LEARNING LESSONS ON IMPLEMENTING PERFORMANCE BASED FINANCING, FROM A MULTI-COUNTRY EVALUATION

KIT (ROYAL TROPICAL INSTITUTE)
In collaboration with Cordaid and WHO

Royal Tropical Institute

Authors
Jurien Toonen (KIT)
Ann Canavan (KIT)
Petra Vergeer (KIT)
and
Riku Elovainio (WHO)

Performance Based Financing

A Synthesis Report: Summary and Conclusion

Drawing lessons from country study reports
Cordaid/ HealthNet TPO experiences in PBF pilot projects in:

Democratic Republic of Congo
Tanzania
Zambia
Burundi
Rwanda National PBF (retrospective study)

Full Report is available on:

http://www.kit.nl/smartsite.shtml?id=SINGLEPUBLICATION&ItemID=2692

Executive Summary

In recent years the 'Performance Based Financing' (PBF) approach has received increasing attention. Evidence to date has largely demonstrated that the actual 'modality input planning' does not incite health providers to perform better, because money flows are not linked to results. The professionals and constituencies that are in favour of PBF support the hypothesis that enhanced productivity and quality of care are contingent on linking outputs to financial incentives. However, benefits of performance based financing are still inconclusive with suggestions that it is not sustainable, it will not have a pro-poor effect, or it may create perverse incentives. The evidence up to now cannot fully substantiate either debate sufficiently in the absence of more extensive operational research and formative evaluations.

This synthesis report thereby explores the lessons learned on design, implementation and effects of financial incentives in the form of performance based financing in the health sector, as supported in Sub–Saharan Africa by the two Dutch NGO's Cordaid and HealthNet TPO. Towards this aim a multi-country study was undertaken led by the Royal Tropical Institute of the Netherlands (KIT) in collaboration with World Health Organization (WHO) Geneva and the implementing agencies in DRC, Burundi, Tanzania and Zambia. Rwanda was also visited to study scaling-up from pilot projects to a national program.

In the health sector, PBF utilizes terminology such as, 'results based financing', 'payment for performance', 'performance based financing'; all of these terms describe the levels of incentives and performance rewards awarded, whether organizationally or individually focused. In this case we have adopted "performance based financing" as the working terminology with specific attention to the arrangements at health facility level and the results from the different pilots and scale up initiatives.

The study was designed as a *formative evaluation*, meaning that the purpose was not accountability of the programs studied, or a fundamental research on the effectiveness of PBF, but rather learning lessons on the contribution to health service improvements, including the positive and negative effects of the approach. The study commenced with a desk review of recent performance based financing initiatives and its findings, which informed the design of the methodology including the research instruments. The field methodology involved sampling of health facilities where PBF is operational and where PBF had not been introduced, while appreciating that this is not a longitudinal case-control study. Using an open systems approach, quantitative data were analysed for all performance based indicators as derived from health management information system (HMIS) sources with additional data analysis for non-PBF indicators as well as financial data available. Extensive qualitative analysis was conducted through semi structured interviews with health staff and patients in addition to meetings with key stakeholders at district and national levels to discern determinants of performing and non-performing health facilities. Following each country study, interactive debrief workshops were held in country capitals involving all significant stakeholders and country reports were shared with all relevant national and international stakeholders.

This synthesis report is based on distilling the evidence and experiences from the countries studied, thereby presenting a meta-analysis of the results and providing lessons that may incite the partners involved to adapt their policies and practice. Some key findings show the potential of PBF as a health financing approach while also pointing to institutional dimensions and organizational processes that require further improvement. Our findings are not altogether conclusive but map out areas which require further research, with an extensive research agenda described in the final section of this report.

What are the effects of PBF on the institutional architecture of the health sector?

PBF is intended to contribute to improvement of health provider performance and ultimately to improved quality of health service delivery at the operational level. At the same time it means a fundamental change in the way the health sector is financed with a shift from input to output

funding. This requires changes in accountability structures and concomitant redistribution of tasks and responsibilities between the different actors. Accordingly, the findings show that PBF influences the institutional architecture in the health sector as structures are needed at the operational level for fund holding, mechanisms for accountability and transparency, and agencies to carry out the verification efforts, inclusive of community level.

