

Helpdesk Report: Incentives for Improving the Quality of Health Facilities

Date: 15 April 2011

Query: What types of incentive does evidence show have proved successful in raising the quality of services, at the levels of the district, the health facility, and of individual health workers? How have specific incentives modified outputs and outcomes?

This report builds on the HDRC helpdesk report on accreditation for health facility standards.

Content

1. Overview
2. Financial incentives
3. Non-financial incentives
4. Accreditation
5. Additional information

1. Overview

Financial incentives that have proved successful in raising health service quality include:

- Pay-for-Performance in Rwanda has increased the contraceptive prevalence rate, the percentage of births attended, reduced child mortality and increased vaccinations.
- One report shows that performance-based financing in Rwanda has increased the contraceptive prevalence rate from 0.44% in 2002 to 7% in 2005.
- Rewarding NGOs in Haiti increased performance indicators for immunisation coverage, prenatal care, assisted deliveries, and postnatal care.
- Performance-based incentives improved indicators in Argentina including a 10-40% increase in the percentage of women receiving the required number of antenatal care visits.
- Monetary payments based on implementation of quality improvement plans in Honduras has significantly improved quality of care indicators.

Non-financial incentives for healthcare workers:

- In Malawi, rotating midwives between rural and urban facilities has helped services to reach remote areas.
- One study shows that health workers overall are strongly guided by their professional conscience and similar aspects related to professional ethos.

Successful accreditation schemes include:

- PROQUALI in Brazil increased service quality particularly where the internal champion was someone in a formal position of power.
- The Yellow Star programme in Uganda attained 64.8% of standards from 48.8% three months before. Success was attributed to support from the Ministry of Health and a highly publicised ceremony for the first facility to receive the Yellow Star.

- Higher quality practices in counselling and examination in family planning services in Egypt due to a Gold Star scheme.

2. Financial incentives

A Vision for Health: Performance-Based Financing in Rwanda, End-of-Project Report for the Rwanda HIV/PBF Project

Rwanda HIV/Performance-Based Financing Project, 2009

http://www.msh.org/resource-center/publications/upload/Rwanda-EOP-11-10-09_spreads.pdf

Performance-based financing is a contracting mechanism that is rooted in a simple premise: rewarding health service providers for positive results leads to even more positive results, which contributes to improved health outcomes. The Rwanda HIV/PBF Project started in 2005 with the objective of improving the access, quality, and efficiency of HIV clinical services while ensuring that incentives for HIV services did not negatively affect primary care services.

The project not only achieved that objective, but also contributed to overall improvement in the quality and delivery of basic healthcare services and the strengthening of the Rwandan health system. Although simultaneous introduction of several reforms makes it difficult to single out any one cause for improvement, results from a 2008 World Bank-sponsored PBF impact evaluation revealed that overall clinical care improved significantly in districts where PBF had been introduced.

According to data from the Interim Demographic and Health Survey (2007–08) and other sources, indicators measured by the HIV/PBF Project showed the following improvements in primary healthcare:

- an increase in the contraceptive prevalence rate among married women from 10 percent in 2005 to 36 percent in 2007–08
- an increase in the percentage of births attended by skilled health personnel from 31 percent in 2005 to 52 percent in 2007
- a reduction in childhood mortality from 152 per 1,000 live births in 2005 to 103 per 1,000 live births in 2007
- almost 100 percent increase in the average number of women per health centre (re)vaccinated against tetanus, an avoidable and often fatal disease.

Paying Primary Health Care Centers for Performance in Rwanda

Basinga, P., *World Bank*, 2010

http://siteresources.worldbank.org/EXTDEVIALOGUE/Images/537296-1238422761932/5968067-1269375819845/Rwanda_P4P.pdf

Pay-for-Performance (P4P) schemes provide incentives in the form of bonuses to providers for improvements in utilisation and quality of care indicators.

The report provides evidence that the incentives in the Rwandan P4P programme are significantly associated with increased use and quality of a number of critical maternal and child healthcare services.

In general, the report finds 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.

One of the strongest monetary payoffs is for prenatal care quality. Specifically, every administration of tetanus vaccine and malaria prophylaxis yields US\$0.92, as well as increases the prenatal care quality index score.

Haiti: Going to Scale with a Performance Incentive Model

Eichler, R., et al, in Performance Incentives for Global Health: Potential and Pitfalls, CGDEV, 2009

http://www.cgdev.org/doc/books/PBI/09_CGD_Eichler_Levine-Ch9.pdf

Rewarding NGOs for increasing access to a package of basic services and paying them for achieving population-based performance targets can result in significant increases in essential services such as immunisations and assisted deliveries.

