# Performance-based financing: The forest, not the tree!

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# Our view

- PBF under the fire: critics (Eldridge & Palmer 2009, Oxman & Fretheim 2009, Kalk et al 2010) adopt a narrow view.

- It is about reform : PBF as a potential game changer for public health systems in low income countries.

# Poor performance of health systems

- Three main objectives.
  - Health outcomes.
  - Responsiveness.
  - Social protection.
- Low performance (as efficiency).
- State of affairs is well-known.
- Standard explanation: not enough resources.
- PBF promoters point at poor accountability (WDR 2004). Not the first ones, but lack of clear propositions so far.

# How does PBF fit in this view?

- PBF: a system by which health care facilities and their personnel are, at least partially, remunerated based on their performance.

- Our reference: Rwanda, DRC, Burundi… « the African Great Lakes Model ».

# PBF and the public sector

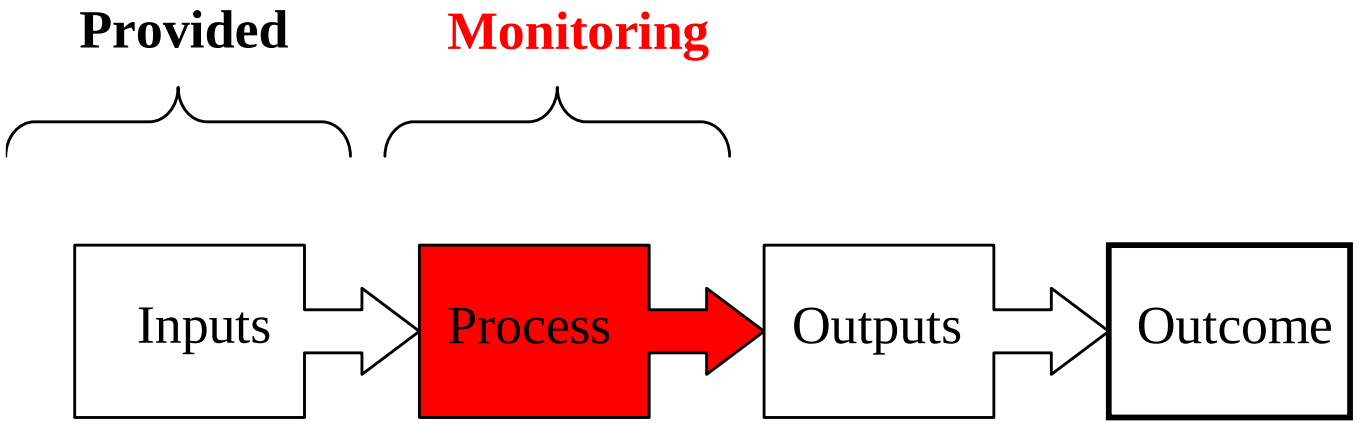
- **Cambodia (1997):** first performance based contracts with a public health facility; within health districts (Pearang versus Sotnikum).
- **Rwanda (2002):** fee-for-service model; separation of functions; national policy; public budget; HIV/AIDS monies; quality index; ICT.
- **Burundi (2006):** contractual approach policy; role of community based organisations; PBF as a strategy to remunerate providers delivering free treatment to target groups; equity across provinces.

# Input- and output-based contracts

- **Pure input-based approach:** (1) the purchaser provides inputs to the provider; (2) he defines what the right production process is; (3) any income derived from selling the output belongs to the purchaser/owner.

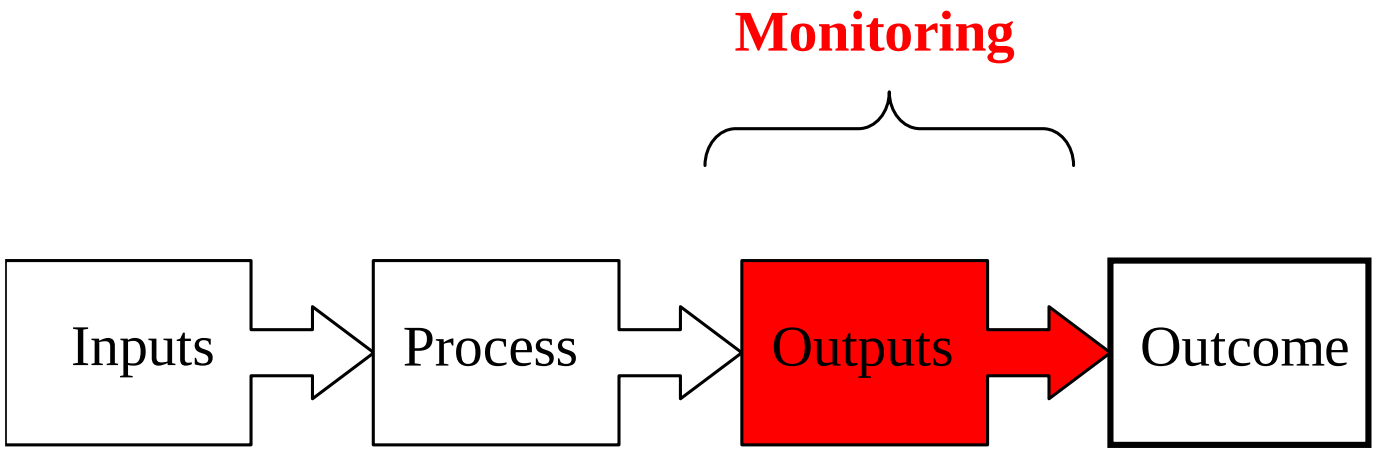
- **Pure output-based approach:** (1) the purchaser decides which output he wants; (2) he pays a price for the output (fee-for-service); (3) he relinquishes to the provider (i) some key decision rights on the input allocation and (ii) the revenue from the sale (‘residual claimant’). « Fee-for-service », « Paiement à l’acte »…