As PBF is, actually, about payment for results, a split of responsibilities between providers, purchaser and regulator is essential whereby greater transparency is implied through checks and balances. In relation to the local fund holder, often called the Fund Holder Agency (FHA), a certain degree of autonomy is needed for the contracting arrangements. Equally, the regulator, already holding the extended role in stewardship and oversight of the health system now becomes one of the main signatories to the contract, thereby taking an active role in verification of commitments at facility level. An important lesson learned is that, to ensure that institutional embedding actually takes place, it is vital to engage with all local and national level health management and providers from the inception of the PBF, even if at pilot stage. Where such an inclusive approach did not exist, PBF proved to be less effective in its contribution to health system strengthening. In a parallel set up, the caretakers tend to be existing non government organizations who undertake multiple roles of fund holding, management functions and verification, which limited a regulatory oversight and ownership by the district, provincial and central level MOH.

Boosting performance and quality of healthcare delivered to the beneficiaries is the raison d'être of this model. The principle of autonomy is central to PBF whereby providers are to be directly involved in the negotiations on contracts. Where contracts were used successfully, they became the negotiation and management tool which manifests in clear commitments and targets to be met by the providers. It was found that in contexts where the systemic model is established (DRC, Burundi, Rwanda) providers gained a greater degree of autonomy due to their role in negotiating the price of indicators and in determining the allocation of incentives to individual health providers, all based on their developed business plan. Establishing contracts, not only between purchaser and provider, but between all the different actors involved, i.e. purchaser, regulator and provider and even between facility and its health workers, at different levels assisted in clarifying and stipulating mandates, expected results as well as consideration of risks and assumptions that are associated with actual implementation of the agreed plan.

The emergence of viable institutional arrangements for PBF in fragile state contexts was noteworthy and may be due to a vacuum in the existing governance and policy environment which allows for the building of 'new' institutions appropriate to the need. On the contrary, the more stable states were found to witness greater challenges when finding a place for the local fund holder within existing institutions, for community involvement and for increased autonomy at health facility level. It may be that pre-existing institutional arrangements as found in more stable contexts are less flexible to assume extended roles and parallel modalities were therefore more in evidence.

Does PBF contribute to health service productivity and quality of healthcare?

While PBF has gained ground in terms of its contribution, it is not the magic bullet to boost health worker performance, nor is it a ready-made solution to resolve a fragmented health system. However, having considered the contextual factors, the confounding factors, and the reliability of the available information, we conclude that in general PBF indeed *can be* instrumental in achieving better results in the health sector if compared to the traditional input financing approach.

Most notably, productivity of health workers did increase in several of the programs studied, with important differences noted between "*before and after*" introduction of the PBF approach. For example, remarkable results were observed in utilization trends for institutional deliveries, family planning and coverage for antenatal services, which is in line with findings from previous studies. For general outpatient consultation services, an upward trend was noted in some projects but in other contexts PBF had a smaller and mixed effect. One of the limitations when assessing health service performance proved to be the scope of the indicators; these were often limited to the important programs for maternal and child health or HIV/AIDS. A broader scope (e.g. disease

control, promotional activities) is recommended to reach the outcome level while adaptation to national or local priorities, instead of global or donor priorities, are needed.

The attribution of improved results to PBF is not undisputed. Results are encouraging in certain contexts, yet wide discrepancies were noted in results between PBF zones and between PBF facilities, whereby sometimes similar improved results were found in non-PBF facilities or improvements had already started before introducing PBF. Improvements could also be explained by confounding factors. For instance, the introduction of health insurance schemes in Rwanda ("mutuelles") had a positive effect on utilization trends which are difficult to disaggregate from the PBF effects in the same health facility. Additionally, lower user fees represented a confounding factor in attributing results to PBF. We therefore suggest that singular attribution to PBF is not feasible in this study and advocate for critical analysis of attribution of results to PBF.

