

INTERAGENCY WORKING GROUP (IWG) NEWSLETTER ON RESULTS-BASED FINANCING (RBF)

July 2009

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Three More Pilot Programs Funded by The Health Results Innovation Grant

Our October 2008 newsletter reported major grants (around \$10 million each) for pilot RBF programs in four countries: Afghanistan, Eritrea, Rwanda, Zambia, and a smaller grant to the Democratic Republic of Congo (DRC). All are making good progress.

Ten countries were invited to submit proposals for Round 2 – Benin, Burundi, Burkina Faso, Ghana, Madagascar, Mali, Senegal, Djibouti, Kyrgyz Republic and Vietnam. All but Mali submitted proposals, which were assessed by an independent selection Panel using clearly defined criteria. Panel members were chosen based on their skills and experience with RBF and absence of conflict of interest in the outcome of the selection process. The 11-member Panel then met on December 10, 2008 and recommended that the following three country proposals be funded:

Country	Task Team Leader (TTL)
Benin	Christophe Lemiére
Ghana	Laura Rose
Kyrgyz Republic	Tamer Rabie

Seed Grants

Starting in September 2008, the Bank began accepting, on a rolling basis, applications for seed grants of \$50,000 from IDA-eligible countries that were not selected as pilot projects for RBF funding. Proposals are selected based on the potential of results-based financing to further national progress towards MDGs 1c, 4 and 5, and the appropriateness of the proposed activity to the level and stage of government interest in results-based financing. Seed grants have already been awarded to India, Lesotho, Liberia, Mongolia, and Sierra Leone.

NGO achieves more than or equal to a ten percentage point improvement



*STRETS OF KABUL
Photo © Michael Foley*

RBF Highlight: Performance bonuses for NGO health service delivery in Afghanistan

With the removal of the Taliban government at the end of 2001, the Afghan health system faced enormous challenges. More than 54% of children were stunted, the under-five mortality was 257 per 1,000 live births, and the maternal mortality ratio was 1,600 per 100,000 live births. Limited physical access to care – about one-third of health facilities had been damaged by war or earthquake – and poor health service quality – only about 30% of facilities offered a comprehensive package of maternal and child health services – were contributing factors, as were poor accountability mechanisms.

In the provinces of Afghanistan that are supported by the World Bank under the Health Sector Emergency Reconstruction and Development Project, the basic package of health services is provided by competitively selected NGOs who, in addition to their regular service payments, are eligible for performance bonuses. They sign performance-based service delivery contracts with the Ministry of Public Health, specifying performance indicators and rules according to which bonuses are paid.

An annual bonus of up to 1% of the contract value is received if the NGO achieves more than or equal to a ten percentage point improvement on its previous year's performance as measured by an instrument called the Balanced Scorecard (BSC). In addition, those NGOs who, at the end of the multi-year contract period, achieve a 30% improvement over their performance at the start of the contract period receive an additional 5% of the contract value as a bonus. In order to align the incentives of the provincial health officials and those of the implementing NGOs, provincial health officials are also eligible for performance bonuses that are related to the performance of the NGOs in their provinces.

The Balanced Scorecard consists of six domains (namely, patients and community, staff, capacity for service provision, service provision, financial systems, overall vision) comprising 29 indicators. Facilities are rated on a scale of 0-100. Annual performance bonuses are paid on the basis of performance across these six domains, while the one-off bonus at the end of the contract period is paid on the basis of an index that adjusts the BSC measure by population coverage.

Independent measurement and verification of performance stands is key. Third-party teams administer the BSC. Spot checks of facilities and of the household members who attend them inform the development of facility-level performance-oriented action plans.

RBF Workshops in Rwanda and the Philippines

Substantial unmet demand for country workshops in the wake of the June 2008 Kigali meeting led to a repeat performance in Gisenyi, Rwanda (October 24-28, 2008) and Cebu, Philippines (January 19-23, 2009).

Second Rwanda Workshop

Seven country teams – from Eritrea, Ghana, Lesotho, Liberia, Mongolia, Sierra Leone and Mongolia – attended the workshop with the following objectives:

- Stimulate discussion among policy-makers and stakeholders about how RBF could contribute to meeting national health policy goals and MDGs 1c, 4 and 5;
- Share RBF experience; and
- Begin to prepare proposals for RBF efforts with national health programs.

Using USAID's "Blueprint Guide", the workshop fully achieved its objectives. Participants were engaged, enthused and hard-working. Each team developed an action plan outlining immediate follow-up steps. The workshop highlighted the pressing need to identify sources of high quality technical support to governments interested in implementing RBF.

The World Bank Institute (WBI), working with the francophone network of African learning institutions, the Africa Region of and the Health, Nutrition and Population Unit (HDNHE) of the World Bank organized a successful study tour of Rwanda for high level officials from Benin, Burkina Faso, Mali, Senegal, Burundi to learn more about the RBF program there. In addition, The World Bank Institute (WBI) will further develop RBF course material for inclusion in public health, medical and economics programs in African universities.

