



Health Results-Based Financing (RBF) in Practice: Ten Institutional Challenges

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Health Results-Based Financing (HRBF) is a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer, or consumer of health services after pre-defined results have been achieved and verified. HRBF is one tool that can be used by governments to increase coverage of the population with high-impact interventions, such as immunization or institutional deliveries. There are different kinds of HRBF mechanisms.

Performance agreements between national and sub-national levels transfer financing based upon achievement of verified health indicators and targets. Performance-based contracts between district health offices and public health facilities or NGO facilities transfer funding based on achievement of quantity and quality outputs, which are verified by third parties. Community-based or household-based schemes can enhance utilization of specific priority health services in return for a cash or in-kind transfer.

Designing, implementing, and monitoring HRBF mechanisms present several institutional challenges to countries. This brief discusses ten of the more salient challenges that have emerged from a recent review of World Bank projects.¹ The challenges associated with monitoring results and evaluating impact are described elsewhere.

CHALLENGE 1: FROM INPUT TO OUTPUT AND OUTCOMES THINKING. The shift to a results orientation usually requires a change in the way countries and donors are used to doing business, which currently emphasizes planning, financing, and monitoring inputs. In Bolivia, implementation of performance agreements changed the logic of interaction between the national level and sub-national departments in the health sector, and the results focus replaced the traditional sector emphasis on inputs.

1. "Taking Stock: World Bank Experience with Results-Based Financing for Health," 2009.

CHALLENGE 2: POLITICAL COMMITMENT AND COUNTRY OWNERSHIP at both national and sub-national levels are essential to effective implementation and sustainability. High-level political commitment and ownership can facilitate and support the transition from an input to a results orientation. Success in Rwanda with HRBF was linked to the strong political commitment of the President, who signed performance-based contracts with each mayor. Lack of ownership by local government authorities at provincial level, however, hampered project implementation in Indonesia.

CHALLENGE 3: INVOLVEMENT OF ALL RELEVANT STAKEHOLDERS IN THE DESIGN of the HRBF scheme helps to mitigate resistance and facilitate understanding and communication of the mechanism. This is particularly so when changing the way health care providers or insurers are paid. In Armenia, involvement of local authorities, the Ministry of Health, and hospital management in both technical and political processes facilitated consensus building and significantly increased ownership and cooperation. A good communications strategy makes expectations explicit: all relevant actors must understand the incentive scheme and the requirements of performance-based contracts.

CHALLENGE 4: ANALYSIS OF THE CURRENT INCENTIVE STRUCTURES that exist in the health sys-

tem and their relationship to health system performance, provision and utilization of services should be the starting point for designing RBF mechanisms. An important lesson from Indonesia, was that the design of the mechanism did not build on existing incentives. The size of the financial incentive relative to current incentives and payments also needs to be considered carefully. In Uganda, the performance bonus was 11 percent of the base grant, or between 5 to 7 percent of operating costs for Ugandan NGOs. The small size of the bonus incentive was thought to be one of the reasons why the RBF was unsuccessful in raising utilization of health services.

CHALLENGE 5: ADEQUATE ORGANIZATIONAL STRUCTURES AND INSTITUTIONAL CAPACITY ARE CRITICAL for HRBF mechanisms to work well.

Fundamental decisions on legal status, organizational arrangements, and governance structures often must be taken before changes can be introduced. Usually, provider management and accounting systems need to be strengthened, purchasing capacity improved, performance and quality standards established, and adequate provider reporting and information systems introduced to allow for appropriate performance monitoring and transparency. A limitation in Armenia was that the project focused on technical aspects of the design (such as payment systems) at the expense of organizational and institutional aspects, such as governance and autonomy, which demanded equal attention

CHALLENGE 6: COMPLEMENTARY REFORMS ARE OFTEN NEEDED FOR SUCCESSFUL IMPLEMENTATION OF HRBF MECHANISMS:

HRBF schemes are embedded in and may benefit from or be constrained by larger efforts to strengthen health systems. For instance, decentralization may result in greater financial autonomy for health facilities and sub-national health authorities. Full-scale decentralization of the Rwandan health system and increased autonomy of health centers, which allowed for the local hiring and firing of health workers, contributed to Rwanda's success. However, other challenges may accompany decentralization. For example, HRBF schemes that rely on local government units (LGUs) to finance performance bonuses may be hampered by inadequate capacity at that level to purchase contracted health care services or to evaluate and verify the reporting of results.

A common lesson from World Bank projects is the

importance of a focused and gradual approach. Creating an enabling environment often requires incremental layering of reforms. For instance, the development of *Plan Nacer* in Argentina evolved from the Maternal and Child Health Insurance Program and its efforts to strengthen the stewardship functions of the provincial health authorities. Such an approach may not be necessary in every setting, however. For example, in Afghanistan, performance-based contracting with NGOs was established within a relatively short period of time.

CHALLENGE 7: QUALITY OF SERVICES CANNOT BE OVERLOOKED.

Schemes that seek to increase use of health services often need complementary interventions to improve the quantity and quality of health services. For instance, a project in Mexico was designed to enhance the provision of services through a supply-side component that was a complement to a Conditional Cash Transfer program (CCT). Without this complement, the supply of health services may not have been able to keep up with the increased demand created by the cash transfer, nor would demand have been sustained if quality health services were unavailable. In India and Indonesia, increases in utilization of institutional births related to implementation of a voucher scheme must be met with improvements in the quality of health services to meet these new demands on the health system.

CHALLENGE 8: PERVERSE INCENTIVES AND GAMING

will arise during implementation and steps need to be taken to mitigate these. Perverse incentives occur in relation to the quantity and types of services provided, and the temptation to exaggerate or falsify reports to receive payment. If providers are paid on a fee-for-service basis, there will be a tendency to focus service provision on those services that result in payment at the possible expense of other needed services. Patients with conditions not covered in the RBF payment scheme may be referred to other providers or not attended to at all. Quality of services provided also might suffer as the incentive is to increase quantity to boost the level of the financial reward.

CHALLENGE 9: SUSTAINABILITY. HRBF schemes usually require additional resources not only to finance the incentive, but also to set up the accompanying systems required for successful implementation, such as management modifications and improvements to the health management information system. The design of HRBF mecha-

nisms, therefore, needs to reflect how these schemes will be sustained financially once donor support is no longer available. At a minimum, the cost of the HRBF mechanism, both during and after the project period, needs to be assessed as part of project design to estimate the recurrent costs and fiscal impact of the incentive. In theory, successful schemes could convince governments to allocate some portion of the budget to support results-based schemes. In Cambodia, performance-based contracting pilots supported by the donor community contributed to increased use of services. Subsequent phases of this project are looking into sustainability issues and national support to the scheme more closely.

CHALLENGE 10: PLANTING THE SEEDS FOR

SCALING UP: Promising HRBF schemes are often piloted to see whether the scheme works and has the desired impact. Piloting, however, can have its drawbacks. In Indonesia, implementing externally financed pilots at the local level was easier than convincing local governments to support these initiatives after pilot project completion. Pilot efforts that are not well-connected to the broader health sector context risk not being scaled-up, even if successful at the pilot stage. Policy makers and planners need to plan for scaling up at the design stage.