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Policy brief

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Performance-based grants for reproductive health in the Philippines

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Introduction

Over the past decade, performance-based grants (PBGs) have emerged as a new set of interventions in which specific actions are requested, received and paid for. They reward results with payment, aiming principally to resolve issues of access, utilization and provider performance (Meesen et al., 2006; Canavan, Toonen & Elovainio 2008). Defined here as "the provision of incentives to improve predetermined performance actions or targets", PBGs seek to change the behaviour – of individuals, of centres and clinics, and of the system itself (Jack, 2003; Eichler 2006; Meesen et al., 2006; Oxman & Fretheim, 2008).[1]

In their ideal form, PBGs are carefully designed instruments that lead more users to seek the care they need, and more providers to offer the care their clients require (Eichler, 2006; Petersen, 2006). Whether targeting the supply side (e.g. health-care providers) or the demand side (e.g. health-care seekers), on the national or subnational levels, PBGs typically follow the patient (Canavan et al., 2008). The greater the health-seeking behaviour of patients, the greater the rewards for those seeking and/or providing care.

In many low- and middle-income countries (LMICs), there are PBG supporters and PBG opponents. For the authors of some papers on the subject, PBGs represent an alignment between the health system and the logic of the free market, where quality can correlate with expenditure (Jack, 2003; McNamara, 2005); for others, the complexity of carrying out a public good is not so easily equated with market dynamics (Petersen et al., 2006).

PBG supporters cite greater provider "enthusiasm", strengthened health-management information systems that encourage greater use of data, improved equity, greater community participation, and a renewed focus on quality and innovation (Loevinsohn & Harding, 2005; Eichler, 2006; Soeters et al., 2006; Naimoli & Vergeer, 2010; Perrot et al., 2010). PBG opponents, however, observe that these claims are not supported by an evidence base and that there has been very little scientific inquiry into their effectiveness (Oxman & Fretheim, 2008; Eldridge & Palmer, 2009; Toonen et al., 2009).[2]

[1] The term performance-based grants (PBGs) will be used throughout this brief. In the literature, PBGs are also known as (though not necessarily synonymous with) results-based financing (RBF) (Oxman & Fretheim, 2008; Brenzel 2009) performance-based financing (PBFs) (Hecht et al., 2004; Canavan et al., 2008; Toonen et al., 2009), and pay-for-performance (P4P; PFP) (Eichler, 2006; Mathematica Inc.).

[2] Eldridge & Palmer (2009) reviewed bias within research into the effectiveness of PBGs. They noted that only one such study incorporated a control site and this control site outperformed the sites that did use PBGs (see Lundberg, 2007). Despite this, they concluded that "most of the papers reviewed provided a favourable assessment of PBP".

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Despite the range of pilot projects aimed at testing and refining PBGs there is little that is conclusively known about them. Do they, for instance, introduce significant distortions into fragile health systems (Canavan et al., 2008)? Do they introduce a range of unintended effects and undesirable behaviours, from gaming and corruption to cherry-picking the patients who will best achieve a performance target (Oxman & Fretheim, 2008; de Savigny & Adam, 2009)? Are there specific types of behaviour or domains for which PBGs are best suited or less-well suited (Basinga et al., 2009)? And, do the effects of PBGs diminish over time (Oxman & Fretheim, 2008; Toonen et al., 2009)?

PBGs have evolved into several different forms and models. They typically vary with respect to who pays the PBG and who receives the reward, and with respect to targets and performance (Eldridge & Palmer, 2009).

