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Commentary

Pay-for-Performance Debate: Not Seeing the Forest for the Trees

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Over the past 10 to 15 years, results-based financing (RBF) has gained increased prominence in global health. Though the term RBF encompasses a variety of demand- and supply-side incentives to increase output or enhance access and quality,[1] the focus of this special issue and our commentary is on incentives that target service providers. In high-income countries including the UK, France, and the United States these types of incentives are typically referred to as pay-for-performance (P4P),[2-4] defined as financial incentives to hospitals, physicians, and other health care providers "aimed at improving the quality, efficiency, and overall value of health care."[5] The term performance-based financing (PBF) has acquired a wider use in low- and middle-income countries (LMICs) and refers to supply-side financial incentives where payment depends explicitly on quantity of services delivered and "on the degree to which services are of approved quality, as specified by protocols for processes and outcomes."[1] PBF may not only target health facilities but also include ministries of health, local governments, provincial and district health teams, and central medical stores. Though terminologies may differ, at their core, PBF or P4P is a provider payment mechanism, which uses information on provider activities and the health needs of the population they serve to drive resource allocation in order to maximize societal objectives. For purposes of this commentary, we will use the term P4P to refer to this mechanism.

In this commentary, we argue that it is crucial to pay greater attention to the "forest"—that is, overall health system reforms and how provider payment arrangements interact with these to influence health outcomes, as opposed to looking almost solely and more narrowly at the "trees"—that is, the details and impact of a P4P mechanism divorced from the underlying health system. P4P is a category of strategic purchasing, the effectiveness of which depends critically on its connections with the wider environment of purchaser–provider relations. In the following paragraphs, we unpack the potential health system benefits of P4P. Next, we briefly

outline our concerns around the current P4P debate that has too often focused on the trees (e.g., specific payment arrangements focused on boosting a few indicators) but ignoring how these fit within and are affected by the wider forest (larger health system reforms). We conclude by suggesting some ways forward as to policy framing and country reform.

THE POTENTIAL HEALTH SYSTEM BENEFITS OF P4P

First and foremost, P4P is a strategic purchasing tool, helping to translate stated priorities into services. In its most generic sense, *purchasing* simply refers to the allocation of resources to providers for delivery of health services and related goods (e.g., medicines) on behalf of the population.[6] *Strategic purchasing* implies that this allocation is driven, at least in part, by information on provider performance, the health needs of the population they serve, or a combination.[7] Because P4P involves an explicit link between purchasing and benefits, with payment driven by verified data on the use of defined services, it is a form of strategic purchasing. When approached in this way, as it has been in several Organization for Economic Cooperation and Development countries, P4P can have beneficial effects.[8] Case studies from Australia, France, Germany, and Turkey show that P4P combining quality and quantity criteria prompted purchasers to pay greater attention to important issues, including setting coherent strategic objectives, putting in place appropriate information systems, and continuously reassessing the incentives under which providers operate.[8]

In LMICs, partly as a result of the push from development partners,[9] P4P initiatives have spread rapidly and demonstrated some clear benefits. The PBF movement,[10] which has had a major role in establishing P4P initiatives in LMICs, has brought real implementation experience and a shift in the dialogue on health financing, moving away from simply bemoaning low funding levels and toward how to use money more effectively. In many countries, P4P has brought three clear benefits: it has (1) broken the bureaucratic inertia associated with historical budget allocation processes, shifting the focus from merely executing budgets to a more data-driven output orientation; (2) opened the financial management conversation on the linkage between resources and results; and (3) brought money directly to frontline providers.[11] These three benefits have proven to be particularly critical to the success of reforms that involved the removal of user fees. For example, in Burundi,[12] the combination of user fee removal and the introduction of P4P maintained the direct cash flows and the incentives for productivity that user fees previously brought to health providers, while lowering the financial barrier for patients.

P4P has also served as an impetus for granting much discussed but rarely implemented autonomy to service providers. Greater health facility autonomy is a precondition for P4P's success.[13,14] Autonomy is a broad concept and can include autonomy in the areas of governance (the process of setting overall policies, goals, and objectives), management (the day-to-day direction of operations), financial management (control of the generation of revenues and the use of funds), and personnel management (the selection and use of the facility's staff). Autonomy in each of these areas exists along a continuum. But at least some degree of financial management autonomy is essential for P4P to succeed. This typically requires facilities to have their own bank accounts to receive payments and some degree of spending authority over the revenues received, although broad parameters are often set to ensure that funds are spent appropriately.