NGOs in the project network performed considerably better than all of Haiti in a sample of four key indicators: full immunisation coverage, prenatal care, assisted deliveries, and postnatal care. A comparison between 2000 and preliminary 2005 Demographic and Health Survey data for Haiti and aggregate performance of the NGOs in the project network during each of the post-pilot contract periods indicates considerably better performance in three indicators and slightly better performance in one indicator. Overall project performance was best in 2005 when the majority of NGOs were under performance-based payment.

Nicaragua: Combining Demand- and Supply-Side Incentives

Regalía, F. & Castro, L., in Performance Incentives for Global Health: Potential and Pitfalls, CGDEV, 2009

http://www.cgdev.org/doc/books/PBI/11_CGD_Eichler_Levine-Ch11.pdf

A conditional cash transfer programme should incorporate both demand-side and supply-side performance incentives. Significant improvements are seen in immunisations, growth monitoring, and reductions in stunting. Two-phase impact evaluation does not disentangle the individual impacts of demand-side and supply-side incentives, but its results suggest that a well-targeted strategy of supply-side performance incentives could, on its own, be enough to achieve and maintain high levels of health care service use among poor rural populations.

Performance-based Incentives in Mozambique: a Situational Analysis

Connor, C. et al., *Health Systems 2020*, 2011

<http://bit.ly/h9qUb5>

Argentina's federal government pays the provinces partly based on achievement of indicators related to newborn, child and maternal health.

Argentina's performance-based incentive (PBI) scheme, introduced in 2004, is composed of federal government transfers to the provinces. Operating in the poorest regions in the country, an maternal and child health insurance scheme called *Plan Nacer* specifically targets vulnerable population groups, namely children under six and pregnant women. Payment to provinces is based partially on enrolment levels and on 10 performance indicators (called tracers), which primarily address maternal and child health and family planning.

Goals are to reduce the maternal and infant mortality rates, strengthen the incentive framework for efficiency, enhance the 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. *Plan Nacer* began as a World Bank project in 2002 with the expectation to transition to full government funding. Based on 2009 data, goals were achieved for six out of the 10 tracer indicators. For example, a 10–40 percent increase in the percentage of women receiving the required number of antenatal care visits was observed and is attributed to implementation of the programme.

In Honduras the national government, with support from donors, provides monetary payments to hospitals based on their implementation of quality improvement plans. Plans emphasise appropriate and effective implementation of a package of maternal and newborn services, and the payment amount depends on the degree to which quality—primarily process indicators—are met. Targets are established by the central MOH and each individual hospital. A small portion of the hospital incentive payment goes directly to members of the quality improvement teams. PBI introduction has resulted in significant improvements in quality of care indicators. Additionally, other programmes outside of maternal and newborn health have become adopted quality improvement methods.

Rwanda: Performance-Based Financing in Health

Rusa, L. & Fritsche, G., in: Sourcebook on Emerging Good Practice, *Managing for Development Results*, 2007

<http://www.mfdr.org/sourcebook/2ndEdition/4-3RwandaPBF.pdf>

This report introduces performance-based-pay in Rwandan health services and discusses application the scheme and problem solving for all levels of the health system.

Results include increases in new users, institutional deliveries, vaccinated children and contraceptive prevalence rates (CPRs). One model reported an increase in CPR from 0.44% in 2002 to 7% in 2005.

3. Non-financial incentives

A Review of Non-Financial Incentives for Health Worker Retention in East and Southern Africa

Dambisya, Y.M., *EQUINET*, 2007

<http://www.equinet africa.org/bibl/docs/DIS44HRdambisya.pdf>

Blantyre health district authorities (Malawi) have experimented with a novel Human Resource Management approach to scarcity of healthcare workers in rural facilities. Instead of posting midwives to the rural areas, they rotate them between urban and rural health facilities. According to research, the system works as the staff find it easier to stay at the rural facilities for short spells, as opposed to longer term postings. It is not clear how widely applicable that practice would be, or how feasible it would be to extend that approach to the entire country.

Health Worker Motivation in Africa: the Role of Non-financial Incentives and Human Resource Management Tools

Mathauer, I. & Imhoff, I., *Human Resources for Health*, 24(4), 2006

<http://www.human-resources-health.com/content/4/1/24>

The study shows that health workers overall are strongly guided by their professional conscience and similar aspects related to professional ethos. In fact, many health workers are demotivated and frustrated precisely because they are unable to satisfy their professional conscience and impeded in pursuing their vocation due to lack of means and supplies and due to inadequate or inappropriately applied human resources management (HRM) tools. The paper also indicates that even some HRM tools that are applied may adversely affect the motivation of health workers.