Supply-side models

Supply-side models target both public and non-state providers (see Figure 1). Three different models are currently employed in LMICs (Hecht et al., 2004):

(a) national governments transfer funds to a "fund holder" (typically an NGO or the private sector) to deliver or facilitate essential health services;

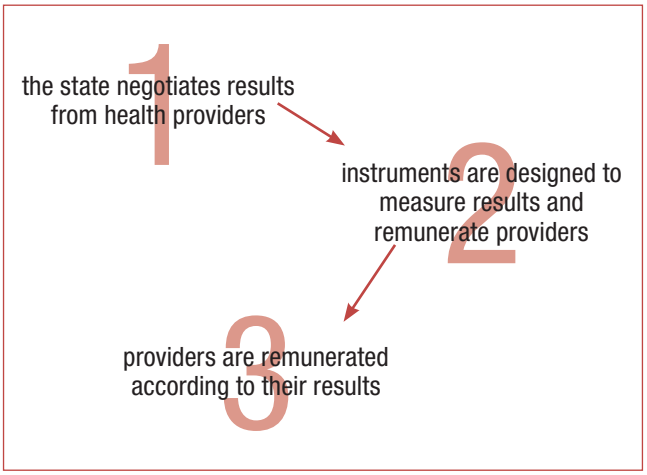
(b) national governments transfer funds to local governments;

(c) global donors disburse funds to public or private recipients on achievement of targets.

Demand-side models

Demand-side models typically address the barriers households face in accessing health care (Eichler, 2006). They are best illustrated by the conditional-cash transfer (CCT), which provides direct monetary incentives for individuals to seek and receive health care.

Figure 1. A supply-side performance-based grant.



Examples of performance-based grants in maternal and child health

Brazil

The World Bank has long supported Brazil's Family Health Project. This makes "per capita transfers to local municipalities on the basis of planned increases in certain services, such as safe delivery of babies for low-income women, monitoring of infants' nutritional status and growth, and treatment of poor children for various illnesses. If the municipalities reach these targets and several others, they will continue to be eligible for future financial transfers; otherwise, the level of central government support will be reduced." (Hecht et al., 2004)

India

The Janani Suraksha Yojana (JSY) scheme "aims to promote institutional deliveries amongst poor pregnant women. Accredited Social Health Activists (ASHA) are female honorary volunteers [who] receive performance-based compensation for promoting a variety of primary health-care services in general, and reproductive and child health services in particular, such as universal immunization, referral and escort services for institutional deliveries, construction of household toilets, and other health-care delivery interventions." (Oxman & Fretheim, 2008)

Argentina

Argentina's Plan Nacer scheme focuses on uninsured pregnant women and children under the age of 6 through "an incentive mechanism between the National Ministry of Health and the Provincial Government, and between the Provincial Government and health-care providers, to enhance quality and accountability in health-service provision. The financing scheme provides a results-based incentive mechanism to reinforce inclusion of the target population, with ten indicators (tracers) measuring program output and health outcomes to determine financing." (World Bank Argentina, 2009)

Use of performance-based grants for reproductive health in the Philippines

The Philippines has adopted a unique approach to PBGs. Like other PBGs in LMICs, they are being used here to address maternal morbidity and mortality in children aged under 5, specifically to reduce the many challenges faced by pregnant women. PBGs in the Philippines thus address:

- pregnancies that are mis-timed, unplanned, unwanted or unsupported;
- inadequate care provision during the course of pregnancy;
- the absence of skilled birth attendants during delivery (approximately 40% of births are attended by traditional birth attendants or *hilots*);
- lack of access to emergency obstetric and neonatal care.[1]

[1] These risks were highlighted in a 2006 Family Planning Survey conducted by the Philippines National Statistics Office.

With the achievement of the Millennium Development Goals in mind, the Department of Health created in 2009 a framework known as the integrated Maternal, Neonatal and Child Health and Nutrition (MNCHN) strategy. This describes indicators of maternal and child-health outcomes and outlines interventions to improve them, paying particular attention to antenatal visits, facility-based births and the provision of family-planning services.

The PBGs are an important operational element of this strategy as the Department of Health has been implementing a health financing strategy that moves away from input-based allotment to performance-based block grants. By blending different PBG modalities, with incentives on both the supply and demand sides, the Department of Health sought to improve performance of local government units (LGUs) in terms of both access to and funding of its maternal and child health programmes.

PBG-1 and PBG-2 grants

Two different PBGs were initiated in 2008, entitled PBG-1 and PBG-2.

The PBG-1 were incentivized grants designed to fund local governments' family planning and reproductive health programmes. A memorandum of agreement specified the roles and expectations for a range of actors within different geographical areas. The grants financed free family-planning services for poor clients, and the goods and services needed to provide them, and supplemented any associated maintenance costs.

