics/ processes related to policy (re)design/(re)formulation and implementation of P4P/PBF programs can affect health system performance and/or building blocks in countries adopting varied models of primary health care (PHC), which are at distinct stages of development? What are the main actors involved in policy (re)design/ (re)formulation? How international organizations, national policymakers and stakeholders, policy brokers, entrepreneurs (diffusion), and consultants have influenced the policy-making process? What types of policy learning and policy feedback have been taking place at both the design/ formulation and implementation levels? To what extent policy (re)design/ (re)formulation have taken into consideration implementation failures and involved national/local government actors, communities of knowledge and front-line health workers? What are the main policy and performance drivers/mechanisms that have characterized the implementation of P4P/PBF and how differently or commonly have they impacted health systems in high-, middle- and low-income countries? How motivations, behaviours and discretionary decisions/power have varied in contexts with distinct organizational capacities, in different stages of development of a culture of monitoring and evaluation at both the policy-making and implementation levels? If/how unintended consequences or political paradoxes such as gaming, cheating and spillover effects have characterized those processes?

SCIENTIFIC RELEVANCE:

Public Policy theories and analysis are relevant to uncover the policy and political dynamics of (re)design/ (re)formulation and implementation processes of rational-based programs such as P4P/PBF. This is because Public Policy offers some key concepts and methods/approaches for understanding why/how different and similar policy and political processes affects health systems performance and/or building blocks. However, and despite the spread of P4P/PBF on the globe, Public Policy theories and analytical approaches have been little (or practically not) employed in the analyses of P4P/PBF in various countries and comparatively (especially). In general, studies tend to focus mainly, albeit differently, on outcome analyses. In high-, middle-, and low-income countries, there are few (or no) publications focusing on the design/formulation of pay for performance programs, so that we do not analytically and in a systematized way know how the design / formulation of P4P/PBF varies and can be compared within different contexts and models of PHC. As far as the implementation process is concerned, there is still a research gap and especially (but not only) in high- and middle-income countries. In low-income countries adopting PBF, and despite the diversity of methods and types of qualitative and system analysis, elements / concepts of Public Policy have been privileged by few studies.

P4P/PBF programs have been interrupted in countries such as Scotland, Mali and Mozambique, and presents a risk of discontinuity in others (as in England). Its continuity in countries like Brazil and scale-up in Zimbabwe occurs at a time where there is still a gap in comparative knowledge from other cases considered both as success and failures cases. We argue that the non- or low-use of Public Policy theories delays this process of learning/ transference of comparative knowledge. Public Policy could contribute to speed-up, in a

comprehensive way, the opening of the so-called "black box" of P4P/PBF, highlighting how policy drivers or mechanisms could, in an inter-related way, contribute (or not) to the sustainable development or scale-up of P4P/PBF.

CALL FOR PAPERS

We are calling researchers, policymakers, practitioners and policy experts from high-, middle- and low-income countries to propose papers on pay for performance programs (P4P/PBF) to this panel: “Public Policy and Pay for Performance Programs in health: in High-, Middle- and Low-income countries”. We welcome papers applying Public Policy theories and related (or complementary) theories and concepts/frameworks in Health System Research to study the design/formulation and/or implementation processes of pay for performance programs (P4P) and performance-based financing (PBF) in health policy in high-, middle- and low-income countries, focused either on theoretical or empirical approaches, as case or comparative study. Analyses should focus on actors, ideas and interests involved in the policy-making and/or implementation, as well as on the characteristics of the institutions involved. Moreover, political contexts and level of economic development should be considered in the analysis. We expect papers to take into account the main theories and concepts (or one or few of them) used by Public Policy in the analyses of policy design/formulation and implementation, such as: social learning, types of policy learning, policy feedback, policy transfer, policy brokers, policy entrepreneurship, policy consultancies, networks or communities, street level bureaucracy or front-line actors, policy transfer or diffusion, as examples. Papers that gather original data/text from surveys, interviews, focus groups, observations, forms of participation are highly encouraged. Studies comparing those interventions where the medical intervention and professional practice has only a partial effect and where self-care and informal care may play a larger role in success are welcome as well. Analyses focusing on the state of the debate and going beyond the polarized debated about PBF in global health, and by means of analysing other broader contextual aspects and from a multidisciplinary perspective are welcome as well. Thematic analysis, documentary analyses, critical reviews, literature reviews and qualitative evidence syntheses analyses employing Public Policy concepts or analytical approaches will be considered as well. Framework analysis, causal inference case studies, process tracing analyses, multi methods, mixed methods and long- term process and longitudinal analyses and comparisons across countries will be highly appreciated.

We will give priority to papers that bring out new findings/contextual evidences to the field due to the employment of Public Policy theories and analytical approaches, but are happy to receive papers that present policy and system themes/ perspectives in any creative or innovative policy relevant ways.

Policymakers, researchers and practitioners will benefit from this proposed panel and discussions. Considering, for instance, that PBF has been developed mainly (or concentrated) in African countries, and that their experiences and discussions/debates have been taking place separately from high- and some middle-income countries (especially from Latin American middle-income countries [and also low-income countries in the Americas]), actors involved with PBF in Africa and Asia or in global networks or communities of practices will have the opportunity to share and discuss their knowledge/experience with and learn from experts/studies focused on high- and middle-income countries in other parts of the globe. High- and middle-income countries will be able to learn how community-based models in primary care have been developing PBF, bring broader and singular lessons to their studies/policy process. All actors will have the opportunity to identify similarities and differences that will strengthen their knowledge regarding what types of policy initiatives/drivers/mechanisms are more effective (or hold middle or low levels of effectiveness) when designing/formulating and implementing diverse but similar types of pay for performance programs.

