



### **Guest Editorial - Policy challenges and innovative analyses of payment for performance in health care**

Journal:	<i>Journal of Health Organization and Management</i>
Manuscript ID	JHOM-03-2021-0091
Manuscript Type:	Editorial

SCHOLARONE™  
Manuscripts

## Guest Editorial - Policy challenges and innovative analyses of payment for performance in health care

There has been significant interest in the use of payment for performance in health care worldwide – both by policy makers and by academics. There many evaluations of schemes but the majority of them have focused on a specific country or on countries from the same region or level of income (Saddi *et al.*, 2018; Anselmi *et al.*, 2020). In high income countries (HIC) we have seen a long period of valorisation of the effect of outcomes; with only a few studies recently looking at the policy process and more comprehensive evidence (Forbes *et al.*, 2017; Roland and Guthrie, 2016; Smith and Cumming, 2017). Those studies have brought new knowledge with respect to the role played by policy entrepreneurs (Smith and Cumming, 2017), to challenges faced at the front line by general practitioners and administrative staff (Roland and Guthrie, 2016), and to lack of evidence of effect on the health of the population (Forbes *et al.*, 2017). In High income countries, comparative analysis between countries with same level of income is rare. consists of a relevant gap as well. It might seem contradictory, but, comparatively, more studies examining a wider range of issues and employing more complex reviews (Lee *et al.*, 2012; Eijkenaar *et al.*, 2013; Singh *et al.*, 2020), qualitative and policy analysis approaches (Ssengooba *et al.*, 2012; Bhatnagar and George, 2016, Bertone *et al.*, 2018) have been carried out in LMICs', especially in African countries. However, they are usually based on a single country or group of countries from Africa, sometimes including Asian countries under a Performance-based Financing (PBF) scheme, and a few recently taking into account European LMICs (Singh *et al.*, 2020). There have been very few case studies and qualitative analyses related to P4P based in Latin America, and particularly in Brazil (Saddi and Peckham, 2018). In LMICs, there is still the need to develop comparative analysis between countries from different regions. Moreover, the findings of research projects and in-depth evaluations considering both HIC and LMICs constitutes a significant gap in our knowledge.

Moreover, international comparative analysis often focuses on organisation and payment systems, which is useful and worthy but does not address context, does not explain, does not draw learning) and not on the contextual/sociological elements that influence policy, such as power relations, political influences, role of the professions. The main policy challenges related to the implementation, design or evaluation of payment for performance have not been analysed from an international viewpoint.

1  
2  
3 In a complementary way, new analytical approaches and perspectives may be needed to  
4 address the policy challenges in relation to P4P/PBF. Therefore, we do not know yet how policy  
5 challenges related to payment for performance vary in different contexts in the world, and from  
6 the perspective of comparative and cross-country learning, and more in-depth policy or  
7 qualitative country analyses in most countries.  
8  
9  
10  
11  
12  
13  
14  
15

### 16 **The aim of this issue**

17  
18

19 This special issue aims to advance our knowledge with respect to policy challenges and  
20 methods for analysing payment for performance programmes (P4P) or performance-based  
21 financing (PBF) programmes in health care, in diverse health systems around the world.  
22  
23  
24

25 The seven papers included in this issue provide examples of varied types of policy  
26 challenges taking place in P4P internationally, such as: practitioners' engagement in policy  
27 design, government systems/power relations and selection of instruments, policymaking  
28 adaptations in a low-income context and impact on health care utilisation.  
29  
30  
31  
32

33 This issue also provides examples of alternative methods and frameworks to better  
34 understand the contexts and challenges related to P4P internationally: policy, document,  
35 qualitative theme and framework analyses, applying interviews and literature review, and  
36 diverse concepts from management, public Policy and Health Policy/Care.  
37  
38  
39  
40

41 Analyses are developed for a variety of high-income countries (New Zealand &  
42 England, France & Germany, European countries), as well as low- and middle-income  
43 countries (Zimbabwe, Burkina Faso, Brazil, LMICs/review) from distinct parts of the globe.  
44  
45  
46  
47

48 Therefore, this collection highlights some of the frameworks that we can use to compare  
49 and contrast how the historical, political, social and cultural contexts influence policymaking  
50 and implementation. The comparative lens provides the ability to think more objectively about  
51 making and implementing policy in different settings; challenging the view that this is the 'way  
52 we have always done it' as being not the only way. Comparison of the contexts within which  
53 health systems operate, within both LMICs or HICs, is challenging – as evidenced by the  
54 studies included in this edition of the journal. However, they also suggest that by using such  
55  
56  
57  
58  
59  
60

1  
2  
3 analytical frameworks we can throw light on what might work in different contexts (Okma and  
4 Marmor, 2013; *GBD 2016 Healthcare Access and Quality Collaborators, 2018*).