In Tanzania, for example, the P4P reform gave substantial impetus to allow facilities to have their own bank accounts.[15] Here and in other countries, the P4P reform included giving health facility managers more discretion to decide how to improve the quantity and quality of their services.[14] In a few countries, P4P has been part and parcel of bold reforms in personnel management. In 2008 as part of Rwanda's P4P reforms, facilities received autonomy to make decisions on staffing, including hiring and firing and establishing new health posts.[16,17] Turkey's performance-based payment scheme in primary care enabled the implementation of major health service delivery reforms.[18] Specifically, it attracted and retained physicians in family medicine by dramatically increasing their salaries. It also overcame constraints to adjusting provider payment under formal civil service regulations.[19] In Burundi, health centers did not have managerial autonomy prior to P4P. The reform included the extension of autonomy for health centers to manage their budgets and, where necessary and as determined by the facility, to recruit staff to be paid solely through funds generated by the health facility (personal communication, S. Sibomana, 28 December 2016).

In aid-dependent countries, P4P may also provide a mechanism to streamline donor assistance around a package of priority services.[11,17] Settings with severe domestic resource constraints generally have a large number of donors often with a specific focus such as disease-specific global health initiatives. Typically, they have distinct funding flows and reporting arrangements with the programs that they support. An output-based payment arrangement for a defined set of services, such as P4P, shifts the focus from supporting programs to delivering services and by doing so can help move away from these parallel vertical mechanisms while maintaining accountability for the delivery of priority services

within an integrated package.[10] This has the potential to serve as a concrete step toward the establishment of an explicit minimum benefits package, based on high-priority services. For example, in Rwanda between 2004 and 2010, P4P reforms brought together various donor funds to support a common comprehensive package of services that responded to the country's health priorities.[17] When P4P was scaled up nationwide, the government of Rwanda provided funding for 16 general health services, and the United States President's Emergency Plan for AIDS Relief agreed to fund another 10 HIV/AIDS related services, and the Global Fund to Fight AIDS, Tuberculosis and Malaria agreed to purchase the reproductive health, HIV/AIDS, and tuberculosis indicators.[11] Their funds, together with those from eight other development partners that joined this effort later, were channeled through the national P4P agency that purchased the services against well-defined indicators. This arrangement contributed to decreased fragmentation of donor assistance in Rwanda.[17] In Burundi, as in Zimbabwe, different donors used P4P to harmonize their support around a comprehensive package of services.[11]

P4P has also contributed to strengthening the focus on measurement, including on measuring quality. P4P links payment to data and can thus create demand for and promote investments in health information systems to improve accuracy of data and enable timely payments.[14,20] Verification is an important element of P4P as with any provider payment arrangement where money is linked to reported data. This is challenging to implement when health information systems and internal auditing mechanisms are weak, particularly where the risk of fraudulent or false statistics is high.[21]

Enhancing verification mechanisms in isolation from the rest of the health information system may, however, have a limited impact. The general aim of verification is to counteract the incentives for overreporting or "upcoding" through administrative mechanisms to verify data validity.[22] Verification processes can be quite onerous.[23,24] In Benin, for example, total funds devoted to verification activities were equivalent to approximately 40% of the bonus payments to facilities.[24] The time taken for verification can also cause delays in P4P payments, as in a current Tanzania pilot.[15] The approach to verification should be guided by cost-effectiveness considerations. The aim is to design and implement the verification mechanism in a way that it is a credible threat against false reporting but doing so at least cost. This means balancing the costs of such mechanisms against the costs of overreporting by providers.[25] In addition, countries should preferably avoid separate P4P reporting forms and information flows and invest in reforming national information systems to include the data necessary to implement output-based payment methods.

