Results-based Financing (RBF) for Health and Immunization

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Introduction/Expectations

- RBF very complex innovation
- We are all on a learning curve

Presentation Goal: Provide overview
  - How we view RBF
  - Why we are engaged
  - What’s in it for immunization?
  - Major pitfalls and challenges
  - What we and development partners are doing
RBF: How we view it

A government tool to disburse some portion of its health budget in cash or goods conditional on measurable actions taken or a performance target achieved
RBF: How we view it

Donors

National Government

Sub-national Region/District

Health facilities
Provider teams
Individual providers

Households or Individuals
RBF: How we view it

- Incentives for individual health workers, facilities, districts or provinces to improve volume and quality of services
- Incentives for communities, households or individual consumers to encourage service utilization
- Schemes: often multiple beneficiaries in a cascading scheme

**Madagascar**

**Increased utilization of MCH services**
- 3 ANC visits
- Institutional delivery
- Complete immunization of children under 1
- Post-partum care within 1 week of birth

**Improved Maternal and Child Health**

- Cash payment to women
- Increased $ resources for health service providers
- Increased $ resources for regional & district health authorities
RBF rationale

- People are motivated by intrinsic forces
- People are motivated by external forces
- If well designed, RBF can reinforce professional pride (intrinsic motivation) with money and recognition (external motivation)
- Incentives matter
Why we are engaged
Country imperative

- Ministries of Finance focused on results
- Ministries of Health need flexibility and creative solutions to achieve results
- Growing demand for assistance
- Word is spreading that RBF schemes have potential to strengthen health systems
Why we are engaged
Country imperative

Health system strengthening
Lessons from Argentina, Rwanda, Afghanistan, Cambodia, etc.

- Innovation
- Governance, accountability & transparency
- Autonomy, authority & flexibility
- Timely, accurate, & credible reporting
- Fiduciary and financial procedures
- Quality of care
- Coverage of population with high-impact interventions
Why we are engaged
Global imperative

Business as usual unlikely to achieve national health goals

MDG4 progress in 68 priority countries
Reducing child mortality

Why we are engaged
Global imperative

Can RBF deliver?

- Economic theory
- Empirical evidence (observations about provider/consumer motivation or lack thereof)
- Policy imperatives (Country goals, MDGs)
- Some solid evidence, more needed
- Mandate to generate new knowledge and expand the evidence base
What’s in it for immunization?

- **Supply-side**: Are current approaches (salary, training, supplies, supervision) sufficient?

- **Demand-side**: Are current approaches (IEC, mobilization) sufficient?

- **Risk**: coverage plateaus without new approaches and focus on results
Supply-side: producers of services
Explicit performance-based agreements

- Service agreement or contract between MOH and different tiers in the public health system or with private entities

- Agreement: payment contingent on results

- Facility payment tied to package of key indicators (4-5)
  - Immunization (DTP3)
  - ANC, Institutional delivery, Post-partum care, etc.

- Mutual agreements present in all RBF countries, including post-conflict or fragile states
Afghanistan in 2002

Reasons to Worry
- One of poorest countries in the world
- Civil war since 1978
- 80% rural
- Little physical infrastructure
- MOPH had limited capacity
- Health workers afflicted by “3 wrongs” (gender, skills, location)
- Little coordination of NGO activities

Response
- Govt. signed Results-Based Contracts with NGOs on a large scale

Source: Benjamin Loevinsohn
Changes in coverage in Afghanistan
Selected indicators (2003-06)

Data source: Household Surveys

Source: Benjamin Loevinsohn
Rwanda: fee for service scheme
Increase in service volume
(after 27 months of implementation)

<table>
<thead>
<tr>
<th>PBF Indicator</th>
<th>January 2006 average/month/health center (258 health centers on average)</th>
<th>March 2008 average/month/health center (286 health centers on average)</th>
<th>Percent increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional Deliveries</td>
<td>21</td>
<td>37.5</td>
<td>78%</td>
</tr>
<tr>
<td>New Curative Consultations</td>
<td>985</td>
<td>1,489</td>
<td>51%</td>
</tr>
<tr>
<td>ANC: second dose of TT</td>
<td>21</td>
<td>52.5</td>
<td>150%</td>
</tr>
<tr>
<td>Family Planning new users</td>
<td>15.5</td>
<td>47.9</td>
<td>209%</td>
</tr>
<tr>
<td>Family Planning users at the end of the month</td>
<td>175.2</td>
<td>711.6</td>
<td>306%</td>
</tr>
</tbody>
</table>

Data source: Service statistics, Rwanda HMIS
Haiti
Performance-based incentives pilot in 3 NGOs

Progress in FIC in 3 service areas

Design: Before/After, no controls
Data source: Household surveys

Source: Eichler et al., Performance-Based Incentives for Health: Six Years of Results from Supply-Side Programs in Haiti, 2007, CGD
Demand-side: users of services
Various schemes to address hidden costs

- Conditional cash payments for the use of a specific health service
- Voucher schemes provided to households for free or highly subsidized health care services
- Conditional cash transfer programs
Demand-side: users of services
Conditional Cash Transfer (CCT) Programs

- Began in Latin America/Caribbean region in 1990s; now widespread

- Cash transfer to household (woman) conditional on completing certain actions

- Many programs have been rigorously evaluated

http://go.worldbank.org/UQEJK2J5EO
CCT: Reducing Present and Future Poverty, WB, 2009
Immunization Coverage Impacts: Mexico & Nicaragua

- Statistically significant increases in immunization coverage

- Biggest effects: children living in households with less educated mothers and ≥ 5km from health facility