The quality of care as perceived by the clients had improved, as derived from exit interviews and interviews with community representatives. The improvements in quality of care as perceived by the professionals was evident only in some contexts and more widely health workers and managers viewed pre-conditions for providing quality of care as the solution to achieving actual quality improvement. Quality was therefore more often monitored in terms of "conditions to provide quality care" rather than actual outcome measures. One of the major challenges in PBF is to ensure that tools to monitor quality of care as an outcome will be developed and built into routine program monitoring, as well as the development of capacities for quality assurance measurement.

Does PBF boost health worker performance through motivational enhancement?

With respect to health worker motivation, one of the major questions is the level of importance of intrinsic versus extrinsic motivators in contributing to improved performance. Intrinsic factors such as responsibility for results and authority for decision making were found to play an important role. In some cases we found that the facility based incentive, while appreciated, is seen as a top-up by the individual which is not necessarily directly associated with improved performance of the same individual. Consequently the effect of the individual incentive on motivation is often more limited to social action within the facility's team whereby the intrinsic effect was more potent than the actual extrinsic (or cash) reward. Conversely PBF bonuses can lead to de-motivating the health worker due to lack of transparency or inequitable distribution of the performance bonus. This dichotomy of intrinsic and extrinsic factors requires more formative research in order to achieve an optimal balance in support to sustained performance of health workers.

In the interviews, health workers expressed that they were more creative in their approach to use of resources for health service delivery. Nevertheless, it became evident that this was contingent on autonomy, management capacities and understanding of the PBF concepts. Significant aspects in this case included; the health workers having clarity on what is expected of them and this being linked to positive (reward) or negative (penalty) consequences of their actions. In cases where PBF had catalysed greater cohesion and dialogue with increased worker solidarity this was attributed by the staff to opportunities provided by the introduction of performance based incentives.

What are the other determinants of success for PBF – from communities to national level?

The study found that there was no specific approach linked to PBF in order to enhance community involvement. Community monitoring relied on classical tools such as household surveys and community health committee reports. For performance in terms of utilization and quality of care to improve, services need to be responsive to community needs. PBF holds a strong promise here through the involvement of the community in the steering committees (SC) and in their role in verification as conducted by contracting agencies. Further exploration of a more active involvement of community members in the cycle of decision making and accountability mechanisms is necessary. Certain key areas have not yet been addressed including; gender balance, targeting the poor and vulnerable as well as the capacity building required for the community representatives.

While the ' locus of control' for PBF lies within the domain of the health systems inclusive of community involvement, external determinants were also found to play a critical role in influencing

the approach and outcomes of PBF. The study highlights the need for further consideration of donor and government policy, governance, capacities of the stakeholders, socio-economic and political factors that all impact on results of PBF. While the approach is still nascent, it is too early to expect profound effects on the sector wide development. However, Rwanda has demonstrated clear commitment to the national scale up of PBF and PBF was integrated within the national policy by 2006, following the NGO run pilot projects. In Burundi and DRC effects of PBF are felt on health systems at the local level while in Tanzania and Zambia the PBF had no direct effect on the health system due to the parallel approach used and the fact that contracting was not directly with the providers responsible for results.

Funding arrangements and buy-in from national governments is one of the major determinants that will influence the progress and scale up of PBF. Historically, PBF evaluations point to the successes attained where pilot projects were initiated by NGOs. There is no doubt that the "piloting effect" in the context of PBF is central to the issue of attribution. As with other piloting initiatives, extraordinary resources are invested with concomitant attention to the opportunity to prove that the approach will work. The issue of scale up requires increased budgetary commitments and accelerated government ownership and responsibility. To date, only Rwanda has succeeded in bringing PBF to national scale, albeit with large donor inputs and with an efficient centralised management for PBF, which appears to have compromised decentralization and community involvement.