As with any output-based payment method, P4P can create moral hazard, increasing the risk of false reporting or overreporting of activities. Information and statistics can be easily distorted, especially in countries where there is no free press, where information is not publicly available, and where individuals cannot easily access and question information provided by public bodies, including state statistical agencies or ministries of health. One author noted the risk of statistical fiction.[21] In a sense, therefore, contexts with greater freedom of information—the right to access information held by public bodies[26]—provide a more conducive environment for P4P reforms to have their desired effect. In settings with overall weak information systems, limited freedom of information and low transparency, any information-driven payment arrangement, including P4P, can be easily compromised. At the same time, because P4P involves a separation of functions and explicit financial flows, it can provide a stimulus for greater transparency by bringing at least some transactions to the surface. Still, certain interventions or programs are not appropriate in certain contexts, and this has to be recognized, particularly by development partners, so that reforms promoted, such as P4P, are tailored to fit with the specific contexts of each country.[27]

CONCERNS AROUND THE CURRENT P4P DEBATE

In the recent past, P4P has mostly been analyzed as a tree, a project in isolation, sometimes as an end in itself, a panacea or a nemesis in health financing, depending on which side of the issue the given expert stands.[11,28-30] Criticism has been harsh but still within that narrow project approach. Over the past few years, a large number of P4P initiatives in LMICs have been designed and implemented as separate projects or programs, frequently without due consideration to the rest of the health system and, more specifically, of how these link to existing provider payment mechanisms and broader public finance reforms.[9] Researchers and practitioners are still debating whether or not P4P worked, rather than trying to draw lessons on the interactions with other payment mechanisms and with the wider environment to influence change at the provider level.[5,31,32]

Overall, there has been limited discussion on the forest—that is, the health system reforms—and how P4P can be integrated and contribute to health system strengthening. To learn from P4P-related reforms, it is necessary to go beyond their labels and unpack their component parts—reforms in provider payment methods, benefit packages, and provider autonomy—and how the changes in these specific aspects

that result from the introduction of P4P interact with the wider health system, particularly in the area of payment and service delivery. In practice P4P takes many different forms. P4P is never meant to be used as a sole payment mechanism but rather in combination with other mechanisms. These others may be seen as the base payment system while P4P reflects the performance element. The incentive environment created by P4P cannot therefore be assessed independent of the base payment system. The consequences of the same P4P arrangement will be very different if blended with a capitation payment mechanism (as for primary care payment in Armenia or the UK)[3,33] rather than an underlying fee-for-service system (as is generally the case in China or France).[34,35]

MOVING FORWARD

Going from project to system means that reforms undertaken under the label of P4P are designed and implemented with explicit broader health system objectives in mind and continuously adapt to country-tailored health reform agendas. An important first step is to align overall provider incentives and accountability mechanisms with core policy objectives. The second is to pay attention not only to the P4P mechanism but also to the base payment system, in particular thinking through what the blended payment system should look like and the incentives it sets up. A third point to keep in mind is the need for reforms to embed output-based payment into national budget and public financial management processes. Specifically, this means a shift from entirely input-based budgeting to at least a partially output-based approach and granting some degree of provider managerial autonomy over internal resources. Fourth is focusing on efficiency and sustainability through attention to both integrating information systems for provider payment and developing affordable, cost-effective verification mechanisms.

Looking forward, there is a need to reframe the P4P debate and direct it toward broad-based health system reforms. In fact, there should be no PBF or P4P debate. Country experience has demonstrated that moving from more passive to more strategic purchasing of health services contributes to progress toward policy objectives embedded in universal health coverage.[36] So the question is not whether to introduce a reform with the label P4P but rather how to introduce, extend, and institutionalize mechanisms for strategic purchasing of health services. It is therefore essential to channel the energy around P4P to lead to sustained, step-by-step extension of strategic purchasing arrangements within the framework of a mixed provider payment system and broad reform of the provider–purchaser relationship. This has implications in terms of specifying benefits, developing information systems, keeping providers accountable, and steering reforms of public financial management systems and provider managerial autonomy.

