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

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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 practicians 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.

In a complementary way, new analytical approaches and perspectives may be needed to address the policy challenges in relation to P4P/PBF. Therefore, we do not know yet how policy challenges related to payment for performance vary in different contexts in the world, and from the perspective of comparative and cross-country learning, and more in-depth policy or qualitative country analyses in most countries.

The aim of this issue

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

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

This issue also provides examples of alternative methods and frameworks to better understand the contexts and challenges related to P4Pinternationally: policy, document, qualitative theme and framework analyses, applying interviews and literature review, and diverse concepts from management, public Policy and Health Policy/Care.

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

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

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

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

Mathias Brunn brings the complexity of power relations to the analysis of P4P as a policy instrument. He employs the theoretical frameworks of public policy instruments and performance of actors to explore differences in P4P in ambulatory care between France and Germany. His comparative analysis is supported by findings from a literature review and interviews with stakeholders. The analysis demonstrates the way key system characteristics and actors shape the development and implementation of P4P policy instruments. In France, the centralised institutional architecture, together with statutory health insurance director personal characteristics and the policy implementation capacity of Social Health Insurers (SHI), shaped the selection of P4P instruments. In Germany, on the other hand, the federal system did not enable the formation of a coalition in favour ofP4P, given the veto players in the federalism and conflicting roles regarding data generation and transmission.

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

Seppey *et al.* employs a sustainability framework to analyse PBF in Burkina Faso. The framework is formed by five components: organizational memory, codes and values, rules and procedure, adaptation and stakeholders' relationships. Both deductive and inductive thematic

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

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

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

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

Future Challenges

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

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

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