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Money into Health

Imagine a health clinic in a rural district in a poor country, far from the gatherings of global health headliners in Geneva, Washington, and Seattle. The staff working there—one doctor, two nurses, and a handful of community health workers—make an effort to respond when patients come in with health complaints. But medicines and equipment are in short supply, the building is in disrepair, and salaries are barely above subsistence levels. Those who fund the clinic's activities—perhaps the government, perhaps a nongovernmental organization (NGO) with headquarters in a distant city—ask few questions about how many patients are being served and whether health conditions are improving, although they require invoices accounting for all funds spent. Staff members struggle to feel motivated in the face of their daily challenges. They know that many of the poorest members of the community find it difficult to obtain the antenatal care and other basic services or treatments they need, but the health team rarely has the wherewithal to organize community health outreach efforts or to follow up on patients who might be failing to receive treatment for tuberculosis (TB) or AIDS.

Now, imagine that something changes. The young doctor, who is also the clinic manager, is told by his supervisor in the Ministry of Health or the NGO that the clinic budget will be increased by 10 percent if 20 percent more children

in the community are vaccinated and if the number of TB patients completing a full course of treatment increases by 30 percent. Other changes also are introduced. Mothers in the community's poorest households receive modest monthly stipends if they can show that their children's vaccinations are up-to-date and that the children are being weighed and measured regularly at the local clinic. Health workers are directed to offer food packets to TB and AIDS patients each time they come in to obtain medicine.

What Will Happen and Why?

What will happen and why are questions worth answering and worth answering soon. The international community now devotes unprecedented resources and attention in an effort to attain ambitious goals to improve health in developing countries. In recent years, many billions of dollars have been pledged to prevent childhood death and disease through immunization and to treat and care for people affected by AIDS, malaria, and TB. Increasingly, donor agencies and philanthropists are recognizing that significant sums also are merited to reinforce maternal and child health interventions, and some global health leaders are urging new responses to the rapidly emerging threats of diabetes, tobacco-related ailments, and other chronic diseases in low- and middle-income countries. With national and provincial governments in developing countries joining with donors to devote ever-larger amounts to health services, whether those resources will improve health hinges on what is happening in those far-away clinics and households. And what is happening in those clinics and households has much to do with what influences the motivation and behavior of individual health workers, patients, and parents.

At the highest level, the focus has been on amounts of money raised for high-visibility health problems. A large share of the new donor funding is being provided through channels earmarked for specific diseases or interventions. The GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization) provides grant funding to seventy-three low-income countries to buy vaccines and to improve the delivery of childhood immunization services. As of August 2008, it had approved some $4.1 billion for the period from 2000 to 2015.[1] As of February 2008, the Global Fund to Fight AIDS, Tuberculosis, and Malaria had approved more than $10 billion for health programs in 136 countries, and the sums may rise to as much as $8 billion per year through 2010.[2] The U.S. Presi-

1. See GAVI website, www.gavialliance.org/performance/commitments/index.php [October 2008].
2. See www.theglobalfund.org [October 2008].

dent's Emergency Plan for AIDS Relief plans to spend more than $60 billion over ten years on AIDS prevention, care, and treatment programs, focusing on fifteen countries. The U.S. President's Malaria Initiative, launched in June 2005, designs and implements malaria control programs in fifteen target countries. Its funding is expected to increase to $500 million in 2010.[3] The governments of Norway and the United Kingdom are backing ambitious plans for developing health systems in Africa, with a particular focus on reducing maternal and child mortality.

In an earlier era, funding for international health programs tended to be directed toward construction, training, and efforts to strengthen supply chains of the public sector and the health results were assumed to follow. Now the majority of donor monies are targeted more directly—for example, to reducing the number of deaths due to vaccine-preventable diseases, TB, malaria, and AIDS. The means are specific and, in concept, measurable: the proportion of babies and children immunized, the detection and effective treatment of TB among susceptible populations, the number of children and pregnant women who use insecticide-treated bed nets to protect against malaria-transmitting mosquitoes, the number of people with AIDS who are receiving and adhering to antiretroviral medicines, and the number of pregnant women who receive good antenatal care and deliver their babies under healthful conditions. Each of these indicators and many others have been embraced by results-oriented governments and donors. In very real ways, they represent what taxpayers in rich and poor countries alike think they are buying.

