Leveraging Performance-based Incentive Programs to Strengthen Civil Society Monitoring of Health Care Providers[1]

Abstract

Performance-based incentive (PBI) programs are burgeoning all over the world, and can be leveraged to strengthen social accountability and overcome key challenges associated with civil society monitoring of health care providers. Community-based monitoring interventions rest fundamentally on the presumption that information about health services is gathered, made available to the community, and used to hold providers accountable. But collecting reliable information is costly and typically abandoned once donor-funded projects end. In PBI programs that offer performance incentives to health care providers, collecting and verifying data about provider performance—both the quantity and quality of services they deliver—is a routine activity that can be performed by communities and used by citizens to monitor or grade provider performance. This brief describes these two key mechanisms by which PBI can strengthen social accountability and sketches a pathway for implementation.

Inside

[1] *This note is based primarily on Community-based Monitoring Programs in the Health Sector: A Literature Review (Croke 2012) and A Rough Guide to Community Engagement in Performance-based Incentive Programs: With Lessons from Burundi, Indonesia, and Mexico (Morgan 2012)*

Performance-based Incentives and Social Accountability

Growing recognition that misaligned incentives and weak governance are at the heart of many health sector failures has focused attention on the role of communities in increasing pressure for accountability of service providers. Community groups that exercise social accountability can have an impact by making the failures of service providers public, thus imposing reputational and political costs, and, in some cases, triggering formal accountability mechanisms (Croke 2012).

Community-based monitoring interventions in the health sector rest fundamentally on the presumption that information about the services being monitored is gathered, made available to the community in a comprehensible and usable form, and used in some way to bring accountability to bear. The evidence also suggests that combining two types of data—subjective (i.e., community perceptions) and objective (i.e., quantitative data about health services)—and presenting them in a comparative format (e.g., comparing local outcomes to national averages) may be most effective (Croke 2012). Collecting reliable information is costly, however, and typically abandoned once donor-funded projects end. In this regard, PBI programs may help to strengthen community monitoring activities.

Many factors drive health worker performance and affect the choices providers make, even when they are intrinsically motivated to provide health services to the community. PBI[2] programs aim to motivate health care providers by offering cash incentives in

> *PBI defined:*
> *"Any program that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered."*
> Musgrove 2010

exchange for health results.[3] For example, a health facility team might receive an incentive for immunizing a certain percentage of children in a given area, or for increasing the number of institutional deliveries performed according to a certain quality standard.

PBI programs also aim to motivate providers by enhancing their autonomy. In many developing countries, providers have limited control over their budgets, but many PBI programs give health workers autonomy over how to spend their performance payments. In addition, PBI programs aim to increase accountability by verifying that results are delivered, which requires scrutiny of health data. All these things combined are intended to motivate providers, and thus improve the quality of services they deliver.

Because the success of PBI programs rests on the ability to accurately monitor and verify health results, PBI programs may contribute to the development of strong health information and management systems. Governance arrangements may also be strengthened by aligning incentives among facilities and their managers at the district and higher levels.

PBI programs are not tools per se, nor is community empowerment their central objective. Rather, PBI programs are an approach to strengthening health system performance, with the aim of improving health outcomes. At the same time, a PBI is highly relevant to strengthening social accountability, and there are many potential mechanisms through which communities can engage in and leverage PBI programs. A full matrix of the possibilities, which include community engagement in conditional cash transfer and voucher programs, is detailed in Morgan 2012. In this brief, we highlight two key and complementary approaches.

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[2] *Also known as results-based financing (RBF) and pay for performance (P4P).*

[3] *There are many types of PBI programs, including those that provide incentives to patients, such as conditional cash transfers and vouchers. Some PBI programs also offer incentives to nongovernmental organizations (NGOs) that manage or deliver care, or to health managers at the district, provincial, and national levels, conditional on such things as timely and accurate reporting, or the performance of the facilities they are responsible for. For the purpose of this short annex, we focus on PBI programs that offer incentives to private or public health facilities.*

> **Burundi: Community-based Organizations Verify Results Reported by Health Facilities**
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> In 2010, Burundi launched a national PBI program that provides incentives to health facilities and national and subnational bodies. Facilities can earn monthly fees on a specified list of 22 (for health centers) and 24 (for hospitals) services that span curative care, preventative care, and reproductive and child health. Facilities can also earn additional bonuses depending on their quality performance, which is determined by an assessment of over 100 composite indicators and patient satisfaction surveys conducted randomly twice a year by community-based organizations (CBOs).
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> CBOs verify the results reported by health facilities – both the existence of patients and that services were delivered – and conduct the patient satisfaction surveys. A facility's score on the community survey determines 40 percent of its quality bonus. The CBOs are selected by local and provincial committees. Among the conditions to participate, CBOs must not have any links to the health center whose results it will verify (e.g., CBO staff must not be related to health facility staff). Contracts with CBOs are signed for one year, and may be renewed if CBO performance is deemed acceptable. The CBOs are paid a fee per survey completed.