- Coverage increases in CCT districts to nearly 100% in Mexico (despite high initial coverage rates)
- Coverage rates for measles, OPV3, and FIC significantly higher in CCT areas than controls
- CCT equalized coverage rates among the more disadvantaged

Study design: RCT
Data source: Household survey

Barham et al., 2007, Beyond 80%: Are There New Ways of Increasing Vaccination Coverage?, World Bank HNP Discussion Paper
Potential pitfalls/challenges

Pitfall
- Unintended side effects
  - Neglect of non-remunerated services
  - Gaming
  - Falsify reporting

Challenges
- Institutional capacity strengthening (HMIS, financial management, etc.)
- Alignment with decentralization, other govt. reforms
- Sustainability

Pitfalls/challenges: mitigated and addressed through sound design, implementation, M & E
WB and Partner involvement in RBF since 2008

The WB Health Results Innovation Trust Fund*

<table>
<thead>
<tr>
<th>Country</th>
<th>Start</th>
<th>End (approx.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eritrea</td>
<td>2009</td>
<td>2011</td>
</tr>
<tr>
<td>D.R. Congo</td>
<td>2009</td>
<td>2011</td>
</tr>
<tr>
<td>Zambia</td>
<td>2009</td>
<td>2011</td>
</tr>
<tr>
<td>Rwanda</td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>2009</td>
<td>2013</td>
</tr>
<tr>
<td>Benin</td>
<td>2010</td>
<td>2012-13</td>
</tr>
<tr>
<td>Kyrgyz Republic</td>
<td>2010</td>
<td>2012-13</td>
</tr>
<tr>
<td>Ghana</td>
<td>2011</td>
<td>2014</td>
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*A $95 m grant from the Norwegian government*
WB and Partner involvement in RBF since 2008

The WB Health Results Innovation Trust Fund*

- Designs evolving
- Majority include immunization indicators
- Rigorous impact evaluation ($1m/project)
- Strong monitoring and documentation
- Wide dissemination of lessons, tools, etc.
WB and partner involvement in RBF

- World Bank routine health projects
- Bilaterals: Norway, AusAid, USAID
- Global Health Partnerships
- Center for Global Development
- Inter-agency working group on RBF
Conclusions

- Innovation and focus on results have potential to contribute to achievement of national health goals

- Some good evidence of RBF effectiveness, but not enough; more evidence forthcoming; much more needed, including cost-effectiveness

- Insufficient information about what happens inside the “black box” of implementation

- The immunization community should be aware and engage where possible
Results-based Financing (RBF) for Health and Immunization

Thank you
Extras
Country snapshots

- **Argentina**: transfers from federal to provinces based on the # of poor women, children enrolled in a social insurance program and performance on key output measures, implemented in 15 provinces with plans to extend nationwide

- **China**: In half of China’s provinces, providers who refer smear-positive patients to a TB dispensary receive a financial payment and those responsible for managing treatment receive a payment when the patient is cured

- **DR Congo**: Health service providers and district level supervisors receive performance-based payments to provide services to 8 million people

- **Mexico**: A government-run program that has evolved over 8 years provides 25 million people (1/4 of the population) a monthly payment that is conditional on school attendance, obtaining preventive care and health education
RBF Pilot snapshots

- **Afghanistan**: performance-based bonus payments to health workers and provincial health staff (complementary to existing scheme)
- **DR Congo**: performance-based bonuses for health workers; facility-based payments based on targeted MCH services delivered (complementary to existing scheme)
- **Eritrea**: demand-side incentives for institutional deliveries (transfer, transport, lottery) and performance-bonuses to providers and regional health teams (new scheme)
- **Rwanda**: performance-based contracting with community organizations, and in-kind commodity incentives for institutional deliveries (complementary to existing scheme)
- **Zambia**: performance-based bonuses for health workers and district management teams- sanctions for mis-reporting; bonuses for community health teams (new scheme)
Conclusions & Recommendations

Cost-effectiveness of CCTs

- Cost/FIC = $20; cost/CCT beneficiary = $40 - $60

- But receive other benefits besides immunization (nutrition supplementation, schooling, other MCH services, health education)
Why RBF may be successful in low-income countries

- Providers widely disbursed, far from support
- Many lack tools, skills and information
- Many operate without supervision most of the time
- Motivating supervisor-provider relationships rare or non-existent
- Little recognition or respect from peers, supervisors, senior management
Why RBF may be successful in low-income countries

- Few opportunities for career advancement
- Civil service salaries low, often irregular
- Teamwork, cooperation usually weak
- Absenteeism
- Local autonomy and innovation limited

Precisely the environment within which incentives have the potential to change business as usual!
RBF Sustainability

- RBF usually represents an incremental amount to existing funding

- External money doesn’t necessarily have to be replaced; if RBF is successful, governments might decide to change their current allocations, reserving some proportion for results-based approaches

- If we can find a successful mechanism for delivering a package of results, $ will follow
RBF integration into SWAps

- RBF is a tool

- Different countries will incorporate RBF as appropriate

- Governments are exploring and deciding how to use and integrate performance-based funding
RBF and user fees

- Hypothesis: RBF could be a possible substitute for user fees, but this needs exploration and research
Qualitative impact of RBF in Rwanda: HW perceptions

- Patients are now clients, and we have to identify and attract them

- We need to keep our facility up to standard, including ensuring equipment is available, procedures are followed, and reports are completed

- More peer pressure since HF benefits or loses based on behavior of the team

- Accountability: mayors and community leaders exert control and pressure over health facilities to perform
Coverage Rate Increases in Nicaragua
Afghanistan NGO contracting scheme 32% improvement in Quality of Care

Study design: RCT

Data source: HFS
Loevinsohn; Peters et al., BullWHO, 2007