Achieving these objectives depends on the ability to translate good intentions and high-level financial commitments into a remarkably complex set of actions among the many individuals involved in any health system—from those who decide on the deployment of personnel and allocation of resources for buildings, drugs, and supplies to those who deliver and receive health services in the most remote locations in the poorest countries.

Arguably the most important actions, in fact, involve the delivery of services—the level farthest from the central sources of money, programmatic direction, and oversight. For example, if reducing maternal mortality depends on making sure that pregnant women receive timely prenatal care and deliver their babies with the assistance of trained attendants, then personnel in clinics must be motivated, empowered, and provided the resources to identify pregnant women in the community, to encourage them to come for checkups at appropriate moments, and to

3. See President's Malaria Initiative website, fact sheet, www.usaid.gov/press/factsheets/2006/fs060608.html [December 2008].

come to the health facility or seek assistance when labor commences. Much also depends on the behavior in households. The women and family members who affect their choices must themselves be motivated to seek care and to follow the guidance of health care providers about nutrition at home and the timing and type of care being sought. The same complex narrative can be constructed for virtually any of the health outcomes now at the top of the global and national agendas. At the end of the day, the new money, technologies, and hopes result in improved health only if those who are seeking and providing services act in particular ways.

The Argument

This book addresses one set of approaches to using money and other material goods to affect the actions of those who are delivering and receiving health services. More specifically, it is about how to use particular types of incentives—those that reward or penalize specific types of results—to motivate health-related behaviors. Performance incentives are defined as the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target. In the conceptualization we use, performance incentives include those that operate at the level of the health facilities (or networks of facilities), the individual provider, the household decisionmakers, and the patients. In other words, we look at incentives on both the demand and the supply sides, at both individual and collective levels. In our framework, we do not include the conditional payments that donor agencies offer to national governments, such as additional grant monies if and when particular policy decisions are made. We look solely at the interface between provider and patient.

We make no claims that performance incentives are the only or always the best way to generate improvements in the delivery and use of health services. At the same time, we do argue—by applying concepts from economics and, significantly, by closely examining a broad set of real-world experiences (see box 1-1)—that this approach should be prominent on the menu of ways to use donor and national government money. In particular, we recommend that donor agencies seeking to support particular types of health outcomes actively consider performance incentives as a way to use earmarked (vertical) funding to foster improvements—a way simultaneously to strengthen systems and achieve measurable results.

Performance incentives warrant both optimism and systematic assessment. Optimism is warranted because material incentives are powerful; when incentives

Box 1-1. *Case Summaries*

—*Latin America: Cash transfers to support better household decisions.* Poor households receive income transfers as long as they access preventive services and attend health education talks.

—*United States: Orienting pay-for-performance to patients.* Patients receive payments if they use priority services or change health-related behaviors.

—*Afghanistan: Paying NGOs for performance in a postconflict setting.* Performance-based incentives are contrasted with input-based payment in a postconflict state with poor health statistics.

—*Haiti: Going to scale with a performance-incentive model.* Supply-side incentives are given, as progressively more nongovernmental organizations are paid based on reaching population-based performance targets.

—*Rwanda: Performance-based financing in the public sector.* Three donor-financed pilots are scaled up into a national model that rewards increased use of basic health services and services for communicable diseases, including HIV/AIDS.

—*Nicaragua: Combining demand- and supply-side incentives.* Monetary transfers to households are linked to service use, and financial incentives for health providers are tied to the achievement of performance targets.

—*Worldwide: Incentives for tuberculosis diagnosis and treatment.* Incentive schemes are targeted at patients and providers to increase case detection and motivate continued adherence to treatment.

have been introduced, the improvements in key health indicators have been large and rapid and appear to have exceeded what would have occurred in the absence of the incentive. Based on an emerging base of evidence, performance incentives appear to be effective ways to achieve important health gains. The positive effects have been demonstrated when only a relatively modest sum was used as the reward (or penalty). This suggests that performance-based elements can be usefully combined with—rather than replace—overall increases in spending on salaries, medicines, supplies, and infrastructure and may be a particularly strategic way to use a portion of the new resources available for health.