Can PBI Programs Strengthen Social Accountability?

In PBI programs that offer performance incentives to health care providers, collecting and verifying data about provider performance—both the quantity and quality of services they deliver—is a routine activity that can be performed by communities and used by citizens to monitor or grade provider performance.

CBO verification of health provider results. Engaging communities to verify results reported by health facilities may have multiple benefits, including cost savings for the program. Verifying results for every facility in a PBI program imposes significant costs, and engaging CBOs to carry out this function is likely to be significantly cheaper than hiring professional auditors, not only because CBO fee expectations are lower, but because the program does not incur the same magnitude of transportation costs (since the CBOs are physically closer to households).

Engaging CBOs to monitor and verify provider performance may also strengthen the programmatic function. Communities are often better informed about the status of service delivery than external monitors, and may have means of punishing providers that are not available to outsiders (e.g., imposing social sanctions). Community monitors may also be able to stimulate increased effort by providing non-financial rewards such as recognition at community gatherings for good performance (Björkman and Svensson 2009).

Leveraging PBI systems and data to strengthen community monitoring interventions. Contracting CBOs to verify results in PBI programs brings benefits of increased capacity (i.e., CBO members may learn new skills) and engagement with the health sector for the CBOs who are contracted. But this model could enhance social accountability more broadly in communities if it is paired with community scorecard interventions, which are discussed later in this report. In this scenario, the performance data from facilities within a predefined area, as well as the national averages, would be shared with CBOs. For example, if the PBI program offers incentives to facilities for increasing the number or quality of facility deliveries, data on each facility's performance on this indicator would be shared with the CBO, along with national averages, and possibly facility targets and data on the performance of facilities in neighboring areas. This would enable the CBOs to compare their own facility's actual performance with (1) what the facility's performance should be (the target), (2) the national goal or target, and (3) the performance of facilities in other, similar areas. If nearby facilities are performing better, communities would know that change is

possible even in similarly constrained communities.

The CBO could use this information in the context of a community scorecard or other similar intervention that brings community members together to grade facilities and requires a combination of subjective and objective data.

Leveraging PBI programs in this regard has several benefits. First, where CBOs are already engaged in verification, they are primed to take this role further to use their knowledge and capacity to facilitate dialogue in their communities. Second, the fact that verification and collection of data on health services is a routine activity in PBI programs may help to overcome a challenge observed in some community engagement programs, which is that once the externally initiated intervention ends, the data collection activity upon which it depends is often not sustained (Croke 2012). A third potential benefit of pairing PBI with a community scorecard or similar intervention is that, in places where PBI programs are institutionalized (i.e., where PBI is part of a country's overall health financing strategy, such as in Burundi, Rwanda, and Liberia), an ongoing scorecard-type intervention could be instituted to empower citizens, thereby potentially addressing another key challenge experienced in many community engagement programs, which presume that facilitating a time-limited intervention will spark ongoing community monitoring, even after the intervention is over. This often does not happen.

A final reason in favor of combining PBI programs and social accountability interventions is that bottom-up pressure from communities can only go so far in changing health care provider behavior if the environment in which they work is dysfunctional (e.g., unmotivated health workers, weak supervision and health management information systems (HMIS), rudimentary supply chains). PBI programs aim to address those dysfunctions, which may improve the impact of community engagement mechanisms over the long term.

Where Has PBI Been Paired with Social Accountability Mechanisms?

Contracting CBOs to verify results reported by facilities is a model seen in PBI programs in many countries, including Burundi, Cameroun, Senegal, Zambia, and Zimbabwe.

However, linking PBI programs with a community scorecard or other similar intervention has yet to be tried. There may be several reasons for this. First, PBI and health sector social accountability interventions are both complex to implement and pilot, and, thus, adding "extra," innovative elements to a program may be overwhelming for program managers. These programs also tend to be managed by different types of actors—health sector professionals in the case of PBI programs and governance professionals in the case of social accountability, and they do not often design programs together. Moreover, PBI is often viewed primarily as a health financing intervention, and is only beginning to be understood as a health systems and governance intervention (i.e., a mechanism to accomplish goals normally associated with programs in other sectors).

When and if an initiative pairing PBI, community verification, and a scorecard intervention is tried, a range of challenges may arise that are common to any community-monitoring exercise, including the risks of elite capture, exclusion, and how to target community pressure at the right level of the health system. For example, not all problems that communities highlight are amenable to change by facilities because of community pressure (see Croke 2012 and Björkman and Svensson 2009).

