

# P4P Research Update

## *Introducing Pay for Performance Approach (P4P) to Improve Maternal, Newborn and Child Health in Bangladesh*

September 2010 P4P Research Update No. 1

### Introduction

The Population Council (the Council) launched testing Pay-for-Performance (P4P) and subsidized voucher approaches for improving maternal, newborn, and child health (MNCH) services in Bangladesh in February 2010. The study provides a unique opportunity for comparing the pay-for-performance approach against the interaction between the pay-for-performance and subsidized coupon models. The objective is testing two service delivery models for increasing utilization of delivery, maternal, and neonatal obstetric care services, and under-five children's life-threatening health care services from facilities to contribute to achieving Millennium Development Goals (MDGs) 4 and 5. The study is part of UNICEF's ongoing MNCH and maternal and newborn health (MNH) projects. This human resource innovation study is under the operational plan for 2010-2011 of the Directorate General of Health Services (DGHS), Ministry of Health and Family Welfare (MoHFW), Government of Bangladesh. James P. Grant School of Public Health (JPGSPH) of BRAC University is collaborating with the Council in the study.



### Why introducing the P4P approach

In spite of having a comprehensive MNCH service delivery infrastructure from grassroots to higher levels, there is significant underutilization of the existing capacity due to both demand- and supply side barriers in Bangladesh.

*“One can build schools and clinics and stock them with books, drugs, and equipment, but if the teachers, nurses, and other providers are chronically absent, these investments will be wasted.”*

*The Abdul Latif Jameel Poverty Action Lab*

On the supply side, shortages of qualified staff, essential drugs and supplies, coupled with administrative delays and clinical mismanagement, and shortage and sub-optimal performance of service providers are key barriers to improve quality MNCH care services.

The government of Bangladesh for being committed achieving the MDGs 4 and 5 has undertaken a range of activities including Demand-Side Financing (DSF) scheme

*Four in ten doctors remain absent in Bangladesh.*

*Chaudhury and Hammer 2003*

in several upazilas of Bangladesh since 2005. Contrary to what the DSF name suggests, in addition to providing vouchers to meet the demand-side barriers, the DSF

offers incentives to the providers to meet some of the supply-side challenges. While measuring the success of the DSF is underway, it is met with several criticisms, especially because for the supply-side financing for not being tied with the quality of care. On this backdrop, an alternative model, the P4P approach has emerged to inform the policy makers about the ways to tie incentive with the performance measured in terms of both quantity and quality. Thus, the P4P approach offers financial incentive to reward service providers for meeting certain performance measures as a way to address underutilization of services and quality of care.

Under this study, financial incentive will be provided to the providers based on achieving the institutional target of MNCH services.

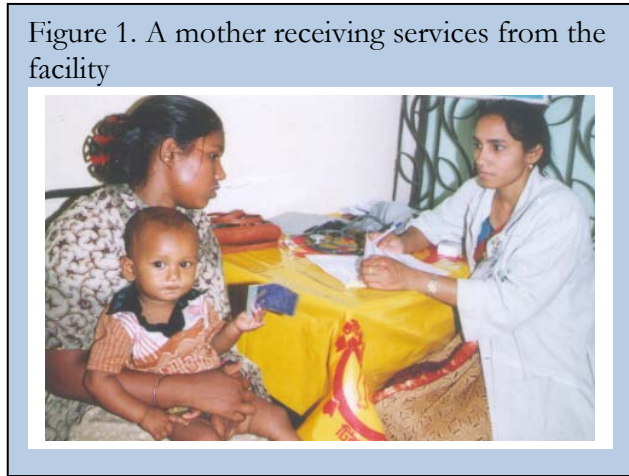
**Difference between the DSF and P4P scheme**

As reflected in the names, DSF finances to meet the demand-side gaps whereas pay-for-performance finances the supply-side factors to

**Table 1. Key differences between DSF and P4P approach**

DSF	P4P
<ul style="list-style-type: none"> <li>• Incentive amount is based on individual cases</li> <li>• Linked with quantity of services</li> <li>• Targets- mostly the poor pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Incentive amount is based on institutional target</li> <li>• Linked with quantity and quality of services</li> <li>• Targets- the poor, pregnant women, neonates and under-five children</li> </ul>

improve outcomes. The P4P allows paying an incentive for achieving at least a benchmark level of performance to providers as a team to improve the quantity as well as the quality of services they deliver. DSF is about transfer of purchasing power to the poor or targeted population to receive services directly from the accredited providers of their choice while the providers are reimbursed for their services from a special fund against the vouchers of services.

