Knowledge Brief

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VERIFICATION OF PERFORMANCE IN RESULTS BASED FINANCING: THE CASE OF PANAMA'S PSPV PROGRAM

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KEY MESSAGES

- In 2013-2014, service coverage targets were generally achieved at a rate exceeding 90 percent, showing progress towards increased health equity in Panama.
- Financial autonomy appears to be a determinant of performance, with non-profit providers meeting almost 78 percent of their performance targets while government institutions only achieve 16.1 percent of these targets. Qualitative evidence attributes this discrepancy to the additional resources and flexibility enjoyed by non-profit providers.
- The complex, labor-intensive and disjointed nature of verification in Panama creates inefficiencies and leads to high transaction costs. It also shifts the focus from the achievement of results towards the completion of processes, in turn reducing the effectiveness of Results-Based Financing.

Context

On average, Panama performs well on key health indicators with an infant mortality rate of 16 deaths per 1,000 live births, an under-five mortality rate of 19 deaths per 1,000 live births (World Bank, 2012), and a maternal mortality ratio of 85 deaths per 100,000 live births (World Bank, 2013). These averages, however, mask disparities in health outcomes between urban and rural and indigenous areas. For example, in 2010, in the rural province of Bocas del Toro and in the indigenous area of Guna Yala, the under-five mortality rate was respectively 2.6 and 0.6 times higher than the national average (PAHO/MINSA, 2012).

Over the past decade, the Government of Panama has used different RBF approaches to improve the coverage, quality and equity of health services, including the Health Coverage Expansion Strategy (EEC). The EEC incentivizes health service providers for the delivery of two related health service packages:

1. The Integrated Package of Health Care Services, targeting indigenous communities; and
2. The Health Protection for Vulnerable Populations Program (PSPV, for its Spanish acronym), targeting the non-indigenous rural poor.

Introduction

This HNP Knowledge Brief focuses on the key findings of the World Bank case study entitled "Verification of Performance in Results-Based Financing (RBF): The Case of Panama's Health Protection for Vulnerable Populations Program (PSPV)" (2014).

The case study covers 2011 and 2012 and concentrates its analysis on data stemming from two sources: quarterly

reports produced during the verification process, and interviews conducted with stakeholders involved in the implementation of the PSPV program.

RBF PAYMENTS

Under the PSPV, a portfolio of 15 incentivized indicators are delivered by (i) contracted non-profit providers (OEs) and (ii) government health professionals (GIs) working within basic health units (UBAs). Incentives are paid in three ways:

1. **Every two months** based on the percentage of targets achieved for five coverage indicators (Table 1) during rural health visits (for example, mobile clinics). This payment can represent a maximum of 65 percent of the capitation rate.

Table 1: Coverage Indicators

Indicator	Definition
Communities visited	UBAs should visit at least 85 percent of the communities in a population group during each health round.
Population groups protected	UBAs should "protect" a minimum of 80 percent of the resident beneficiary population in the communities belonging to the population group that they are responsible for during each round. A population group is considered to be protected when at least one of its inhabitants has received the package of PSPV preventive and curative services via the UBA in its community or corresponding community center.
Population groups receiving appropriate preventive and curative services	UBAs should treat a minimum of 50 percent of the protected population through the different promotion, preventive and curative services established in the portfolio of incentivized services (CPP).
Children (under 24 months) receiving appropriate preventive services	UBAs should treat a minimum of 80 percent of the registered population younger than 24 months old, through growth and development check-ups outlined in the CPP.
Days of services	UBAs should provide the CPP with 38 days of direct medical services to the population, per health round.

2. **Every four months** based on the achievement of ten service-provision indicators (Table 2). Each indicator is weighted equally and this payment can represent a maximum of 30 percent of the capitation rate.
3. **Every year** based on the results of a patient-satisfaction survey. This payment represents five percent of the capitation rate.

