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Innovative financing through pay-for-performance for providers to improve quality of care in Bangladesh: Transforming research into action

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WORKSHOP BRIEF

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INNOVATIVE FINANCING THROUGH PAY-FOR-PERFORMANCE FOR PROVIDERS TO IMPROVE QUALITY OF CARE IN BANGLADESH

TRANSFORMING RESEARCH INTO ACTION

BACKGROUND

To improve access to and use of facility-based obstetric and newborn care in rural areas, Government of Bangladesh is implementing two innovative performance-based financing programs, namely demand-side financing (DSF) and pay-for-performance (P4P). Both DSF and P4P programs have contributed to the increase in institutional deliveries, yet, not enough women receive the recommended care during pregnancy and delivery. Moreover, the country is facing challenges to improve quality in health care services. DSF and P4P are implemented in parallel with their own merits and limitations, yet there is scope for modifications.

PURPOSE

With the purpose to identify the lessons learned and limitations of P4P and DSF models, and scopes for cross learning, a two-day workshop was organized on 12-13 December 2011 in Dhaka. The workshop was also intended to draw recommendations for the Ministry of Health and Family Welfare (MOHFW) to incorporate changes into the DSF scheme or to modify the P4P approach for further expansion.

DSF AND P4P: AN OVERVIEW

Started in 2006, DSF program provides conditional financial support to poor women for receiving safe delivery services in rural areas. If deliveries are conducted at the facility or by skilled birth attendant, poor pregnant women receive financial assistance to receive service. Supply side is also financially benefited through the DSF program where service providers receive case-based incentive. Incentive is given only to direct providers and their assistants not to indirect providers and management, administrative and support staff. Provider performance has been linked with quantity of services alone. Incentives are provided monthly, calculating the total number of services provided to poor pregnant women. Currently, the program is being implemented in 53 upazilas.

P4P project is a human resource innovation project – paying an incentive to the institution for achieving pre-determined performance targets. Three District Hospitals and nine Upazila Health Complexes tested P4P approach for 14 months. At the supply side, conditional incentives are provided to the institution, which cover managers, direct and indirect providers related to maternal, newborn and child health (MNCH) services, and administrative and support staff. Quarterly targets are set for the institution as a whole, which takes into account both quantity and quality of services. Quality Assurance Group, consisting of specialists from nearby higher-level hospital (Medical College Hospital or District Hospital) and professional body, determines performance targets, performance achievements, and eligibility for incentive. At the demand side, poor pregnant women and newborns and under-five children of poor mothers receive financial assistance to meet costs of transportation, medicines and other incidentals for receiving services.

KEY RECOMMENDATIONS

Both DSF and P4P have the same goal but they differ in approaches and outcomes. The key difference between these two initiatives is that P4P implemented a "quality of care" based incentive mechanism for MNCH care, which has the potential to improve the monitoring of the health service delivery in rural areas of Bangladesh. The workshop resulted in several recommendations to modify DSF and P4P schemes.

Suggested modifications for DSF model

Incentive beneficiaries. At the supply side, whole institution approach should be adopted, i.e., all units of a facility should be brought under the umbrella of conditional incentive. Incentives should be given to service providers at the institution level, instead at the individual level. At the community level, it is necessary to introduce referral fees for fieldworkers to promote institutional delivery. At the demand side, DSF should target neonates and under-five children's services in addition to existing services for pregnant women.

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Performance measurement system. Provider performance should be linked with both quantity and quality of services instead of calculating the number of services provided to poor women.

Quality assurance system. DSF needs to form "quality assurance group" within each district, where faculty from Medical College or consultants from District Hospital will visit Upazila Health Complex quarterly to assess performance and provide mentoring. For internal quality assurance system, unit-based "quality assurance teams" can be formed to monitor and review performance every week and ensure coordination between team members.

Incentive payment mechanism. Performance should be measured quarterly replacing the current monthly measurement system.

Suggested modifications for P4P model

Incentive beneficiaries. To sustain performance momentum, it is critical to establish reward system for outstanding performer along with the existing institution-based incentive mechanism. Fieldworkers and their supervisors should be incorporated as beneficiary. A whole district approach, incorporating all Upazila Health Complexes of a district, is required for the referral system to work effectively.

Performance measurement system. It is required to introduce separate performance targets for the family planning unit of a health facility to become eligible for incentive.

Quality assurance system. Expanding the quality assurance system at all upazilas will be a big challenge due to limited availability of experts from tertiary-level hospitals. In the interim period, a "quality assurance group" may be opted for certain number of facilities. Alternatively, there could be quality supervision from district to upazila.

Programmatic challenges

Although both DSF and P4P have shown promises in rapid reduction of maternal deaths, they are laden with a risk of sustainability. These programs are still in trial phase and are highly valued for their contribution towards increasing institutional delivery. Nevertheless, human resources, sustainable funding and delegation of authority remain as the key challenges.

Human resources. Highest importance should be given to ensure pair (Gynecology and Anesthesiology) at Upazila Health Complex, for which it is necessary to continue emergency obstetric care training, create new post of anesthesiologist, and ensure no transfer or deputation, without having appropriate substitute.

As an interim measure, Civil Surgeon needs to rearrange the workforce across Upazila Health Complexes, so that every Upazila Health Complex will have minimum required staff-mix.

Alternative health care financing. "User fee" can be introduced as an alternative source of financing to use private funds to supplement government budgetary resources, with the exemption for poor.

For sustaining a program, reactivating health management committees at different tiers of health-system service delivery is necessary to prompt a sense of ownership among community people, where health programs can be jointly managed by the government and local people.

Delegation of authority. Empowering facility managers is critical so that they can undertake local recruitment, reward the outstanding performer, and discipline staff. Delegating local managers to keep and spend the user fees that they collect rather than return them to the state treasury is also necessary for sustainable improvement of quality of services.

WHAT NEXT

Performance-based incentive mechanism is an innovative strategy to tackle issues related to service use and provider performance. In Bangladesh, the need for continuing performance-based financing programs to meet Millennium Development Goals 4 and 5 and other health indicators is beyond argument. Specifically, such encouragement is required until certain level of institutional deliveries and improvement in maternal and child health are reached.

This brief report was prepared by

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