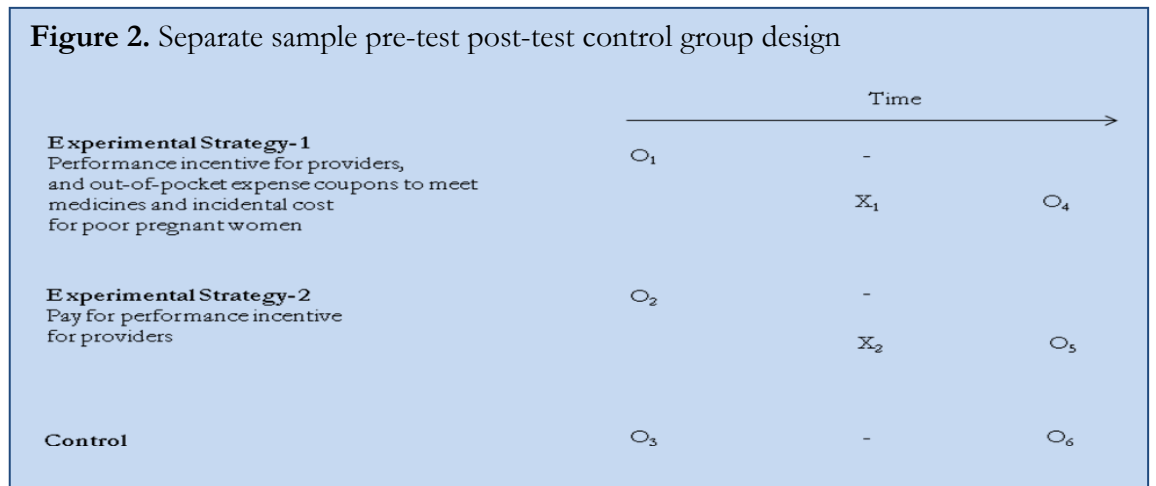


However, the DSF scheme in Bangladesh finances both demand- and supply-sides and the supply-side is linked with the quantity of services while the P4P approach is tied with both the quality and quantity of services.

## Study design

The study is using a separate sample pre-test/post-test control group design with three arms: a control and two intervention arms. Two strategies will be employed in the intervention arms for 12 months, while the control group will be unexposed of any intervention. The first strategy is a combination of the pay-for-performance and subsidized coupon model while the second strategy employs only the pay-for-performance incentives for facility-based providers. Comparison between the control and intervention groups will measure the effectiveness of the intervention activities while comparison between the two strategies - one receiving the incentives for the providers, and the other is a combination of incentives for providers and subsidized coupons for the patients - will measure the relative effectiveness of the two financing models in terms of changes attributable to each program intervention. Given the resource constraint, testing the two strategies will better inform the policy makers for future replication.

