Overview of strategies and best practices to strengthen HR capacity and motivation to deliver immunisation

Linked Immunisation Action Network

Dr. Akaki Zoidze, 26 July 2022, Tbilisi

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Empowering PHC health workers for immunization

- Beyond the ability to change the vaccination practice and process to improve the immunization coverage, Health Workers (HW) have a powerful influence on the vaccination behavior and vaccine acceptance of their patients and the public at large.

- Yet realizing the full potential of their positive impact for the improved immunization coverage is complex, as HW may face knowledge gaps, barriers and challenges related to vaccinating their patients and may have concerns about vaccines and vaccination themselves.

What kind of strategies and actions are needed for HW empowerment

- Address the barriers and drivers experienced by health workers and patients
- Be tailored to specific categories of health workers and their contexts
- Relate to individual, organizational, system and policy levels. They should be informed by public health, societal, cultural and economic considerations
- Ensure that no one is left behind.

Desired health worker behaviors

Accepting	the vaccine themselves
Administering	vaccines in a way which promotes uptake and makes patients feel safe, respected, comforted and informed
Recommending	the vaccine to patients and managing their expectations, regardless of their role in the immunization process

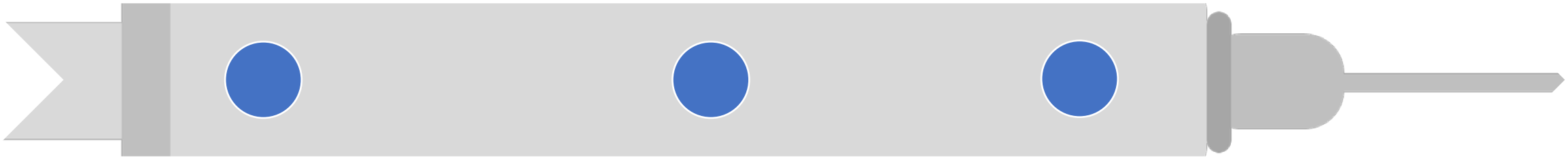
Key strategies empowerment

Understand HW

Make continuous efforts to listen to health workers and understand the barriers and drivers they experience

Engage and Motivate HW

Engage health workers as active agents and partners in shaping the overall immunization effort and provide financial and non-financial incentives, acknowledgment and support.



Build HW Capacity

Make effective and regularly adjusted efforts to build the knowledge, skills and confidence of health workers on immunization and its communication

Understand Health Workers

Conduct studies with health workers	Establish feedback mechanisms	Conduct Supportive Supervision Visits	Test
• Conduct focus groups, in-depth interviews or other types of studies with HWs to explore the barrier and drivers they face in recommending and delivering vaccination to the public.	• Establish mechanisms for HWs to report on their well-being and support needs, and systematically register, analyze and respond to the feedback collected. Health workers may feel frustrated if the sense that their input is being ignored by management.	• Conduct supportive observations or visits at vaccination sites. Conduct regular supportive observations at vaccination sites using list of key points to notice. Everyone involved should consent to these visits and understand that the intention is to support staff, not to check them.	• Test information materials. Invite different categories of health workers to reflect on planned messages and information products, either individually online or in groups. Allow them to speak freely and present them with several options which they can comment on.

Build Health Workers' Capacity: Knowledge, Skills and Confidence in vaccination

HWs are increasingly expected to have general and specialized technical competencies to meet the growing complexity of immunization service delivery and integration with other health interventions.

Pre-service education and training of the health workforce focuses on building specialized knowledge and skills.

In-service training of health professionals already employed aims to maintain technical knowledge and skills, develop those required to implement processes specific to the position and keep pace with continuing changes in policy and practice.

In-service training that utilizes adult learning principles, including on-the-job training, mentoring and feedback, and follow-up (e.g., START, BRICK) has been shown to increase job satisfaction and health worker motivation.

Several considerations for the HWs' capacity building

Consider key areas for building knowledge, including vaccine safety events and interpersonal communication

Combine the passive education with active engagement (which in turn can increase motivation)

Adapt and institutionalize the global and regional immunization training programs in the national undergraduate, postgraduate and continuous education curricula.