Well-designed P4P projects could be a good entry point to reforming the health ecosystem or forest. However, this will not happen automatically. If P4P is to play the catalytic role needed to enable strategic purchasing to go from scheme to system, it requires a broader approach. In particular, several issues require attention:

- P4P affects *marginal* productivity. Thus, a key policy variable to consider is the share of provider income to be derived from each source of funds and how the combination creates an incentive environment for providers, particularly in light of the local labor market environment.
- The role of financial incentives within an overall quality and access improvement strategy should be clarified. A quality improvement strategy that depends solely on financial incentives is not adequate and potentially risky because it can lead to cost inflation, patient avoidance, and other forms of gaming, but a quality improvement strategy can include P4P as one of its core components.[23,37,38]
- The processes of budget formulation and reporting on outputs within public financial management arrangements need to be integrated in broad budget reform efforts including fiscal decentralization where relevant.
- The role of P4P and its coherence with reforms of the provider–purchaser relationship needs to be considered, including decentralization and providers' autonomy, civil service or workforce statute reforms, and governance reforms.
- Information used to support output-based payment and its integration into overall health information and provider payment systems is an essential part of the reform process. There is thus a need to develop cost-effective, sustainable verification processes, maintaining a credible threat at least cost.

Our view is that the benefits of P4P can only be achieved if integrated in a broader health system and health financing reform. The next generation of studies on P4P should move away from impact evaluations of discrete and noncomparable interventions and pay greater attention to examining some of these key policy questions. The relevant policy question is thus how P4P can contribute as part of a wider incentive and accountability framework that can be institutionalized to

sustain improved coverage with good quality health services in a variety of different contexts.

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REFERENCES

[1] Musgrove P. Financial and other rewards for good performance or results: a guided tour of concepts and terms and a short glossary. Washington, DC: World Bank; 2011.

[2] Jha AK, Joynt KE, Orav EJ, Epstein AM. The long-term effect of premier pay for performance on patient outcomes. N Engl J Med 2012; 366: 1606-1615.

[3] Roland M, Campbell S. Successes and failures of pay for performance in the United Kingdom. N Engl J Med 2014; 370: 1944-1949.

[4] Michel-Lepage A, Ventelou B. The true impact of the French pay-for-performance program on physicians' benzodiazepines prescription behavior. Eur J Health Econ 2016; 17: 723-732.

[5] James J. Health policy brief: Pay-for-performance. Health Affairs. 11 October 2012. Available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78

[6] Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. Health Policy 2001; 56 (3): 171-204.

[7] World Health Organization. Purchasing and provider payment systems. 2016. Available at http://www.who.int/health_financing/topics/purchasing/en/ (accessed 21 December 2016).

[8] Cashin C, Chi Y-L, Smith P, Borowitz M, Thomson S. Health provider P4P and strategic health purchasing. In: Paying for performance in health care: implications for health system performance and accountability, Cashin C, Chi Y-L, Smith P, Borowitz M, Thomson S, eds. Berkshire, England: McGraw-Hill Education & Open University Press; 2014; 3-22.

[9] Independent Evaluation Group. World Bank Group support to health financing: an independent evaluation. Washington, DC: World Bank; 2014.

[10] Meessen B, Soucat A, Sekabaraga C. Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform? Bull World Health Organ 2011; 89 (2): 153-156.

[11] World Bank. A smarter approach to delivering more and better reproductive, maternal, newborn, and child health services. Washington, DC: World Bank; 2014.

[12] Sibomana S, Reveillon M, Belgium H. Performance based financing of priority health services: Burundi case study. Geneva: World Health Organization; 2015.

[13] Soucat A, Gertler P, Basinga P, Sturdy J, Vermeersch C, Sekabaraga C. Incentives for provider performance. In: The labor market for health workers in Africa: new look at the crisis, Soucat A, Scheffler R, Ghebreyesus T, eds. Washington, DC: World Bank; 2013; 235-254.

[14] Fritsche G, Soeters R, Meessen B. Performance-based financing toolkit. Washington, DC: World Bank; 2014.

[15] Bigirimana E, Chitama D, Meessen B. Process assessment of the pilot project in Kishapu health district—Shinyanga region. Dar es Salaam, Tanzania: World Health Organization, GIZ; 2016.

[16] Sekabaraga C, Soucat A, Diop F, Martin G. Innovative financing for health in Rwanda: a report of successful reforms. In: Yes Africa can: success stories from a dynamic continent, Punam C-P, Manka A, eds. Washington, DC: The World Bank; 2011, 403-416.

