

# HOW ARE SCHOOLS LIKE CLINICS?

## *SP&L, HNP & EDU JOINING FORCES ON RBF*

The three sectors of Human Development came together in November 2016 to exchange experiences on Results Based Financing; identify the key lessons learned in each sector; and discuss to what extent those lessons apply cross-sectorally.

There are many similarities and portable lessons regarding linking service provision to demand; guaranteeing the quality of services; and process related issues such as identifying indicators and verification. At the same time, delivering and obtaining services is different in schools and clinics, particularly in that the results chain and protocols are often (although certainly not always) clearer in health than in education where additional internal and external factors influence how much and what children learn in schools.

This note includes the primary conclusions of expert round tables that focused on the following key areas:

### **1. System-wide lens**

*\*Samer Al-Samarrai, Sachiko Kataoka & Peter Holland (EDU), Ronald Mutasa & Mickey Chopra (HNP)*

### **2. Indicators**

*\*Michael Crawford (EDU), Aneesa Arur & Maud Juquois (HNP)*

### **3. Incentives**

*\*David Evans, Melissa Adelman, Cristian Aedo & Waly Wane (EDU), Alaka Holla & Marion Cros (HNP)*

### **4. Demand-side incentives**

*\*Harry Patrinos (EDU), Damien de Walque & Rifat Hasan (HNP)*

### **5. Sustainability**

*\*Andrea Guedes (EDU), Emanuela Di Gropello (SP&L), Magnus Lindelow & Andrew Sunil Rajkumar (HNP)*

### **6. Verification**

*\*Luis Benveniste (EDU), Petra Vergeer (HNP)*

*\*List of expert discussants providing the key information for this note.*

Additional Resources and contact information are provided in the end of the note.

## KEY CONCLUSIONS

### SYSTEM-WIDE LENS

- **What level to incentivize?** Front line actors have a limited capacity to address underlying systemic issues. In education, incentivizing individual teachers may only lead to short-term impact and one-time gains. Incentivizing schools can have a bigger and longer-term impact, but in order to impact systemic change, it may be more effective to incentivize the meso (e.g. district) level.
- **What to incentivize?** Relatedly, consideration must be paid to what to incentivize: performance, outcomes, or processes. Shifting the incentivization mechanism to focus on processes can help focus attention on key constraints and address systemic and long term barriers. Intervening simultaneously at different levels of the system can have a complementary effect.
- **Declining impact of incentives:** The strength of incentives can decline over time: It is relatively easy to incentivize service providers when there is lots of room for outcomes to improve, but it gets more difficult to incentivize when outcomes have reached a higher level. Also, increased verification and supervision can cause “burnout” and have a demotivating effect in the long run. (See the ‘verification section’ for guidance on how to prevent this by changing the verification strategy based on learning curve.)
- **Other pitfalls of incentivizing/sanctions:**
  - How (to whom and how much) incentives are paid can have a counter effect: it is important to consider perceptions of each other’s contribution and the risk of rivalry when giving monetary incentives.
  - Sanctions can also have unintended effects: in Israel, financial penalties used in kindergartens to compel parents to pick up their children on time resulted in parents leaving their children for longer as the payment reduced parental guilt linked to imposing upon teachers.

### INDICATORS

- **To determine the aspired results,** a strong results chain leading there is needed.
- **Agreeing on how services are to be delivered** is often half of the battle in coming up with the appropriate indicators.
- **Selection criteria** for health sector indicators:
  - Easy to measure accurately and independently.
  - Has a causal link to the ultimate outcomes of interest.
  - Uses indicators the countries are already reporting on regularly (e.g. through national health information system) to minimize administrative burden
  - Focuses on areas that require more attention, and on limiting constraints.

- Comprehensive package of preventive and curative services and having broader focus than just maternal and child health (covering areas such as malaria, HIV etc. as well)
- **Finding a balance:** Signaling is an important value of RBF. Therefore, the indicators should not be too wide ranging especially when there is a specific area with limited improvement that needs special attention. At the same time, the range of indicators needs to be comprehensive enough to avoid unbalanced focus on a single dimension. The challenge is to find the right balance.
- **Constraints and shifting focus:** The binding constraints to achieving outcomes shift over time. Skills and knowledge have been the primary constraint in health RBF projects. To address this, some health RBF projects revise indicators over time to include those that relate to health worker skills. However, it is important to consider how skills are built, measurement alone won't get the job done.
- **Measuring quality:** Measuring quality is difficult but its links to outcomes are strong. Temptation by staff to fudge the data that measure quality needs to be taken into consideration and mitigated for when introducing quality indicators in health. This is also applicable to education, such as when considering rewarding teachers for student performance as captured by test scores, which could in turn be manipulated.
- **Impact of Indicators:** For the indicators to have impact, constant verification and regular measurement are required. Also, meaning of each indicator decreases when a number of indicators are lumped into one rating.
- **Non-incentivized indicators:** There are examples of non-incentivized indicators improving, but it is a balancing act to find the right set of indicators.
- **Individual vs. group incentives:** It seems that the incentives in education are individual, more often than in health, where the incentives are distributed to facilities who further distribute them to the individual workers to incentivize team work. The provision on incentives is complicated by not granting the health facilities full autonomy to use the money.
- **Education sector is moving towards data informed instruction**, identifying gaps at the student level, setting goals, and measuring progress in those areas. This is promising, and perhaps indicators that focus on teachers using such processes are more appropriate for RBF than providing an incentive for teachers to try to game test scores (e.g. No Child Left Behind in the United States).

