RBF and strategic purchasing: don’t lose sight of the forest (system) while perfecting your trees (scheme)

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RBF is an example of strategic purchasing

- Purchasing (generic): allocation of resources to providers

- Moving towards **strategic purchasing** is a key to building domestic health financing systems
  - Using information on provider performance or population health needs to drive resource allocation

- By linking payment to defined services or service targets, RBF mechanisms are examples of strategic purchasing

- Great potential to strengthen national capacity
  - People have to analyze/use this information for decision-making
  - Can change system culture, shake up bureaucratic inertia
To embed within the wider system, need to unpack RBF

- Break it down into health financing and system functions
  - Revenue raising, pooling, purchasing, benefit design

- RBF/P4P: an explicit link between purchasing and benefits, combined with provider autonomy
  - e.g. paying providers for each attended delivery, paying providers for each child immunized, paying providers for achieving certain screening targets, etc., rather than for inputs combined with a promise to provide such things
  - A means for transforming stated priorities or policies (e.g. free MCH care) into reality through explicit resource allocation incentives (an instrument for allocative efficiency)
Under different labels (and in different ways), being implemented across the world

- Many OECD countries, low income countries, and those in-between doing some form of P4P
- Concept the same, even though context differs
Attention to wider system issues has varied

- Approach to this reform from both a policy and research perspective seems to differ
  - RBF/PBF in LMICs: a self-contained “health financing mechanism”, often run as a pilot project for “proof of concept” (impact evaluation), and not adequately (in my view) on medium to longer term system strengthening
  - P4P in OECD: one (usually quite small) piece of a mixed provider payment system
As with health insurance schemes, think from scheme to system with PBF

- PBF/RBF should not be run like a "scheme" or "project", but as a step in the process of moving systems towards more strategic purchasing.

- Requires thinking about how to incorporate this approach within overall health financing system...as a part of a mixed provider payment arrangement.
RBF AS PART OF MIXED PAYMENT SYSTEM: OUR RECOMMENDED ISSUES TO CONSIDER
Assessing Performance-Based Payments for Forest Conservation: Six Successes, Four Worries, and Six Possibilities to Explore of the Guyana-Norway Agreement

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Jonah Busch and Nancy Birdsall
But it is really here

New issue of *Health Systems and Reform*, with many contributors here at our meeting
1: interface of P4P with base payment system

- Relative magnitude of P4P vs base payment mechanism?
  - In OECD, typically small, go for marginal impact
  - In LMIC RBF, often very large

- Challenges
  - Key contextual difference: base payment in OECD usually “decent” and paid on time, but not the case in poorer countries. This requires analysis, otherwise, RBF may be just an easy excuse to avoid fixing a poorly functioning PFM system
  - Where you start big, hard to scale down
  - Take seriously the danger of creating a system that is driven mainly by fee-for-service incentives (China as a warning)
2: Sustainable, cost-effective verification

- Verification in many LMIC RBF cases often extremely heavy, costly, intensive…raising questions of sustainability

- But in any payment system, a good purchaser has to check the data to ensure claims are accurate, quality is good, there is limited fraud

- This requires thinking through the balance between the cost and the “return” on the investment in verification
  - Aim is to be a “credible threat”
  - Logic seems similar to the “risk-based verification” idea, but it is a part of any “normal” output-based payment system
3. Who is the purchaser, how many, and with what system(s)

- Is purchasing under an “RBF program” done by a different agency/entity than others paying health service providers in the system (e.g. MOH, NHIF)?
  - Are we dividing scarce capacity?
  - Are we running separate information systems?
  - If we are adding to these fragmentation problems, are we really contributing to the institutionalization of strategic purchasing in the health system, or just trying to ensure our “project” succeeds?
4. Is RBF the quality strategy, or is the quality strategy complemented by RBF?

- Quality
  - Do you have an RBF strategy that includes quality, or do you have a quality improvement strategy of which one part is RBF?
  - What are the dangers of making it all about the money?
  - Is there recognition that certain types of activities are better suited to direct payment, and others are worse?
5. PFM alignment

- As sources shift from donor to budget (or donor on-budget), PFM accommodation becomes critical
  - Is your PFM system sufficiently flexible to enable budget revenues to pay for either specific services or for services provided to specific populations?
  - What to do if PFM only allows you to pay for buildings and inputs?
  - Can you pay private providers with public money?
  - Are public providers able to move funds across line items?
  - Do they have bank accounts? Etc etc.

- If we are not looking at this, then we never move away from pilots
What is required to go from scheme to system

- Governance – a recurring theme from yesterday

- Someone (the Ministry of Health) responsible for putting the pieces together, ensuring they are well-aligned with each other and overall system objectives
  - With objectives assessed as the level of the system/population, and not merely beneficiaries of the scheme

- Otherwise, good implementation can lead to bad outcomes