



# Understanding how Financial Incentives Can Affect the Success of a Program

A background paper on understanding financial incentives to optimize the behavior of providers and clients for maternal and neonatal health

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# **Table of Contents**

Abbreviations and Acronyms	iii
Acknowledgements	iv
Preface	1
Introduction	2
Section 1: Understanding How Incentives Contribute to Behaviors of Health System Actors	5
The Demand Side: The Health Care User Perspective	5
The Supply Side: The Health Care Provider Perspective	7
Section 2: An Overview of Financial Incentive Interventions Aimed at Enabling Clients and Providers to Make Decisions that Improve Health	10
Demand-Side Interventions	10
Supply-Side Interventions	13
Section 3: A Practical Tool for Assessing Financial Incentives	16
Conclusion	19
References	20
Annex 1: Summary of Key Characteristics of the Most Common Health Financing Models	23

# **Abbreviations and Acronyms**

CBHI	Community-Based Health Insurance
CCT	Conditional Cash Transfer
DHS	Demographic and Health Surveys
DHSS	Demographic and Health Surveillance Systems
JSY	Janani Suraksha Yojani
MNH	Maternal and Neonatal Health
NCMS	National Central Medical Stores
NGO	Nongovernmental Organization
PBI	Performance-Based Incentives
PE/E	Pre-Eclampsia/Eclampsia
PEPFAR	U.S. President's Emergency Plan for AIDS
PICT	Provider-Initiated Counseling and Testing
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPH	Postpartum Hemorrhage
SHI	Social Health Insurance
TBA	Traditional Birth Attendant
USAID	U.S. Agency for International Development
WHO	World Health Organization

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# Preface

Down a bumpy road, in a village set among arid hills and bracken, in a remote stretch of the country, a young woman named Flavia lives with her husband and children. Flavia is 26 years old and has lived here all her life. She works most days, taking care of her kids, cooking, hacking away at maize, and getting water from the local pump a nongovernmental organization installed last year. Flavia is like any other young woman in her town; she is also pregnant with her third child and will deliver any day now.

We all know what kind of world we want for Flavia. We want her to live close enough to a health clinic that it's not too hard for her to get there. And we want her to make decisions about when and whether to go to the clinic based on what's best for her health—not on worries about money. We want her family and friends to support her to make sure she gets good medical care, and at the clinic, we want the midwives, nurses, and doctors to be kind and give her the best quality care possible. We want them to provide her with a bed net, vitamin and mineral supplements, immunizations, and antihelminthic drugs for de-worming. We want them to take her blood pressure, recognize the warning signs of complications, and assist Flavia in making a "delivery plan" that will help her get to the health facility on delivery day. The clinic itself would be well-staffed, with health workers who are paid a fair wage, well trained, and enthusiastic about serving their communities and saving lives.

We want these things because we want Flavia and her baby to live. However, many women her age, in countries and towns and villages just like hers, do not. Many never make it to health facilities, and when they do, they receive substandard care. And many die—from conditions that are largely preventable and treatable.

The reality is that that during her pregnancy, Flavia made only two antenatal care visits to the local government primary care clinic, where a nurse gave her a free bed net, iron supplement pills, and a tetanus toxoid immunization. No one checked her blood pressure, tested her urine, or gave her deworming drugs or information about delivery complications.

Weeks later, when the contractions start, Flavia decides to deliver at home with a traditional birth attendant (TBA) from her village, who she and her mother know well. She didn't like the nurse at the government clinic, and the private clinic is too expensive.

When labor begins, the TBA suspects complications, but she does not refer Flavia to a health facility. Maybe this is because she never received training for complications, or maybe it's because she earns her fee only if she delivers Flavia's baby herself. Whatever the reason, after hours of increasingly difficult labor, things are looking grim, and the TBA and Flavia's husband decide to take her to the district-level government hospital, which is about two hours away.

It's already evening when they arrive. There are two nurses on duty; the doctors and clinical officers, who are trained in obstetric complications, have already gone for the day. The maternity ward is hot, overcrowded and poorly lit, and the nurses are tired and unsympathetic to Flavia's moans. They insist that her husband buy supplies (i.e., soap, gloves, a razor), and pay "a little something extra," before they will see her.

Flavia delivers a child—a baby boy—but quickly shows signs of postpartum hemorrhage. The nurse hadn't administered a uterotonic immediately after the baby was born, nor did she promptly cut the cord. Maybe she forgot the sequence of treatments, or maybe she is just exhausted and ambivalent. Whatever the reason for this clinical failure, she is now on her own—her colleague has gone to attend to someone else—and is slow to recognize the gravity of the situation. Flavia dies several hours later.

# Introduction

Much progress has been made all over the world in improving prospects for women and their children: between 1990 and 2010, maternal deaths declined by nearly 50 percent worldwide (WHO, 2012a). But despite this progress, maternal and neonatal mortality remain unacceptably high in developing countries (Hogan et al., 2010; Lozano et al., 2011). Pre-eclampsia/eclampsia (PE/E), postpartum hemorrhage (PPH), sepsis for mother and newborn, obstructed labor, and newborn prematurity and asphysia continue to drive mortality and morbidity, and 287,000 women continue to die each year from complications related to pregnancy and childbirth (WHO, 2012b).

Access to and provision of basic maternity services (Table 1) could eliminate 80 percent of existing maternal mortality and 40–70 percent of neonatal mortality (Darmstadt et al., 2005). But as stories like Flavia's remind us, the mere existence of effective, life-saving interventions and technologies does not guarantee their routine and effective use.

Maternal and Neonatal Health Condition	Key intervention
PPH	Use of uterotonic/active management of the third stage of labor
PE/E	Use of magnesium sulfate (MgSO4)
Obstructed labor	Use of partograph
Maternal sepsis	Case management
Newborn asphyxia	Newborn resuscitation
Prematurity	Kangaroo Mother Care
Newborn sepsis	Case management

## Table 1. Key Maternal and Neonatal Health Interventions

Healthier mothers and children depend, to a large degree, on the behaviors adopted by the various health system actors—both clients and providers. These behaviors are shaped by the incentive environment in which these actors work and live, which is itself composed of a complex mix of financial and non-financial incentives that drive behaviors.

In the case of Flavia, the record books will show that she died from PPH, but she also died because of the multiple, overlapping health system failures that occurred during her pregnancy and delivery: her initial experience at the government health clinic, which prompted her subsequent decision to deliver at home; the delay in referring her once complications arose; and the quality of care she received at the district hospital. In other words, her death is inextricably related to, even determined by, the incentives she and her health care providers faced and how they responded to those incentives.

Many kinds of incentives drive behavior—including social norms and taboos on the demand side, and desire for peer recognition and intrinsic motivation on the provider side. Financial incentives are among the drivers of behavior and they are the focus of this paper.