It is important to note that although there are no specific indicators linked to service quality, compliance with protocols is an integral part of contracts signed with UBAs and as such, quality is regularly verified.

Table 2: Performance Indicators

No.	Indicator
1	Percentage of pregnant women with at least three antenatal check-ups (one per trimester) by the end of the third trimester
2	Percentage of pregnant women registered out of estimated total
3	Percentage of pregnant women with second dose or booster of TT or TD
4	Percentage of births attended by trained staff
5	Percentage of women 20 years or older who have had pap smears
6	Percentage of children under one year who have had four or more growth-and-development check-ups
7	Percentage of children under one year with a complete vaccination record
8	Percentage of children aged four with at least two growth-and-development check–ups
9	Percentage of children aged one to four years old with a complete vaccination record
10	Percentage of symptomatic respiratory diseases recorded out of estimated total

VERIFICATION MECHANISMS

To ensure that targets are achieved, the PSPV includes two verification mechanisms. The first verification is internal. Carried out quarterly by the Ministry of Health (MoH), this internal process requires mobile clinics to submit enrollment reports for the preparation of regional consolidated reports. These consolidated reports are then verified by the MoH at central level (DPSS) for accuracy and completeness by comparing reports to information contained in the National Database of Civil Registration and Identity Cards. These figures provide the denominator for three coverage indicators, and for most service provision indicators.

The second verification mechanism concerns **third party verification**, whereby the government contracts a private firm. It includes three components:

a) A quarterly **verification of beneficiary-related data.** As a first step, 100 percent of the records are checked against the beneficiary population register and against the Identification Verification System to ensure that information entered for each beneficiary is accurate and complete. A second level counter-verification is carried out on a 10 percent sample of beneficiaries, ensuring concordance of beneficiary records and beneficiary enrollment forms.

b) The **verification of the quantity of services is delivered** by comparing the information contained in the EEC database against the Identification Verification System. This verification seeks to ensure that services reported in beneficiary records are actually delivered with each individual beneficiary having at least received one incentivized service. In parallel, the verification of quantity also includes a quarterly verification of the number of community visits carried out and service days reported. This is done by comparing UBA reports with health facility records and ensuring actual service delivery with a 10 percent sample (i.e. the same sample as the 10 percent checked for beneficiary enrollment). Compliance with treatment protocols is also verified.

c) Social audits are carried out three times a year in all regions and in all of the UBAs to assess patient satisfaction.

Study Findings

Although the study highlights the need to further extend appropriate curative and preventive services to population groups, it shows progress in service coverage (Table 3): UBAs are reaching communities and delivering appropriate health services to children under 24 months. In addition, there is a clear improvement in the attendance of healthcare providers, with a 100 percent score in "days of services."

Table 3. UBAs RBF Service Coverage Indicators (2013-2014 Period)

Indicator	Result
Communities visited	99%
Population groups protected	99%
Population groups receiving appropriate preventive and curative services	62%
Children (under 24 months) receiving appropriate preventive services	97%
Days of services	100%

Source: MOH-UGSAF Progress Report for the Period July 1, 2014 to December 31, 2014

Nevertheless, service provision indicators highlight performance disparities between non-profit providers (OEs) and government health professionals (GIs), with (a) an average target achievement rate of 67 to 94 percent among OEs for the first nine indicators; and (b) an average achievement rate of 11 to 23 percent among GIs.

The case study suggests that the high performance of non-profit providers is attributable to greater access to financial resources, enabling OEs to further invest in rural health visits and providing them with added flexibility.

The case study examines the difference between DPSS approved records and third party approved records (Table 4). It indicates that differences have decreased between 2011 and 2012, rarely exceeding 1 percent in 2012. This suggests that the internal verification mechanism was performing well in 2012.