In this panel a selection of papers may be considered for the publication we intend to organize.

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Session 1P4P/PBF: Policy Comparisons and Trajectories

Thursday, June 27th 16:30 to 18:30 (MB 5.265)

Discussants

Fabiana SADDI (Universidade de Brasília)

Stephen Peckham (Centre for Health Services Studies, University of Kent)

How institutions influence instruments of performance governance in primary health care – A comparative study of six jurisdictions.

Viola Burau (Aarhus University)

Tim Tenbensel (University of Auckland)

Since the beginning of the twenty-first century, the performance of primary health care providers and organisations has emerged as an important new object of governance in high-income countries. Over that period, a variety of policy instruments have been developed with the aim of stimulating and/or stipulating improvements in arenas such as quality of care, effectiveness, efficiency and equity in the primary care sector.

Possible policy instruments can be divided into two broad categories. Firstly, hierarchical performance requirements and market-type instruments, which tap into extrinsic sources of motivation. Secondly, network-type instruments based on professional self-regulation or inter-organisational mechanisms, and which draw on intrinsic motivations of providers. The relative balance between the two types can have significant consequences for the steering capacity of governance arrangements. Therefore, it is important to understand how and why particular instruments become dominant.

In this paper, we compare primary care performance governance in six high-income jurisdictions with a view to assessing:

(1) To what degree there is international convergence and/or divergence in the types of instruments used to govern primary care performance?
(2) To what degree are commonalities and differences shaped by broader policy, public management and health system institutions?

In terms of theory, the study draws on the literature on policy instruments and governance to develop a typology of policy instruments for performance governance in primary care. We combine this with insights from historical institutionalism to account for the importance of institutional legacy and to identify specific sets of policy, public management and health system institutions that possible shape the choice of policy instruments for performance governance in primary care.

Methodologically, the study employs a cross-country comparative research design that includes Australia, Denmark, Germany, the Netherlands, New Zealand and Quebec; the jurisdictions are characterised by interesting variations in institutional contexts. The analysis draws on primary and secondary sources gathered by each of the six authors in relation to their respective jurisdiction of expertise. This formed the based for descriptions of performance governance that followed a common template to account for the specific mix of policy instruments and the particular institutional context in each jurisdiction.

Our findings will be located on a continuum of relative institutional determinism. Under strong institutional

determinism, the adoption of primary care governance instruments is fundamentally shaped by prevailing institutional conditions. These could include (i) political institutional characteristics, such as concentration of constitutional power and adversarial or consensual party systems; (ii) prevailing public management institutions, such as the degree to which new public management routines are entrenched; and (iii) specific health system institutions pertinent to primary care, covering the dimensions of financing, provision and governance. Under weak institutional determinism, there may be significant degrees of freedom for the development of policy instruments. This could be the case as primary care performance governance is a relatively new arena, where policy actors have the capacity to create new regimes that are only weakly constrained by institutional legacies.

Pay-for-performance in French and German health reforms: similar instruments, distinct trajectories

Matthias Brunn (Institut d'Etudes Politiques de Paris (Sciences Po))

Health systems undergo important transformations, triggered by budgetary pressure and rationalisation. In this context, France and Germany have introduced pay-for-performance (P4P) measures to provide financial incentives for providers meeting certain objectives. While there are similarities in both systems, the nature and timing of these policies differ, which we hypothesised to be related to differences in the collective organisation and institutionalisation of physicians. We used a comparative study design: the introduction of P4P in ambulatory care in France in 2009 and its potential introduction in Germany. We performed a literature review and semi-structured interviews of 23 actors. From an analytical perspective, we blended the approaches of public policy instruments, policy transfer and programmatic actors.

We advance two main arguments. First, development of P4P in both countries is intrinsically linked to preceding policies as instruments prolonging the larger, long-term system transformations: the growing role of the State and statutory health insurance (SHI) in parallel to a fragmentation of the medical profession. It was embodied in France by the 2004 reform redefining the mission of SHI. In Germany, in addition, we emphasise the growing role of competition elements since the 1990s.

This leads to our second argument: the prolongation of the long-term transformations did not lead to the same results in France and in Germany. In fact, P4P has seen a rapid uptake in France, facilitated by a relatively strong and proactive coalition led by SHI, which suggested that the reform be set within a coherent line of measures and ideas. Arguments of de-professionalization and ethics played a role in the ensuing discussions, with the majority of individual practitioners ultimately opting for P4P in balancing cognitive and material implications. A clear leadership role was assumed by the SHI director, by starting with P4P as individual contracts and then later integrating it in collective agreements. The cognitive focus was on cost containment via generic prescription, with SHI’s strategic goal of fostering IT in physician offices. Its backbone was a well-staffed strategy department scanning foreign experience.

However, in the case of Germany, the picture is less clear, with many providers remaining reserved towards the idea of P4P and key actors uncertain about the net political gains. One major initiative for P4P in ambulatory care came from physician representatives in self-regulating bodies in a move to regain regulatory edge, hoping also to gain control over data or at least over data collection methods. Yet, it was rejected by its base over concerns about de-professionalization and the allocation of funds. It was followed by long technical debates about quality indicators that may be seen as delay tactics. The ensuing debate concerned issues over data and the balance of power among the self-regulating partners (physicians, SHI, hospitals). A P4P component will be introduced for hospital payment and is likely to yield advantages for SHI and private hospitals.