Some of the more tangible organizational successes that were evident in most countries included improved procedures and reporting systems, albeit in some cases these running parallel to the national systems. Where the systemic model is in operation, enhanced governance structures for accountability and transparency were seen, through improved analysis of indicators of performance and holding service providers accountable for results. There is, however, room for further improvement in terms of mainstreaming the data management, for results based conditionality, into the national health information system.

We are unable to provide any solid evidence in terms of contribution of PBF to health outcomes as this is not feasible to study within the confines of a formative evaluation. A call is made for investigative research to study the contribution to overall health systems performance, but also significant is to uncover the issues of attribution; this can be done through longitudinal comparative studies with other health financing approaches.

What is the cost of PBF?

Previous reviews of PBF have alluded to the high costs of implementation and management to be made when scaling up from pilots to national level. It has also been argued that the additional costs of the PBF arrangements can be too high for the countries to bear after the withdrawal of external funds.

Firstly we found that it is still difficult to judge the efficiency of the approach, due to the diverse budgeting modalities used by the non-governmental organizations (NGOs) where disaggregation of budget lines to reveal true administration costs from other program costs was not attainable. Where financial trends were available, analysis reveals that costs are high: costs for the administration of PBF vary between 15-30% of the per capita health expenditure. However, solid evidence is not available for comparisons with the costs incurred in input based financed projects. In such comparisons increased outputs, improved quality of care, responsiveness of the services to the clients, improved accountability, improved monitoring and evaluation (M&E) systems and efficiency gains made should be taken into account. In virtually all contexts where PBF is operational it relies on financial donor support, not only for piloting PBF but also for capacity building, for creating necessary preconditions, for scale up: this will continue to require external funding to augment national government revenue.

A more detailed prospective costing study is necessary if we want to elicit the total investment costs for design and set up of PBF both in country and for donor technical assistance (TA) investments; the information that is actually available does not allow for such an analysis. This is therefore only possible in a prospective study carried out in a clearly delimitated area, where it is

possible to find comparable control areas and to study only the variable indicators. As a consequence it is difficult to make a judgement on the financial sustainability of PBF in the countries under study.

Is PBF a sustainable approach for boosting of health service performance?

Based on our analysis and synthesis of the findings we concur that PBF brings the attention to downstream accountability and transparency, to the operational level, where the results are focused on delivering more and better quality healthcare for the ultimate beneficiaries. So, PBF is about improving the performance at service delivery level.

To enable the embedding of the PBF approach in the national health policy, the central level of the MoH should participate from the start in piloting the approach. It is necessary that the scale-up proceeds at an appropriate pace if the approach is to retain the basic decentralized principles of PBF. The process of introducing PBF needs to be incremental, not only while extending PBF on a national level, but also a phased approach when introducing in a district: the actors need to understand their new roles.

The place of a local NGO in the process is in accompanying local actors, helping to establish structures, instruments and local capacities of each of the stakeholders. The local NGO should have an exit strategy from the start, and not take the sole responsibility for important institutions for PBF like the local fund holder. The 'new' institutions (e.g. FHA) established for PBF create a challenge in fragile states for scaling-up to a national approach. These FHA furthermore provide an important additional cost and need to be integrated in the national governance structures. This study clearly indicates that scaling up requires new institutional arrangements at both central and local level which has implications for compatibility with existing structures and for sustainable funding of transaction costs. While the Ministry of Health (MoH) has assumed a lead role in the national implementation framework in most cases, it is evident that reliance on external aid is necessary to support building these additional operational structures. The question of "building on" or "building back better" implies that where post-conflict health system recovery is concerned, it is likely that new structures and systems are required as in Rwanda and Burundi, or existing ones need to be adapted to PBF requirements.

Overall, this study shows that PBF is a promising approach, but that more research and critical reflection are necessary to enable PBF to continue to adapt to each context and to evaluate if it is indeed the most effective approach for delivery of improved health services. The methodology of introducing the PBF approach requires operational research and field-testing of different approaches to understand which one leads to the most sustainable and successful results. The research agenda defines the priority areas that call for more evidence based analysis in order to strengthen the approach while ensuring that it becomes embedded within the health system.