5  
6  
7 The first paper by Verna Smith is a policy analysis comparing development of the  
8 English and New Zealand P4P programmes. It identifies a key difference between the  
9 approaches to general practitioners' engagement between the two countries, which may explain  
10 the differences in their achievements and longevity. In the UK, where P4P had much better  
11 buy-in from general practitioners, the policy approach was to align scheme design with the  
12 profession's values. Particular features of the approach in the UK were highly skilled  
13 negotiators, principle-based negotiations and involvement of academics in selecting indicators.

14  
15  
16 Mathias Brunn brings the complexity of power relations to the analysis of P4P as a  
17 policy instrument. He employs the theoretical frameworks of public policy instruments and  
18 performance of actors to explore differences in P4P in ambulatory care between France and  
19 Germany. His comparative analysis is supported by findings from a literature review and  
20 interviews with stakeholders. The analysis demonstrates the way key system characteristics  
21 and actors shape the development and implementation of P4P policy instruments. In France,  
22 the centralised institutional architecture, together with statutory health insurance director  
23 personal characteristics and the policy implementation capacity of Social Health Insurers  
24 (SHI), shaped the selection of P4P instruments. In Germany, on the other hand, the federal  
25 system did not enable the formation of a coalition in favour of P4P, given the veto players in  
26 the federalism and conflicting roles regarding data generation and transmission.

27  
28  
29 The paper by Kadungure *et al.* explores contextual factors explaining adaptations that  
30 occurred in PBF in Zimbabwe between 2010 and 2017. Based on policy documents and  
31 interviews, the paper stresses that the PBF went through key adaptations during this period,  
32 mainly due to its phased design, in which the scale-up planned implementation permitted  
33 revisions and extraction of lessons to other LMICs. It also points out that exogenous factors  
34 had been underestimated in the process and they could have been used to anticipate problems  
35 and improve effectiveness. The study provides essential lessons to researchers and  
36 policymakers and managers of PBF/P4P: the importance of considering both endogenous and  
37 exogenous factors in the policy process.

38  
39  
40 Seppey *et al.* employs a sustainability framework to analyse PBF in Burkina Faso. The  
41 framework is formed by five components: organizational memory, codes and values, rules and  
42 procedure, adaptation and stakeholders' relationships. Both deductive and inductive thematic  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 analyses are developed from interviews and observations data. Their analysis shows that there  
4 is a need to know more about what/how contextual issues can either enable or hinder  
5 sustainability in PBF. The authors call attention to the relations that exist between  
6 implementation issues and sustainability, something which is rarely studied. They also analyse  
7 “global issues” that can threaten sustainability, such as the effect of power imbalances on  
8 ownership. In sum, the authors use the Burkina Faso case to highlight the factors that can hinder  
9 sustainability and which should be taken into account in the study of PBF in LMIC.

10  
11  
12  
13  
14  
15  
16 Saddy *et al.* develop a policy analysis of a P4P programme in primary care in the city of  
17 Goiania, Brazil, employing a qualitative approach. Interviews are thematically and  
18 hierarchically analysed according to themes coming from both implementation theory and  
19 political studies on performance, such as; policy knowledge, policy adherence, forms of  
20 accountability, alternative logics, organizational capacity and policy feedback. Their analysis  
21 shows that successful implementation requires adaptations and increases in organizational  
22 capacity, knowledge, participation and policy feedback at the frontline.

23  
24  
25  
26  
27  
28 Paul *et al.* reports the findings of a scoping review to locate theories used to justify the  
29 adoption of PBF the health sector in LMICs. The authors selected sixty-four studies that had  
30 cited a programme theory underpinning PBF in LMICS. They found that economic theoretical  
31 bases were predominant with two thirds of studies citing economic principal-agent theory.  
32 However, few studies explained how theory could justify PBF and few alluded to more than  
33 one theoretical basis.

34  
35  
36  
37  
38  
39 The final paper by Hayes *et al.* examines if payment methods – including payment for  
40 performance - for integrated care adopted by European countries have affected health and  
41 primary care use by people with multimorbidity. The authors use survey data from twenty  
42 European countries from 2011-2015 to analyse the associations between types of P4P and  
43 outcomes. Findings reveal that payment methods exert little effect on reported health and  
44 number of medical visits, suggesting that current P4P policies may not effectively incentivise  
45 care for people with multimorbidity.

## 54 **Future Challenges**

55  
56  
57  
58  
59  
60 There is a need to advance comparisons in the health sector between HICs and LMICs  
in a more systematised way, as well as to start developing cross-sector comparisons. Moreover,  
given the Covid-19 crisis around the Globe, researchers and policymakers need to better

1  
2  
3 understand challenges faced by P4P/PBF schemes during the pandemic in diverse countries of  
4 the globe, and if and how P4P/PBF will continue to play a role in funding health systems after  
5 the pandemic. To what extent could payment for performance schemes be considered an  
6 essential tool to reconstruct or re-initiate health programmes and types of health care in diverse  
7 health systems around the world? If they are, policy challenges and innovative analyses  
8 presented in this issue offer lessons on both policy development and programme evaluation. It  
9 is clear that more attention should be paid to policy design, considering power relations in  
10 distinct government structures, adaptations in policymaking, prioritizing sustainability issues  
11 and frontline staff perspectives during the design and implementation processes and that  
12 analysts should draw more on social (action-based) theories.  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

