THE FUTURE OF PERFORMANCE-BASED FINANCING

AN INSTRUMENT AND DRIVER OF HEALTH SYSTEMS STRENGTHENING

NOVEMBER 23RD, 2022 / THE HAGUE

REPORT OF A VIRTUAL SESSION

Cordaid BUILDING FLOURISHING COMMUNITIES

CONTENTS

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Keynote speakers:	Ellen van de Poel, GFF (Global Financing Facility), technical advisor GFF secretariat Abebe Alebachew, Partner in Breakthrough International Consultancy Maarten Oranje, Cordaid, PBF and data systems expert

1. INTRODUCTION: WHY THIS POLICY DIALOGUE?

One of the most prominent ambitions of Cordaid, already for decades, is to improve health system performance, particularly through performance-based financing (PBF). Cordaid is known for pioneering PBF initiatives, which evolved over time and became large, at times national, applications. Many of these initiatives have been subject to rigorous impact evaluations which yielded positive outcomes, thus suggesting the efficacy of this form of health financing intervention.

However, as Cordaid, we have been less involved in the discourse on alternative health financing mechanisms. Yet we are quite aware of the diversity of developments in the field and seek to gain further knowledge on how best to leverage our experience in future programs. Hence, we have organised the policy dialogue and have invited experienced speakers to address the core topic that is included in the title of the policy dialogues. The speakers will address the topic from:

- The donor perspective,
- The country perspective and
- Cordaid's (INGO) perspective.

2. KEY NOTES

1. Ellen van de Poel: The donor perspective on PBF as a financing instrument and driver of health systems strengthening

Ellen van de Poel opened by noting that performance-based financing (PBF) has a large body of research surrounding it. The potential for significant impact with PBF was shown by early research in Rwanda, Burundi, and Cambodia, and led to extensive funding through amongst others, the World Bank (through the Health Research Innovation Trust Fund). The causal impact of these programmes, and others that followed is well supported by rich evidence-based data across many countries. However, there are challenges to achieving durable results.

Ellen van de Poel

Ellen is part of the secretariat of the Global Financing Facility (GFF) and is currently stationed in Dakar, Senegal. She works on developing and implementing strategies to increase domestic resources for health and increase the efficiency of health spending in West Africa. Prior to this role she was an assistant professor of health economics at Erasmus University, Rotterdam, where she had obtained a PhD in health economics.

Three lines of thought marked Ellen's presentation:

- Pros and cons of stringent application of (expensive) verification mechanisms

Ellen has contributed to an evaluation to see whether meaningful results could still be attained without giving money in a specific manner in line with PBF and control features[1]. The results were encouraging, with increases in service utilisation in most countries. Direct facility financing (DFF) was found to perform equally well as PBF. This would suggest that the efficacy lies in the fact that facilities are directly receiving flexible funding with autonomy to make decisions on what to spend it on. It is argued that stringent verification is not the primary driver of impact. Facilities should have money, and ideally, they should have bank accounts and autonomy to make decisions with that money. And there should be some focus on results and a minimum level of accountability. However, it must be done in a cheaper and more sustainable way to guarantee that PBF will lead to better and more sustainable outcomes.

- Effectiveness of PBF or DFF

The question whether PBF or DFF is more effective may not be that relevant. We should shift towards exploring how we can support governments to increasingly decentralise funds to the facility level, with a focus on increasing autonomy and improving results. To do this, we need to analyse how we can build in a degree of acceptance for waste (funds not accountable for) if it means the scheme can become much cheaper and more sustainable.
The World Bank and the GFF may evolve towards providing more technical support for governments in terms of public financial management (PFM) reforms. Practically, this can be done through decentralised funding flows to allow for the type of long-term continuity of funding that is necessary for facilities to create long-term development plans. This implies institutionalisation of these funding mechanisms and a shift away from project-based, internationally funded programs. Tanzania e.g. learned a lot from PBF but has implemented a nationalised program that closely resembles DFF.

- Data systems

It is important to invest in data systems which collect data on financial arrangements and strategic purchasing, on service utilisation by population segments so to be better able to channel resources towards the areas that are in need. There is much innovation in technological tools, even artificial intelligence, that will make this easier to implement.