There has been considerable interest in recent years in how financial incentives drive behavior, and how they can be harnessed to address and modify behaviors and social norms among health care providers and clients. In many low-income countries, the status quo creates *dis*incentives for clients and providers to take actions that would lead to better health: the cost of services and transport and the opportunity costs of time away from work may discourage clients from seeking and accessing care. For health workers, low, fixed monthly salaries, paid irrespective of

their actual performance, may discourage providers from exerting the effort needed to deliver high-quality care. They may also encourage workers to supplement their incomes with the per diems they receive when attending workshops or training programs—incentivizing health workers to attend more workshops and possibly neglect patient care at their facility—or by moonlighting in private clinics. In other words, these financial incentives and disincentives contribute to the gap between the actual and desired behaviors of actors in the health system.

Financial incentive reforms—changes in user fee policies, conditional cash transfers for use of maternal and neonatal health (MNH) services, expansion of community and social health insurance systems with coverage for maternity care, voucher schemes, and implementation of performance-based incentive schemes for providers—aim to enable clients to access services, and to motivate providers to deliver quality care.<sup>1</sup>

Financial incentives are potentially powerful and can have complex and unintended effects. Indeed, even reforms like those listed above can lead to perverse incentives if they are introduced without careful assessment of the incentive environment. The removal of user fees, for example, is typically motivated by a desire to remove financial barriers to access for the most deprived population groups. If implemented in an environment where health resources are scarce and health workers underpaid, however, such policy could have the opposite effect by triggering an increase in informal payments or refusal to serve those most in need.

Understanding how clients and providers behave, and the financial incentives that affect and drive their behavior, is important. Health managers and planners must have insights into how the financial incentives providers and clients face affect their interventions. With such understanding, MNH programs can be better designed, implemented, and scaled up, which, in the long run, through the increased coverage and quality of MNH interventions, supports progress toward improved MNH outcomes.

This paper explores the ways in which the behaviors of key health system actors are driven in part by financial incentives (see Figure 1). Our aim is to give program managers an in-depth understanding of how health financing policy interventions could affect the implementation of MNH activities. Specifically, this paper aims to:

- Help national health planners and program managers understand how the health financing environment contributes to shaping the behavior of providers and clients. Financial incentives that alter this environment could have both positive and negative, or intended and unintended, consequences on behavior.
- Propose an approach for analyzing the incentive environment in order for MNH program managers to consider how to address perverse incentives and/or leverage financial incentive reforms, which may enhance the impact of their interventions.

We first explore the demand side—the health care users' perspective—to understand why women like Flavia deliver at home. Then we explore the supply side—the service providers' perspective—to understand why clients often receive compromised care when they access health care facilities. This discussion explores the status quo of financial and other incentives these actors face when making decisions about health care, with a focus on how they can lead to a gap between desired and actual behavior.

<sup>&</sup>lt;sup>1</sup> Evidence on the impact of these instruments is reviewed in a new series published in the Journal of Health Population and Nutrition.

Figure 1. Overview framework: understanding the incentive environment stemming from a country's health financing system



In Section 2, we examine how financial incentive reforms can affect such a gap, and in the final section we guide readers through the main steps for analyzing the mix of financial incentives at play in the places where they work, and to think through how incentives may affect the success of their MNH programs. Our framework and tools can be used by individuals or teams of decision-makers and program implementers in the context of health sector reviews, evaluation of current programs, and, particularly, in the design and planning of new MNH activities. The proposed steps include:

- Mapping key financial incentives and the behaviors they affect, both among clients and providers
- Understanding how perverse financial incentives contribute to a gap between the actual and the desired behavior of health system actors
- Consider how these incentives interact with MNH programming and can be leveraged or compensated by MNH programming

The purpose of this background paper is *not* to be comprehensive or to provide a single answer or a one-size-fits-all prescription for MNH programming, but rather to provide a framework to guide health planners and managers in understanding the incentives that shape behaviors of health system actors and the implementation of MNH interventions. Though we focus on financial incentives, we recognize that there are many other things that influence the behavior of clients and providers. Where possible, we draw upon a hypothetical example—Flavia's story—that illustrates the challenges of a woman attempting to navigate the system in order to obtain good-quality care for herself and her child during delivery.

## SECTION 1: UNDERSTANDING HOW INCENTIVES CONTRIBUTE TO BEHAVIORS OF HEALTH SYSTEM ACTORS

For MNH interventions to be effectively delivered, health system actors, on both the demand and the supply side, must adopt specific behaviors. The pregnant woman, for example, needs to visit the health facility at specific times in the course of her pregnancy, and health workers at that facility need to perform well-defined tasks, adhering to clear guidelines.

But there is typically a gap between the desired and the actual behaviors of health system actors. What drives the decisions that health care users and providers make?

## The Demand Side: The Health Care User Perspective

Between the time a woman discovers she is pregnant and the time she gives birth safely, she must seek and be able to access quality care. But there are many barriers that can act as disincentives to seeking or accessing care. These barriers are often organized following the three delays model developed by Thaddeus and Maine (1994).<sup>2</sup> The first delay relates to the decision to seek care. Barriers causing this first delay may include inadequate knowledge of warning signs of complications or low appreciation for services in general. A woman's social environment can also act as a barrier—there may be pressure in the community to use a TBA rather than go to the facility, or a woman may simply prefer a TBA because she is familiar. Even if a woman would like to seek care at a facility, there may be delays in actually getting there, which may relate to the official and unofficial direct costs of services (the cost of complicated deliveries is often catastrophic, defined as in excess of 10 percent of yearly household income (Borghi et al., 2006)), transport, lodging, food, and the opportunity costs of time away from home and work. Home births have no transportation costs. lower time costs, fewer fees for care providers, no unofficial payments, and are potentially less burdensome to the family than facility-based births. At the facility itself, further delays may, for example, be caused by the fact that staff is absent, supplies need to be purchased outside the facility, or staff lack knowledge about the recommended course of action.

Table 2 presents an overview of reasons why many health care users might not make the best decisions for their health. These are grouped under three headings: affordability, availability, and acceptability (McIntyre et al., 2009). In other words, a user's decision about whether to seek care depends on the costs, whether services are available, and whether services are appropriate, according to the user's criteria and values.

Dimension	Description			
Affordability	<ul> <li>Financial protection</li> <li>Family's ability to incur costs         <ul> <li>Direct costs</li> <li>User fees</li> <li>Official</li> <li>Unofficial</li> <li>Other direct costs</li> <li>Transportation costs</li> <li>Indirect costs</li> <li>Lost income</li> <li>Lost productivity</li> </ul> </li> </ul>			

## Table 2. Summary of reasons why users might not seek or access health care services

<sup>&</sup>lt;sup>2</sup> The three delays relate to (1) seeking appropriate medical help; (2) reaching an appropriate facility; and (3) receiving appropriate care when a facility is reached.