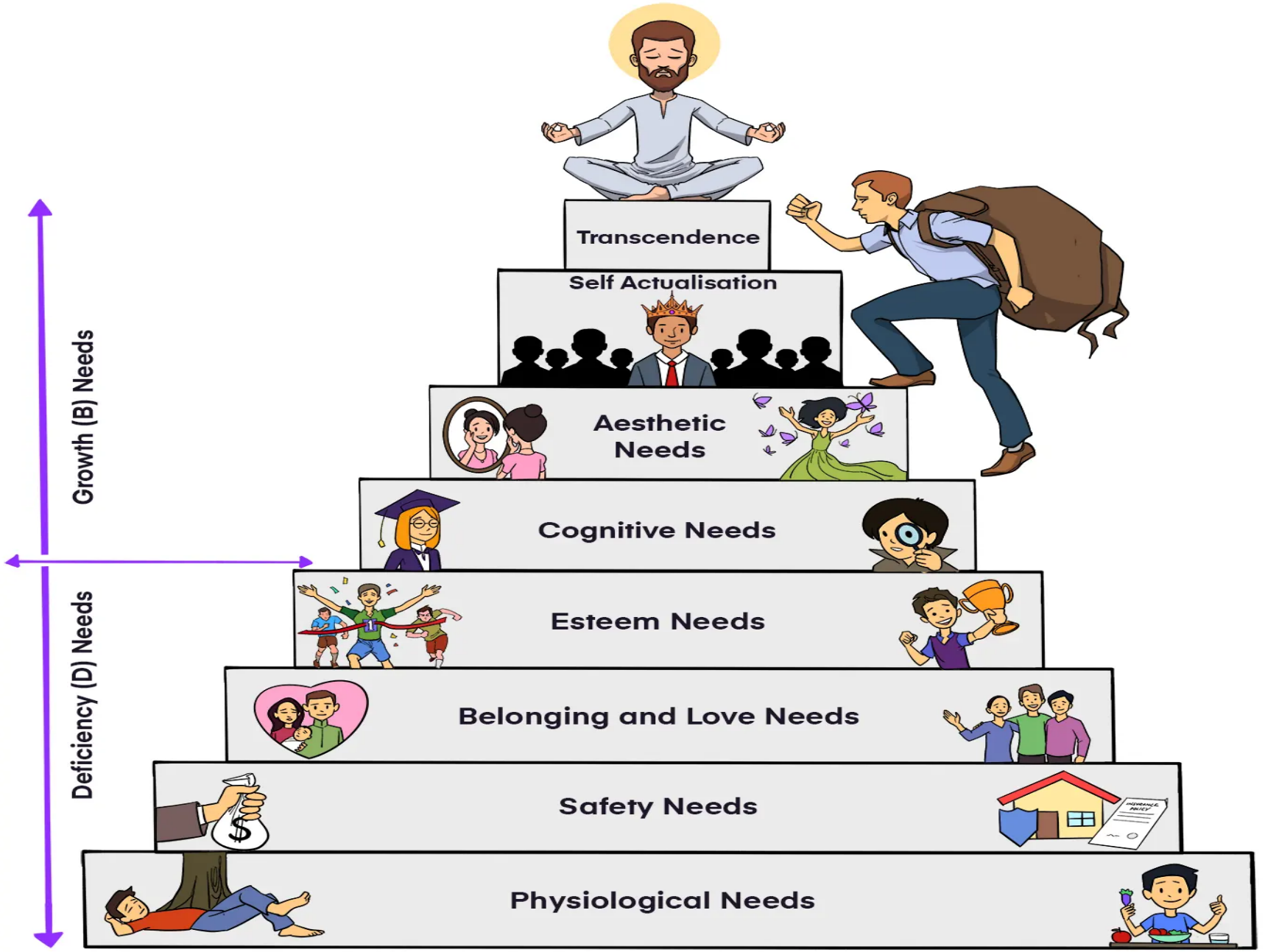
Make sure trainings and information are meaningful, culturally sensitive and tailored.

Key areas for HW capacity building

Vaccines and immunization process	can provide technical information on vaccine production, prequalification procedures, transportation and storage, appointments and administration, contraindications, pain mitigation, vaccination schedules, prioritization of target groups and legislation frameworks, supply, the use of different kinds of vaccines, vaccine ingredients and safety, vaccine efficacy and effectiveness, vaccine side effects, and balanced information about the risks and benefits of vaccines.
Adverse Events Following the Vaccination (AEFIs)	Trainings can also offer information about the different types of AEFIs, AEFI investigation and causality assessment, national response and reporting mechanisms for AEFIs, and appropriate responses to AEFIs.
Interpersonal Communication	Trainings can build health workers' skill in discussing vaccination with the public and tailoring their conversations to those who are accepting of vaccination, those who are hesitant and those who are refusing. This may involve unambiguous, easily understood language using a guiding style, respectful conversation techniques, and motivational interviewing to explore the position of patients and support them in overcoming concerns. Trainings ca also provide guidance on how to manage social media communication.