[1] de Walque, Damien; Kandpal, Eeshani; Wagstaff, Adam; Friedman, Jed; Neelsen, Sven; Piatti-Fünfkirchen, Moritz; Sautmann, Anja; Shapira, Gil; Van de Poel, Ellen. 2022. Improving Effective Coverage in Health : Do Financial Incentives Work?. Washington, DC: World Bank. © World Bank.

Conclusion

Ellen noted that there are few countries that have the government budget to take on PBF subsidies in the short-term. However, there are a lot of efficiency gains to be made in aligning partners behind certain models. As we move forward in health financing, there needs to be greater emphasis on core functions, such as strengthening the capacities of governments, with less dependency on perpetuating laborious PBF modalities such as rigid performance verification.

There is no need for PBF mainstreaming, which governments associate with WB (World Bank) projects, rather than nationalised health financing mechanisms. Rather, there is a need to bolster the focus on PHC services in a data informed manner. Ideally, this would be through capitation with block grants and some fee-for-service top-ups for indicators that risk being neglected otherwise: supporting government driven strategic purchasing mechanisms is the ultimate ambition.

On a final note: one should acknowledge the importance of community level engagement and Civil Society Organisation (CSO) advocacy to hold governments accountable for the provision of a basic package of services for which money is being allocated through mechanisms like strategic purchasing.

2. Abebe Alebachew: The country perspective on PBF as a financing instrument and driver of health systems strengthening

Abebe Alebachew

Abebe is the principal partner of Breakthrough, an international consultancy based in Ethiopia. He has 35 years of working experience in health, strategic planning and policy, health financing and reforms. He has a master's in human resource economics, and health, education, and labour economics. He contributed to the Lancet Global Health Commission report 'Financing primary health care, putting people at the centre' (April 2022)[2].

Abebe brought his local experience in the PBF field to the session and described three main ideas regarding the transition from project based PBF projects towards government institutionalised programming.

- The first point: concerns the role of international agencies in building government capacities to take on PBF programming. From his experience, while working in Ethiopia, he concludes that more understanding and agreement is needed on how much should be paid to the different levels of the healthcare system and for which services. The healthcare system that provides the service package has a lot to gain by adopting good Primary Health Care (PHC) services.

- The second point: he noted that it is his belief that there should be minimum quality standards for facilities before they join a PBF programme. This means that not all facilities should be able to join immediately; they must meet a baseline quality level first to be able to achieve selected quality indicators.

- The third point: he described how sustainability in PBF programming should be a central target when implementing pilot programs. This requires working with governments from the outset to establish the co-financing of programs, building local/central government commitments and enabling integration of the PBF programme with national health programming.

Counter to Ellen's statements, he believes strongly in the importance of verification systems in PBF programming. While there are many costs associated with the verification systems, he underlined that much of the success of existing programs is due to the follow-up and oversight built into verification mechanisms.

[2] Hanson, Kara, Nouria Brikci, Darius Erlangga, Abebe Alebachew, Manuela De Allegri, Dina Balabanova, Mark Blecher et al. "The Lancet Global Health Commission on financing primary health care: putting people at the centre." The Lancet Global Health 10, no. 5 (2022): e715-e772.

3. Maarten Oranje: PBF has never been static, but has changed dramatically since its original conception, as it has been continuously adapted to different contexts and over time

Maarten started by sharing his observation that the past years of PBF have been marked by greater emphasis on the importance of integration of PBF programmes in local health systems. To substantiate this, Maarten brought in three primary areas for contemplation.

Maarten Oranje

Maarten has worked with Cordaid since 2014 as an PBF expert specialised in health systems strengthening in low-income countries. He has supported the implementation of PBF programs in health across Sub-Saharan Africa, and increasingly in the Education sector. Recently, he has worked with the WHO as a long-term consultant focusing on the use of digital technologies for health financing.

- The first point refers to the need for technical alignment, primarily in terms of health systems components that facilitate health care delivery in the country. For example, assessing what sort of data systems already exist in the country such that parallel or duplicate systems are not layered on-top. This type of forward thinking or in-depth context assessment is essential in the pursuit of creating sustainable programmes that guarantee long-term, positive change in health outcomes.