In both countries, these developments challenge established patterns, pointing towards a “divergent convergence” of healthcare arrangements.

When the Travelling Model settles down: Replication, Strategic Usage and Hybridisation of Performance-based Financing in Health

Jean-Benoît Falisse (University of Edinburgh)

Performance-Based Financing (PBF) in health has travelled extensively. French development anthropologist Jean-Pierre Olivier de Sardan even calls it the quintessential example of a travelling (public policy) model. The nature of those travels –and the ‘diffusion entrepreneurs’ (Gautier) that have facilitated and organised them– are now well-documented. Yet, besides diffusion and the equally well-researched questions of the technical implementation and effects (or lack thereof) of PBF, it is also crucial to approach PBF as a political

object that goes through various forms of re-territorialisation. Building on Engle Merry's concept of 'vernacularisation' and Berhend's 'traveling model', this paper looks into the arrival and deployment of PBF in Burundi and Sierra Leone. The former case is often heralded as a success story while the second is widely regarded as a failed attempt to 'make PBF work'. The analysis of interviews with key actors and grey literature shows that PBF implementation in Burundi has been highly strategic –donors and diffusion entrepreneurs did play a key role but, perhaps equally importantly, PBF has been used as a tool for achieving a policy of selective free health-care and reinforce a technocratic elite within the Ministry of Health. In Sierra Leone, where the same question of free health-care was on the agenda, the implementation of PBF has not gone beyond a botched replication of a somewhat rigid model. The two cases are compared, highlighting the importance of the Ministries of Health internal politics, and the paper then discusses the importance of the strategic (national) dimension of the travelling model.

Scaling up PBF in Burkina Faso: going from PBF to user fees exemption strategic purchasing

Mathieu Seppey (Institut de recherche en santé publique)

An increasing number of countries follow performance-based financing (PBF) reforms to improve healthcare service's quality and quantity, even more specifically in sub-Saharan Africa. However, only few PBF reforms successfully manage to go through the different scale-up phases. In Burkina Faso, a pilot project has been implemented in 15 districts as a first step towards a national reform. A scaled-up PBF program is however still at embryonal stage after years of implementation.

Therefore, the objective of this study is to better understand this project's scale-up potential by using the WHO's theoretical framework. This case study will provide with an empirical example that can be helpful to strengthen the conception of scale-up, in regards to PBF programs. The scale-up of this PBF program was examined through the assessment of the intervention, the host organisation, the scale-up team, the planned/used strategies and their context. In-depth interviews (n=37) were carried out in 3 different health centres (n=19) and in Ouagadougou (n=18) to discuss the scale-up with healthcare providers, implementers, decision-makers and external experts. The software QDA Miner © was used to manage the data and help in the thematic analysis.

The results of this study illustrate that the potential of a PBF scale-up is low, if the project would remain unchanged. The low involvement of some key stakeholders (mainly decision-makers) as well as the unstable context did hinder the ownership of the project therefore its prioritisation on the political agenda. Not being a priority, PBF reform lost its momentum to the benefit of a user fee exemption program. That later program was also perceived as more beneficial since it acted upon the access to health services, in comparison to services' quality, which was PBF's relative advantage. A scale-up of some PBF elements (ex.: PBF purchasing tools) is however still in discussion, but would integrate PBF within the user fee exemption program. Increased costs during PBF's implementation gave the impression that the project was too costly and not scalable. The involvement of an important funding agency (World Bank) also fed that impression of high costs that demotivated different actors, especially decision-makers.

Two lessons are to be remembered. First, a new way of implementing project should be put forward by further interacting with local/national actors, building trust and creating long term and more effective partnerships. Ensuring a more participative approach to scale-up (or project implementation) could then reduce actual flaws in the field of project implementation, such as national policy/priority distortions or undue pressure towards projects implementation aspects. Second, more attention should be given to the implementation's contexts within which project are taking place. Like the situation of in Burkina Faso, the context's influence on projects' implementation is too important to be occulted, even more when it is question of national policies or scaled-up projects. Political, social, cultural or economic aspects should therefore be assessed and accounted for to better understand their potential impacts on projects, programs or policies.

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Session 2P4P/PBF - Results-based and Contextual Evidences

Friday, June 28th 08:00 to 10:00 (MB 5.265)

Discussants

Stephen Peckham (Centre for Health Services Studies, University of Kent)

Miriam Nkangu (University of Ottawa)

Effects of Performance-Based Financing Interventions on Health System in Low-and-Middle Income Countries: An Evidence Gap Map

Miriam Nkangu (University of Ottawa)

Lawrence Mbuagbaw (McMaster University)

Janet Hatcher Roberts (University of Ottawa)

Sanni Yaya (University of Ottawa)

Authors: Miriam N. Nkangu, Lawrence Mbuagbaw, Loveline Lum, Patrick M. Okwen, Orvill Adams, Christine Mathew, Janet Hatcher Roberts, Sanni Yaya

Background

Performance-based financing is a trending approach within the health sectors of many low-middle-income countries. Debate in the literature is polarized on its design and implementation, most specifically in terms of effectiveness, efficiency, and equity. Evidence gap maps are important tools for informing strategic evidence-informed decision making and for research prioritization for policy-making. An evidence gap map of PBF interventions is a first step in mapping out clusters and gaps in the available evidence and providing a structured and accessible guide for PBF policy across the health systems.