Dimension	Description
Availability	<ul> <li>Geographical distribution of health facilities</li> <li>Hours of service</li> <li>Opportunities for outreach/home visits</li> <li>Transport options</li> <li>Individual need</li> <li>Nature and extent of health needs</li> <li>Range of services, drugs, and supplies</li> <li>Quality of services, drugs, and supplies</li> <li>Mix of health professionals</li> <li>Health system responsive to patient's gender, cultural, and religious needs</li> <li>Health care provider professionalism</li> </ul>
Acceptability	<ul> <li>Providers treat patients with respect</li> <li>Interactions with health and referral system are efficient</li> <li>Role of traditional medicine</li> <li>Patient's respect for health care providers' professional status</li> <li>Social/cultural factors</li> <li>Patient's satisfaction with how their provider respects their special needs (e.g., culture, gender, religion)</li> <li>Patient compliant with treatment</li> </ul>

**Source**: Drawing from McIntyre et al., 2009.

Box 1 describes how the elements captured in Table 1 become real in the lives of people like Flavia. Many of the barriers described below relate to financial considerations: users make tradeoffs, striking a delicate balance between upfront costs (both direct and indirect, known and unknown), beliefs, and knowledge about the quality and effectiveness of care, as well as family and cultural influences.

## Box 1. Understanding Flavia's decision to deliver at home

Dimension	Flavia's Story
Affordability	<b>Cost of care:</b> Delivering in a health facility is expensive. Though the government eliminated user fees for maternal and child health services over a decade ago, it is still widely understood that patients must pay—buying their own supplies and offering "gifts" to the nurses. If these costs are too high, the family budget will take a major hit, and Flavia feels pressure from her family to save this money to buy fertilizer for the upcoming planting season, as well as to pay for school uniforms for the next school year.
Availability (links to affordability)	Availability of health facilities: Flavia weighed her options about where she could go. She heard that care was better at the mission hospital in the regional capital, but, as with private clinics, this is an expensive option. Though the mission hospitals receive partial subsidy payments from the government for each patient they treat, these payments do not fully cover costs, so user fees are still charged. And the greater distance means higher transport costs. There is also a new NGO-run community health insurance program, which covers delivery care in exchange for a modest annual premium. But Flavia didn't have the cash on hand when it was time to pay the premium this year. And because the public clinic usually asks for unofficial payments anyway, she does not have much confidence that she will really get free care in exchange for her premium, even if she did enroll. If she goes to the public facility, at the very least, she'll have to pay for transport and buy supplies. And in addition to the potential unofficial payments, which are damaging in themselves and are unpredictable, so families cannot save or plan for them, Flavia also would have incurred productivity costs associated with going to a facility, getting care there before and after the birth, and missing regular work duties for this period of time. These issues translate into lost income and lost productivity.

Dimension	Flavia's Story
Acceptability	<ul> <li>Perception of the quality of services: Flavia is also unhappy with the quality of care at public facilities. Her two children have fallen sick with malaria several times over the past year and whenever she takes them to the nearby clinic, they are out of artemisinin combination therapy drugs (ACTs) used to treat malaria, and the nurse sends her to the private drug shop in the village where ACTs are expensive (and sometimes, unbeknownst to Flavia, counterfeit). Moreover, the nurses she's encountered aren't nice to her. She doesn't like being around them, being frowned at or yelled at. She doesn't except things to be much better at the district hospital either. Flavia's trust in the system is low.</li> <li>Perception of risk: Flavia has already had two successful deliveries at home in her village, and she knows many other people who have also delivered at home without major complications. She doesn't want to pay cash upfront for a delivery that might be fine at home. She thinks that she <i>probably</i> won't have a complicated delivery, and this is not an unreasonable assumption. It's also more comfortable to be at home, near loved ones who will treat her well and try to make her feel comfortable.</li> <li>Culture and family: In many countries, husbands are the sole decision-maker in the household (for example, 38 percent of women in Uganda and 39 percent of women in Tanzania report this to be the case).<sup>3,4</sup> Though Flavia and her husband make many decisions together, his words carry more weight. Initially, he does not want her to go to the health facility, not because he doesn't care for her (when the crisis hits, he was willing to spend all the money he had to save her), but for the same reason Flavia hedged: because he is not sure she needs to. Her previous births were fine. He was not with her during the antenatal care visits when the nurse told her why she should deliver in a facility so he was not aware of the dangers she faced.</li> </ul>

The relevance of these factors to a particular setting may vary based on equity trends and patterns. For example, availability might be a bigger issue in rural areas than in urban ones. Costs would pose a more significant barrier to poor, rural populations than well-off, rural populations.

Many of these drivers relate to finances—the direct and indirect costs of seeking and receiving care. Financial incentive programs seek to address these barriers by giving people incentives (subsidies) to use services. For example, user fees might be removed to make services more affordable. Other interventions might provide mothers with a clean delivery kit package, which can be brought to a facility lacking supplies or can be used by a birth attendant in the woman's home. To address high transportation costs, maternity homes might be set up near facilities that have skilled birth attendants.

## The Supply Side: The Health Care Provider Perspective

Between a woman's arrival at a facility and her discharge from the facility as a healthy mother with a healthy baby, health workers must provide her with high-quality, lifesaving care (or refer the client to the level in the health system that is adequate to treat them). Many factors in the environment can either enable and motivate or prevent and demotivate health care providers to provide such care. And the behavior of providers—from community-level health workers, such as village health teams, to specialized, formally trained cadres—often differs from what is expected or desired.

The reasons vary for why gaps in provider behavior arise. Providers often do not receive sufficient training, particularly continuing medical education. At the same time, many low and middle-income countries suffer from severe shortages of skilled personnel and very poor health systems (i.e., inadequate infrastructure, equipment, medical supplies, information systems). Health care providers often do not get paid a living wage, and because they attempt to get compensated from various

<sup>&</sup>lt;sup>3</sup> Uganda Demographic and Health Survey (DHS) 2006; Tanzania DHS 2010.

<sup>&</sup>lt;sup>4</sup> Note that in many contexts, mothers-in-law also play an important role, especially when it comes to MNH-related decisions.

sources (e.g., informal fees, dual practice, attending training for per diem), they often face conflicting incentives and conflicts of interest. Box 2 illustrates the providers' behaviors in Flavia's case.