- The second point: PBF programmes need to be financially viable, with real consideration for the cost-effectiveness of the programs in place. Ensuring that programme costs can be accommodated by domestic financing in the future, or at least partially, means that key facilities like verification methods need to be cost-effective. Especially with regards to the verification methods employed, he described the 'risk-based verification' mechanism that is employed in Zimbabwe, pointing towards ways to reduce the costs of verification while still ensuring the responsible use of funds.

- The third point: as Ellen and Abebe has mentioned, there is an increasing need for political consideration when implementing PBF programmes. Maarten explained how several of the guiding themes in PBF, such as autonomy, transparency, and accountability, are all political in nature. The integration of PBF programmes needs to be in line with the policies and practices that are already in place. This often requires finding champions for change within the government. While the Ministry of Finance is often in favour of programmes such as PBF, within the Ministry of Health there are often diverging opinions about the advantages of PBF, with some departments or individuals being proponents while others defend the status quo.

Conclusion

In conclusion, when implementing PBF in a country, understanding the relations between national and subnational governments is important. When implementing programmes that will change the nature of health service delivery and associated health care systems, exploring the degree of autonomy that distinct levels of the government have and how the dynamics evolve is key to systemic implementation. "We need to understand the political context in which we are operating and what the chances of success are for certain interventions, but also what kind of discourse do you need in a country to advance an agenda like this." Often, a pilot project is important for generating proof of concept, and to show local leadership what is possible with a finance mechanism like PBF.

3. QUESTION AND ANSWER

On quality of care

Ellen stated that while quality of care is important, "We don't really know how to measure it well and especially not through a regular data system. We only make use of surveys that often come too late and are expansive and complex and therefore much too expensive. So, it is hard to manage something you cannot measure." She referred to a recent article on exploring different methods of incentivising quality improvement in the DRC (Democratic Republic of Congo). She finds this merely an extensive checklist, which is too transaction heavy – and therefore costly – in its application. She points towards the World Bank's notion of service delivery redesign agendas. Such agendas would strive to orient health systems on quality improvement as a central focus, rather than an add-on based on laborious checklists. To do this, she suggests using targeted quality of care incentives to strategically drive health service volumes, especially at the primary care level. For example, services such as institutional deliveries by skilled midwives could be incentivised if they are shown to curb mortality.

Maarten replied in agreement, noting that the "quality component of PBF or any sort of incentive that you try to use to improve quality, it needs to be finetuned." The aim is always to provide the best possible health outcomes, in terms of improved access to a defined package of essential health services, improved service quality and improved (financial) equity. The question that faces those who try to provide support is "How can you use some sort of incentive, financial or non-financial, to change behaviour of people in such a way that you get those better outcomes?" It is essential to have a full understanding of which level of service delivery would optimally provide those desired outcomes. While there are different demand and supply side mechanisms applied in different settings, there is no 'magic bullet' solution that works in all contexts."

Endris[3] described how in Zimbabwe, the economic challenges facing the country have impacted health financing and workforce. In this context, PBF is seen as complementary to input financing, besides solely being a lever for improving quality of care. However, the current input financing is severely restricted and is insufficient to lay the foundation for the quality-of-care ambitions of the PBF programme, leading to stagnation in the quality and quantity of care used.

Further, he explained how in Zimbabwe, PBF is included as a line item on the government health budget, which is a big milestone for the health sector. The government is recognising that PBF is not just as a financing mechanism, but a rich source of health system information as well. He noted that there is still need for technical assistance to support government in whatever course they take.

Lastly, when the Zimbabwean government is implementing PBF, it is increasingly related to service indicators, which were previously funded by large donors that now pool funds to target specific health services such as TB, to avoid critical funding gaps.

Ellen acknowledged the dire economic circumstances in Zimbabwe and noted that mechanisms like PBF should be on the margin until sufficient infrastructure is in place and salaries are paid—then PBF can be leveraged to incentivise quality improvements. She states that in many PBF programmes, there was an initial overshoot, where PBF models were applied to "compensate for the fact that there were low salaries, not paid in time, with little structural quality." So she says, the WB/GFF have learned to first leverage input financing and then use PBF on the side.

Further, she notes that in PBF programming the differentiator is the fact money is paid fee-for-service, while everything else is merely plain financing. She isn't sure that we should be advocating for governments to take ownership of this sort of health financing model, given the associated implementation costs. To her, it is more about a government identifying a package of essential PHC services and taking ownership of that, learning from implementing PBF and then doing something more sustainable.

