



Results-Based Bonus in Tanzania

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Outline

- MDG 4 and 5 in Tanzania
- NTPI, national context, P4P
- Design: proposed & actual
- Key Risks
- Policy Process
- Research Questions

MDG 4 & 5 Status

- **Persistently high maternal mortality ratio**
 - From 529 (1986-1995) to 578 (1995-2004)
 - No significant change in skilled birth attendance
 - MDG5 out of reach
- **Major gains in child mortality since late 1990s**
 - Under-five mortality (5q0) down 38%
 - Neonatal down 28%
 - Neonatal mortality now accounts for 50% of all infant deaths
 - On trajectory to meet MDG4.

International Policy Context to NTPI

- Norway et al instigate “Global Business Plan” to accelerate progress on MDG4 & 5
- Presented at 2007 World Health Assembly; led from Prime Minister’s Office
- Focal countries (incl. Tanzania) selected
- Norway-Tanzania Partnership Initiative
 - Focus on achieving RESULTS (MDG4,5)
 - “Paris Declaration” principles

National Policy Context

- Highly decentralised system (districts)
- Roadmap for maternal, newborn & child health
- Chronic HR shortages & mal-distribution
- Low pay, low morale
- Absence of results-orientation at all levels
- Basket funds for districts
- Tightly coordinated Donor Group (esp. Basket funders)
- No Norway presence in Health Sector
- NTPI initiation: PM Norway – President Tanzania
- Rapid implementation: \$36m/5 years, 2008ff

Payment for Performance

- Direct link between donor fund and results achieved
- *But* can be disbursed through “pooled fund” mechanism
- Concept introduced by PMO-Norway as centre-piece of the NTPI

The perfect blend of Paris Principles with driving forward the MDG Business Plan??

Design principles

- Link bonus to *measurable* performance on maternal & child health
- Incentivise those who can effect change
- Reward *extra* effort
- Performance target must be achievable
- Distribute reward fairly
- “Do no harm” (avoid perverse incentives)
- Reinforce local accountability
- Match design to funds available
- Feasibility: simple, doable

Design Parameters - recommended

- Supply AND demand-side incentives
- Reward health facility staff & managers x2 p.a.
- 4 key performance indicators (reduced from 10), measured quarterly
- Facility-specific targets (require improvement)
- National coordination unit; training; performance audit (expensive!)
- Strengthen HMIS (performance measurement) & roll out in phases
- Build in monitoring & evaluation component
- Align with GOT financial year (July 2008)

Design Parameters – Actual (1)

- Demand-side incentive rejected
- Measure & reward 4 indicators (primary facilities)
 - DPT-HB3 coverage
 - OPV zero (proxy for early HF contact)
 - IPTp coverage
 - % births in health facilities
- Plus: partographs properly used (hospitals)
- Plus: 100% HMIS reporting compliance (district)
- All indicators have equal “weight”
- Include CHMT, Regions

Design – Actual (2)

- Fixed lump sum reward per facility type, shared among staff (by salary scale)
- Hospitals: HMT decide how to distribute to staff
- Reward payable x2 per year
- Same performance target for all facilities
- No pilot/phasing: immediate implementation
- Implementation by GOT staff (Central, Regional, District): no project unit
- District implementation March 2009ff(?)

Key Risks

- Do districts understand the proposal?
- Can actual performance be measured? (HMIS)
- Will reporting be biased/inflated?
- Will bonuses just be paid out anyway?
- Is the bonus enough? (US\$ 50 each p.a.)
- Will other staff be de-motivated?
- Effect on performance?
 - High performers (already meeting targets)
 - Low performers (little prospect of meeting targets)
 - Non-rewarded indicators
- How will we know the impact? (M&E?)
- What (really) happens to unspent bonus funds?
- Sustainability: worse than doing nothing?

Policy Dynamic: who wants what?

A personal viewpoint

- Divergent views among stakeholders
 - Govt of Norway
 - MOHSW
 - Basket Partners
 - GOT (MOF, Local Govt, Public Service Mgt.)
- Solution identified before the problem
- Politicised policy process + time pressure

Government of Norway

- Under pressure from PMO
- Pay for Performance non-negotiable
- Must spend the money (even prior to P4P preparation & implementation)
- Must do it through the basket fund (notional earmarking)
- Want to see (and measure) impact

Basket Partners

- Suspicious of new agenda from “outsider”
- Irritated by consultation process
- Resent political pressure on BP consensus
- Agree that results-orientation needed, but...
- Not (totally) convinced that P4P will work
- Want “veto” on use of “their” money
But won't get it

MOHSW

- Must agree to get the money!
- Under pressure from President's Office
- Tired of donor in-fighting; resent BP "veto" attempts
- "Perfect is the enemy of the Good"
 - Start quickly, improve as we go
 - Fix the HMIS as we go
- Avoid PIU implant: do the training & guidelines ourselves
- M&E lower priority than rapid implementation
- Ambivalent about P4P effectiveness
- Health workers need extra money anyway

GOT (outside MOHSW)

- Public Service Management
 - Different approach than Performance Management Model
 - Avoid repeat of salary supplement errors
- Local Government
 - Rewards for health department – not others
 - More concerned with staff *distribution*
 - Role in design, implementation?
- Largely excluded from policy formulation & implementation design – but will go along with it anyway

Research Questions

- **Interesting case study of policy process**
 - From Global commitment to country implementation
 - Highly divergent views, wants
 - Imperfect implementation process
 - Significant risk of adverse consequences
- **What actual impact on performance?**
 - Some indicators at expense of others?
 - Some facilities/staff at expense of others?
 - Any impact on “results-based management”
 - Any impact on staff distribution?
 - What matters: P4P or just extra money?
- **What impact on governance?**
 - Accountability to health facility committees
 - Accountability to District Council

*An interesting experiment from both
technical and policy-analysis points of view*

THANK YOU

Any questions?