## Box 2. Understanding the behaviors of Flavia's health care providers

- Village health teams: The first level of health care, at least according to the national health plan, consists of trained village health teams. These health promoters could have advised Flavia and her husband about the benefits of delivering in a health facility, tipping the scales in favor of this decision. In reality, these health teams have only become operational in certain districts where projectized donor funds pay their stipends. Elsewhere, this level of the health system is basically non-existent, leaving TBAs, such as the one Flavia turned to, as the main source of health advice in rural villages.
- Traditional birth attendants: As we saw in Flavia's case, the TBA is trusted by local women and affordable, but she lacks the training and tools to handle serious complications, as well as the knowledge and authority to insist on immediate referral. Furthermore, she also lacks any incentive to refer her patients to another provider, as she lacks links to the formal health system and "loses business" if her patients move to a formal health facility.
- District hospital doctors: At the district hospital where Flavia sought care, the highly trained doctors who could have reduced the risk of PPH or ultimately treated it were absent when Flavia arrived. Their salaries are low, so they also spend some of their time providing services in private clinics, sometimes as far away as in the capital. The supervision system is broken; they face little punishment for absenteeism. And, their salaries and jobs do not depend on their performance.
- District hospital nurses: Several hospital nurses are present at the facility and work to care for a large caseload. But they also delay in attending to Flavia, and then give her substandard care. The first reason for delay is that, despite the official absence of user fees, nurses impose a de facto user fee and they force Flavia's husband to go and buy supplies. (Recall that the unpredictability of this charge contributed to Flavia ending up delivering at home.) They charge these de facto user fees to supplement their own salaries, which are much lower than those of the medical and clinical officers. They insist that Flavia's husband provide supplies because the overall budget for basic consumables does not cover the supplies they need. Then when the nurse finally attends to Flavia, her inadequate training means she is ill-prepared to effectively take steps to reduce the risk of PPH or to quickly recognize and treat it. She has been to many training courses in recent years, but they usually focused on voluntary counseling and testing for HIV/AIDS; a higher donor priority than maternal health. At some level, this may have been logical: HIV/AIDS is a very serious problem in the country, and this kind of hospital-level emergency obstetric care is where the trained obstetrician should play his part. But in the absence of the obstetrician-gynecologist specialist, the nurses' skills gap proved fatal.
- Health system supports: Even if the nurse had provided better treatment, her ability to treat Flavia was limited by a further issue: the supply chain system, which is supposed to ensure an uninterrupted supply of uterotonics, failed to fulfill its role. Such essential drugs are supposed to be purchased by the district hospital from the semi-autonomous drug distributor, National Central Medical Stores (NCMS), financed in part by district decentralized funds, and in part by centrally managed funds, which the Ministry of Finance gives directly to NCMS. But the district government's financial management practices are poor, which often results in late disbursement of funds to the hospital. The most recent quarter's health funding was late. The hospital's order to NCMS was reduced, and as a result, misoprostol—used to prevent postpartum hemorrhage—was out of stock. No one at the district level or at the health center faces any direct sanction when there are stock-outs, or receives any recognition when such stock-outs are avoided. So there has been very little creative thinking at the hospital level about ways to solve the stock-out problem or to bridge gaps for key commodities.

In summary, Flavia died because her PPH was not treated; but she also died due to overlapping health system failures. While these failures are complex and multi-causal, several of them are related to the financial incentives that actors face, which are often themselves products of the country's health financing system.

What are the financial incentives at work, driving the behaviors of the actors described above? Box 3 provides an overview of how health facilities are paid, and Box 4 provides a closer look at some of

the typical provider payment mechanisms, which together give a glimpse of the universe of status quo financial incentives that often drive poor health care provider performance.

#### Box 3. Financing to facilities: a typical scenario

**Government financing**: The budget allocation that the facility receives from the district government on a quarterly basis has both a fixed and variable component.

- The fixed component acts as a "global" budget; it is based on the types of services provided by the facility and on the catchment area. All facilities with comparable catchment areas receive the same allocation. It is intended to cover the provision of all of the basic services that are delivered by this level of health facility.
- The variable component is based on the facility's actual use of drugs, vaccines, and consumables. Previously, all facilities of the same level used to receive an identical kit of essential drugs, but after a series of national supply chain reforms, facilities now must order drugs from the NCMS on the basis of actual utilization over the past month. There is also a small capital improvement budget, which is allocated on an as-needed basis among facilities of similar level, at the discretion of the district health management team.

**External financing**: Outside of the formal government finance system, the facility also receives additional funds for the HIV/AIDS provider-initiated counseling and testing (PICT) and the prevention of mother-to-child transmission of HIV (PMTCT) services that it provides. These funds are allocated to the facility on a per capita basis; that is to say, as a fixed amount per person in their treatment population. This payment tracks actual service delivery closely, because the HIV/AIDS program has installed a parallel patient recordkeeping system that is more accurate than the routine health management information system. Maintaining this record system is one of the activities for which the nurses receive their salary "top up." **User contributions**: The final component of facility-level health finance and payment comes from a nascent community health insurance system. In this system, premiums are collected at the facility level and remitted to the district. They are then added to the district health budget and are used to reimburse facilities on a fee-for-service basis.

#### Box 4. Provider payment mechanisms and related financial incentives

- Monthly salary: In the facility where Flavia received antenatal care, nurses are employees of the Ministry of Health and are each paid a monthly salary that ranges between US\$130 and US\$200. Their salary is based on their rank (which is determined by their training level) and has no relationship to their performance. Salaries of clinical officers at the district hospital, where Flavia went for delivery, are about US\$275 per month. Like the nurses, their salary is based on their educational gualifications and years of service and has no link to performance.
- Per diems/allowances/top ups: Nurses supplement their salary with per diems and sitting allowances, which they receive when they attend trainings. They also receive salary top ups when they participate in delivery of certain outreach services, such as Vitamin A supplementation and immunization camps. In Flavia's country, a larger source of salary supplements comes from HIV/AIDS programs, which finance PICT for all pregnant women who come to the facility for antenatal care and PMTCT for those pregnant women who test positive for HIV. Clinical officers also receive per diems and sitting allowances for the trainings they attend and earn a salary top up for participating in the PICT/PMTCT program.
- User fees: Another component of the nurses' income comes from user fees. User fees are charged for all outpatient services with the exception of maternal and child services; by law, pregnant women and children under five are exempt from user fees. Income from user fees is collected at the facility and at the end of the month, 50 percent is distributed among the staff as an income supplement, and 50 percent is used for supplies and facility maintenance. Both nurses and clinical officers are rumored to sometimes receive unofficial side payments from patients. In Flavia's case, she had to pay "a little something extra" to the nurse.
- Additional jobs: None of the nurses have additional income-generating activities that they pursue when they are absent from work, although they regularly take advantage of relaxed supervision to take care of outside responsibilities during working hours. Clinical officer, unlike the nurses, can work part-time in a nearby private clinic in the afternoons and evenings.

## SECTION 2: AN OVERVIEW OF FINANCIAL INCENTIVE INTERVENTIONS AIMED AT ENABLING CLIENTS AND PROVIDERS TO MAKE DECISIONS THAT IMPROVE HEALTH

Financial incentives—provider payment, patient subsidies, etc.—are intended to influence health system actors: on the demand side, to access the right services at the right time; on the supply side, to provide the right services, of high quality, to all those who need them.