HWs' motivation: theory

- Multiple theories of human motivation: e.g., Maslow's Hierarchy of Needs; theory by Herzberg, Cognitive Evaluation Theory by Porter and Lawler and Self-determination Theory by Ryan and Deci, similarly view motivation from the perspective of intrinsic and extrinsic factors or motivators.
- *Intrinsic motivation* occurs when an individual is driven by interest and satisfaction doing the work.
- *Extrinsic motivation* is when an individual is driven by the external consequences of performing a task. Extrinsic motivation may be tangible (regulation, supervision, financial) and verbal (positive - recognition or negative - shaming).
- Intrinsic and extrinsic motivation can be positively or positively interactive.



Maslow's Hierarchy of Needs - Extended

communicationtheory.org

Motivators and demotivators

Individual, organizational/structural and societal determinants of healthcare workers' motivation function interdependently.

Overall, motivating determinants were either individual-based while most demotivating determinants were organizational (health-facility-based) or structural (health-system-based).

While the individual determinants are mainly intrinsic in nature, the organizational and societal determinants are primarily extrinsic of the healthcare workers (*Muthuri et al. 2021*).

Income and the *perception of a fair distribution* of incentives were both statistically significant in association with higher job motivation scores (*Keovathanak, 2016*).

Financial motivators for HWs: Pay for Performance (P4P)

1. Received attention since 90ies, during the last 30 years mixed results were reported, however, according to the systematic reviews of *Rotundo et al.; Jia et al.* and *Tampi et al.,* most studies showed that immunization programs with a *robust* P4P schemes has produced higher immunization coverage and reduced missed opportunities for vaccination.
   - No study has reported a negative impact of financial incentives on vaccination rates

- Currently, in many countries the immunization coverage rates are included as a one indicator for achievement in incentives programs for health workers: e.g., UK NHS, US Medicare and Medicaid, Australia, New Zealand, Italy, Estonia (*Rotundo et al., 2018*).

Some examples of successful P4P for immunization

- The US Medicare community-based initiative - 10% top up pay for reaching 70% and 20% top up for 85% immunization rates. The average immunization rate in the incentive group was 73.1% versus 55.7% in the comparison practices (*Kouides et al., 2019*).

- Scotland – payment incentive (£1,800 for >90% and £600 for 70-89% immunization rates) introduced in 1990. The practices achieving 95% more than doubled for primary immunizations and tripled for preschool children in 1991 (*Ritchie at al 1992*).

- The US inner cities experiment produced higher up-to-date immunization rates with bonus payments and top-up fees (Fairbrother et al., 1999).

Some examples of successful P4P for immunization (continued)

- Two Medicaid programs with P4P scheme resulted in raising attendance levels (compared to the national mean) at the well-child visits in which the immunization series is delivered (*Felt-Lisk et al., 2007*).
- In 2006, Estonia started the P4P quality system for family doctors, which includes immunization coverage indicator. Doctors joined to the quality system met the 90 per cent vaccination criterion more frequently compared to doctors not joined to the quality system (*Meriland et al., 2014*).
- The UK remains in the vanguard of such schemes, with the Quality and Outcomes Framework (QOF), which includes immunization rates, paying out around £1 billion (20% of total GP budget) to general practices (*Oliver, 2014*).

Common pathways for improved performance outcomes of P4P schemes

- Facility Level:
  - community outreach; adherence to clinical guidelines, patient-provider interactions, patient trust, facility improvements, access to drugs and equipment, facility autonomy, and lower user fees.
- Contextual factors shaping the system response to P4P include:
  - degree of facility autonomy, efficiency of banking, role of user charges in financing public services; staffing levels; staff training and motivation, quality of facility infrastructure and community social norms.
- Programme design features supporting or impeding health system effects of P4P included:
  - scope of incentivized indicators, fairness and reach of incentives, timely payments and a supportive, robust verification system that does not overburden staff.
- Facility bonuses are a key element of P4P but rely on provider autonomy for maximum effect. If health system inputs are vastly underperforming pre-P4P, they are unlikely to improve only due to P4P (*Neha at al. 2021*)