The PBG-2 were direct performance-based grants for women's health teams and pregnant women. They aimed to help with the transition from home-based to facility-based deliveries. Under this scheme, traditional birth assistants were offered a cash incentive to refer pregnant women to a health facility for their prenatal care, labour and delivery. Pregnant women were offered a cash payment to offset any expenses (e.g. travel costs) associated with a facility-based delivery. The midwife received a stipend payment for each delivery. The women's health teams also received a payment for tracking, referring, counselling and supporting women through their pregnancy and delivery.

The PBG-2 in practice

The main focus of the PBG-2 is the women's health team (WHT). A single team is typically made up of three members:

- a midwife;
- a *barangay* (village) health-worker (BHW); and
- a traditional birth attendant (TBA).

The Philippines is divided into provinces, four of which are discussed here, namely Ifugao, Sorsogon, Capiz and Surigao del Sur.

The World Bank is currently funding PBG-2 in Sorsogon and Surigao del Sur as part of its Second Women's Health and Safe Motherhood Project (WHSMP2). The way the PBG scheme is applied varies slightly across the different provinces.

Sorsogon province

A payment of 1000 Philippine Pesos (PHP) (US$ 22) is received by the local WHT for every birth that takes place in a health facility (rather than at home).

The payment is divided among the team, thus:

- 60% to the TBA;
- 20% to the midwife; and
- 20% to the BHW.

The mother receives a separate sum of PHP 500 (US$ 11).

Surigao del Sur province

Here, PBG-2 provides the same monetary incentive of PHP 1000, again to the three members of the WHT, but this time they share only 60% of the total (PHP 200) each, with the remaining 40% being paid out thus (the mother receives the same separate sum amount, i.e. PHP 500 (US$ 11):

- 10% (PHP 100) to the delivering doctor;
- 10% (PHP 100) to the attending nurse; and
- 20% (PHP 200) to the health facility.

Taken together, these PBGs represented a new way of reaching desired outcomes, both locally and nationally. But were they actually working? What early lessons emerged? How might they be adapted or improved? Given the core challenges for any PBG, how does the experience in the Philippines compare? These questions were explored in a rapid assessment conducted in 2009.

Rapid assessment of the performance-based grants: design and data collection

The WHO Department of Reproductive Health and Research supported a study team from the Health Unit of the Ateneo Graduate School of Business from Ateneo de Manila University, to conduct the assessment.

The project aimed to capture and document progress of the two PBGs in four different provinces of the Philippines. To conduct a rapid assessment (rather than an impact evaluation) their progress was described without making any firm conclusions about their efficiency or effectiveness, or the release of funds from national to local levels. The investigators sought to determine what early lessons had been learnt, and how the programmes might adapt and evolve.

For PBG-1, the study team asked the following:

- What has been the provincial and LGU experience with the PBG on family-planning programmes and commodity purchase?
- How have LGUs actually used the PBG funds?
- How are they managing the procurement of contraceptives?
- Has the PBG improved the availability of contraceptives?
- What recommendations do stakeholders have for refining this PBG-1?

For PBG-2, the study team asked the following:

- How is the women's health team model adapting to the Filipino context?
- How is payment made to the teams, to TBAs, and to women, and in what amounts?
- Is there any evidence of improved service coverage as a result of these payments?

The study was exploratory, with the aim of obtaining results that would be useful in the design of a more comprehensive evaluation. The study team visited several municipalities within each of the four provinces, which were recommended by the Department of Health and local government authorities. They then met with regional and provincial and local health officials to collect testimonies and encourage reflection on the progress of the PBGs at that time. A comprehensive desk review followed, to examine programme documentation, memoranda of agreements, reports, meeting minutes and any special studies. Local expenditure and other financial information was also collected.

The study team analysed this information and produced a formal rapid assessment in November 2009, approximately 1 year after the launch of PBG-1 and 2 years after the launch of PBG-2.