In the previous section we reviewed how status quo financial incentives often shape the behavior of health system actors engaged in MNH interventions. We mapped the existing financial incentives, which are determined by health financing policies and programs, and described how they contribute to actors' behaviors.

In this section, we discuss financial incentive reforms that are being increasingly implemented to close the gap between the actual and the desired behavior of health system actors.

Governments may introduce financial incentive interventions one at a time or as part of a reform package. However, they are never implemented in a vacuum. We therefore present and reflect on countries that have introduced such policies and the intended and unintended effects that arose along the way. As the relevance of these policy interventions varies in each context, these examples and references are for illustrative purposes only. We have organized our examples in two groups—supply-side interventions and demand-side interventions. We acknowledge, however, that the effects of these policies can sometimes cut across both groups.

## **Demand-Side Interventions**

## **Removal of User Fees**

User fees are the official out-of-pocket payments that patients make in return for health services. As described above, they are often levied in order to supplement health facility budgets. There is now a fairly strong consensus in the literature that user fees reduce access to maternal health care (Ensor et al., 2005). Borghi and colleagues (2006) point out that user fees are in general "problematic for services such as maternal health, for which demand is inadequate." This relative consensus on user fees is consistent with the emerging experimental literature that shows even very small positive prices reduce demand sharply for preventive health services and products (Kremer et al., 2011). In response to such evidence, "many countries have again begun to reduce or eliminate user fees for certain services (fee exemptions); abolish fees for certain groups, such as pregnant women or children under five (fee waivers); or abolish user fees entirely at primary care facilities" (Hatt et al., 2013).

User fees are but one component of out-of-pocket expenses for patients. While the removal of user fees for maternal care may seem like a "stroke of the pen" policy reform that can rapidly reduce financial barriers to maternal health coverage, the removal or reduction of user fees alone is rarely sufficient to ensure that patients receive quality care, and could even be detrimental.

For example, though the policy intends to drive increased utilization of MNH services, an absence of user fees may mean less revenue for the facility and for health workers. In the absence of policies to replace the revenue previously obtained from user fees with revenues from some other source, providers will in effect get a pay cut just as their workload increases.<sup>5</sup> The temptation for providers, in environments with poor supervision and low accountability, is to substitute side payments for the removed user fees. Drug stock-outs might also increase if the user fee revenue had been used for drugs and if it is not replaced with other funding for drug purchases.

<sup>&</sup>lt;sup>5</sup> This presumes that health workers were receiving at least some salary supplement from the collected user fees.

A recent example of such a reform comes from Burundi, which with little preparation removed user fees for delivery care and for care provided to children under the age of five. In the short term, according to Nimpagaritse and Bertone (2011), Burundi experienced frequent stock-outs, breakdowns in the referral system, staff demotivation, and reduced quality. Similarly, in Uganda, abolition of user fees (for all primary health services) led to increased utilization and was broadly pro-poor in its distributional effects (Deininger and Mpuga, 2004), but the lack of attention to supply-side factors created what Nabyonga et al. (2011) call "the Uganda paradox": the increase in utilization by poorer members of society, together with the emergence of a dual health system, whereby richer Ugandans use the private sector, which has left *poorer quality* but free services for the poor. A third example of the need for preparation and complementary interventions to accompany user fee removal comes from a pilot project in two districts in Niger, where Ridde, Diarra, and Moha (2011) recount that nurses responded to the reduction of income and revenue by diverting drugs and other commodities away from free services and into paid services, by engineering artificial shortages of items needed for the program, such as health booklets, and finally by simply ignoring the abolition of user fees and continuing to charge them to patients. On the demand side, the authors report large-scale stockpiling of medicines by the population, who evidently believed that free services would not last.

To avoid such undesirable effects, Gilson and McIntyre (2005) suggest a set of policy changes that should accompany removal of user fees, including:

- Overall increases in health sector funding and improvements in the equity of allocation;
- Clear communication with front-line health workers and the public about the rationale for the change;
- Replacement of user fees with flexible funding that health center managers have discretion to use in the same way that they previously spent user fee revenues; and
- Informational campaigns, so that the public knows that user fees are no longer permitted, thereby preventing continuation of illegal charges to users.

The prevalence of side payments can be further reduced by strengthening oversight from above or accountability from below. The evidence base on interventions to reduce this form of corruption, however, is fairly weak; more knowledge, including experimental evidence about consequences of reform, is needed.

User fee reform that takes into account second-order effects is being attempted in some of the poorest countries in the world. In 2010, Sierra Leone removed user fees for all pregnant and breastfeeding women and children under five. As discussed above, this could have led to a de facto salary cut for health workers and reduction of primary facility budgets. But instead, the user fee policy was coupled with supply-side reforms, including a five-fold increase in health worker salaries, a reform of the drug procurement and supply system, and a large-scale communication campaign to inform citizens about the elimination of user fees (Wakabi, 2010). Ghana similarly combined the elimination of user fees for delivery care in 2004 with complementary reforms, whereby health worker salaries were increased and providers could make claims for lost user fees on the public health budget. Witter et al. (2009) note that the exemption scheme was underfunded and even the full removal of fees by law did not reduce actual paid fees to zero; in fact, it only reduced fees by 28 percent. But it did increase utilization and improve the equity of maternal health spending.

## Vouchers

A voucher system entitles pregnant women to receive free or heavily subsidized maternal health care at participating facilities, in both the public and private sectors, and represents another option for changing the health-seeking behavior of women. This is administratively more challenging than simply mandating free services. But it can be a lever to improve quality and spur competition, for example, if vouchers can also be used at accredited private facilities.

Voucher schemes have been used in a number of countries—e.g., Bangladesh, Cambodia, Kenya, Nepal, Pakistan, and Uganda—to bolster demand for maternal health services (Beith, Eichler, and Morgan, 2011). Both vouchers and user fee elimination aim to increase utilization, but in voucher programs there is also a supply-side component: a purchaser contracts accredited health facilities, and providers are reimbursed for the cost of provision, plus a reasonable profit, after delivery has been verified.