## INCENTIVES

- **How to:** Incentives are implemented on a case by case basis, answering the following questions:
  - What is the underlying problem (lack of motivation, attitudes, etc.)?
  - Will the incentive be provided for an individual, or a group?
  - Should the incentive be financial or non-monetary?
  - What is the budget?

- **Understanding the country context**, the structural and cultural conditions is essential in determining the type of incentives that will lead to greatest impact on outcomes.
- More and better **evidence** of which incentives work in which environments is **needed**.
- **Surveys among the target group** (e.g. teachers) can help to understand what they would like to see and what incentives they would most prefer.
- **Determining the incentives** needs to be **a process**, and it is critical to involve the counterpart in each step; they need to be presented and able to play with the numbers and understand the various scenarios before making the ultimate decisions.
- **Emerging evidence:**
  - Teacher incentives have been successful when it's clear what the teachers need to do differently to get it (e.g. show up regularly, unlike before), but unsuccessful in less clear circumstances (e.g. in the U.S. where the required changes are less obvious)
  - Frequency of incentives does seem to matter.
  - Evidence on whether group or individual incentives work best is mixed. See: <http://www.rbfhealth.org/blog/what-do-we-know-about-linkage-between-rbf-and-health-worker-performance-and-motivation>
- **Do insurance purchases make incentivizing easier in the health sector?** In health sector, there is typically a payer (insurance) that purchases services from clinics and incentives are linked to those purchases. In the education sector, most performance based incentives (PBI) are provided based on favorable outcomes and verifying them takes time. Voucher systems come closest to being similar with the insurance system, using student attendance rates as the measure.
- **Piloting with different levels of incentives** can provide a range of what might work – or not - to consider alternatives before implementing a program. In health, programs typically pilot in 1 district for 1 year, sometimes with different levels of incentives and other variables. It should be noted that very short testing may see a very sharp initial rise which may conflict with what is sustainable.
- **Respect/being valued is an important incentive**, but it's often best indicated through financial incentives. In high-performing education systems, there are no teacher incentives, but there is a highly professional, respected teacher force. In health, an HRH study revealed that staff are not focused on the monetary value of the incentive as such, but consider a high portion of the RBF to indicate being valued and respected as professionals.

## DEMAND SIDE INCENTIVES

- **Understanding the country context**, the structural and cultural conditions, is essential in determining the type of demand side incentives required. A thorough analysis of the barriers is critical to determine the theory of change which should drive the decisions.

- **National (vs. donor funded) incentive programs** improve sustainability of outcomes. Even in low income countries, incentives (whether donor or nationally funded) can help provide a way to use limited resources more effectively, and if results materialize, this can motivate longer term reforms and higher government commitment.
- **Engaging local communities** can play a critical role in achieving better results. In some countries, results-based mechanisms can be employed at community level to foster community mobilization and ownership of priorities.
- **Supply side improvements – and often incentives – typically need to accompany demand side incentives.** If the system doesn't have sufficient capacity/resources to secure a continuous provision of incentives, it will negatively affect the program results.
- **Higher incentives can help redistribute services to remote or otherwise underserved areas/target groups**, but it is not easy to find the right level of incentives to encourage health care workers or teachers to relocate. When higher incentives are provided in e.g. remote locations, it's very important to monitor and verify that the services are provided as agreed.
- **Providing incentives to individuals, households, or facilities** can have a very different impact.
- **Surveys:** To better understand the effect of incentives, *client-satisfaction* surveys can be carried out. This helps to understand how the communities evaluate and perceive the services they receive.
- **Quantifying the service delivery** and determining the size of an individual incentive may be easier in schools, where a teacher is usually responsible for delivering a service whereas in health facilities, many services are delivered by a group of health workers making it more complicated to determine the distribution of the incentive. However, there are examples of how the incentives can be shared among a team of staff based on individual performance and responsibilities.

## VERIFICATION

- **Verification is a learning process** – data collection and use can be improved, particularly where it is done in partnership with the government. Also, it is important to plan for the verification and learn from what has worked in other sectors.
- **Who should do verification?** Verification can be done by a variety of actors, and it's most reliable when done by third parties. 3<sup>rd</sup> party can be a local organization, NGO or for example the Internal Auditor or CAG, not only an international firm.
- **How to verify?**
  - Using existing systems where possible, or improving them.
  - Seeking involvement from outside actors (community organizations, universities, think tanks, survey companies, etc.) – especially organizations with an existing verification role.