Conclusions

This is a synthesis report based on a formative evaluation which was aimed at learning lessons on implementing PBF, rather than fundamental research on it. The early PBF pilot results as reviewed from relevant literature showed promise and demonstrated potential for improvement in health service utilization and quality of healthcare. It provided this review with a framework of issues and topics to be studied. This evaluation focuses on lessons learned on these issues, while also extrapolating unanswered questions which are translated into an agenda for future research.

PBF continues to be an approach of interest not only to stable countries but, in fact, is gaining even greater attention in the context of health system recovery post-conflict. It is not a magic bullet to boost health worker performance, nor is it a ready made solution to reform a fragmented health system. However, having considered the contextual factors, the confounding factors, and the reliability of the available information, we may conclude that in general, PBF indeed may be instrumental in achieving better results in the health sector if compared to the traditional input financing approach. This evaluation did address each of the components of a classic evaluation; relevance, appropriateness, efficiency, effectiveness, impact and sustainability in the context of the country case studies. This synthesis report, however, focuses on the lessons learned from those country studies. Ultimately, the enquiry leads us to the question whether PBF is a viable means of boosting health services and if it should be adopted as a national approach for performance improvement of health systems.

Key results of the PBF review

Almost all indicators in this study had improved when compared to before the introduction of PBF. Contexts had a determining influence, such as those found in North Kivu, where instability and poor infrastructure overrides investment in output financing, thus having an effect on the utilization of services. In other projects positive trends were found particularly in relation to and in reproductive health indicators, where an increase in interventions, such as family planning and institutional deliveries, that historically are difficult indicators to improve due to the multitude of causal factors like acceptability, do effect their uptake. Of equal interest is that HIV related indicators (e.g. Voluntary Counseling and Testing (VCT)) reported important increases which may be accounted for by other donor inputs (Global Fund, PEPFAR). Overall, the scope of indicators was narrow whereby the majority were focused on MCH or in some cases mainly on curative care (in Zambia and Tanzania), but seldom addressed a more comprehensive basket of indicators, including for example, priority programs, disease control programs, promotional and prevention activities.

Performance is not only about healthcare outputs, as it is also intended to improve the quality of care for the user. If quality had improved in the PBF context then what were the drivers of change? Frequently, the providers in PBF facilities explained that they had already anticipated to improve the quality of care as they expected this would increase utilization, hence increase their bonus and because it was made clear what was expected from them and that this was monitored and results had positive or negative consequences. In the case of Rwanda and part of Burundi, after introducing PBF, one can judge on quality of care but only if conditions are met to provide quality of care, not if the care provided was of good quality. Most commonly, quality of care focused on provision of the conditions; equipment, drugs, and infection control and this is a limited definition of 'quality care' and only from the 'professional' perspective. The patient-provider interface and the patients perspective of quality are measured, but only in costly one-off studies which are not replicable. Hence, only in some cases could we show measurable improvements in quality of care provided; measuring the quality of services delivered to hold service providers accountable to, still needs more attention, being a key element in the PBF approach. Patients (or their representatives) and providers expressed, also in this study, that in their perception quality had improved after introducing PBF. Due to the lack of standardized tools for measuring quality of care provided this remains anecdotal and ad hoc. With mainstreaming of client satisfaction surveys and more community oriented feedback efforts, and with introducing indicators on quality of services provided, the quality of care would gain more attention in future PBF initiatives.
Did PBF do better than other approaches? In terms of productivity the study shows that in some places it was likely that PBF led to better results compared to areas where PBF had not been

introduced. However, the variance of results between and within PBF zones was important, and often non-PBF zones showed similar or even better results. We are faced with multiple confounding factors that could explain the 'good' results, even in non-PBF areas, such as the case of health insurance (Rwanda), or user fee abolition or decrease in fees (DRC, Rwanda, Tanzania, Zambia), installation of equity funds (DRC) or simply because socio-economic conditions and the safety of the environment had improved. Hence, to prove attribution of the results to the PBF approach, more research needs to be undertaken. This study brings up several issues for future research in line with the need for more rigorous attention to the progression of PBF and concurrent indices in relation to the wider determinants associated with health service outcomes.