Challenges to CBO Verification in PBI Programs

At least three key challenges are associated with contracting CBOs to verify health facility results: capacity, conflict of interest, and patient privacy. We address each of these challenges below.

Capacity

One of the aims of contracting CBOs to verify health facility results, in addition to potential cost-savings, is the desire to build the capacity of, and thereby empower, CBO members. Capacity building and empowerment are linked: "Empowerment is the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes."[4]

Delegating program functions to actors whose capacity may be limited or weak may accomplish the goals of inclusivity and of building the capacity of citizens who are otherwise marginalized, but it may also compromise the efficient functioning of the program. In Burundi, for example, the capacity of CBOs varies widely, and in some cases is quite low. This may impact the quality of their work, both in terms of organizing the logistics around verification, and in the quality of the data collected.

It is critical to balance empowerment goals with ensuring that programmatic functions are robust. Verifying results is at the heart of any PBI scheme, because paying for reported results gives providers an incentive to over-report. It is thus essential to verify and counter verify what is reported. Moreover, the process of verification provides one of the important benefits of PBI—strengthening the HMIS—which is unreliable in many countries. Where engaging communities to carry out PBI programmatic functions requires skills and experience, community engagement may be at odds with a desire to engage a broad representative swath of the community.

4 http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/ EXTPOVERTY/EXTEMPOWERMENT/0,,content MDK:202 45753~pagePK:210058~piPK:210062~theSitePK:486411,00. html (accessed December 12, 2013)

Conflict of interest

Another issue is the conflict between the need for the entity that conducts verification to be independent and free from a conflict of interest and the desire to engage community members in carrying out this function in the first place.

In Burundi, CBOs are typically assigned one facility each; they then verify the results reported by that facility by checking the registers at the facility and visiting patients. Since the CBOs are based in the community, members of the CBO may know the personnel of the health facility that they are being asked to assess, which can create a conflict of interest for CBOs and may result in collusion.

Patient privacy

Another challenge to using CBOs for verification is maintaining patient privacy. Members of CBOs may know the patients whose households they visit, since, in small communities, they are likely to be their neighbors, and this raises important questions about patient privacy. It also raises ethical questions around whether community members should question their neighbors about the health services they receive. This may be especially important for particularly sensitive services, such as HIV testing and treatment or family planning.

Ironically, in Burundi, this was one of the rationales behind engaging CBOs in the first place: it was hypothesized that households would be more willing to talk to people they know rather than to strangers. But the opposite might be true: households may be more open and honest about their medical experiences if a survey is carried out by a stranger with whom they would have no further interaction after the survey (Bhuwanee and Morgan 2012).

Leveraging PBI Programs for Community Engagement: Essential Steps

1. Clarify your objectives

It is important to determine the objective of contracting CBOs to verify results. In the PBI program in Burundi, the goal is primarily cost savings and programmatic efficiency, with empowerment as a secondary goal. Sometimes the goals of cost savings and empowerment compete with one another, and programs considering engaging communities should think through the implications and decide what to prioritize: the programmatic function itself or community empowerment. As Morgan (2012) argues, rigorous PBI implementation should be the first priority of any PBI program, with community empowerment as secondary, which may at times argue in favor of engaging more highly skilled, less marginalized members of the community in implementation. Program managers must decide whether CBOs have sufficient capacity to do the job.

2. Consider the risks and establish checks and balances

Community engagement and the concept of social accountability are sometimes romanticized, but as Croke (2012) and Morgan (2012) note, individuals and organizations at the "community" level have the potential to be just as political, coercive, and unrepresentative as any other actors or institutions. There is no guarantee that indigenous community structures are representative, fair, or "owned" by communities. Indeed, community structures may be deeply flawed and corrupt, and engaging them (i.e., equipping them with resources and power) may exacerbate these issues. It is therefore critical to build in robust checks and balances to avoid potential dangers and abuse.

Where CBOs are contracted to verify provider reported health information, what CBOs verify should be periodically counter-verified by an independent body. Verification in PBI schemes aims to establish that reported data accurately reflect actual performance, both by detecting and correcting misreporting, and by identifying and deterring fraud. In doing so, PBI verification ensures credibility of the program, so that stakeholders can trust that what is being rewarded is real. In order to ensure the rigor of verification, many PBI programs counter verify a small, random sample of verified results using an external agent such as a national or international NGO or an auditor. Doing so enhances the credibility of the program and mitigates against the risk that CBOs will be fraudulent in the verification exercise, as is reported in some countries (Bhuwanee and Morgan 2012).