4. Formal recognition/Accreditation

PROQUALI: Development and Dissemination of a Primary Care Center Accreditation Model for Performance and Quality Improvement in Reproductive Health Services in Northern Brazil

Blak, S.M. et al., *JHPIEGO*, 1999

<http://www.jhpiego.jhu.edu/resources/pubs/TR/tr9903sum.htm> (Executive Summary only)

A paper copy of the report can be ordered for free

http://www.jhpiego.org/scripts/pubs/product_detail.asp?product_id=42

PROQUALI is a service performance and quality improvement accreditation model funded by USAID. Specific competencies serve as minimal standards for service delivery point practices, against which clinic level performance is observed and performance and quality improvements are promoted over time.

Outcomes:

- A dramatic increase in service quality was observed within all five participating health clinics.
- Performance improvements were most substantial in clinics that were performing at a moderate to high level at baseline, where the internal champion for the project was someone in a formal position of power, and where the least amount of staff resistance or conflict occurred.
- Changes were least evident in the physical facilities and environment performance assessment areas.
- Health agency and participating clinic personnel and clients were all positive about the success of the project.
- Financial support for commodities and staff increased as a direct result of these interventions.
- Positive changes in client satisfaction, service delivery and utilisation statistics were also observed.
- Service quality improvements were achieved but only following a considerable amount of training and technical assistance.

Improving Quality of Health Care: The Yellow Star Program

DISH II, 2002

<http://www.ugandadish.org/YSSuccess.doc>

A facility is awarded a Yellow Star from the Ministry of Health (MOH) if it successfully reaches and maintains a set of 35 basic standards of care.

After three months, health facilities met on average 64.8% of the programme standards, improvement on an initial assessment of 48.8%.

Key success factors were ongoing support from the MOH and a highly publicised ceremony for the first facility to receive the Yellow Star.

Impact of Quality Improvement Programme on Family Planning Services in Egypt

Hong, R., Misra, V. & Fronczak, N., *Eastern Mediterranean Health Journal*, 17 (1), 2011

http://www.emro.who.int/emhj/V17/01/17_1_2011_0004_0010.pdf

A facility that met all 101 quality criteria for 2 consecutive quarters was awarded a Gold Star certificate, which had to be maintained at successive quarterly evaluations to retain the status.

A survey found Gold Star facilities had significantly better availability of family planning methods, counselling and examination services than non-Gold Star facilities, independent of type, size and geographical location. Providers in Gold Star facilities were also more likely to adhere to higher quality practices in counselling and examination than in non-Gold Star facilities.

The Nicaragua Mother and Baby Friendly Health Units Initiative: Factors Influencing its Success and Sustainability

Quality Assurance Project & United Nations Children's Fund, *USAID*, 2006
<http://www.hciproject.org/sites/default/files/NicMotherBabyFriend.pdf>

Quality assurance has been important to success. Certification uses rigorous, quantitative measurements by a multi-disciplinary team of external experts selected by UNICEF/Nicaragua and the Ministry of Health.

The certification process is initiated by the health unit itself and may take a year or more, but during that time, the health unit discovers its shortcomings and corrects them; learns to carry out and appreciate the value of good standards and rigorous measurements; and generally develops a culture that supports measurement, planning, and improvement. The long certification process is usually intense and emotionally charged. The greatest learning usually occurs during the self-assessment and improvement phase that precedes the official certification visit.

The estimated cost of certifying one typical municipality (one health centre and five health posts), based on average certification costs incurred by the Ministry of Health in the past year (05/06), is US\$ 4,686. This includes training, evaluation and certification costs (see p28 for a breakdown of costs).

5. Additional information

Author

This query response was prepared by **Laura Bolton** l.bolton@ids.ac.uk

About Helpdesk reports: The HDRC Helpdesk is funded by the DFID Human Development Group. Helpdesk Reports are based on up to 2 days of desk-based research per query and are designed to provide a brief overview of the key issues, and a summary of some of the best literature available. Experts may be contacted during the course of the research, and those able to provide input within the short time-frame are acknowledged.

For any further request or enquiry about consultancy or helpdesk services please contact just-ask@dfidhdc.org

Disclaimer

The DFID Human Development Resource Centre (HDRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor programmes in education and health, including nutrition and AIDS. The HDRC services are provided by three organisations: Cambridge Education, HLSP (both part of the Mott MacDonald Group) and the Institute of Development Studies. The views in this report do not necessarily reflect those of DFID or any other contributing organisation.