Key findings

Experience with PBG-1

At an individual level, many health-workers were unaware of PBG-1, or were not clear about the details of it, even in places where PBGs had been allocated to LGUs. At an institutional level, the LGUs purchased various types of reproductive health commodities and distributed them to individuals and organizations who needed them, but they claimed they had purchased similar quantities of these commodities in the years before implementation of PBG-1. In some settings, the release of funds related to PBG-1 had been delayed, which made it difficult to determine whether PBG-1 facilitated the availability of RH commodities, outreach services and the increased awareness of the community to family-planning services.

For example, there was some variation between provinces in the methods used to report and document their contraceptive usage:

- In Ifugao, contraceptive expenses were reported under the broad category of "drugs and supplies".
- In Sorsogon and Surigao del Sur, information on contraceptive availability was only available from data on current users vs new acceptors. No separate reporting was done for purchasing of reproductive-health commodities in 2008.

The Department of Health has had relatively little experience of using performance-based approaches, but there is great interest in understanding and improving the performance of pilot schemes like PBG-1. At the time these results were released, the Department of Health had recently identified three domains of assessment:

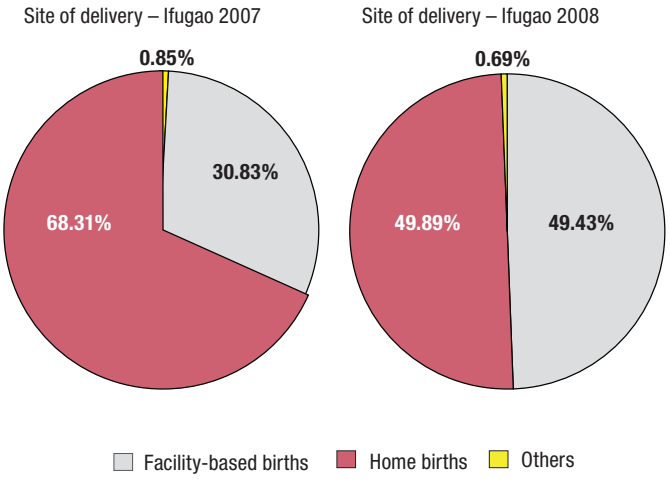
- To determine how schemes like PBG-1 have contributed to the achievement of key national outcomes as specified in the integrated MNCHN strategy.
- To understand the current capacity of the provinces to deliver core MNCHN services and provide critical commodities and supplies.
- To gauge national and provincial commitments to pursue improvement in the delivery of health services.

Experience with PBG-2

The early results for assessing PBG-2 also had limited information from which to draw any comprehensive conclusions. Some key stakeholders in the provinces visited revealed that cash payments to the WHTs and mothers were often delayed, For some TBAs (particularly in Surigao del Sur) the PBG-2 payment of PHP 200 for a facilities-based birth was not an attractive incentive; indeed, it represented a significant loss of income because the birth assistants received PHP 1000–1500 for a home birth (paid by the family).

Despite the initial lack of information, the data collected from each province did show changes (sometimes dramatic) in the number of births taking place in health facilities. Figure 2 shows the situation in Ifugao, in which there was a significant increase in women delivering in a health facility between 2007 and 2008.

Figure 2. Changes in the number of births taking place in health facilities between 2007 and 2008 in Infugao.



Based on recent literature (e.g. Oxman & Fretheim, 2008; Toonen et al., 2009), the study team proposed that a number of other (confounding) factors contributed to this trend. They consider that health-system strengthening reforms, or the PBG itself, or some other factor or mix of factors might be involved. For instance, at the time of this study in Surigao del Sur and Sorsogon, the provincial governments had just made home delivery a punishable offence for both TBAs and pregnant women – one that would lead to a prison sentence or fine. This factor was very likely to influence the observed behaviour change. However, there was also a reported poor compliance with the ordinance whereby some TBAs continued to perform home deliveries in Surigao del Sur.

Conclusions

The rapid assessment process was hindered by difficulties in accessing information and data, but its observations were of some value. On the basis of its results, some firm suggestions have been made for the future. They are not only relevant to the Philippines but also to any LMIC governments and funding agencies who are launching or modifying their own PBG programmes.