To mitigate the risk of collusion with facilities, it may also be beneficial to contract CBOs on a per-district basis, rather than on a facility basis, since if CBOs are from the same community they are verifying, their independence is diminished. This may also partially address privacy concerns about having CBOs verify the health services received by their neighbors; if the CBO is not from the community, its members are less likely to know the patients. This, along with obtaining informed consent from patients at the point of service (i.e., obtaining their permission to be contacted later for the purpose of verification), can help to uphold patients' rights to privacy, while also sending a signal to patients that they may choose whether or not to participate.

3. Link CBO verification with community scorecards

If enhancing and sustaining social accountability in the health sector is a primary objective, countries may want to consider pairing their PBI programs with a community monitoring/ community scorecard intervention, which would leverage data collected as part of the PBI program.

The strongest setting for this intervention is probably one in which the country has a well-developed PBI program and a well-functioning verification system in which CBOs are already contracted to verify results, as they can easily be engaged to take on the scorecard intervention, which is a natural extension of their verification role.

Since this type of mechanism has yet to be tried, no clear-cut blueprint exists. But here we offer a few suggestions for getting started.

Assess feasibility: The success of pairing a scorecard initiative with a PBI program depends on the program's ability to share aggregate data with CBOs. Thus, the PBI program must

have the capacity and personnel available to take on this role. Countries interested in testing out this approach need to consult with the unit responsible for managing PBI, whether at the national or provincial level, to understand who manages performance data and how easily it can be gathered into a useable form and shared with CBOs. In some cases, data may be managed as part of the HMIS, and, in some cases, additional data may be gathered on separate forms and entered into separate data management systems.

Decide what kind of data to share with CBOs: As noted above, managers of community-based monitoring schemes have choices to make about what types of data to use to empower communities to hold providers accountable. Decisions must be made about whether to share information in a comparative context, or in raw form and devoid of comparison.

Plan a pilot: There is more than one way to implement a PBI community scorecard pilot, but below are some key steps:

- Find a CBO to manage the scorecard process. In some cases, where CBOs already conduct verification in the PBI program, countries may decide simply to extend their role. In other cases, countries may want a competitive process so that a range of CBOs can apply to participate, perhaps working together with the CBO involved in the PBI program. In cases where CBOs do not currently verify results in the country PBI program, countries will have to manage a process of requesting and reviewing proposals and contracting the entity.

- Determine who will contract and manage the CBO. In countries where CBOs already verify results, additional responsibilities could be added to their existing contracts. However, countries that wish to involve new CBOs in the scorecard initiative will need to determine who will contract the CBO, write the terms of reference, and train and manage them. In some cases, this may happen through an international NGO or donor, as is usually the case in scorecard interventions, but a regional government could also take on this role. The country may also need

to seek technical assistance in the short term in order to implement the first pilot.

- Choose a geographic location to implement the program. The decision as to where to pilot the program should be guided by a number of considerations, including accessibility, costs (including transportation), and external factors such as political stability, among others.

- Organize a management team. In order to manage a pilot that involves PBI program management, CBOs, and the government, it may be useful to identify counterparts at each grouping who can plan the pilot and make decisions, particularly decisions about who in the PBI program will be responsible for packaging and delivering data, and to whom it will be delivered at the CBO.

- Assemble the data and help the CBO learn how to interpret and use them.

- Train the CBO in its verification function.

- Conduct the scorecard pilot.

- Learn from the pilot and revise as necessary.

Time and Resource Requirements

CBO verification

In PBI programs, the cost—both in terms of money and time—of verification is influenced by many things, including the fee expectations of the CBO, training needs of the CBO, the amount of data to be verified (sample size) and frequency at which it is to be verified, and the distances and transportation costs associated with the activity, among others. Verification is a recurrent cost in PBI programs that typically decreases over time (i.e., it is usually higher in the beginning while the system is being set up and during the resource intensive pilot period) (Ergo and Paina 2012).

PBI-community scorecard interventions

As with CBO verification, the costs of the intervention depend on design decisions such as the type of data that will be presented to the community and the time involved in assembling it; whether the process will include subjective data

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January 2014

about health services and whether this will be gathered during community meetings or through external actors through surveys or interviews; the number and frequency of participatory meetings with communities and health facilities; and the amount of follow up conducted following the scorecard exercise (i.e., to check in on progress toward meeting community-identified gaps).

Conclusion

PBI programs may contribute to efforts aimed at strengthening social accountability, and there are many potential mechanisms through which communities can engage in and leverage PBI. In PBI programs that offer performance incentives to health care providers, collecting and verifying data about the quantity and quality of services providers deliver is a routine activity that communities can perform and citizens can use to monitor or grade provider performance. By pairing this PBI programmatic function with a community scorecard intervention, PBI programs can help to overcome key challenges associated with traditional community empowerment schemes.

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