It may have been expected that PBF would have less effect in fragile states, as preconditions (such as human resources, equipment, etc) are not always in place. Surprisingly, the most impressive results of PBF in this study were found in fragile states, where many of the preconditions did not originally exist at the time of PBF inception. It should be noted that in Rwanda (and in Burundi to a lesser extent) many indicators already showed a positive trend before introducing PBF though, probably related to the post-conflict return to normal life and improved access to health facilities. However there are also outliers within the fragile state contexts that do not produce expected results such as North Kivu where the most basic conditions were not in place and results had not improved.

Determinants of success for PBF

Ultimately, this study is not about proving whether PBF is working better than 'input planning', it is concerned with learning about how PBF can make health services perform (better). This study revealed a number of issues that pertain to the macro level governance and the local level operational structures that collectively can have a positive influence on provider performance and outputs of the health facility. The key determinants that emerged from this study in relation to PBF effects include; (i) autonomy of health providers (e.g. to prepare business plans) and other key stakeholders at the operational level; (ii) creating national ownership from the start of introducing PBF; (iii) use of contracts with agreed upon expected results between all actors at different levels; (iv) the presence of a local fund holder; (v) split of responsibilities between providers, the purchaser/ fund holder and regulator; (vi) a functioning monitoring system that includes outputs, quality assurance and monitoring of quality of services provided; and before all (vii) linking consequences to improving performance.

To elaborate further on the key determinants; firstly, a results driven approach seems to elicit more positive outcomes, contingent on clarity of purpose regarding the results expected, autonomy of providers to develop their own strategies (they developed in their own business plan), to attain the agreed indicators and thereby holding them accountable for delivering the performance. The link with national ownership and buy in from national authorities from the start is central to the success of PBF. Where PBF became a national policy in Rwanda and in Burundi, it is no longer an isolated vertical approach but embedded within national plans and directives.

Secondly, success relies on the set up being achieved in a predictable and systematic way and a clearly expressed contract, as agreed between the local fund holder and the health providers, and most importantly in compliance with a split of responsibility functions to ensure that judgment on the results and deciding on the incentives are impartial.

Thirdly, this leads to an important condition sine qua non; a high degree of autonomy at the operational level is needed. This may be easier in (former) fragile states than in 'more stable states', as here different hierarchical levels are not (yet) fully operational. Important issues to be mentioned here include; (i) the presence of an autonomous local fund holder that has the mandate to purchase services; (ii) contracting providers to obtain expected results; and (iii) deciding on rewards in case of attaining good results. It is argued here that PBF contracts are relational, whereby the parties involved negotiate the terms and conditions including performance indicators at the level where results are to be achieved. This offers greater autonomy to the health providers and ensures adaptation of their interventions to local conditions. Hence, PBF is not merely a matter of changing funding mechanisms. It is about holding people responsible for the results they obtain,

making sure that providers are autonomous in decision making at the operational level and ensuring that providers are accountable to the clients.

Does that mean that providers should be completely autonomous in their decision making at the operational level? Boundaries are, through agreed contractual commitments, reinforced by national stewardship and monitored by the regulator. In the end, PBF provides also the opportunity to translate national health priorities in funding terms, to link results to national funding. The study revealed that the providers themselves understood that they needed to be (more) responsive to the needs of the clients when they were designing their strategies to increase utilization (hence incentives). Hereto, it is imperative that the population (or its representatives) has voice and vote in managing the facility's health interventions. There is an important potential in PBF to enhance involvement of the community but the PBF approach still lacks a clear concept of community involvement in health services.