All the workshop materials (presentations, working papers, session briefs and participants' list) are posted on the World Bank's interim website on results-based financing (www.worldbank.org/hnp/rbf)

Asia Pay-for-Performance (P4P) Workshop, Cebu, Philippines

USAID, AusAID, NORAD, the Center for Global Development (CGD), and the Bank sponsored this workshop from January 19-23, 2008. Fourteen teams from 9 countries – Afghanistan, Bangladesh, India, Nepal, Pakistan plus Cambodia, Indonesia, the Philippines and Vietnam – participated to share ideas and learn more about how to design and implement P4P/RBF programs.

The workshop focused on steps in developing RBF; country experiences; operationalizing mechanisms; and developing advocacy strategy. Six elements of the USAID Blueprint were highlighted:

- Identifying the main health system performance problems;
- Identifying recipients;
- Selecting indicators and measuring them;
- Pros and cons of alternative payment mechanisms;
- Operationalizing RBF;
- Advocacy strategy.

Participating countries could apply (by February 28, 2009) for seed grants of up to \$80,000 from AusAID (managed by CGD) or up to \$50,000 from the Bank-managed Health Results Innovation Trust Fund (for more information, go to <http://ao.worldbank.org>)

RBF – Why Bother?

RBF and other innovative financing mechanisms are part of a rich and constructive debate about how to strengthen health system performance and achieve better results on the ground. RBF is neither new nor a magic bullet. What makes it interesting to many is the way it juxtaposes the long known ability of incentives (monetary or in-kind) to change behavior (of clients and providers in the health field) with a major focus on results, as advocated in the 2007 Bank Strategy for HNP.

Participants in Gisenyi and Cebu argued that the results to date of RBF programs, while not definitive, show promise. What was impressive, in the view of many colleagues, was that a variety of RBF mechanisms appeared to work well, **even in inhospitable settings**.

Participants also concluded that careful attention to design and implementation, and flexibility in making changes, are key to success in RBF.

The results of RBF efforts are starting to accumulate en route to constituting a body of evidence. Some results from Latin American efforts are already in, including from Plan Nacer in Argentina and conditional cash transfer programs in Mexico, Brazil and elsewhere. Data from rigorous impact studies are now starting to coming in, for example, from Rwanda. Rwanda began paying for performance at the health facility level in 2006, in an effort to improve maternal and child health. The program was rigorously evaluated, and results, released in May in Kigali, show that the program had a significant impact on the use and quality of maternal and child health services, with initial results indicating improvements in child health outcomes. The Bank and other partners will collaborate in the analysis and documentation of these results and will report them on the RBF website (see below) and in future newsletters.



www.RBFhealth.org

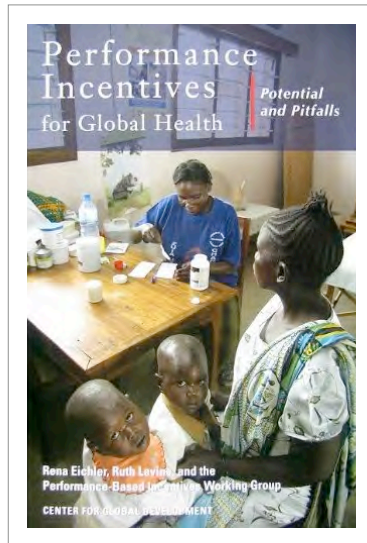
Results-based Financing Web Site

The site is being launched on July 29. The Health, Nutrition, Population Group worked closely with World Bank Institute (Global Development Learning Network) on design of the website, in creating a pipeline of content, and in structuring the database and search functions. Content types to be posted include:

- Country program snapshots (2-3 pages);
- Technical briefs (5-10 pages);
- Feature stories (6-8 page pieces in journalistic style);
- Technical working papers;
- Tools and guidelines;

We are keen to know what kinds of web content will be of most interest to members of the Interagency Working Group, Bank staff and others working on RBF programs, including developing country policymakers and program managers, the international health community, academics, researchers, students, NGOs, the international development community, and bilateral and multilateral donors. Please email **Tony Measham** (ameasham@worldbank.org), RBF web editor or **Rachel Skolnik** (rbskolnik@worldbank.org), RBF web administrator, with any comments or suggestions you might have.

Selected reading:



In *Performance Incentives in Global Health: Potential and Pitfalls*, a new book from the Center for Global Development, Rena Eichler, Ruth Levine and members of the Working Group on Performance-based Incentives document a host of experiences with incentives for maternal and child health care, tuberculosis, child nutrition, HIV/AIDS, chronic conditions and more. “NGOs, donors, and governments in low- and middle-income countries, are looking for ways to improve the way health systems function,” says Levine, “and to achieve ambitious goals for health improvement. When we look across strategies to do that, one of the most promising innovations being explored is the introduction of performance incentives.” *Performance Incentives in Global Health* describes seven of the worst mistakes in performance incentive design and offers advice on how to design effective programs, including how to avoid potential pitfalls. This collection of evidence strongly suggests that incentives can improve health and strengthen health systems—and in a variety of settings.

Reader comments and suggestions – we want to hear from you!

Please send us information about projects, RBF success stories (and failures), your questions, comments, suggestions, and ideas for recommended reading. Send e-mails or documents to Ameasham@worldbank.org and Rbskolnik@worldbank.org.