

**Bruno Meessen et al.**

**Performance-based financing**

## **Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform?**

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### **Abstract**

Performance-based financing is generating a heated debate. Some suggest that it may be a donor fad with limited potential to improve service delivery. Most of its critics view it solely as a provider payment mechanism. Our experience is that performance-based financing can catalyse comprehensive reforms and help address structural problems of public health services, such as low responsiveness, inefficiency and inequity. The emergence of a performance-based financing movement in Africa suggests that it may contribute to profoundly transforming the public sectors of low-income countries.

### **Introduction**

The United Nations Millennium Development Goals are approaching their deadline of 2015 but progress to date has been insufficient. Public expenditure on health – both domestic and official development assistance – have increased over the past few years in most low-income countries<sup>1</sup> but results have been slow. As the public health system remains the backbone of national health policy and the main beneficiary of international aid, it is most likely part of the problem. In too many countries, the public health system does not meet user needs and demands.<sup>2</sup> It is inefficient due to resource leakage<sup>3</sup> and worker absenteeism.<sup>4</sup> Equity, in terms of utilization and contribution, is unsatisfactory and public spending often benefits richer groups disproportionately.<sup>5,6</sup> Ministries of health and their international advocates often cite insufficient funding as the underlying cause of low performance. Others argue that it also stems from a lack of accountability within public health systems.<sup>7</sup> Although many observers and users likely share this view, few proposals for reform have been put forward. Our opinion is that performance-based

financing, as it is being developed in several sub-Saharan African countries, is a strategy that could help address the structural problems plaguing health systems.

Performance-based financing can be defined as a mechanism by which health providers are, at least partially, funded on the basis on their performance. Performance-based financing can be contrasted with the line-item approach, which finances a health facility through the provision of inputs (e.g. drugs, personnel). Haiti is the first low-income country in which health service providers (national nongovernmental organizations) were contracted and remunerated according to their performance (which was measured by the attainment of some coverage rates).<sup>8</sup> In Cambodia, performance-based financing was applied to the public sector.<sup>9-11</sup> However, despite promising results, it did not materialize into a national policy. This breakthrough did, however, take place in Rwanda. Several pilots initiated in 2002 allowed for a better understanding of major issues, then the country rapidly adopted performance-based financing as its national policy and scaled up the approach to the entire country in 2005.<sup>12-14</sup>

The Rwandan experience has attracted a lot of attention. It has rapidly inspired neighbouring countries like Burundi and the Democratic Republic of the Congo and has consolidated an interest in performance-based financing at regional and global level. Today, more than 20 countries are in the process of introducing or scaling up performance-based financing in Africa. Performance-based financing also fits into the Millennium Development Goals aid paradigm and global efforts for rapid progress on a few key indicators. Yet several authors have expressed concerns about this wave of enthusiasm.<sup>15,16</sup> Our assessment is, however, that their critique reflects a view of performance-based financing as solely a provider payment mechanism and overlooks the potential of performance-based financing to reform health systems. These critiques can't see the forest for the trees.

## The reform package

In most low-income countries, some kind of national health service remains the backbone of the health system (at least in theory). These public systems rely on the central government and the ministry of health, in particular, to fulfil nearly all functions of the health system including: resource collection, pooling of funds, purchasing, regulation,

provision, employment, drug supply, ownership of infrastructure and equipment, monitoring and evaluation. Decisions related to these functions, including those related to health-care provision, are usually highly centralized. It is the central level of government, for example, that decides the required mix of staff for a health centre, allocates personnel and pays salaries.