A good recent example of a policy designed with careful consideration of incentives facing all actors in the MNH system comes from Nepal. The policy process leading to the Nepal Maternity Incentive Scheme followed something like the process that the tables and tools presented in this paper (Section 3) are intended to facilitate. First, the policy team commissioned research on the specific nature of the barriers to care. The research showed that direct fees were not that large as a percentage of the total cost barrier, at just US\$9 out of the total US\$70 cost of an uncomplicated birth at a facility. This suggested that user fee elimination alone would be insufficient. Based on this finding, the policy team developed a menu of four policy options: free care for all mothers; free care for poor mothers only; supply-side performance-based incentives; or a demand-side incentive, such as a voucher or cash transfer. Research did show that transport costs were a major component of total costs. Nepalese policymakers ultimately combined a cash payment to women who delivered in health facilities (to offset total costs including travel) of US\$19.70, US\$13.10, or US\$6.60, depending on the terrain of the district. This payment was combined with free delivery for the poorest women, as well as a supply-side bonus of approximately US\$4 to health workers for attended deliveries. Notably, however, this approach results in cost-sharing rather than free delivery. The thinking was that offsetting the full cost was unaffordable, but just removing user fees would not take enough off of the price. Nepal has since eliminated the remaining user fees, moving to free delivery care. These reforms have contributed to a doubling of the percentage of women who delivered in health facilities between 2006 and 2011, increasing from 18 percent to 35 percent (Asia-Pacific Leadership and Policy Dialogue for Women's and Children's Health, 2012).

## **Conditional Cash Transfers**

Another option for changing the financial incentives facing pregnant women is to provide actual cash payments to women in exchange for their use of certain key maternal health services, known as conditional cash transfers (CCTs). CCTs have been used extensively in Latin America, where the evidence is clear that they can increase health services utilization (Lagarde, Haines, and Palmer, 2009), including maternal health services. More recently, CCTs targeting maternal health have also been tried in Afghanistan, India, the Philippines, and Rwanda (Beith, Eichler, and Morgan, 2011).

Traditionally, CCT programs only focused on providing cash to individuals; however, many newer CCT programs combine such demand-side incentives with small incentives for the lowest-level health workers, such as community health workers or TBAs. For example, India's *Janani Suraksha Yojani* (JSY) program, in addition to rewarding women with cash payments for facility deliveries, also provides small cash incentives for community-level health workers (known as Accredited Social Health Activists) who identify pregnant women and encourage them to deliver in the nearby health facilities (Mazumdar et al., 2012).

While CCTs may help to reduce the cost of maternal health services, they also bring about the possibility that cash payments will incentivize non-desired outcomes at the same time as they

promote antenatal care visits and other positive maternal health behaviors. For example, Honduras' CCT program, *Programa de Asignacion Familiar (PAF)*, was notably successful in increasing use of antenatal care services, well-child checkups, and growth monitoring. However, it was also associated with higher fertility in the treatment group (Morris et al, 2004; Stecklov et al. 2007). Similarly, impact evaluations of India's JSY program, which offered cash payments to mothers for delivering in health facilities, shows some preliminary indications that the cash payment may have inadvertently provided an incentive for increased fertility (Mazumdar et al., 2012).<sup>6</sup>

However, just as with the user fee examples, careful design and attention to incentives can mitigate these challenges. Stecklov et al. (2006) also analyze comparable CCTs in Mexico and Nicaragua, where fertility did not increase, suggesting that it was the design of the Honduran program that drove increased fertility. First, unlike in Mexico and Nicaragua, eligibility for the Honduras PAF program was open, meaning that households without a child at the time of program design could become eligible if they had a child in the interim. Second, the size of the benefit in Honduras depended on the number of children (up to two), rather than being a lump sum. The possibility for perverse incentives in the Honduran program is clear—and so is the potential to avoid such incentives through careful program design based on understanding of the incentives facing health care users.

## **Supply-Side Interventions**

### **Health Insurance**

Affordable health insurance schemes provide another option for reducing out-of-pocket costs to individuals, albeit a more administratively complex one. This does not eliminate payment, but rather shifts it in time and spreads it among a broader population, pooling risk to protect women from catastrophic delivery care costs. The challenge for health insurance is implementation, especially incentivizing adequate uptake, and designing payment policies consistent with equity and cost control. The expansion of health insurance can have perverse system-level effects if not carefully designed.

One challenge relates to political-economy: many developing countries, particularly in Latin America, began expanding insurance only to find themselves in a situation wherein relatively well-off, formal sector workers were covered by social health insurance (which involves compulsory membership), while the rest of the population (often the rural poor and urban informal workers) had to pay out of pocket for private care or use free, but low-quality, poorly resourced public facilities. This scenario is especially likely if the health insurance scheme has a fee-for-service payment, which can create a "partial reform" trap whereby cost inflation in the social health insurance system requires significant public subsidies, which are used to deliver care to relatively well-off users, while the larger and needier fraction of the population receives fewer resources and lower-quality care in the public sector.

In many sub-Saharan African countries, challenges with insurance tend to center around administrative capacity. Social health insurance schemes covering the government and formal sectors are created, but the state simply lacks the administrative capacity to collect and pool annual premiums from the much larger informal sector.<sup>7</sup>

Finally, choice of the mechanism by which providers are reimbursed is also a key for understanding the incentives insurance creates. If an insurance system is set up with fee-for-

<sup>&</sup>lt;sup>6</sup> Another unintended possibility is crowding out: Mills et al. (2011) show that as many as one-third of the increase in public health facility births attributed to JSY maternal incentive scheme in India were not new facility births, but rather shifts away from private sector and toward public sector care. Whether this is a good or bad thing depends on how much better health outcomes are in the private sector, swaying women into poor-quality care via a cash payment is not a particularly sound policy.

<sup>&</sup>lt;sup>7</sup> For enrolled households, another possibility is moral hazard, in which covered households might be less likely to take needed preventive steps when they know that their treatment costs are covered. Overuse of services is also theoretically possible in a fully insured context.

service reimbursement for maternal health care, providers may be tempted to overuse expensive procedures. In the maternal health context, this could lead to overuse of surgical delivery procedures, such as cesarean sections.<sup>8</sup>

Kenya and Tanzania provide examples of African countries that expanded health insurance to urban, civil service, and formal sector groups, only to get stuck at this level of inadequate coverage, without the political will or administrative capability to extend coverage to the rural poor (Haazen, 2012). Two countries in Africa provide more successful examples of a health insurance strategy to increase access to care. Rwanda has increased facility deliveries through its *Mutuelles de Santé* national health insurance system.<sup>9</sup> *Mutuelle* premiums in 2007 were US\$1.83, compared to the US\$3.70 average cost of facility deliveries (Wakabi, 2007). These policies appear to be working, as health facility births have increased dramatically, from 28 percent of all births in 2005 to 69 percent in 2010 (Measure DHS, 2013).

In another example, following the elimination of user fees for maternal care, Ghana rolled out national health insurance in 2005. While the Ghanaian experience has been challenging, it also included careful, incentive-compatible design elements: to avoid adverse selection (when highrisk consumers enroll in insurance that is priced for lower-risk consumers, making the system financial vulnerable) in one district, for example, authorities offered premium discounts for children less than age 18 if everyone in the household was enrolled, which succeeded in reducing household-level adverse selection (Rajkotia and Frick, 2012). Other aspects of program design were less incentive compatible. For example, fee-for-service reimbursement was adopted, and providers were allowed to influence the decision on reimbursement rates, resulting in high, potentially unaffordable rates. This approach was seen as a needed compromise to get the health insurance bill through parliament, and was to be addressed later. Higher prices have been paid by, and more drugs have been prescribed to, enrollees, along with more direct visits to hospitals (instead of first-level health posts). Yet despite these challenges, one-third of the population was enrolled within two years; increased utilization has been observed, and preliminary analysis suggests that the expansion of health insurance has led to increased access to antenatal and delivery care (Brugiavini and Pace, 2011).