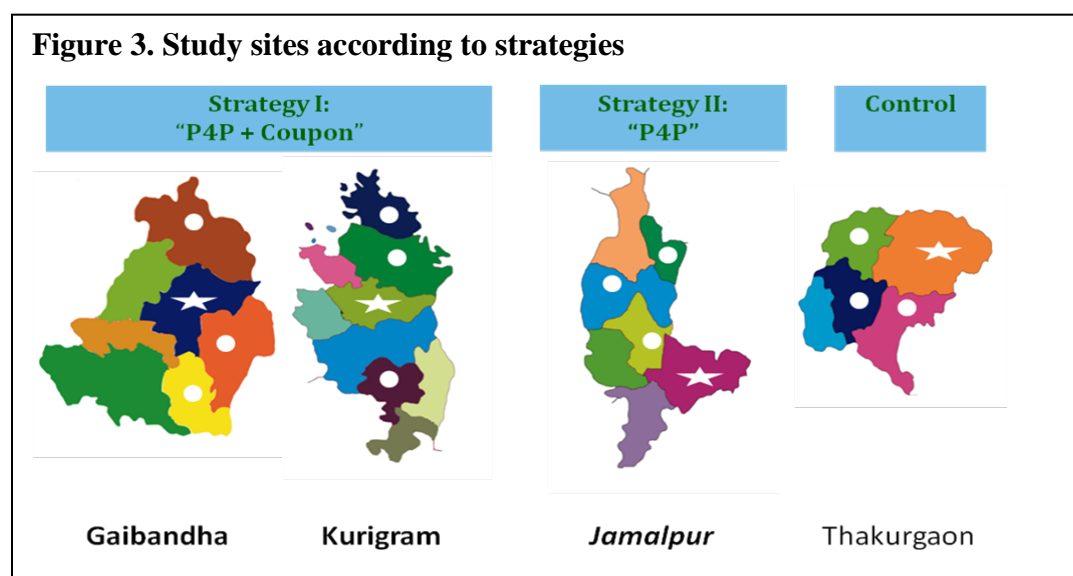
**Figure 2.** Separate sample pre-test post-test control group design



*Note: X<sub>1</sub> and X<sub>2</sub> represent intervention activities corresponding to strategies one and two, respectively. O<sub>1</sub> to O<sub>3</sub> refer to observations from the pre-intervention surveys with the poor pregnant women, and service providers. Terms O<sub>4</sub> to O<sub>6</sub> refer to observations from the post-intervention surveys.*

### Study sites

Twelve public health facilities of Jamalpur, Gaibandha and Kurigram are the intervention sites while four facilities of Thakurgaon comprise of the control site.



The intervention facilities include three District Hospitals, and 9 Upazila Health Complexes (UHC). Six facilities are supposed to provide comprehensive emergency obstetric and newborn care (CEmONC); and the remaining facilities provide

the basic emergency obstetric and newborn care (CEmONC) services.

**Table 2. P4P scheme implementing facilities**

<i>Jamalpur</i>	<i>Gaibandha</i>	<i>Kurigram</i>
• Jamalpur District Hospital	• Gaibandha District Hospital	• Kurigram District Hospital
• Islampur UHC	• Sunderganj UHC	• Nageshwari UHC
• Melandah UHC	• Fulchhari UHC	• Bhurungamari UHC
• Bakshiganj UHC	• Saghata UHC	• Chilmari UHC

### P4P incentive scheme

Quality of care and utilization of MNCH services depend on well coordinated teams at the facility, which consists of managers, direct and indirect service providers and support staff. The team spirit and commitment, dedication and efficiency are crucial to improve the utilization of services. Therefore, managers, direct and indirect service providers and support staff of the MNCH services will receive incentive based on achieving the institutional target according to their level of efforts. The level of effort ranges from 50-100%. Field workers will receive incentive for successfully referring complicated cases. Before introducing the scheme, the Quality Assurance Groups (QAGs) are visiting the facilities to accredit and ensure that the facilities provide minimum acceptable level of MNCH care, and to set benchmark and targets. The P4P committee consisting of six members are coordinating with the QAGs and activating the facility-based quality assurance teams to identify problems and find out solutions to improve the services.