Performance-based financing takes a radically different approach to the health system, giving organizational units substantial decision rights on their resources (i.e. autonomy). Organizational units do not rely on hierarchical relationships but on contractual or regulatory ones. Interaction through contracts requires that the steward or its proxy clearly define performance for each organizational unit. Different types of contracts are possible. For health facilities, the approach currently favoured in Africa is paying for a quantity and quality mix, a fee-for-service look-alike model combined with scoring based on a quality checklist. For a restricted list of key services, each additional unit of service produced (e.g. one more fully immunized child) is thus rewarded. This approach also encourages the health facility to set up a bonus contract with each staff member. This contract does not try to measure individual performance (as most outputs are produced by the whole team), but takes into account individual contribution through working days, responsibilities and qualification.<sup>12</sup>

For countries such as Burundi or Rwanda, adopting performance-based financing led to a complete reconsideration of roles and functions in the health system. Functions are bundled in coherent packages to maximize economies of scale and scope, yet with a new concern to avoid conflicts of interest. As much as possible, this approach favours a “separation of functions.”<sup>12,13</sup> This often requires the set-up of new bodies, such as a purchasing agent to act as a third-party payer, and the active involvement of new stakeholders, such as community-based organizations to help verify activities reported by the health facilities. Growing evidence indicates that this reform package can address the problems of low responsiveness, poor efficiency and inequity in the public health system.

### **Greater accountability**

Performance-based financing is a powerful means to improve the way health facilities respond to users. As health facilities are remunerated according to their outputs, they

have strong incentives to satisfy users. Granted more autonomy in exchange for greater accountability for results, health facilities can tailor initiatives to the populations they serve. They might, for example, extend opening hours, provide consultations during the weekend, subcontract community actors or offer baby clothes to mothers who deliver in a health centre, as is the case in Rwanda. The pressure for results impacts the entire system. Health facilities, for instance, will put pressure on their suppliers, including the central medical store and national programmes, to receive the inputs required to make their provision of services attractive. In addition, health workers view health information systems differently under performance-based financing: properly completing and filing health information forms is a “must,” as the data provide the basis for part of their remuneration.

Performance-based financing can also empower consumers. In traditional low-income country health systems, citizens have limited or no way to influence the availability and quality of health services. In contrast, with performance-based financing, the community can help verify results and provide feedback on the quality of services received.<sup>13</sup> More fundamentally, patients “vote with their feet,” as deciding to seek care elsewhere entails a direct loss for the health facility budget and, through this, the amount available to remunerate personnel. This may be more effective in terms of accountability than voicing one’s discontent.<sup>7,17,18</sup>

### **Improved efficiency**

Performance-based financing can help improve allocative efficiency by strengthening stewardship. Implementation requires the ministry of health to clarify key health priorities to finance, such as interventions aimed at reaching the Millennium Development Goals or reducing other important causes of morbidity or mortality. Performance-based financing can also lead to greater technical efficiency in the health sector by increasing the quantity and quality of services delivered for a given amount of money.<sup>19</sup> This is obtained by modifying incentives for health workers. Evidence shows that performance-based financing can boost staff productivity, an important outcome in countries experiencing a human resource shortage.<sup>20</sup> By increasing the income of health providers – often a prerequisite for accepting reform – performance-based financing can

secure greater motivation, reduce the brain drain and even encourage staff to work in remote areas.

In Rwanda, performance-based financing helped trigger a major reform of human resource management. The number of health workers increased by 62% between 2005 and 2008 and public subsidies for health worker remuneration more than tripled. Moreover, the average remuneration increased by 60% to 100%, depending on the facility.<sup>21</sup> The successful experience with performance-based financing convinced the central Government of Rwanda that facilities could successfully manage wage payments. It subsequently devolved this responsibility to health facilities, while also giving them the power to hire and fire staff.