- Budgeting in an “acceptable” level of error, which should reduce over time
- Functioning like the IRS; identifying highest error rates and outliers to spot check.
- Changing verification strategy based on learning curve: as data collection improves and error rate goes down, could reduce sample size or frequency.
- Technology (tablets/mobile tech/e-systems) can be used to improve data collection efforts, and make it easier to verify the data.
- **Cost of verification:** Governments are responsible for paying for the verification and need to be clear on it. Cost reductions can be achieved through economies of scale. Different sectors should collaborate when planning for verification and try to combine efforts. Each sector benefits from verification from all the three sectors.
- **Perceptions:** The perception of verification is improving – it is not a policing effort, but can yield valuable lessons for policy-making. Also, verification is not just about the accuracy of the results but to signal that business is not the same as usual
- **Limitations:** Limitations of the LQAS model – binary, does not account for those that almost reach the goal.
- **Ownership:** When it comes to leveraging impact, government ownership is essential. Some government entities are often more reluctant to engage in processes such as distribution of demand-side incentives than others.
- **Interdisciplinary approach:** Combining demand side and supply side incentives requires an interdisciplinary approach between health, education and social protection. This is not always easy in country where the three sectors are managed by three separate ministries, but can be made easier if the Bank teams work together.

## SUSTAINABILITY

- **Building in sustainability into the design phase:**
  - Ensuring that the government contributes/commits part of its budget to the program from the beginning (co-financing/disbursement condition in the legal agreement)
  - Deciding on the level of incentives that is both effective and affordable.
  - Linking the Program to country priorities.
  - Building on the existing systems.
- **Sustainability in scaling-up:** Financial sustainability also needs to be factored in when considering scaling up
- **Institutionalization:** Institutionalization, especially of the verification function is important for the sustainability. (See the ‘verification section’ for more points on the importance of using existing systems that already do verification.)
- **Transfer mechanisms:** In the education sector, the existence of transfer mechanism within the government’s budget can facilitate the establishment of

programs where budget is decentralized from national to subnational/school level.

- **Politics:** Sustainability also depends on the political reality, in what is considered an appropriate level of financing, or in the degree to which incentives should be high or low powered.
- **Pitfalls:** Performance pay incentives are quickly incorporated into salaries, needing to be adjusted to have continuous effect.

## ADDITIONAL RESOURCES

- RBF Education (REACH TF): <http://www.worldbank.org/en/programs/reach>
- RBF Health: <https://www.rbfhealth.org/#> (RBF Health)
- “Completed Impact Evaluations and Emerging Lessons from the Health Results Innovation Trust Fund Learning Portfolio” by Eeshani Kandpal: [http://www.rbfhealth.org/sites/rbf/files/IE%20and%20emerging%20lessons\\_Eeshani%20Kandpal.pdf](http://www.rbfhealth.org/sites/rbf/files/IE%20and%20emerging%20lessons_Eeshani%20Kandpal.pdf)
- “The Golden 10 Operational Lessons from PBF in Health: Learning from Implementation” HRITF presentation: [https://docs.google.com/presentation/d/1HNvMTR\\_Rf\\_tVXBFI5n6Y3Biw81IO3xJSD5PeU-YdkLE/edit?usp=sharing](https://docs.google.com/presentation/d/1HNvMTR_Rf_tVXBFI5n6Y3Biw81IO3xJSD5PeU-YdkLE/edit?usp=sharing)
- Vouchers/scholarships in education: “Unlocking the potential of the private sector to improve education: Education for all: the private sector can contribute by Harry Anthony Partinos and Oli Lusk-Stover in [http://www.proparco.fr/jahia/webdav/site/proparco/shared/PORTAILS/Secteur\\_privé\\_developpement/PDF/SPD20/Proparco\\_PSD\\_20\\_UK.pdf](http://www.proparco.fr/jahia/webdav/site/proparco/shared/PORTAILS/Secteur_privé_developpement/PDF/SPD20/Proparco_PSD_20_UK.pdf).
- Blog: “What do we know about the linkage between RBF and health worker performance and motivation? Reflections from a recent 3-country study: <http://www.rbfhealth.org/blog/what-do-we-know-about-linkage-between-rbf-and-health-worker-performance-and-motivation>

## CONTACT INFORMATION

- RBF Education: Peter Holland, Program Manager, REACH, World Bank
- RBF Health: Petra Vergeer and Dinesh Nair, HNP, World Bank

### WITH THANKS

*We want to thank the lead discussants\* and all the participants of the “How are Schools like Clinics” event for sharing their valuable knowledge and experiences. This summary note of the round table discussions was created by Minna Mattero, based on notes taken by Aissa Socorro, Anna Astvatsatryan, Ellen Afra Bien, Jessica Cross, Jessica Lee, Joy Gebre Medhin, Koen Geven and Meaghen Quinlan-Davidson, under the supervision of Peter Holland and Petra Vergeer.*