# Monitoring under the input-based contract




- Monitoring mainly consists in deciding ex ante what the right process is, monitors the compliance with this right process and gives regular orders on new things to do (incomplete contract).
- If the work effort is not monitored, little will be done (the staff has little incentive to work: they get their salary, regardless of the level of output produced).

# Monitoring under the output-based contract

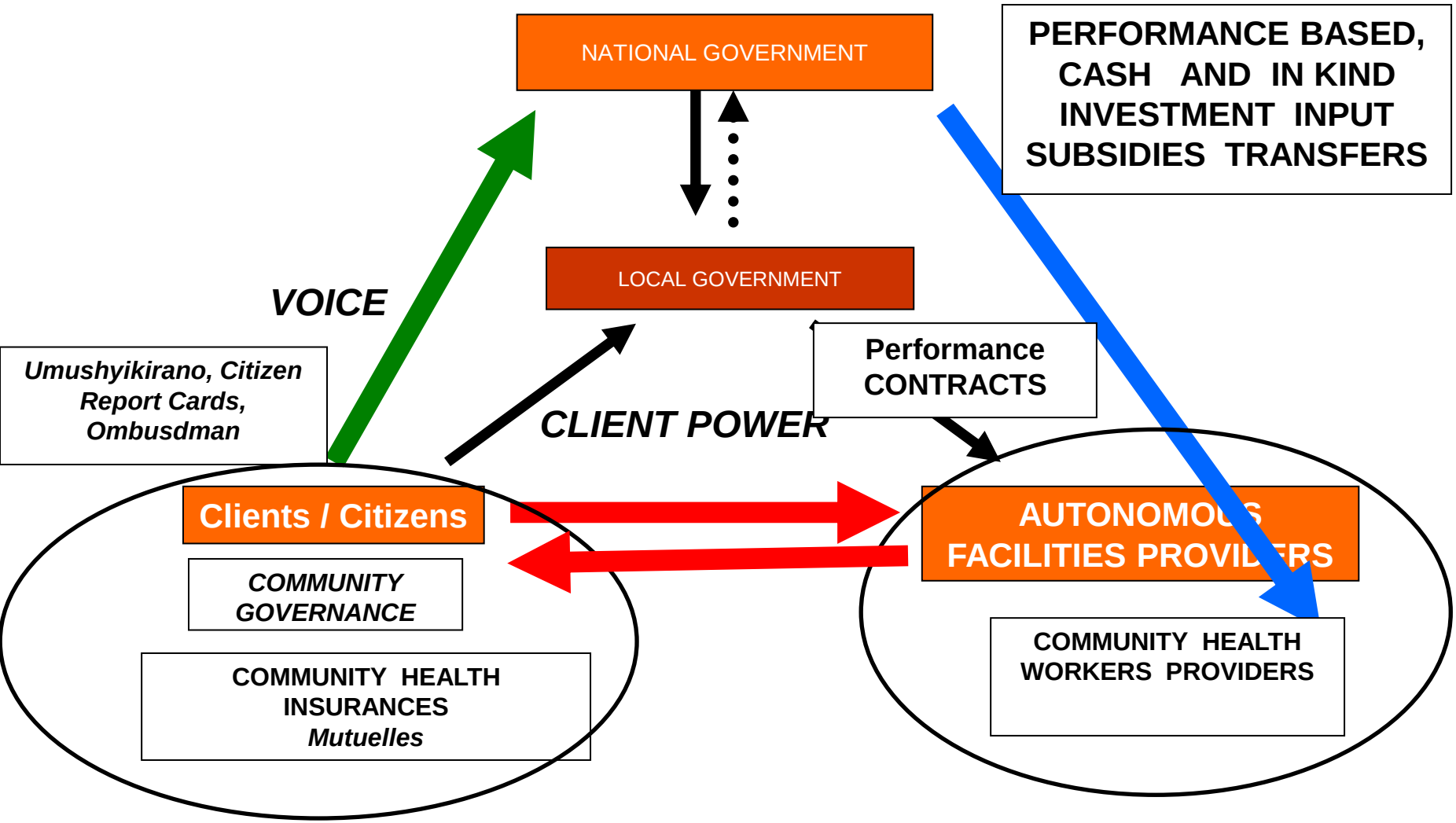



- Monitoring mainly consists in observing whether the provider delivers the service (quality and quantity) agreed in the contract (complete contract).
- If monitoring is not done, the provider will declare more outputs than what he actually produced, induce demand that is not necessary, deliver service of lower quality.

# An illustration

| **Rubona** | **Fee (rwf)** | **August 2002** | **Total (rwf)** |
|---|---|---|---|
| N.C | 40 | 839 | 33.560 |
| Delivery | 2500 | 13 | 32.500 |
| Ref. deliv. | 2500 | 6 | 15.000 |
| Tet T 2-5 | 250 | 27 | 729 |
| Family Pl. | 1000 | 9 | 9.000 |
| DTP 3 | 250 | 58 | 14.500 |
| Measles | 250 | 33 | 8.250 |
| **Total** | | | 119.560 |

# Strengthening accountability in the health sector in Rwanda



# PBF: the reform package

- NHS:
  - the State fulfills all the functions.
  - High centralisation.
  - Input based funding.
- PBF:
  - Health system = linking quite autonomous organisational units. Contractual and regulatory relationships instead of hierarchical ones only.
  - Output based funding (on top of other existing arrangements).

# Implications

- Performance must be defined for each unit.
- A payment formula.
- Reconsideration of who should do what.
- How functions should be bundled. Packages must be coherent: economies of scale, of scope and limitation of conflict of interest.

$\Rightarrow$Separation of functions.

$\Rightarrow$Creation of new organisational bodies (purchasing agency, verification agent…).

# PBF as a means for greater accountability and responsiveness

- Performance can include quality of services. More fundamentally, output-based payment sets strong incentive to satisfy users.
- PBF will push providers to put pressure on their own suppliers and ancillary services.
- PBF leads providers to better report their activities (HIS).
- PBF empowers consumers: (1) vote with their feet: their health seeking behaviour decisions affect resources received by health facilities (*exit* versus *voice*); (2) community actors can be contracted to verify the reality of remunerated outputs.