[3] Dr Endris Seid, team leader Cordaid Zimbabwe Office

On Community Based Health Insurance (CBHI)

Ellen first stated that there is an issue with the terminology used around PBF; it is often used interchangeably with strategic purchasing. While there is cross-over, it is not the same thing. As countries attempt to institutionalise the PBF programs, e.g. by incorporating (elements of) PBF into an existing health insurance scheme, they face challenges, especially if they are not fully incorporated into the national health strategy. Further, she noted that CBHI schemes are not very impactful, as finance pooling is often at a too low a level. Schemes that are successful are often not true CBHI schemes as the pooling is done at a much higher level than would typically constitute a community-based programme.

Maarten added that while the institutionalisation of PBF can be challenging, the Rwandan system currently operates with a parallel financing structure, where two financing modalities, CBHI and PBF, complement each other. While PBF programme serves the supply side, stimulating quality improvements and increased capacity of health facilities, the CBHI concurrently serves to stimulate demand for health care by removing financial barriers to the access to care.

Additionally, Maarten pointed at Mali, where PBF and CBHI are to some extent institutionally integrated, e.g. the same agency (CANAM) is involved in the supervision of both schemes. By leveraging the verification mechanism associated with PBF to help manage CBHI, and using audit outcomes for both schemes, countries could be more cost-effective. .

The role of verification in PBF programming: the existing trade-offs?

Fenneke[4] asked Ellen about the trade-off between output verification in PBF quality and quantity mechanisms, and a risk of fraud. This notion goes against the message across the sector that there is zero tolerance of fraud, despite that fact that behind closed doors, some donors will accept that in some settings it is unavoidable.

Ellen explained that her statement on the need for alleviating the verification models to reduce costs was more towards the government perspective in the sense that even in developed countries there are challenges with providers 'skimming on the sides'. In terms of the trade-off, she referred to supporting governments autonomy to develop its systems in a sustainable and sensible manner.

Further, she noted that moving towards a capitation-based model is an example of this, with facilities paid based on their catchment population, where of course there is potential for facilities to not uphold their commitments, but there is no need for such a costly verification framework to uphold these commitments. A fee-for-service mechanism can work alongside capitation for incentivising certain key functions like vaccination or institutional deliveries, so that they evolve into a type of blended payment mechanism.

She also clarified that the World Bank is not an implementing agency, but a provider of loans to governments that flow through the Ministry of Finance, with fiduciary controls to ensure that the money is spent according to prearranged agreements. This is different from the control at the level of health facilities that is increasingly implemented by lower-level government structures, often with the support from NGOs (Non-Government Organisation) like Cordaid.

[4] Fenneke Hulshoff, Operational Expert Program Unit Cordaid Global Office in The Hague, Netherlands

4. CONCLUSION

Ylse[5] concluded by thanking the three speakers for participating in the policy dialogue. As the future of Cordaid is looking to system strengthening approaches, rather than short-term projects, it was a very stimulating discussion on how the organisation can orient itself on the features and feasibility of alternative health financing schemes when moving forward.

While it is clear from the discussion that there is no 'magic bullet' solution for the direction of health financing incentives, especially in the complex settings that exist in developing countries, there is enormous benefit from collaboration between the international donor community, governments, and NGOs towards the common goal of contributing to better health for all. Some of the key take aways for Cordaid are noted below:

- The health system strengthening realm is very dynamic. New approaches must be approached with an open mind, as the integration of new mechanism features can yield better results in the long run.
- Verification in PBF is a contentious feature, given its burdensome costs. However, there exists a divide between favourable perspective of local stakeholders, and the less enthusiastic perspective of some global financing agencies. Given this, Cordaid should carefully assess how to streamline verification systems, while still ensuring the beneficent outcomes are maintained.
- PBF and DFF are competing health financing modalities, with less rigorous verification in the capitation based model of the DFF system garnering attention of the World Bank. This is important for Cordaid to consider as we position ourselves as a program implementer who works extensively with PBF.
- Cordaid may do well to explore tweaks to PBF programming, given that it has been acknowledged that there is no 'magic bullet' for health financing incentives. The degree of financial risk that is accepted may be the crux that needs to be balanced.

[5] Ylse van der Schoot, Chief Operating Officer (COO) Cordaid