Objective: To provide a structured and accessible guide to inform PBF policy-driven decision making and research on PBF by providing an overview of the evidence on the PBF intervention strategies and absolute gaps across the health systems.

Method

The Evidence gap map will follow the methodology developed by the Campbell Collaboration. The process starts by defining the scope and developing an evidence-informed framework that helps to identify the interventions and outcomes. The key intervention domains of the EGM are focused on the framework of the health system pillars, which include service delivery, finance, human resources, governance, information system, and medicines. The primary outcomes are conceptualized within the PBF framework developed by the Health Innovation Trust Fund which is used to guide the design, implementation, and evaluation of PBF programs, alongside a PBF monitoring and evaluation framework on the effects of health systems. Long- and short-term outcomes are categorized according to the framework into organizational and behavioural outcomes. These outcomes are sub-categorized using the Cochrane Effective Practice and Organization of Care (EPOC) categorization of outcome reporting, including the secondary outcomes. This is followed by a search strategy developed with the help of an information scientist for the following data bases Ovid Medline, Embase, CAB Global Health, CINAHL, Cochrane Library, Scopus, including grey literature. Studies

that meet the inclusion criteria will be coded by extracting data on intervention, outcome, measures, context, geography, equity aspects and study designs. Systematic reviews will be critically appraised using standard checklist and, impact evaluations will not be appraised but will be coded according to the study designs. The final stage is the creation of the map which produces an evidence gap map graphic that will display the available evidence according to the PBF interventions and outcome framework.

Results and Conclusion: The Evidence Gap Map is on-going and directly relates to the panel's objectives on evaluating performance-based financing and will help direct where research is most relevant and evidence informed policy. The results will be available during the presentation at the conference and a graphical presentation of the map will be used to display the finding. The EGM will inform PBF policy and direct research objectives and prioritization.

A pay for performance scheme in primary care: Meta-synthesis of qualitative studies on the provider experiences of the Quality and Outcomes Framework in the UK

Nagina Khan (University of Kent at Canterbury)

Stephen Peckham (Centre for Health Services Studies, University of Kent)

Background & objectives

The QOF was introduced as a mechanism to motivate GPs to achieve a change in aspects of general practice delivery and performance.

Over the past few years there has been an increasing call for the QOF to be abolished and in 2016. Scotland ended the scheme which only continues in England, Wales and Northern Ireland (1,2). In early 2017, the British Medical Association called for the QOF to be suspended to reduce bureaucratic pressures and free up clinical time (3).

To date most studies have focused on evaluating the impact of QOF on clinical performance and not broader impacts on the organisation and provision of care. The impact of QOF is considerably broader than the clinical domains. Usefully some studies have examined the broader impact of QOF or, in discussing more narrow clinical concerns provide useful contextual qualitative data.

It is therefore important to understand the impact of funding and contractual mechanisms on the provision of primary care and how different payment models drive different types of behaviour (4,5). In order to understand the critical motivators of such behaviour and attitude changes. We analysed this evidence using Schwartz's 'Value Theory' (6,7), using a six part conception of values framework to report and contextualise our emerging concepts from the studies in our review.

Method

We undertook a meta-synthesis in order to understand the broader impact of QOF on the individual clinicians and other groups of professionals in primary care. We carried out this work specifically using a Lines-of-argument (LOA) synthesis. The LOA synthesis involves building up a picture of the whole from the studies of its parts (8). A meta-synthesis draws on the subjective and interpretive nature of existing qualitative research to construct more complete and plausible understandings of reality than what is currently available from the existing literature (9).

Our search aimed to identify published peer-reviewed empirical research relating to pay-for-performance schemes in primary care in the UK, focusing particularly on QOF. Although multiple studies are used, the sample is purposive and therefore not entirely exhaustive.

Results

We identified 6 broad themes:

· Loss of autonomy & uncertainty;

· Incentivised conformity

· Holism and continuity

· Structural & Organizational changes

· Control and ownership

· 'Grey' ambiguous nature of work in primary care

While these are associated with the ongoing impact of QOF, they may have more long lasting significance for the future workings of general practice.

Conclusion

The Values Theory suggests that everyone experiences conflict between pursuing openness to change values or conservation values and between pursuing self-transcendence or self-enhancement values. Conflicts between specific values (e.g., power vs. universalism, tradition vs. hedonism) are also near-universal (6). The papers in this review showed that achieving some balance in this now appears to have been crucial and the evidence suggests that embracing a more complimentary working between the two, with more focus on the combined efforts is more successful to drive complex initiatives. Since values serve as standard or criteria; tend to guide the selection or evaluation of the actions, policies, events. Consequently, quality improvement initiatives should then integrate the personal and professional values that clinicians find vital into their processes, as clinicians are driven by their views, beliefs, and experiences, and not just by hierarchy and the externally imposed constructs.

Community Performance Based Financing: A Report of Public Policies in Implementation in Cameroon

Patrick Okwen (Effective Basic Services Africa)

Mireille Manga (IRIC, University of Yaoundé II)

Evidence-based policy, especially in health public domain is not yet an entirely common practice in sub-saharan African countries. So, Performance-Based Financing (PBF), program imported from other Asian and African countries and implemented in Cameroon, showed mixed results. Impact evaluations of PBF have shown that PBF had a positive impact on some health outcomes, but no impact on others. Reflections on the PBF approach have suggested that increasing the demand for health services at the community level, could increase the efficiency and effectiveness of PBF. There are existing opportunities, including the use of lay community health workers (CHWs), that could be used to mobilize communities to support health facility performance and increase healthcare demand.