# PBF as a means for health outcomes / technical efficiency

- Performance can include quantity of services and quality of care (Basinga et al 2010).
- Higher productivity (Meessen et al. 2007): interesting if HRH crisis.
- Together they should lead to better health outcomes.

# PBF as a means to more allocative efficiency

- Implementing PBF requires the steward to identify key health priorities to be « purchased ». Preference for high impact interventions.
- Possibility to tap the three big diseases funding.
- Staff will follow the money (better HRH allocation).
- Money will follow the outputs and reach the facilities (no capture by intermediary levels).

# PBF as a means to health equity

- PBF can incorporate different prices to account for remoteness.
- Complementary to CBHI.
- Probably the right approach to compensate health care facilities when services are to be provided for free to the users (Meessen et al. 2009).

# PBF as a means to resource mobilisation for health

- PBF can win the commitment of Ministry of Finance and donors.
- Institutional arrangements are there to create trust to favour transactions.

# PBF as a means to public sector reform

- PBF is part of the New Public Management agenda. Reforming the health sector can lead to broader developments.
- PBF sheds new light on decentralisation in health. Very consistent with previous reforms (e.g. Bamako Initiative).

- PBF may allow better involvement of the private sector. Reduction of health system fragmentation.

# PBF in public health systems: challenges

- Ownership: donors AND government.
- Translation to country context requires local experience: pilot experiences crucial?
- Public finance.
- Window of opportunity for a privileged health sector: 2-3 years, before other sectors to oppose?
- The health administration.

# Conclusions

- **PBF is much more than a provider payment mechanism. It offers an opportunity for wider reforms**. It can address several structural problems. **This will be the right metric to assess the success of the experiences, much more than the few remunerated indicators.**

- Yet, it is not a panacea. Performance is multidimensional and some are different to contract (not verifiable). Classical support and other payment mechanisms remains crucial.

- There are technical and political economy challenges. There is a role for external actors.

- There are risks and possible perverse effects. At short term and at long term.

- But experience in Central Africa seems to indicate that this is manageable.