



Utilizing Performance-Based Financing to Achieve Health Goals

Issues Addressed by PBF

Ineffective incentives faced by both providers and households hinder achievement of health outcomes. Currently in most low- and middle-income countries providers are not rewarded for achieving health results. This lack of connection between what is rewarded and the reason for providing health services – to improve health – is one of the underlying causes of poor health outcomes. Compounding the problem is that households have limited ability to motivate service providers to be responsive to their needs.

At the individual health worker level:

- Fixed salaries with raises are not necessarily tied to performance, thus acquiescing to low productivity, absenteeism, poor quality, or lack of innovation (public sector, NGOs).
- Payment of fees by households results in high volume of fee generating services

(typically curative care), and inadequate attention to preventive care and quality (private sector).

At the health providing institution level:

- Fixed budgets justified by the costs of inputs (e.g., equipment, training, staff, and drugs) focus on justifying the costs, not results. There is no incentive to expand coverage, promote preventive and primary care services, or solve systemic problems (public sector; NGOs receiving grants).

At the household level:

- Limited household incomes cause households to prioritize urgent curative services, not essential preventive care. Providers have weak incentives to be accountable and responsive to the households they serve.

While increasing health spending may be needed, this alone is not sufficient to producing better outcomes. Performance-based financing aligns resource use with the motivational factors that promote hard work, innovation, and results. By doing so, payment is made not just for inputs but also for health outputs and outcomes. It is a strategy that holds promise for the public, NGO, and private sectors.

Concept of PBF

Working definition: Transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target.

- Demand side examples: Conditional Cash Transfer Programs in much of Latin



Brief



America that provide households with income transfers for obtaining preventive care services; money and food to motivate TB patients to complete treatment.

- Supply side examples: PBF to service providing institutions in Afghanistan, Democratic Republic of Congo, Haiti, Nicaragua, and Rwanda.

PBF imposes financial risk. Payment is received when (or withheld until) results (or actions) are verified. By doing so, PBF aims to align health worker and household actions with goals for increasing the volume and quality of services rendered.

Premise: Service providers (individuals and institutions) are motivated by intrinsic forces (e.g., professional pride, altruism) and extrinsic forces (money, recognition, awards). Recognizing that financial and material incentives are not the only drivers of behavior change, PBF focuses on extrinsic motivation, which helps reinforce intrinsic forces.



Country Experiences with PBF

AFGHANISTAN: Three donors are contracting NGOs to deliver health services: USAID, the World Bank, and the European Union. Until recently, only the World Bank approach tied payment explicitly to achievement of performance targets. Other donors now intend to adopt this approach because of the superior results it appears to have generated. The capacity of the Afghan Ministry of Health has been developed to manage the contract process and to oversee some elements of performance monitoring and transfer of funds. As each donor has distinct accountability requirements, the ability to transfer this responsibility to local governments differs.

In Afghanistan, NGOs were chosen to provide a basic package of services to people living in an entire province through a competitive process that followed World Bank Quality and Cost-Based Selection (QCBS) procurement guidelines. Winning NGOs received a contract that pays them the budget they proposed plus the opportunity to earn up to an additional ten percent if performance targets are reached. Performance bonuses are earned if scores improve on the "Balanced Score Card (BSC)" mechanism that assigns scores for performance in a range of priority areas. Because BSC scores are computed for all provinces in Afghanistan it is possible to compare performance of provinces with NGOs that are paid for performance to other provinces with cost-based reimbursement. Overall performance is better in these World Bank provinces causing other donors to consider PBF. It is also important to emphasize that factors other than payment incentives contribute to differences in performance in a complicated context like Afghanistan, making it hard to fully attribute the better performance in PBF provinces to the incentive approach. (3)

HAITI: Starting in 1999, the USAID mechanism used to pay contracted NGOs changed from reimbursement for documented expenditures to a fixed price subcontract plus an award fee linked to attainment of predetermined performance targets. Some examples include: "increase in the percentage of children under one who are fully immunized to a specified percent" and "increase in the percentage of pregnant women who receive at least three prenatal care visits according to ministry of health norms." For each indicator, a baseline measure is determined at the beginning of a contract period and a target for improvement is established. Subcontracts clearly establish these targets, describe how performance will be measured, and determine the award fee associated with attainment of each target.

Remarkable improvements in key health indicators have been achieved over the six years that payment for performance has been phased in. Now covering 2.7 million people, NGOs provide essential services to the Haitian population in the complicated context of violence, poverty, and limited government leadership. A series of regression analyses that adjust for other factors that might determine performance suggest that being paid based on results is associated with highly significant increases in both immunization coverage and attended deliveries. Regressions suggest that payment for performance was responsible for increasing immunization coverage as much as 24 percentage

points, implying that as many as 15,000 additional children were immunized in Haiti because of the changed payment regime. Attended deliveries increased as much as 27 percentage points, implying that up to an additional 18,000 women were provided a safer environment in which to deliver their babies.