The study seeks to evaluate the experiences and effectiveness of a community performance-based financing approach employing and see how does this impact on decision making process in health domain in Subsaharan countries especially in Cameroon.

The study is based on consultations and stakeholder meetings with community members, NGOs, local councils and ministry of health in Cameroon. Such first research strategies have helped to design approach of community PBF that will not include financial incentives for community or service users (demand side).

Between 2015 and 2017, community monitoring was implemented in four health districts, including 96 communities, in the North-West Region of Cameroon. Community monitoring is an approach to (i) facilitate the community mobilization process to enhance healthcare demand, (ii) support health facilities improve their performance and (iii) add value to activities of CHWs. This approach was used to provide feedback on health priorities within the communities including; what were the ongoing challenges, level of performance of health facilities and CHWs. This feedback was then incorporated into the business plan of health facilities. We calculated the contributions of PBF to hospital production (equity and quality bonuses), quality of care, outreach, and the ability to use community voices for decision making. We focused on diseases with the highest disease burden, including malaria, HIV/AIDS and sexual and reproductive health services.

A qualitative assessment was used to highlight the experiences of communities, health facilities and CHW, which will help in the meaningfulness of the program to these groups.

So the intentions of the proposal will be to present our first results of the study and see how they can impact on decision making process in health domain in Cameroon Even though those previous suggest that a systems approach facilitated ownership in community members and stimulated inputs into the political system and thereby ensuring sustainabilty and reducing cost of intervention.

ASHAs in India: Gender, Voluntarism and Performance Based Payment

Bijoya Roy (CENTRE FOR WOMEN'S DEVELOPMENT STUDIES)

Community Health Workers play an important role in dispensing healthcare services to remote and far-off areas. During the first decade of the 21st century with the absence of skilled healthcare workforce in remote rural and urban slum spaces and push for universal health coverage, India witnessed a second wave of expansion of CHWs through Accredited Social Health Activists (ASHAs) who are primarily women. ASHAs are envisaged as honorary volunteers and are remunerated through performance-based payment (PBP); one of the largest in the world. The PBP system varies in each state.

From the operations management and human resource perspective PBP works as means to control the

behavior of the employee – i.e. employees' performance (output) will improve with the incentives. WHO recognizes payment as a means to sustain programme and as one of the motivational factors as CHWs from LMIC are poor. This paper precisely takes a look across PBP in India where the issue of voluntarism, remuneration, informalization of work within the public sector and gendered nature of work has not been enough explored. In this context, we review the growing body of evidence in India about how performance incentive or compensation systems have been developed, function in practice and how individuals respond and adapt to them over time, drawing primarily on examples from different states. The effort is to explore and understand how the PBP system is being implemented and the challenges of implementing PBP.

In India for ASHAs from the rural and marginalized area being CHWs has emerged as an avenue for future employment and empowerment. Performance-based incentive, without any minimum wage, becomes the sole base for ASHAs earning a certain level of income for her and her family. Inability to meet the targets results in non-payment to CHWs. ASHAs being women are considered as natural caregivers and policy assumption reflects that they can be underpaid. In the recent times ASHAs across different states have demanded minimum monthly wage as they feel they are lowly remunerated for time and skill insisted and to be recognized as paid workers even when it is an economic activity for them.

The state level policy frames show that within the complicated nature of health sector PBP is designed in such a way that tasks which are easily measurable gets priority and tasks without incentives face neglect increasing the moral hazard costs. In a low-middle income country like India lack of minimum monthly wage and only incentive based income leads to such separation of work tasks. It surfaces as a highly contextual issue. It shows that PBP does motivate ASHAs to join as CHWs beside personal goals and altruism. At the same time the public sector in healthcare has to develop better systems of measuring and understanding programme management, sustainability and accountability and value and recognize ASHAs work who are poor.

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Session 3P4P/PBF: Contexts, Policy Diffusion and Theory-Driven Researches

Friday, June 28th 10:30 to 12:30 (MB 5.265)

Discussants

Lara Gautier (Université de Montréal)

Viola Burau (Aarhus University)

Fitting Health Financing Reforms to Context: Examining the Adaptations in Results-Based Financing Models and the Reasons for (Perceived) Slow National Adoption in Uganda (2003-2015).

Aloysius Ssennyonjo (Makerere University)

Freddie Ssengooba (Makerere University)

Background and Rationale: Results-Based Financing (RBF) that links payments to providers or consumers to quantitative or qualitative indicators has been promoted as an innovative mechanism to improve the performance and resilience of health systems towards universal health coverage. However, there is limited documentation of how and why different RBF models are adapted within the same health system overtime. In Uganda, several RBF models were implemented between 2003 and 2015.This paper uses the diffusion of innovation (DOI) theory to examine how and why RBF models in Uganda have been adapted over this period and the reasons for perceived slow adoption of RBF as a national program

Methodology: This was a qualitative research and the data on RBF designs was collected through document/literature review and key informant interviews. Comparison of RBF models was done to illuminate modifications overtime. The reasons for the slow national scale up of RBF were analysed using variables from DOI theory.