As with any health financing strategy, performance-based financing must be seen as part of a broader vision. Ideally, this vision supports universal coverage. Some countries may be inspired by the Rwandan experience, which has shown how the performance-based financing approach can complement community-based health insurance. Performance-based financing focuses on preventive services and quality control, leaving access to curative care and protection against catastrophic expenditures to the community-based health insurance. Others may prefer the example of Burundi, which develops reform plans using performance-based financing to remunerate providers that deliver free health care to mothers and children. This is a promising strategy since free health care financed through input provisions seems to reach its limits in many countries.<sup>22</sup> Performance-based financing could also tackle geographical inequities. For instance, it can improve equity by introducing higher prices for services delivered in remote areas; this will help to attract staff there. Furthermore, many actions taken by health facilities to increase their revenue from the performance-based financing scheme may help improve access (e.g. reducing user fees to attract more patients).

Performance-based financing can also better align donor initiatives with country frameworks. The management of funds from global health initiatives and “verticalized” aid programmes present important challenges. The Rwanda experience, however, has shown that if the performance-based financing system is harmonized, properly designed and adopted by all funders, it can facilitate the pooling and integration of all financing

sources, including the government budget and specific programmes, such as the United States President's Emergency Plan for AIDS Relief.

### **Spill-over effect**

Performance-based financing is all about public finance and, in many countries, has become central to the public sector reform toolbox. Ministries of finance and local governments see health performance-based financing as part of a strong international movement towards more results-based and client-oriented public finance models inspired by the new public management model. Many countries have embarked on some form of budget reform, including performance-based budgeting, and needs- and performance-based formulas for intergovernmental transfers. The health sector may resist these reforms or pioneer them. The Government of Rwanda, for example, has established performance contracts with departments and district councils for all sectors; the contracts link funds received to performance. The health sector is one of the drivers of the reform and contributes to shaping it.

Delivering results can also win the commitment of ministries of finance to fund the health sector. In Burundi and Rwanda, performance-based financing strengthened the position of the Ministry of Health vis-à-vis the Ministry of Finance by showing a clear link between funding and outcomes. In Rwanda, the performance-based financing budget increased from US\$ 0.8 million in 2004 to US\$ 8.9 million in 2007. Practical implementation of more transparent public finance management is also a key benefit of performance-based financing. Public expenditure tracking surveys often find that resources allocated for service provision never reach the frontlines.<sup>23</sup> A major benefit of performance-based financing is the direct transfer of resources to frontline providers, which dramatically reduces leakages.

Finally, performance-based financing sheds new light on decentralization in the health sector. During the past decades, many countries have invested in ill-conceived decentralization reforms of their health systems. In some cases, these reforms have actually led to a decline in performance.<sup>24</sup> The performance-based financing experience suggests that the central level of government should keep decision rights regarding key public health priorities, firmly exercising this right through its purchasing power. At the

same time, it should be ready to transfer decision rights related to the delivery of priority health interventions to health facilities. This is consistent with 30 years of policy agenda, which tried to implement primary health care through greater autonomy of health facilities (e.g. the Bamako Initiative in sub-Saharan Africa). Performance-based contracts may also help level the playing field for public, private-for-profit and not-for-profit facilities, an interesting policy option in low-income countries whose health sectors are growingly pluralistic.

## Conclusion

We do not pretend that performance-based financing is a panacea; more classical support and mechanisms will remain crucial for strengthening health systems in low-income countries. The strategy has limits: some dimensions of performance are difficult to measure and, therefore, to remunerate. Performance-based financing is difficult to design and implement correctly and some conditions are necessary for its success. As with any provider-payment mechanism, there are short- and long-term side-effects. What is very relevant at one point in time may be counter-productive later. Issues of path dependency will have to be managed. Yet, fee-for-service, a remuneration system which has become an evil in high-income countries, is probably needed in contexts where the main problem is insufficient use of health services.

Recent experience in central Africa indicates that these challenges are probably manageable. More interestingly, they have revealed the opportunity for wider reform offered by performance-based financing. If it is incorporated into a broader reform context, it can help address several structural problems facing health systems around the world, problems that have proven intractable for years. This could be the right metric to assess the success of ongoing pilot schemes and mean much more than progress towards a few outcome indicators.

## Competing interests:

None declared.

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