Table 4: Indicators Accepted by the MOH and Rejected by the

Region	2011 (%)			2012 (%)		
	Q 1	Q 2	Q 3	Q 1	Q 2	Q 3
Bocas del Toro	0.80	-1.00	0.40	0.20	-0.20	-
Chiriquí	1.86	5.00	5.29	0.29	0.43	1.00
Coclé	2.33	0,00	5.50	1.00	1.33	1.33
Colón	4.00	4.25	6.75	-0.25	0.75	0.75
Darien	1.14	2.71	2.14	-0.29	0.14	-
Herrera	-	2.00	4.00	-	-	1.50
Kuna Yala	1.00	2.00	2.00	0.67	-	1.67
Los Santos	-	1.00	2.00	-	1.00	1.00
Ngobe Buglé	3.88	6.44	6.84	0.76	0.92	1.44
Panamá Este	0.67	2.33	2.33	-0.33	0.67	-
Panamá Oeste	1.50	6.00	6.00	0.50	1.50	1.17
Veraguas	6.22	2.33	2.33	0.22	0.56	1.00
Total general	2.81	4.22	4.65	0.39	0.70	1.01

External Verifier, per Region (2011-2012)

Lessons Learned

In light of these mixed results, the case study draws several lessons and recommendations, highlighting further opportunities to improve RBF verification and performance.

The RBF verification mechanisms of the PSPV employs multiple systems—the database of the overall health strategy, the MoH's health information system and the Identification Verification System—which function in a fragmented manner. At times, this fragmentation requires lengthy manual reviews, which increase workloads and heighten transaction costs. The case study draws the following lessons:

- The use of information technology systems should be better coordinated. The lack of coordination inherent to health rounds and reporting increases the complexity and the inefficiency of both monitoring and verification processes. This can delay payments and, in turn, undermine the RBF incentivization system.
- The third party verifier and the MoH need to be better aligned. Detailed verification of protocol compliance is critical to fully grasp the extent to which the PSPV's provides added value.
- The verification of protocol compliance has value beyond simply affecting payment. Further streamlining of payment and verification processes is needed. Currently, these processes involve many steps as well as many actors, amounting to the preparation of approximately 72 reports each quarter.
- A simplification of payment and verification processes is needed to ensure a focus on the results achieved and not the processes.

References

Gesaworld. 2013. *Propuesta Metodológica versión ajustada*. Panama

_____. 2012. *Guía de Auditoría Técnica*. Panama

Gesaworld, Informes bimensuales y cuatrimestrales (varias ediciones)

_____. 2012. *Primer Informe de Auditoría Técnica Externa para la Certificación Del Padrón de Población Beneficiaria de la Estrategia de Extensión de Cobertura Periodo 2011 – 2012 – Versión Ajustada.* Panama

_____. 2012. *Guía de Auditoría Administrativa Financiera*.

OLACEFS. 2008. *Auditoría de los Programas Sociales*. El Salvador

Panama Ministry of Health and Pan-American Health Organization.. (2009-2010) *Indicadores basicos de salud, panama 2009-2010.*

PAHO (Pan American Health Organization). 2012. *Panama Country Chapter*. Washington DC: Health in the Americas.

Perazzo, A. 2012. *Proyectos:"Mejora de la Equidad y Desempeño en Salud" y "Protección Social – Apoyo a las Redes de Oportunidades ».* World Bank

UNDP. 2013. *Human Development Report.* Available at: http://hdr.undp.org

UGSAF. 2012. *Caja de Herramientas para el agente de verificación*. Panama

_____. 2010. *Provisión del PAISS+N y PSPV a través de giras institucionales - Reglamento operativo*. Panama

_____. 2010. *Provisión del PAISS+N y PSPV a través de Organiaciones Extrainstitucionales - Reglamento operativo*. Panama

UGSAF. Evaluation Forms

World Bank. 2013. *World Bank Open Data*. Available at: http://data.worldbank.org/country/panama

_____. 2008. *Project Appraisal Document (PAD), Health Equity and Performance Improvement Project*. Washington, DC

_____. 2007. *Social Protection: Opportunities Network*. Washington, DC

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