Key findings: This study covered seven RBF schemes implemented in Ugandan health sector between 2003-2015. The RBF scheme designs evolved in several aspects: 1) Actors in the pilots – NGOs played prominent roles in most pilots and the private providers were more involved than public providers. 2)Population coverage-the schemes have been implemented in almost all regions in the country 3) Benefit packages - demand side schemes offered majorly maternal and child health services while supply side schemes provided wider (but limited) service packages. Packages of services were reportedly designed to address Millennium Development Goals and donor concerns and less from service needs in the communities. Perceived ability of RBF to enhance system performance (relative advantage) and ability to pilot RBF (trialability) were the main reasons for expansion of RBF schemes. The main reasons for slow national adoption of RBF were perceived complexity and incompatibility with public sector systems. RBF implementation thus concentrated in the private sector. Several barriers to public sector reforms were highlighted although recent adjustments to the schemes to involve public providers were noted. Progressive learning across schemes and time was noted. This was however, reportedly inadequate.

Conclusion and scientific relevance: Overall, the study findings show that modification has taken place across RBF schemes implemented in Uganda between 2003 and 2015. RBF is complex intervention. The various models overtime in Uganda indicate progressive efforts and re-designing a model appropriate for the Ugandan context. From this study, we advise that Uganda and similar countries should undertake a system fitting of RBF by custom designing its schemes and desist from importing “best-practices” from other contexts. The concepts from DOI theory are useful constructs to explain the evolutions of RBF approaches

as well as the efforts required to adapt RBF approaches to a country's specific context.

Key words

Results-Based Financing, Performance-based financing schemes, Diffusion of innovations, adaption, healthy systems integration, Uganda

Participatory policy development and theory-driven research: Results-based financing for Tuberculosis in Georgia

Ibukun-Oluwa Abejirinde (Institute of Tropical Medicine, Antwerp)

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Background

Tuberculosis (TB) is particularly challenging in high burden, resource-constrained settings especially given the rise of drug resistance. Georgia has a relatively high prevalence of drug-resistant TB (31%) and service delivery is problematic because TB services are poorly integrated at primary care level. Low remuneration and poor motivation of TB professionals further exacerbates the problem.

In order to improve TB service provision, the Government of Georgia considered adopting a Results-Based Financing (RBF) policy. This was supported by findings of a qualitative study on treatment adherence. The *Results4TB* research consortium collaborated with policymakers to implement and evaluate the new policy. We adopted a theory-informed study design that combines a trial, economic assessment and a realist evaluation. Here, we present the iterative process of participatory multi-stakeholder engagement conducted at the start of the project, which led to informing both the policy and the evaluation design to be used.

Methods

Realist evaluation is a theory-based approach recognized for its usefulness in directing evidence-informed practice. It identifies *"what works in which circumstances, how and for whom?"*. The starting point is the development of an initial program theory (IPT). We set up a participatory multi-stakeholder dialogue to elicit the assumptions of policy actors about how the proposed RBF policy will work in the Georgian context. Two workshops were conducted with key actors from the Ministry of Health, the Global Fund, National TB programme and with TB service providers, interspersed by reflection meetings within the research team. We used causal mapping and concept mapping to visualise how the actors understand the challenges of TB service provision and potential means by which an RBF policy could address these challenges. In addition, we reviewed policy documents and relevant publications. VenSimÓsoftware was used to draw causal loop diagrams that summarised and visualized the pathway of change underlying the policy and the broader programme theory.

Results

The workshops proved helpful in both informing the policy process and the research design. Stakeholders' knowledge and expertise on TB service delivery and RBF were leveraged to co-design the policy. Causal loop diagrams allowed for systematic in-depth discussions which showed that beyond provider incentives, additional policy components (training service providers, re-distribution of roles to support an integrated care model, and refinement of policy monitoring tools) were necessary to achieve the desired goals. Identifying key health system elements for successful TB care and applying the realist heuristic of context-mechanism-outcome configurations helped highlight specific factors necessary to drive TB service integration at various levels. Close interaction between policymakers and researchers helped in refining the research design.

Conclusion

Developing policies that address complex issues, such as TB care in Georgia, as well as conducting policy research, requires methods that facilitate the linkages between multiple stakeholders including researchers,

and between theory and practice. In adopting a participatory approach to developing the initial programme theory, realist methodology helped us to highlight crucial hotspots for action. The new policy now reflects a more complex intervention, which will be tested using a combination of realist, trial and cost-effectiveness tools.

Global, African and local diffusion entrepreneurs' contribution to the diffusion of performance-based financing in Mali: a qualitative case study

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Ridde Valery (Institute for Research on Sustainable Development)

Background. Since the late 2000s, several donors have promoted performance-based financing (PBF) in Africa, in view of increasing the quantity and quality of health services provision. In Mali, after participating in a first pilot PBF project in 2012-2013 led by European organisations, the Ministry of Health and Public Hygiene included PBF in its national strategic plan and piloted this strategy region-wide in 2016-2017. This second pilot project was part of a World Bank-funded programme aiming at strengthening reproductive health. PBF pilots involve technical assistance from European and African experts. We call them "diffusion entrepreneurs". Using a longitudinal approach (from 2009 to 2018), we investigate the contribution of foreign and local diffusion entrepreneurs to PBF diffusion.

Methods. This longitudinal qualitative case study uses the framework on diffusion entrepreneurs (Gautier et al, 2018), which builds on the policy diffusion literature. Drawing on this framework, we examine the characteristics of European, African diffusion entrepreneurs (DEs); their making of local DEs, and their contribution to policy framing, emulation, experimentation, and learning, across locations of PBF implementation. Using an interpretive approach, and informed by the DE framework dimensions, we analyse data from qualitative interviews (N=33), policy documents from 2009 to 2018 (N=17) and observation notes (N=5). Interviews and observation sessions were carried out in three waves: first in January 2016, second from January to April 2017, and third in November 2017.