## **Performance-Based Incentives**

Performance-based incentives (PBI) are incentives paid to providers or patients for measureable health results. Many types of PBI programs are being implemented in countries such as China, the Democratic Republic of the Congo, Philippines, Senegal, Tanzania, Uganda, and Vietnam. In Rwanda and Burundi, they have been scaled up to the level of national programs. Most PBI programs also reward recipients for the quality of the services delivered, as measured by quality checklists or quality indices (Ergo et al., 2012).

Maternal and neonatal health care is particularly well-suited to PBI, because many key interventions, such as antenatal care visits, facility births, or immunizations delivered, are among the health outputs that are more straightforward to measure and verify using routine health information systems.

Similar to the cases of vouchers and CCTs, PBI is often combined with demand-side financial incentives. For example, Rwanda is experimenting with variations to their PBI program, including an augmented approach that combines facility-level provider incentives with rewards for health care users and community health workers for specified MNH service delivery

<sup>&</sup>lt;sup>8</sup> For example, Comfort et al. (2013), in a review of insurance programs and their impact on maternal and neonatal health, find six studies that present suggestive evidence of over-provision of cesarean sections in response to provider payment incentives through health insurance.

<sup>&</sup>lt;sup>9</sup> Rwanda also implemented a policy whereby women can receive free delivery care in government facilities if they complete four antenatal care visits.

services. These cash transfers not only eliminate direct costs by making a facility visit a source of income (rather than a cost) for women, but they can also help to defray other treatment-related costs, such as transport or the opportunity cost of lost labor income for those who accompany the woman to a health facility (Wakabi, 2007; Basinga et al., 2011).

Unintended effects can also pose challenges for supply-side financial incentive reforms, such as PBI programs. Careful design and implementation can mitigate many of these concerns; for example, by ensuring that non-rewarded indicators are also monitored to determine whether there are any "crowding out" effects, and including robust data verification mechanisms (Ergo and Paina, 2012). One additional potential challenge with conditioning payment on performance is ensuring buy-in for the program at all levels. If such buy-in is lacking, the system is unlikely to be well-implemented. One example comes from an experiment designed to improve incentives for nurses to come to work in rural India. Banerjee and Duflo (2008) show that a system in which nurses in Udaipur district had their compensation depend upon their actual attendance at work functioned very well for about six months. But, because their supervisors ultimately had no incentive to continue this system, they began colluding with the nurses to redefine justified absenteeism, thus rendering the performance-based program completely ineffective.

Adam and DeSavigny (2009) underline the importance of "system level thinking," which situates isolated financing reforms within the broader health financing context. Because incentives are powerful, PBI and other financial incentive programs need to be well aligned with pre-existing financial incentives in the health system. Careful design can mitigate these effects. An example comes once again from Rwanda. The initial iteration of PBI in Rwanda had positive effects on facility deliveries and quality of antenatal care, but failed to increase access to antenatal care (Basinga et al., 2011). Yet because the program was developed with robust monitoring of impact and with strong high-level political support, the second iteration of the program could be improved and incentives could be shifted; for example, by changing the relative weight of payments for different elements of the service package and by adding demand-side payments for women who attend antenatal care, as well as incentives for community health workers.

## **Changing Provider Compensation**

Looking back at Flavia's story, the other major set of incentive problems created by the health finance system for providers was the fact that much of their compensation is tied to activities that are either unrelated or counterproductive to the provision of MNH services, such as the collection of large amounts of user fee revenue and the extraction of side payments from patients. For example, if user fees are a major source of facility and staff revenue, and if these user fees are only applicable for certain services (e.g., maternal and child health care are exempt), staff attention is likely to be drawn to these non-exempt services. Or if the rewards for participation in training or other specialized categories of services for which staff receive salary top ups are comparable or greater than basic salary levels, we should not be surprised if these activities become the priority.

For managers of larger facilities, their budgets are likely to be determined by a fragmented funding system, with a global budget for most routine activities, plus reimbursement for all drugs and consumables used up to a capped amount, plus fee-for-service reimbursement for health insurance enrollees, plus user fee income for non-MNH services. This situation creates few incentives for high-quality, universal MNH care; rather, the incentives are for inefficiency in use of resources, non-rational prescription of drugs, and focus of scarce skilled clinician time and equipment on the few patients who will pay out of pocket or whose care will be reimbursed.

The various provider payment mechanisms are not described in detail here, but broadly include line-item budgets for facilities, salaries for individual providers, fee-for-service payment, capitation payments (a fixed amount for each person enrolled with a provider—typically a general practitioners—for a given period of time and irrespective of whether or not that person seeks care), and case-based payments (typically for hospitals). The latter three mechanisms are more typical of the private sector than of the public one. These mechanisms can be explored further in the literature, such as the guide for designing provider payment mechanisms by Langenbrunner and colleagues (2009).

# SECTION 3: A PRACTICAL TOOL FOR ASSESSING FINANCIAL INCENTIVES

The purpose of this section is to help readers think about how financial incentives, though not necessarily in the control of a health planner or manager, can shape the overall incentive environment and affect provider and client behavior as it relates to their intervention. Using Table 3 as a template for synthesizing information, we aim to help program managers map existing financial incentives, think through their impact on the behavior of clients and providers, and consider how this will affect their MNH program. It may be that there are opportunities to leverage financial incentive reforms to enhance the impact of your intervention, or it may be that you should consider adapting your program design to tackle disincentives in the environment,

In trying to develop an understanding of existing financial incentives, National Health Accounts (WHO, 2013) and Public Expenditure Tracking Surveys (World Bank, 2013) can provide important information about how much health care users pay out of pocket for services and how much of this is financed through either the public or private sectors. Information about actual provider compensation will be important, as in many resource-poor contexts, health care providers have multiple forms of compensation outside of their government salary that influence their incentives (e.g., holding multiple jobs, per diems). Additional information could be extracted from research reports, evaluations, and project documents produced by development partners and both local and international research organizations. Because data availability varies by setting and obtaining the necessary information will require interactions with multiple stakeholders, this initial phase also allows for an informal mapping of the key stakeholders engaged with financial incentive strategies and programs.

A second step involves thinking through the incentives that these policies generate, both on the demand and the supply side, as well as the potential influences that these could have on the behavior of health system actors. As such, one should examine the policies that are currently in place, their current stage of implementation, and qualitative research (if it is available) on the effectiveness of implementation, as well as which unintended consequences and/or interactions arose from these policies—either a single policy alone or through interaction with other policies and programs. This information will likely have to be collected from discussions with knowledgeable stakeholders.