Being on the watch for potential pitfalls, however, is as important as being willing to innovate. Precisely because incentives are powerful, they call for careful design and implementation as well as monitoring of both intended and unintended consequences. Caution is warranted, in fact, for several reasons. One is that rigorous evaluations have been rare so far, and the body of evidence about the impact of performance incentives—though stronger than for many other approaches taken in global health—is not yet conclusive. Another is that monetary incentives enable those with flexible financial resources—often

public and private donor agencies—to impose their own priorities. Finally, there is a set of potential unintended negative consequences, from undermining the integrity of information systems to inducing imbalance in the types of services provided, that have the potential to weaken the apparent benefits of performance incentives.

Organization of the Book

This volume, prepared with input from an expert working group (see box 1-2), is intended for policymakers and practitioners in the health sector in developing countries. We particularly focus on those in the donor community who are seeking to use resources as effectively as possible, are aware of the need to address shortcomings in health system performance, and may be considering or have already committed to a results-oriented approach. In chapter 2, we discuss three persistent health challenges in developing countries, highlighting issues related to how providers and patients behave: low use of services, inefficient services, and poor quality of services.

In chapter 3, we summarize knowledge from published and gray literature about the use of performance incentives in wealthy, middle-income, and poor countries. Chapter 4 moves to the elements of good design and implementation: what to consider when trying to understand the existing incentive environment, define indicators, set the targets and rewards, measure and verify performance, and more. Recognizing that the story on performance incentives is still being written, chapter 5 sets forth a learning agenda and a framework for evaluation. If shared across those who are financing and implementing programs that involve

Box 1-2. *Working Group on Performance Incentives*

The Center for Global Development convened the Working Group on Performance-Based Incentives in February 2006 (see the list of working group members at the beginning of this book). The working group brought together experts in health systems, incentive programs, and evaluation to review the available evidence and arrive at shared conclusions about the potential to apply various types of performance incentives in the health sector in low- and middle-income countries. Its explicit goals were to bridge the gap between demand- and supply-side approaches and to draw practical, policy-relevant conclusions from available knowledge about pay-for-performance experiences in low, middle- and high-income countries. This book is a result of both the deliberations of the working group and a set of case studies commissioned to inform the group's work.

performance incentives, that framework could yield a major expansion in the body of evidence about what works, what does not, and why.

In the second part of the volume, we present a series of cases about particular types of incentives (conditional cash transfers), particular countries (Haiti, Nicaragua, Rwanda, and Afghanistan), and a particular disease (TB). The cases give a feel for how programs are being implemented and what results are emerging when incentives are introduced, on both the demand and the supply sides.

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1800 Massachusetts Avenue, N.W.
Washington, D.C. 20036
www.cgdev.org

Performance Incentives for Global Health: Potential and Pitfalls may be ordered from:
BROOKINGS INSTITUTION PRESS
c/o HFS, P.O. Box 50370, Baltimore, MD 21211-4370
Tel.: 800/537-5487; 410/516-6956; Fax: 410/516-6998; Internet: www.brookings.edu

Library of Congress Cataloging-in-Publication data
Eichler, Rena.
Performance incentives for global health : potential and pitfalls / Rena Eichler, Ruth Levine and the Performance-Based Incentives Working Group.
p. ; cm.
Includes bibliographical references.
Summary: "Describes the rationale for introducing incentives tied to achievement of specific health-related targets, and provides guidance about designing, implementing, and evaluating programs that provide incentives to health care providers and patients. Presents case studies that focus on recent uses of incentives addressing a range of health conditions in diverse countries"—Provided by publisher.
ISBN 978-1-933286-29-7 (pbk. : alk. paper)
1. Medical economics. 2. World health. 3. Health promotion. I. Levine, Ruth, 1959– II. Center for Global Development. Performance-Based Incentives Working Group. III. Title.
[DNLM: 1. Delivery of Health Care—economics. 2. Program Evaluation—economics. 3. Reimbursement, Incentive—economics. 4. World Health. W 84.1 P4376 2009]
RA410.5.E43 2009
338.4'73621—dc22 2009000907

9 8 7 6 5 4 3 2 1
The paper used in this publication meets minimum requirements of the American National Standard for Information Sciences–Permanence of Paper for Printed Library Materials: ANSI Z39.48-1992.

Typeset in Adobe Garamond

Composition by Circle Graphics, Inc.
Columbia, Maryland

Printed by Versa Press
East Peoria, Illinois