Results. DEs framed PBF as the logical continuation of decentralisation and contracting policies. Global and local diffusion entrepreneurs thus deliberately framed PBF as matching Mali's national priorities. Policy emulation started with global DEs galvanising local actors' interest in PBF, and succeeded thanks to pre-existing and longstanding relationships between local and global DEs, who used to work together. Koulikoro region-wide pilot involved both European and African technical assistance. Learning was initiated by global DEs through training sessions and study tours outside Mali, and by African DEs transferring their passion and knowledge to PBF implementers. The short time, misunderstandings and miscommunication between the donors and implementers, and the numerous gaps of the second PBF pilot led to incomplete policy learning.

Discussion. The making of local diffusion entrepreneurs was found inextricable from the diffusion of PBF in Mali. PBF pilot projects served as strategic leverage for policy learning and emulation in Mali. However, the pitfalls of the second pilot project cast a shadow over the continuation of this policy in Mali. While preparations for the next are undergoing, lessons learnt from policy experimentation should be transferred from the subnational to the national level.

Conclusion. Documenting the extent of policy diffusion across national actors (including the ways they understand, experiment, learn, and socialise through the policy) can be useful to those willing to invest in the policy, and ensure its ownership and sustainability in a given setting. Future research should further investigate the making of successful local DEs by global DEs advocating for a global health policy.

T17P09 / Public Policy and Payment for Performance Programs (P4P/PBF) in Health: in High-, Middle- and Low-Income Countries

Chair : Fabiana SADDI (Universidade de Brasília)

Second Chair : Stephen Peckham (Centre for Health Services Studies, University of Kent)

Third Chair : Lara Gautier (Université de Montréal)

Session 4P4P/PBF Policy Process and Effects on Health Systems

Friday, June 28th 14:00 to 16:00 (MB 5.265)

Discussants

Nick Turnbull (University of Manchester)

Fabiana SADDI (Universidade de Brasília)

Pay-for-performance in Primary Health Care in Brazil: Results of the Program for Improving Access and Quality

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Almeida Brito da Silva João Paulo (Fiocruz Brasília)

Armando Raggio (Fundação Oswaldo Cruz)

The Program for Improving Access and Quality (PMAQ) is the performance-payment model developed by the Brazilian Government in order to qualify the provision of the service and increase access to facilities in Primary Health Care by adopting quality standards. The PMAQ, which added about $ 780 million, adopts an institutional model of financial incentives for results addressed to the local level of PHC management within the Family Health Program teams. However, the manager of the local health system is able to transfer financial resources to the teams. Thus, there are teams adhering to the PMAQ that do not receive P4P for themselves. In this peculiar context, we define the research question: What is the association between the teams that receive P4P and the scores in the PMAQ? What are the associations in the different social, demographic, economic and human development contexts? Objective: To analyze the association of the teams that receive P4P and the score obtained in the PMAQ, considering the different social, demographic, economic and human development contexts of the Brazilian municipalities. Methodology: This is a cross-sectional, population-based study that analyzed some 28,500 teams in more than 4,700 Brazilian municipalities that joined the 2nd cycle of PMAQ, for the years 2013 and 2014. We stratified the teams through social indicators (PMAQ municipal stratum), demographic (municipal population size), economic (FIRJAN Index of Municipal Development) and human development (Municipal Human Development Index). Next, we divide the teams that receive and do not receive P4P, and later we check the scores of the teams in an interval scale adapted from PMAQ. Finally, we performed statistical analysis using the chi-square method to ascertain the associations of teams with and without P4P in relation to performance in different contexts. We define the p-value is less than 5%. Although the preliminary results point out the existence of statistically significant differences between making the P4P in all contexts. There are still important considerations regarding performance pay and higher scores in the PMAQ in different contexts.

A Public Policy and health system strengthening analysis to explore the politics and effectiveness of P4P/PBF programs in LMICs around the globe: mixing the qualitative review, interviews and survey results

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Germano Araujo Coelho (Universidade Federal de Goiás)

Jaqueline Damasceno Silva (Centre Universitário Alves Faria)

Other co-authors: Renata Lozano, Joao Paulo Dantas, Renata Almeida, Maria Barretos, Cristiane Lemos/UFG-Brazil

Paper project

Background - It is widely known that Public Policy theory and Health Policy and System Research(HPSR) offer critical integrative/relational concepts/themes that can be used to uncover the politics and/or effectiveness of rational based programs, such as pay for performance(P4P/PBF). However, we do not comparatively know yet how both types of integrative/relational concepts in an inter-related manner have been employed in the analyses of both formulation and implementation of P4P/PBF programs in LMICs. Objective: This paper develops a public policy and health system framework analysis, to verify how integrative/relational concepts from both theoretical realms (Public Policy theory and HPSR/HSS) have so far been employed as factors explaining changes/challenges in the implementation and re-formulation of P4P/PBF programs, affecting (or not) performance drivers and HSS(workforce and leadership) in LMICs.

Questions

Main question: To what extend higher levels of integration between formulation and implementation could contribute to the strengthening of health systems leadership and workforce thorough the adoption of P4P/PBF? Sub-questions: To what extent policy (re)formulation/(re)design has been characterised by high levels of policy learning, feedback and communicative practices/dialogues with national/local actors? To what extent front liners' health workers know and effectively adhere and participate in the implementation of P4P/PBF programs in distinct LMICs. What were the main performance drivers (policy, organisational restructures and behaviours) and how they have enabled the strengthening of leadership and workforce?