Policy category	Financial incentives given to:	Potential poli (mark with X i exists in you region)	icy if it ır	Stage of implementation (e.g., pilot to full scale)	How might this change patient behavior?	How might this change provider behavior?	Are there any potential adverse effects	How does this relate to my MNH program?
Insurance	Patients (subsidy through the benefits package)	Social health insurance						
		Community- based health insurance						
		Private health insurance						
		Others:						
	<b>Providers</b> (through reimbursement for insurance patients; in some cases, may be conditioned on performance on quality)							
User fees exemption policiesPatients (some user fee exemption policies may be implemented with commensurate support to providers)	Patients (some user fee exemption policies may be implemented with commensurate support to	Government exemption						
		Sliding-fee schedule						
	Others:							

Policy category	Financial incentives given to:	Potential pol (mark with X exists in you region)	icy if it ur	Stage of implementation (e.g., pilot to full scale)	How might this change patient behavior?	How might this change provider behavior?	Are there any potential adverse effects	How does this relate to my MNH program?
Vouchers	Patients (subsidized package of services)							
	<b>Providers</b> (through reimbursement for voucher patients—in some cases, may be conditioned on performance on quality)							
Conditional cash transfers	Patients							
Provider	Providers	Salary					Include any	
payment mechanisms		Fee for service					interactions among health care providers (e.g., doctors get little pay,	
		Case-based payment						
		Capitation					have	
		Informal payments					private practice; nurses don't have the same flexibility, which can create animosity)	
		Allowances and per diems						
		Performance payments						
		No payment						

# Conclusion

Although the interventions needed to lower maternal and neonatal mortality and morbidity are well-known and generally cost effective, creating a system that results in reliable delivery of these interventions is a challenge in many of the poorest countries. This task is complicated by the fact that a variety of factors, including the inducements created by financial incentives, influence the behavior of health system actors—on both the supply and the demand side. When not optimized, these behaviors can hinder the effective provision of key MNH interventions, as illustrated through Flavia's story. Financial incentive interventions that are introduced in a particular context can contribute to realigning the behavior of health system actors. However, these policies can have both intended and unintended consequences, which can also influence MNH activities.

It is critical that health managers and planners understand and acknowledge these incentives when designing, monitoring, implementing, and evaluating MNH programs. Our background paper intends to assist health managers and planners in several ways. The paper explores health financing policy interventions and provides country examples of how policy interactions and adverse effects could be mitigated in the context of MNH services. It also proposes a simple framework for systematically assessing and mapping the incentives of actors engaged in the provision of priority MNH services. This includes reviewing MNH-related contextual elements, mapping existing health financing policies, and understanding the incentive environment and the extent of the gap between the desired and actual behavior of health system actors. The framework can be used by health planners and program managers in the context, the evaluation of current programs, and, particularly, in the design and planning of new MNH activities.

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## Annex 1: Summary of Key Characteristics of the Most Common Health Financing Models

General Revenue Financing (National Health Service System)						
Pros	Cons					
<ul> <li>National health service systems cover the entire population and general taxation may be the fairest way to generate the required funds.</li> <li>Resources for health increase over time as the economy grows.</li> <li>High degree of political accountability in democratic political systems through regular legislative budget processes.</li> <li>State-funded systems are relatively easy to manage.</li> </ul>	<ul> <li>Health system has to compete with other sectors for funds.</li> <li>Depending on the types of taxes and economic conditions, revenues can be unpredictable/fluctuate.</li> <li>Taxation can be inequitable depending on the type of taxes used and the level at which they are collected.</li> <li>In states with weak governance and accountability, being able to control general revenues can lead to favoritism and corruption.</li> </ul>					
Social Hea	Ith Insurance (SHI)					
Pros	Cons					
<ul> <li>The social contract structure can increase citizen's willingness to pay, as there is greater trust that benefits will be delivered.</li> <li>Social health insurance (SHI) schemes have the greatest potential for providing effective risk protection, particularly in high-</li> </ul>	<ul> <li>Scheme does not cover everyone; particularly in low-income countries, SHI usually only covers workers in the formal sector and only pools the health risks of its enrollees.</li> <li>Requires both adequate fiscal capacity of the government and popular acceptance.</li> </ul>					

- Can result in higher real cost of labor due to higher social insurance premiums.
- Though SHI contributions are often technically not "taxes" but "premiums," they may look and feel like taxes to the public and suffer from some of the problems that reduce the effectiveness of tax collection.

income countries.

#### **Private Insurance**

Pros	Cons
<ul> <li>Private insurance will mobilize resources in addition to what governments can generate.</li> <li>Since non-payers do not get coverage, problems of tax-evasion (which may occur under tax-based schemes like social health insurance) can be minimized.</li> </ul>	<ul> <li>Competitive private insurance is very prone to risk selection. This occurs when insurers are able to favor enrolling the healthier groups in a population, leaving those more likely to be sick and incur higher health expenditures to have their needs met in other ways. This gives the impression that private insurance is lower cost or more efficient when it may be that it is simply insuring those with loss</li> </ul>
<ul> <li>when people can chose their own plan they may feel more empowered and willing to pay for health care.</li> <li>Those with different attitudes and values.</li> </ul>	<ul> <li>need. Conversely, private insurers may also charge very high rates to those more likely to be sick.</li> <li>This method offers less risk pooling than social</li> </ul>

- including those at different income levels, will prefer different health care plans. A competitive market for private insurance should then respond by offering a range of insurance plans, which can improve consumers' welfare.
- insurance or general revenue financing; groups with the highest risks and costs are typically excluded.
- Competitive private insurance is also prone to having higher operating costs. Competition requires marketing and other expenses and smaller risk pools may mean fewer efficiencies in administration.
- Private insurance poses a complex set of regulatory . and management issues to the government, which require high levels of analytical competence and political integrity that many countries do not have.

Community-Based Health Insurance (CBHI)			
	Pros		Cons
•	Local control may produce more transparency and accountability. Local financing and administrative arrangements may be attractive to citizens reluctant to use government-run facilities further from their homes. CBHI can be more easily combined with other community-based initiatives such as micro-finance and livelihoods programs or local organizations of occupational groups. When pre-paid and compulsory, community financing can offer a good degree of risk protection.		Schemes are often voluntary; but to be really effective, membership should be compulsory. Communities may not have mechanisms to achieve that aim. The populations involved in these schemes are often poor; it can be difficult to raise enough money to provide adequate coverage and these schemes often need to be supplemented by tax-based schemes. Risk pools in CBHI can be small and schemes are vulnerable to unexpected high-cost events or epidemics. CBHI is dependent upon the capacity and
		-	organization at the local level.

Source: World Bank (2010)