PBF requires reliable systems for reporting, monitoring and validating results at facility and district level where individual health facilities are receiving bonus payments. Data from the routine monitoring system should contribute information that informs whether performance is improving on key indicators according to the contract. Independent verification is vital, which needs to be carried out by other stakeholders, not providers alone (for instance in Rwanda providers in the MoH are the main actors to verify outputs and quality). In addition, countries may want to track progress on a list of indicators that are not being rewarded to identify unintended consequences of the PBF scheme. Responsibility for development of tools, instruments and guidelines necessary for monitoring usually resides with the MoH in full consultation with the fund holder and the providers. Technical assistance is usually provided by the NGOs or directly financed by the donors. Evaluation of progress, however, needs to be contracted to a third party.

Based on the evidence from country studies, agreement needs to be reached on; (i) mechanisms for determining performance outputs; (ii) modalities for monitoring performance, client satisfaction surveys and compliant reporting; (iii) incentive mechanisms and motivation for employees; and (iv) independent verification mechanisms.

Basic principles in PBF are linked to the contracting approach aspects of it; agreement on results between clients, purchaser and providers, defining clearly what is expected, rigorous monitoring if commitments are being respected and linking incentives to the results, in the case of PBF, financial consequences.

Institutional development and PBF

When it comes to the question of institutional development, what contribution has PBF made and what is its potential in the future? Changing the institutional framework is a sine qua non when addressing a split of functions and decentralization. In other words, the approach requires institutional reform and adaptations including a rethinking of extended roles of the regulator, the health providers and the voice of the community. It is concluded here that little has been undertaken to test different options or approaches, e.g. the degree of alignment with the existing structures: more operational research is needed.

PBF is essentially a contracting approach with a change in the funding mechanism from input based financing to output financing through a results based approach. While certain preconditions are assumed vital for this purpose, it is now evident that minimum conditions are necessary to initiate the PBF approach. Investment in capacities, in supplies and in adequate information systems needs to be considered as part of the project design; this investment may take the form of input funding, but also as output related funding as occurred in DRC by HealthNet TPO.

Real decentralization may prove to be more important in the PBF approach in improving results than the financial incentives. Thus, the question arises; are the financial incentives in fact the most important aspect of this approach? They do undoubtedly play an important role, but perhaps staff would also become more motivated and improve their performance based on enhanced autonomy and improved opportunities for empowerment in their work. There has been relatively little testing in whether other types of incentives could be added to the PBF approach, or could receive more

attention. Intrinsic incentives may have an equally powerful effect on health worker motivation and productivity while other tools in support of a client oriented provider efficient approach have also shown to contribute to improved health outputs. Comparative studies have not been undertaken to establish the relative benefits of provision of intrinsic versus extrinsic rewards.
Promising practices in implementing institutional change at the operational level came from Kassaï and Burundi. A lesson learned from Kassaï may be that an institution (here an NGO) is needed to accompany the process, supporting the different kinds of stakeholders in learning and getting used to their new roles and responsibilities. The lesson from Burundi is similar, but here it is that an interesting type of 'new' institution was set up (like in Kassaï) which is elaborate and expensive, albeit interesting when piloting, this may become an important issue in scaling up from pilot to national program

Changes in the health system as a whole are limited, for now. Only in Rwanda PBF is part of the national health strategy and instrumental in boosting health at a national level; Burundi will follow shortly. Lesson learned from Rwanda include that standardization for a rapid scaling up of PBF to national level may result in neglect of some of the essential issues mentioned above, mainly decentralization, community involvement and a split of functions which was limited to the different levels inside the MoH. The incremental growth in Burundi over the last few years may prove to be more successful given the continued investment by NGOs in collaboration with local health authorities to ensure a decentralized approach.

It should be remembered that results may improve initially as a first effect of the financial bonus while it is too early to determine if this has a long term lasting effect. There is a risk that after a certain period, the health workers get used to the bonus; hence the effect of the PBF approach will decrease again. It will be critical to predict the long term effects as linked to the determinants mentioned above. As results of the PBF approach and attribution are not yet well evidenced, this calls for more comparative studies that can test the different approaches and the compatibility and mutually enhancing effects of alternative health financing interventions (e.g. PBF and co-existence of social health insurance). It would be worthwhile to study the contributing factors and determinants for increased performance by a quasi-experimental study design and/or intervention studies.