Methodology

Our general hypothesis is that the absence or low performance of integrative policy-drivers/concepts tends to deter/hamper changes in system performance, undermining HSS. Interviews (14) and on-line survey (25) were conducted with experts from different countries. The search of qualitative papers was performed in Medline, Scopus, Web-of-Sciences, Crochrane Lybrary and Google, selecting articles published in 2006-early 2018 (76 papers). Interviews, survey and review are being analysed according to policy/system integrative/relational concepts. All data are being organized/associated in an Excel/matrix and classified as Effectiveness Levels of Integration between implementation and re-formulation(ELIs), revealing forms of influence on HSS. Consulting group was consulted during the design of the matrix and questionnaires, and will be consulted to confirm the review/analysis. Results: We are currently analysing all data collected. Preliminary general results show that ELIs are low in most cases where (re)design/formulation has followed a top down approach, and policy learning, feedback and communicative practices/dialogues with national/local actors were lacking. Front liners' low levels of knowledge/acceptance and participation in the implementation contributed to the maintenance of low ELIs. Later policy integration learning/responses have produced slow and adaptive policy paths and forms of influence on HSS. Absence of policy integration resulted in failure or halt of programs. Earlier/deeper involvement of national/local actors in the design/formulation and implementation is highly desirable. Analysis will be completed and paper written by March.

How it fits with the panel: We employ Public Policy theory in the analysis.

Effects of Performance-Based Financing program on out-of-pocket payments on access and utilization of maternal health services in Cameroon. A Grounded Theory Approach

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Janet Hatcher Roberts (University of Ottawa)

Authors: Miriam N. Nkangu, Alison Krentel, Sanni Yaya, Janet Hatcher Roberts

Background

Health equity and financial protection has been a concern in the global health literature over the past 25 years. These concepts were absent from the Millennium Development Goals but are integral to the Sustainable Development Goals. The introduction of equity in service use within the Performance-based financing programs in low-middle-income countries aimed to address equity concerns towards achieving the SDGs. One of the ways to asses this impact is to examine whether financial protection is improving because of the PBF program and if it protects households from the risk of large out-of-pocket expenditures.

Objective

Most PBF programs focused on maternal health services, this study explores women's experiences with out-of-pocket expenditures for maternal and child health in Cameroon with the introduction of PBF reforms as well as providers experiences. The objective is to explore whether out-of-pocket expenditures is improving with the introduction of PBF towards access and utilization of maternal health services.

Methodology

The qualitative study design uses a grounded theory approach in order to gain understanding of the social processes and the ways in which women and men's experiences with out-of-pocket expenditure are related to access and utilization of maternal health services before and after the introduction of PBF. The data collection for out-of-pocket expenditure was collected in the North West region of Cameroon from several sources, including in-depth interviews conducted with women and healthcare providers, district medical officers and PBF national and regional offices. This is followed by focus group discussions with men. Participants are selected purposefully, and the criteria included data mining of women who have used the services before and after the introduction of PBF and have delivered at least one child or pregnant at the time of the study and are considered as "vulnerable" within the PBF context of Cameroon. Sample size was determined using a sample frame mapped within the selected health facilities that are representative of the health district. Data is coded and analyzed using MaxQDA and inter-rater reliability will be assessed. Secondary data on cost was collected using the breakdown down of out-of-pocket expenses as follows- medication, provider cost, facility cost, contraception cost and laboratory cost on antenatal, skilled delivery and family planning services. Results of the study will be available at the time of the conference.

Conclusions: The paper directly relates to the panel's objective on evaluating performance-based financing outcomes and the results can be used to monitor the effects of PBF programs over time and to provide input into the way PBF programs are designed and implemented.

Investigating the impact of payment for performance on health worker antenatal care knowledge

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Background: Payment for performance (P4P) schemes aim to improve the coverage and quality of essential maternal and child health services by incentivising providers. Although health worker knowledge levels are not typically incentivized within P4P schemes, clinical knowledge may improve with the introduction of P4P through a variety of pathways. To date only a limited number of studies have considered the effects of P4P on clinical knowledge of providers in relation to antenatal care (ANC).

Methods: We estimated the effect of P4P on health worker knowledge related to antenatal care in Tanzania through a controlled before and after study in January 2012 and 13 months later. Data were collected across 150 facilities in seven intervention districts and four comparison districts in each round. We interviewed 2-3 health workers from each of the sampled facilities. The health worker survey measured health worker characteristics and knowledge in relation to 45 items in the Tanzanian clinical guidelines for ANC through clinical "vignettes". Items corresponded to four dimensions of care giving: patient medical history (including history taking of previous and current pregnancies), physical examinations, laboratory investigations, and drug prescription. We undertook descriptive analysis of knowledge items and scores across dimensions and overall. A difference-in-difference (DiD) identification strategy was employed to assess the independent effect of P4P on knowledge overall and in relation to each dimension of care.

Results: Health worker knowledge levels were generally low, with health workers reporting just over 30% of the relevant clinical care components within the vignettes overall at follow-up across both study arms. P4P

resulted in a statistically significant increase in health worker knowledge levels by 13.4 percentage points (95% CI: 6.4 to 20.4). The greatest impact was on the share of knowledge related to laboratory investigations, increasing by 18.5 percentage points (95% CI: 9.7-27.2).

Conclusions: Knowledge levels for antenatal care remain very low for many aspects of care among health workers in Tanzania. P4P can improve knowledge of clinical care guidelines for antenatal care across a range of activities related to and beyond the incentivised indicators.