Non-financial motivators for HWs

- Provide opportunities for the career development
- Ensure fair staff appraisals and transparent promotion procedures
- Promote positive work environments, including supportive supervision
- employ properly-trained managers who set clear expectations; spent more time with HWs and establish transparent incentive schemes
- Delegate sufficient autonomy in decision making
- Ensure public recognition of competency and achievements
- Improve and ensure safe working and living conditions

Overall considerations for improving HW motivation

Incentives within the payment system could have an important role to play in effectively driving change in specific and well-defined areas. However, these could be complemented by non-financial incentives which can also be effective in motivating service delivery improvement.

The design of the incentive is therefore a key consideration. Moreover, it may be the case that P4P is potentially most effective when targeted specifically at individuals in relation to tightly specified discrete actions, rather than at the level of general organizational-level change (*Oliver, 2014*).

Balance of different incentives: A mix of well-designed financial and non-financial incentives are likely to be most effective. Financial incentives that offer a small financial reward (as opposed to threatening financial penalties) may best encourage innovation and organizational change within the sector.

Benchmarking: Public rankings and benchmarking against other teams or organizations can be effective but need to be managed in a way that ensures they are used constructively to promote continued learning and improvement, and do not damage morale.

Impact on different actors: Incentives that are designed to operate at an organization level must flow through to have an impact on the behavior of the individuals who make the day–to-day decisions that ultimately determine the care that patients receive.

Innovation: Incentives that create an environment of risk aversion may have an adverse impact on people innovating to improve service delivery.

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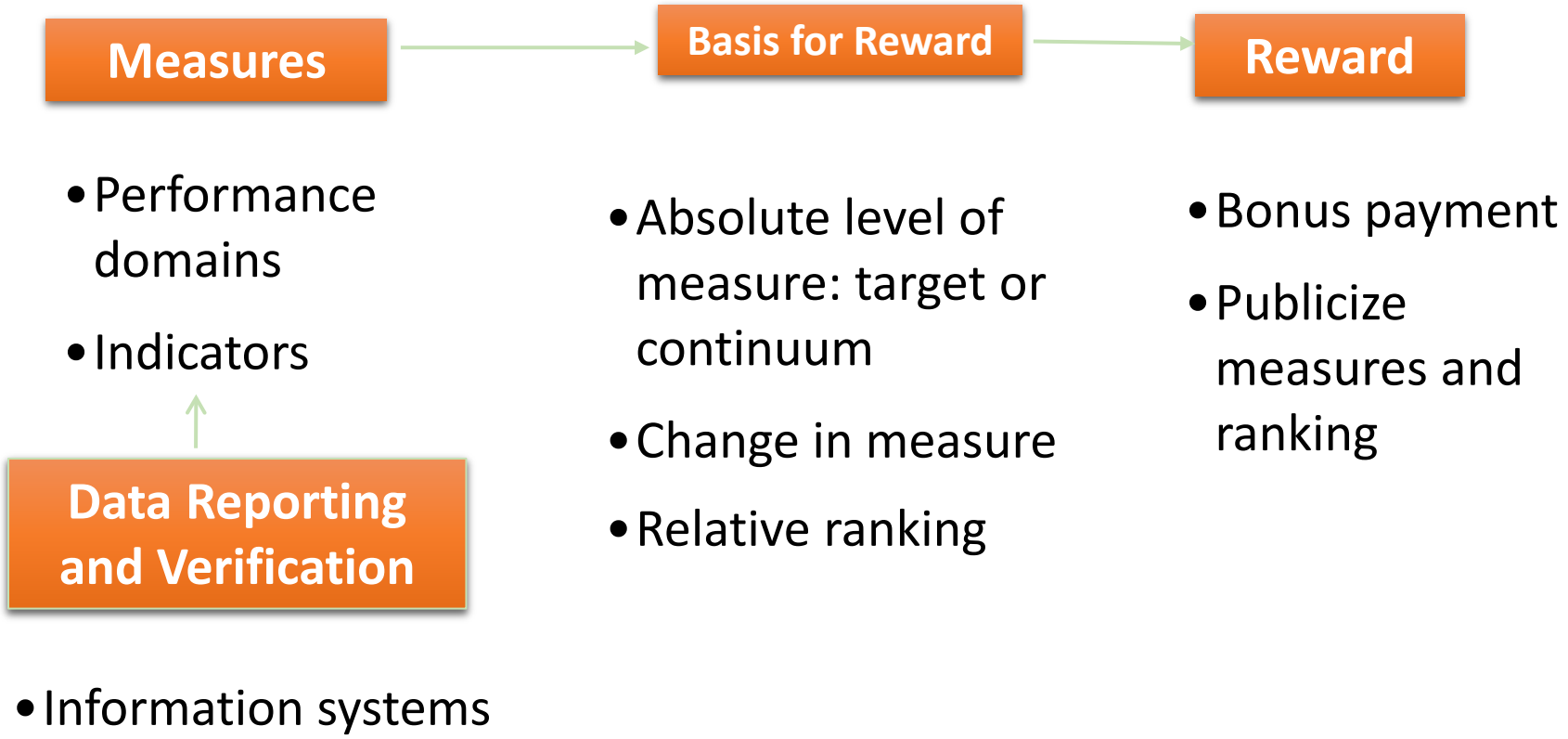
A standardized framework for P4P