## 23 References

- 24 Anselmi, L., Borghi, J., Brown, G., Fichera, E., Hanson, K., Kadungure, A., Kovacs, R.,  
25 Kristensen, S. R., Singh, N. S. and Sutton, M. (2020), “Pay for Performance: A  
26 Reflection on How a Global Perspective Could Enhance Policy and Research”,  
27 *International Journal of Health Policy and Management*. Vol 9, Issue 9, Pages 365-369,  
28 Available at: [10.34172/IJHPM.2020.23](https://doi.org/10.34172/IJHPM.2020.23)  
29  
30 Bertone, M.P., Jacobs, E., Toonen, J., Akwataghibe, N. and Witter, S. (2018) “Performance-  
31 based financing in three humanitarian settings: principles and pragmatism”, *Conflict*  
32 *and Health*, 12, 28 (2018). <https://doi.org/10.1186/s13031-018-0166-9>  
33  
34 Bhatnagar, A. and George, A. (2016), “Motivating health workers up to a limit: partial effects  
35 of performance-based financing on working environments in Nigeria”. *Health Policy*  
36 *and Planning*, Vol. 31, Issue, pp. 868–877.  
37  
38 Eijkenaar, F., Emmert, M., Scheppach, M. and Schöffski, O. (2013), “Effects of pay-for-  
39 performance in health care: a systematic review of systematic reviews”, *Health Policy*,  
40 Vol. 110, Issue 2-3, pp. 115-130, available at:  
41 <https://doi.org/10.1016/j.healthpol.2013.01.008>  
42  
43 Forbes, L.J., Marchand, C., Doran, T. and Peckham, S. (2017), “The role of the Quality and  
44 Outcomes Framework in the care of long-term conditions: a systematic review”, *The*  
45 *British Journal of General Practice*, Vol. 67, No. 664, pp. e775–e784, available at:  
46 <https://doi.org/10.3399/bjgp17X693077>  
47  
48 GBD 2016 Healthcare Access and Quality Collaborators (2018), “Measuring performance on  
49 the Healthcare Access and Quality Index for 195 countries and territories and selected  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

- 1  
2  
3 subnational locations: a systematic analysis from the Global Burden of Disease Study”,  
4 *The Lancet*, Vol 391 June 2, 2018, available at: <http://dx.doi.org/10.1016/S0140->  
5 [6736\(18\)30994-2](http://dx.doi.org/10.1016/S0140-6736(18)30994-2)  
6  
7  
8  
9 Lee, J.Y., Lee, S., Jo, M. (2012), “Lessons From Healthcare Providers' Attitudes Toward Pay-  
10 for-performance: What Should Purchasers Consider in Designing and Implementing a  
11 Successful Program?”, *Journal of Preventive Medicine and Public Health*, Vol. 45, No.  
12 3, pp. 137-147.  
13  
14  
15 Okma, K G and Marmor, T. R. (2013), “Comparative studies and healthcare policy: learning  
16 and mislearning across borders”, *Clinical Medicine* 2013, Vol 13, No 5: 487–91.  
17  
18  
19 Roland, M. and Guthrie, B. (2016), “Quality and Outcomes Framework: what have we  
20 learnt?”, *BMJ*, 354, pp. 1-4, available at: <https://doi.org/10.1136/bmj.i4060>  
21  
22  
23 Saddi, F.C. and Peckham, S. (2018), “PMAQ seen from a global health and public policy  
24 perspective - What does it mean for research and policy?”, *Journal of Ambulatory*  
25 *Care Management*, Vol. 41, Issue 1, pp. 25-33, available at: doi:  
26 10.1097/JAC.0000000000000220  
27  
28  
29 Saddi, F C; Peckham, S, Mundim, P. (2018), “Presentation: Pay for Performance,  
30 Formulation, Implementation and Policy Success”. *Sociedade e Cultura*, v. 21, p. 4a-  
31 11, available at: <https://doi.org/10.5216/sec.v21i2.56304>  
32  
33  
34 Singh, N.S., Kovacs, R.J., Cassidy, R., Kristensen, S.R., Borghi, J., Brown, G.W. (2020), “A  
35 realist review to assess for whom, under what conditions and how pay for  
36 performance programmes work in low- and middle-income countries”, *Social Science*  
37 *& Medicine*, Dec 18; 270:113624, doi: 10.1016/j.socscimed.2020.113624  
38  
39  
40  
41 Ssengooba, F., Mcpake, B. and Palmer, N. (2012), “Why performance-based contracting failed  
42 in Uganda – An “open-box” evaluation of a complex health system intervention”,  
43 *Social Science & Medicine*, Vol. 75, Issue 2, pp. 377-383.  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60