In addition to the contribution of the performance-based payment strategy to increasing coverage and the quality of health services, field assessments strongly suggest that this strategy has catalyzed the development of the institutions involved. This is reflected in the changed behavior of managers and service providers at all levels; they are observed to be more proactive, innovative and focused on being more accountable for results. These behavior changes have resulted in improved information systems and the effective use of data for decision making; strategic use of technical assistance; improvements in human capacity development and management; strengthened financial management; and increased cost effectiveness. All of these changes will contribute to the likelihood of the viability of the service providing organizations making this a long-term development strategy as well as an effective strategy to "buy" results. Recent enhancements include engaging the Ministry of Health to introduce PBF in public facilities. (2)

RWANDA: The government of Rwanda has taken bold steps to pioneer the institutionalization of PBF. In 2005, PBF was adopted as a national policy. Plans are underway to achieve national coverage by 2008. This effort draws upon experience with three pilot schemes, known as the Cyangugu model, Butare model, and Belgian Technical Corporation model (for Kigali Ville, Ngali, and Kabgayi regions). While the schemes differed in their execution (e.g. ,in terms of their means for verifying performance, listing of target indicators, and the institutions serving as fund holders, etc.), all three had the overriding goal to improve the utilization (and more recently quality) of health services through supply-side mechanisms.

Results from the Cyangagu and Butare models compared with provinces with similar characteristics that did not implement PBF suggest that the strategy holds promise. Large increases in the number of curative consultations and institutional deliveries have been seen with a smaller increase in measles and new family planning acceptors. (4, 5, 6) A planned impact evaluation will improve the evidence base by adjusting for "other" determinants of performance that simple comparisons do not capture.

Impact of PBF on HIV/AIDS services appears promising with results in the first 12 months showing a more than doubling of VCT, a 20% increase in PMTCT, a 65% increase in HIV+ clients receiving Co-trimoxazol prophylaxis, and a 17% increase in HIV+ women treated with Nevirapine.

	Contracting provinces 2001	Contracting provinces 2004	Non-contracting provinces 2001	Non-contracting provinces 2004
Curative care/ inhabitant/year	.22	.55	.20	.30
Institutional deliveries	12.2%	23.1%	6.7%	9.7%
New FP acceptors	1.1%	3.9%	.3%	.5%
Measles	70.7%	81.5%	77.9%	78.9%

The national model for PBF will draw from its pilot experience. It will work through local government (in accordance with recent decentralization efforts) and involve broad stakeholder participation through the formation of steering committees. Payment is determined by fees for priority services multiplied by the volume delivered and adjusted by a quality score. Three types of performance contracts will be issued: 1) between ministry of health and administrative districts, 2) between district steering committees and health center management committees and 3) between the health center committees and the individual health workers. While this is an ambitious plan, PBF in Rwanda benefits from strong government leadership and efforts to work with other stakeholders as partners towards common goals.



Lisa Nichols

Factors Associated with Successful PBF

To implement PBF, capacity to design, negotiate, monitor, and manage contracts or performance agreements is needed. Stakeholder engagement is critical to success to assure that the design of the approach will motivate the desired results and that there is sufficient buy-in among recipients to generate cooperation and partnership rather than resistance. Clear performance indicators and targets need to be established and the way payment will be tied to results clearly communicated. Once contracts or performance agreements are designed and negotiated a team is needed to perform the ongoing management of the process that includes monitoring and validating performance, assuring compliance with contract terms, and processing payment.

CONCLUSION

Performance-based programs can work, even where the environment is weak and the full complement of inputs is not in place; incentives can bring about behavior and systemic changes. The lesson here is not to wait until everything is "perfect" before forging ahead. New incentives can be the catalyst that inspires providers and consumers to find innovative solutions in the less than perfect environment that is the reality of health systems in most developing

countries. If well designed and implemented, PBF can be an effective approach to both buy better results now and develop sustainable health providing institutions and the systems that support them for the longer-term.

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Health Systems 20/20

Health Systems 20/20 (HS 20/20), a five-year (2006-2011) cooperative agreement funded by the U.S. Agency for International Development (USAID), offers USAID-supported countries help in solving problems in health governance, finance, operations, and capacity building. By working on these dimensions of strengthening health systems, the project will help people in developing countries gain access to and use priority population, health, and nutrition (PHN) services. HS 20/20 integrates health financing with governance and operations initiatives. This integrated approach focuses on building capacity for long-term sustainability of system strengthening efforts. The project acts through global leadership, technical assistance, brokering and grant making, research, professional networking, and information dissemination.

Why Health Systems?

The delivery of all health services, including the priority PHN services, depends on the underlying health system. To combat malaria, TB, HIV, and maternal and child health problems, the health system needs adequate and appropriately allocated financing, inclusive decision making and accountability, and financial and human resource management systems that deliver inputs where and when needed. A smoothly functioning health system maximizes the delivery of effective and life-saving technical interventions.

How to Access Health Systems 20/20

USAID missions and bureaus can access HS 20/20 by obligating funds to cooperative agreement No. GHS-A-00-06-00010-00. The project can accept all types of USAID funding, including PEPFAR, POP, CS, EFS, as well as funds through EGAT and D&G. As a Leader with Associate mechanism, missions and bureaus can also negotiate and manage separate Associate Awards for which they will designate a CTO.

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For more information about Health Systems 20/20 please contact:

Health Systems 20/20
Abt Associates Inc.
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814 USA
E-mail: info@healthsystems2020.org
www.healthsystems2020.org