[17] Rusa L, Schneidman M, Fritsche G, Musango L. Rwanda: Performance-based financing in the public sector. In: Performance incentives for global health: potential and pitfalls, Eichler R, Levine R, and the Performance-Based Incentives Working Group, eds. Washington, DC: Center for Global Development; 2009; 189-214.

[18] World Bank. Turkey: performance-based contracting scheme in family medicine—design and achievements. Washington, DC: World Bank; 2013.

[19] Bump J, Sparkes SP, Tatar M, Celik Y. Turkey on the way of universal health coverage through the Health Transformation Program (2003–13). Washington, DC: World Bank; 2014.

[20] Cashin C, Borowitz M. Strengthening health system governance through P4P implementation. In: Paying for performance in health care: implications for health system performance and accountability, Cashin C, Chi Y-L, Smith PC, Borowitz M, Thomson S, eds. Berkshire, England: Open University Press; 2014; 41-62.

[21] Jerven M. Poor numbers: how we are misled by African development statistics and what to do about it. Ithaca, NY: Cornell University Press; 2013.

[22] Restuccia J. The evolution of hospital utilization review methods in the United States. Int J Qual Health Care 1995; 7: 253-260.

[23] Dale E. Performance-based payments, provider motivation and quality of care in Afghanistan. Baltimore, MD: Johns Hopkins University; 2014.

[24] Antony M. Design and implementation of operational components of results-based financing schemes: the case of verification in Benin. Dar es Salaam, Tanzania: European Agency for Development and Health; 2015.
[25] Cashin C, Fleisher L, Hashemi T. Verification of perfromance in results-based financing (RBF): the case of Afganistan. Washington, DC: World Bank; 2015.
[26] United Nations Educational, Scientific and Cultural Organization. Communication and information: freedom of information. 2017. Available at http://www.unesco.org/new/en/communication-and-information/freedom-of-expression/freedom-of-information/ (accessed 17 February 2017).
[27] World Health Organization. FIT for context, FIT for purpose health systems: towards universal health coverage for equity and security. Geneva: World Health Organization; 2017.
[28] Kalk A, Paul FA, Grabosch E. "Paying for performance" in Rwanda: does it pay off? Trop Med Int Health 2010; 15(2): 182-190.
[29] Engineer C, Dale E, Agarwal A, Agarwal A, Alonge O, Edward A, Gupta S, Schuh HB, Burnham G, Peters DH. Effectiveness of a pay-for-performance intervention to improve maternal and child health services in Afghanistan: a cluster-randomized trial. Int J Epidemiol 2016; 45: 451-459.
[30] Magrath P, Nichter M. Paying for performance and the social relations of health care provision: an anthropological perspective. Soc Sci Med 2012; 75: 1778-1785.
[31] Scott A, Sivey P, Ouakrim D, Willenberg L, Naccarella L, Furler J, Young D. The effect of financial incentives on the quality of health care provided by primary care physicians. Cochrane Database Syst Rev 2011; (9): CD008451.
[32] Witter S, Fretheim A, Kessy FL, Lindahl AK. Paying for performance to improve the delivery of health interventions in low- and middle-income countries. Cochrane Database Syst Rev 2013; (2): CD007899.
[33] Hakobyan T, Nazaretyan M, Makarova T, Aristakesyan M, Margaryants H, Nolte E. Armenia: health system review. Copenhagen: European Observatory on Health Systems and Policies; 2006.
[34] Yip W, Hsiao W, Meng Q, Chen W, Sun X. Realignment of incentives for health-care providers in China. Lancet 2010; 375: 1120-1130.
[35] Barroy H, Or Z, Kumar A, Bernstein D. Sustaining universal health coverage in France: a perpetual challenge. Washington, DC: World Bank; 2014.
[36] Kutzin J, Yip W, Cashin C. Alternative financing strategies for universal health coverage. In: World Scientific handbook of global health economics and public policy, Scheffler RM, ed. Singapore: World Scientific Publishing Co: 2016; 267-309.
[37] Miller H. From volume to value: better ways to pay for health care. Health Aff 2009; 28: 1418-1428.
[38] Ryan A. Has pay-for-performance decreased access for minority patients? Health Serv Res 2010; 45: 6-23.