The following five suggestions cover information, evaluation, change processes, integration and awareness.

1. Information

Any PBG requires an efficient information system. As PBGs rely heavily (even primarily) on routine reports and statistical data sources, greater attention must be given to health system information – to how it is identified, assembled, collated, transmitted and managed. At the time of this study, information relevant to both PBG programmes in the Philippines is either not available or can only be accessed through key individuals often on a local level.

2. Evaluation

Key indicators of success are critical for the function of any PBG, and for allowing decision-makers and researchers to assess its value. To achieve this, local health systems must have a detailed concept of how the performance of a PBG will be measured, verified and assessed. A formal and comprehensive evaluation plan must be designed before implementation of a PBG and conducted at appropriate intervals throughout the programme's lifespan.

3. Change processes

Designers of PBGs must prioritize strategic-change management processes before implementing the PBG programme. They must consider the involvement of stakeholders from different levels of government and across divisions within the Department of Health, and must ensure that all the key players have a clear understanding of their roles and responsibilities within the wider context.

4. Integration

Projects and interventions must be integrated from the national level to the local level of the Department of Health. In devolved health systems like the Philippines, particular attention must be made to ensure that PBGs must be well integrated and aligned to other local health system interventions. Where PBGs share the same goal, their operational features should be consolidated or otherwise rationalized to streamline procedures.

5. Awareness

Health workers – especially health managers – must become both familiar and comfortable with the rationale behind a PBG. This might involve targeting specific health-care workers, or their institutions, or the patients under their care.

The way forward

The above suggestions are in no way unique to the experience of PBGs in the Philippines. In fact, the primary suggestion relating to information systems and PBGs is a recurring theme that is seen in many different contexts.

Some authors believe that PBGs may themselves strengthen information systems (Naimoli and Vergeer, 2010), but most evidence indicates a very different relationship. In many LMICs, information systems are easily manipulated, and too often they are the source of no information, or inaccurate information. In some cases the weak information systems constitutes a fatal flaw for the implementation of a PBG (Petersen et al., 2006; Brenzel, 2009; Eldridge & Palmer, 2009). As Canavan, Toonen and Elovainio (2008) suggest, a fully functioning and computerized health information system may be an important pre-requisite for any PBG to work.[1]

Equally important are the issues of evaluation and change processes. Given the sparse evidence base on implementation of PBGs in the Philippines and elsewhere, and the shift away from input-based to performance-based allotment of funds, there is much to learn from this PBG process and many adaptations to be made as the programmes mature. This all depends on a robust information base, and this requires a sound evaluation plan, as well as the involvement of multiple stakeholders and a thorough understanding of the principles of change management processes (including issues of leadership and ownership). Many authors have commented on the steps that are needed for designing a PBG (Eichler, 2006; Petersen et al., 2006; Lindenauer, 2007; Perrot et al., 2010), but only a few have given precise descriptions of evaluations relevant to PBGs, or how to involve sufficient numbers of stakeholders in either the design of a PBG or its evaluation (Petersen et al., 2006; de Savigny & Adam, 2009).

The Philippine experience also highlights a number of broader concerns for any PBG. Not only must different PBGs with similar aims be integrated but PBGs must also be situated within the context of other prevailing factors and possible confounders, in addition to overarching, health system opportunities and barriers. In other words, it is necessary to understand how the health system might respond to, complement, or distort the PBG (Toonen et al., 2009). For instance, the health system is currently implementing a number of integrated reforms, including regulatory changes that prohibit home births in some LGUs, which means that assessing the effect of PBGs on shifting births from homes to health facilities may prove impossible. However, PBGs that are designed in the context of these shifting dynamics – rather than as instant solutions in an unchanging or static health system – have, as the Philippine experience suggests, a far greater chance of strengthening health outcomes and contributing to an evidence base.

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[1] Other likely prerequisites include: the "full and sustained engagement of providers and community stakeholders …high-level commitment from the [Ministry of Health] as regulator and steward of the public health facilities, and monitoring capacities at facility and district level". (Canavan et al., 2008)

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