Finally, a lesson to be learned would be to split the responsibilities of TA in the project cycle; not leaving the model, the approach, the set up, the monitoring and the evaluation to the same person(s) to ensure a critical analysis of developments. PBF as an approach is conceptually still growing, so it needs critical guidance during its development to make the approach stronger.

Financial and equity considerations for PBF

This study could only provide a number of elements to answer the questions on efficiency and in all cases there are additional costs in terms of bonuses and administrative costs (salaries and functional costs of the local fund holder), while the outputs varied and efficiency gains were not made. These costs were significant (about 15-30% of the mean costs of health care), even when the investments by the INGO, like TA to develop the approach or the increased evaluation activities, were not taken into account. Prospective research is needed; many of the types of costs (mentioned in the financial sustainability chapter) were not accessible for this study, while comparison with another approach (like input planning) is recommended. A solid base of costing data is compulsory for simulating the financial consequences of introducing PBF nationwide.

Theoretically one could state that PBF is not about changing the type of services or about changing treatments. It is about changing funding mechanisms, modalities, institutional arrangements and changing the organization and most importantly about changing the 'enterprise culture' in health services by the way of financing health services. Another important outcome would be the effect on equity and on targeting the poor. More sound and methodological complex studies are needed to provide evidence as one can currently only address the issue in terms of probability. The internal evaluations give an indication that the poor are not excluded. The fact that in some cases the consultation fees were decreased to increase utilization in a number of health areas, may point to the probability that some of the PBF programs even increased inclusion of the poor and vulnerable. However, this is still to be confirmed by further research.

We are concluding that at a national level, sustainably financed PBF will need a well financed health sector and most probably there will be a need to get additional resources especially targeted to the start up of a PBF program. The origin of these additional resources will vary depending on the context, in a fragile context this will most probably come from the donors and in a more stable and prosperous context there could be more fiscal capacity to allocate internal resources. The latter of these options depends on the political will to (re)allocate more public money firstly into health and secondly in PBF. But political will is also important if the resources come from external sources, since the general and sector budget support mechanisms are gaining importance. In any case, there will be a need to have a high level of external funding in low income countries, certainly if introducing PBF will not be accompanied with a reform. The level of additional funding needed will affect financial sustainability in the form of reliability and predictability of the resources available.

If outputs indeed did increase, and outcome followed, would these results be sustainable? In terms of financial sustainability, it is clear that additional external funding will be needed. However, as long as the budgets that are available for health in these countries is far below the estimated need of $US 34 per capita (Commission for Macroeconomics for Health, 2006), one may ask if it will be possible to provide quality care without external financing through NGOs or other aid mechanisms.

Sustainability of PBF

In terms of institutional sustainability, it should be noted that in most countries the approach was embedded in, and supported by, national structures and policies. Certainly at operational level (the regulatory function was always in hands of the MoH), and increasingly at the central level too. The exceptions are Tanzania and Zambia where the approach was carried out as parallel to the national system, but this is currently being addressed to align and harmonize with the nationalized strategy on PBF. In each of the countries there is a strong commitment to embark on PBF as a national approach, as strongly promoted by the donor community.

In terms of technical sustainability, there is a clear need for capacity building, both on the approach, as well as on its implementation. Relevant actors need technical support at the level of the public health administration and at the level of civil society. It should furthermore not be forgotten that the providers also need technical support to strengthen their management capacities, thus building a critical mass of capacities that will institutionalize the approach at the health facilities, throughout hierarchical levels and among the different types of stakeholders. We therefore call for a systemic approach to capacity building with sustained commitments by the fund holder and regulator (MoH) in this vital process.

The study presents many lessons that can be used in improving the implementation of the PBF approach. It furthermore brings up an important number of topics for an agenda for research as we have outlined in the following section.