Source: Adopted from Scheffler RM: *Is There a Doctor in the House? Market Signals and Tomorrow's Supply of Doctors*, Stanford University Press, 2008.

A diversity of P4P schemes across OECD countries

- This table illustrates the diversity of pay for performance schemes on the supply side in all areas of care, based on a survey carried out in 2008/2009.

- The US, the UK and Australia in the late 1990s and early 2000s have broken new grounds for other OECD countries

Country	Bonus for primary care physicians	If so, targets related to:		Bonus for specialists	If so, targets related to:		Bonus for hospitals	If so, targets related to:		
		Preventive care	Chronic disease		Preventive care	Chronic disease		Clinical outcome	Process	Patient satisfaction
Australia	X	X	X							
Austria										
Belgium	X		X	X		X	X			
Canada										
Czech Republic	X	X		X						
Denmark										
Finland										
France	X	X	X							
Germany										
Greece										
Hungary	X									
Iceland										
Ireland										
Italy	X	X	X							
Japan	X	X	X	X	X	X	X	X		
Korea							X	X	X	
Luxembourg							X			
Mexico										
Netherlands										
New Zealand	X	X	X							
Norway										
Poland	X	X	X	X	X	X				
Portugal	X	X	X							
Slovak Republic				X			X	X	X	X
Spain	X	X	X	X						
Sweden	n.a.			n.a.			n.a.			
Switzerland										
Turkey	X	X		X	X		X		X	
United Kingdom	X	X	X	X	X	X	X	X	X	X
United states	X	X	X	X	X	X	X	X	X	X

Incentives for preventive services: mixed results, but mostly positive for childhood vaccination (OECD)

	Countries providing incentive	Effect?
Cancer screening (breast, cervical)	Australia Brazil New Zealand U.K.	**Significant** increase in screening rates (BR) **Modest** increase in screening rates (NZ) **Targets met** (UK) **No** improvement (AU; FR)
Asthma	Australia U.K.	**Modest** increase in completion of treatment cycles (AU) **Targets met** (UK)
Diabetes	Australia France New Zealand U.K.	**Modest** increase in screening and preventive testing and management (AU; FR; NZ) **Targets met** (UK)
Hypertension	France New Zealand U.K.	**Modest** improvement (NZ) **Targets met** (UK) **No** improvement (FR)
Vaccination	Brazil France New Zealand U.K.	**Significant** increase (NZ—children) **No** improvement (FR; NZ--adults) **Targets met** (BR; UK)

P4P mechanisms aim at addressing these problems and create behavioral change through six factors

1.Health-increasing substitution (+)

Incentives' goal is for new mix of services and inputs to increase health

2.Health-decreasing substitution (-)

Incentives can be perverse, where providers substitute away from unrewarded, yet important, dimensions because they are unobserved or immeasurable

3. Increased provider effort (+)

Provide incentives to increase workers' effort, where increased effort could be for output (LICs) or quality (HICs)

4. Risk premium costs (-)

Need to compensate provider for taking on risk, i.e., for being rewarded for factors beyond its control

Risk premium costs decrease health, because less budget available for health care services

5. Monitoring costs (-)

Monitoring costs decrease health, because less budget available for health care services

6. Net externalities (+ or -)

Positive or negative effects on health, beyond the explicit P4P measures

Positive – better governance and information systems

Negative – workers become less team-oriented