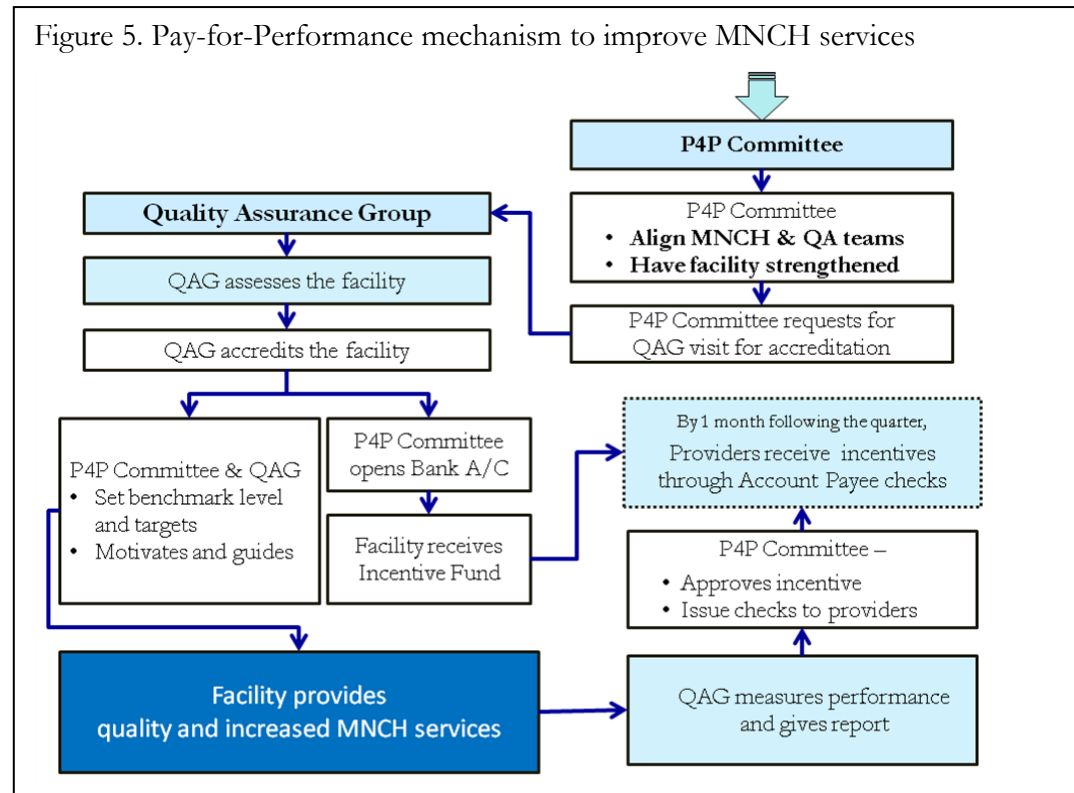
The incentive will be paid on quarterly basis; and the facility-based providers may earn at least *one-month basic salary* in a quarter of a year if the facility attains the first level of target. In case of achieving the second level of target, the providers will receive *one and half month's basic salary* in a quarter. The benchmark and targets are set in the context of each facility.

Qualitative and quantitative indicators are considered in setting the benchmark and targets. The incentive mechanism and indicators have been developed based on the national and district level consensus building workshops, literature reviews and repeated feedback and inputs received from Dr. A.B.M. Jahangir Alam, Director, Primary Health Care and Line Director Essential Service Delivery, DGHS. The indicators include areas of infrastructure, diagnostics, protocols, guidelines, MIS, equipment and supplies, infection prevention practices, post-partum family planning, emergency obstetric,

Figure 4. Consensus building workshop in Jamalpur



newborn and under-five children’s care, safe abortion and post abortion care services. Incentive mechanism for providers of MNCH services in a quarter is depicted below.



### Way forward

Development of incentive mechanism has just been completed with preparation of the guidelines, formation of P4P committees and quality assurance group visits. Incentive scheme for facility-based providers will be implemented from October 2010. Developing sound financial mechanism ensuring prevention of fraud has been challenging. Development of this innovative processes has so far been rigorous and time consuming but worthwhile given the importance of its implication in informing the policy makers about effective and sustainable framework towards solving the supply-side human resource problem in improving the MNCH care. Implementation activities will be extensively monitored for documenting the lessons learned. Subsequent research updates will discuss the QAGs, the baseline survey findings, and development of coupon to address the demand-side barriers as well as implementation processes.

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*Suggested citation: Rahman, Laila, U. Rob, M.N. Talukder, I. Hena, F. Akter, M.A. Rahman and M. Julkarnayeen. "Introducing pay-for-performance approach to improve maternal, newborn and child health in Bangladesh: P4P Research Update 1. Dhaka, Bangladesh: Population Council."*

*This publication was made possible through the support of UNICEF Bangladesh. The opinions expressed herein are those of the authors and do not reflect the views of the Population Council and UNICEF Bangladesh.*