



RESULTS-BASED FINANCING FOR HEALTH

Performance Incentives in Global Health: Potential and Pitfalls

BY LINDSAY MORGAN¹

I was walking through a park one afternoon when I happened upon two boys careening wildly through the air on a seesaw. There was a world of alternating motion, of two poles vying for ascendancy. Which makes it very much like our own world, the world of global health and development. With each new idea and plan and power point presentation for how to make people less sick and less poor, up we go, brimming with hope and anticipation—perhaps this will work! And with each setback and disappointment, down again we come, disenchanted and skeptical—we’ve seen so many failures.

So it is with results-based financing for health (RBF), a concept designed to help people in poor countries live healthier lives by linking incentives with results. RBF is being supported by the World Bank through the Health Results Innovation Trust Fund, which is financing the implementation and evaluation of six RBF pilot programs in Africa. Benin, the Democratic Republic of Congo, Eritrea, Ghana, Rwanda, and Zambia each will receive between \$10-14 million to implement and rigorously evaluate RBF schemes between 2008-2010, targeting child and maternal health mainly through incentives to service providers. Many are hopeful that these pilots will improve health and strengthen capacity in places where, despite huge investments, health status remains extremely poor. There is also a significant amount of skepticism. But let’s start with the term itself—what is RBF?

What is Results-based Financing?

Results-based financing for health refers to any program that transfers money or goods to either patients when they take health-related actions (such as having their children immunized) or to healthcare providers, when they achieve performance targets (such as immunizing a certain percentage of children in a given area). While the World Bank uses the term “results-based financing” to describe this concept, other donors call it performance-based incentives or pay for performance. But they all essentially describe the same concept of linking incentives with results.

RBF tends to elicit strong reactions. When a savvy Washington politico friend heard that the World Bank had a program that provided aid when results were achieved, he looked like someone had just told him that airplane pilots were now being required to take flying lessons before getting behind a flight deck. “Why weren’t they always doing that?” he asked in astonishment. On the other hand, there was my uncle, a construction worker from California, who, when I told him about the project, carefully set down his Diet Coke and asked “why the hell do you pay people to do something they should do anyway?” There are many who echo his apprehension. Perhaps skeptical donor agencies and NGOs are more diplomatic, but the concern is the same: will incentives interfere with peoples’ intrinsic motivation? Will it make them feel entitled or encourage them to cheat? But many others agree with my political friend, that we should have been doing this all along.

What Makes Results-based Financing different?

Of course, donors have always cared about results. But funding for health has traditionally been directed toward inputs—salaries, construction, training, equipment. Improved health was assumed to follow, but this has not always happened. Despite pouring billions of dollars into health programs in Africa over the last decade, and despite some significant successes², many countries in Africa are still falling desperately and tragically short, particularly in areas that require a functioning health system. Sub-Saharan Africa, for instance, has the highest rate

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of maternal deaths in the world with an average of about 900 deaths per 100,000 live births, according to the World Bank.³ Child deaths and malnutrition are also serious problems.

The fundamental issue, according to Dr. Benjamin Loevinsohn, a Health, Nutrition, and Population Cluster Leader in the Africa Region of the World Bank, is the poor performance of the public health care system, including low levels of physical access in some places; poor quality of care; a lack of adequate incentive structures for health workers; weak management; and inadequate data of sufficient quality to monitor and evaluate progress. In other words, donor commitment and political will are not enough; improved health requires that people far away from donor capitals and ministries of health act in ways that promote and foster good health. Individuals must demand services; health workers must be motivated to deliver adequate care; and the institutions they

work for must be encouraged to make the systemic changes required to achieve health goals. But provider institutions in developing countries typically have not been required to guarantee that services are delivered. Instead, they have either received lump sum grants or were reimbursed for expenditures by governments and donors. This system encourages providers to devote energy to securing funds and justifying inputs rather than to improving efficiency or the quality of care, even when they have the intrinsic motivation to do so.

This is where results-based financing comes in. RBF flips the whole equation on its head, starting with the result—more children immunized, for example—and letting health workers and managers on the ground decide how to achieve them. “I cannot believe we are investing so much in health and getting back so little simply because we miss the right target,” says Adama Traore, Permanent Secretary of Health in Burkina Faso. “The health workers’ external incentives we neglected for so long.”

A Growing Interest in Linking Incentives with Results

Some African governments, painfully aware that their countries are unlikely to achieve Millennium Development Goals 4 or 5—which call on countries to reduce the under-five mortality rate by two-thirds, and the maternal mortality ratio by three-quarters between 1990 and 2015—unless something changes dramatically, are eager to test RBF in their countries. Many more submitted proposals for World Bank pilot funds than could be accommodated, prompting the Bank to issue seed grants of around \$50,000 to several additional countries (Sierra Leone, Lesotho, Liberia and Madagascar) to explore the potential for RBF in their countries. Other countries such as Tanzania, Ethiopia and South Africa are going ahead with RBF programs with funding from USAID, Norway and other donors, while others such as Djibouti are looking for sources of funding so they can give RBF a try. In other words, there is a strong demand for results-based financing in Africa. Rena Eichler, President of Broad Branch Associates and an expert on the application of incentives to improve health system performance, says, “country teams are really excited; it resonates.”

The role of the Trust Fund in this context is therefore very much like a tug boat. With an initial \$95 million from the Government of Norway, the Fund will finance and evaluate—essentially shine the spot light on—this promising new policy idea, and thereby aim to entice (or “tug”) the 10,000-ton supertanker (i.e., the World Bank) and other donors, in a new, maybe even better, direction.

As the RBF concept gains currency in health policy circles, many are watching the Bank pilots closely, hopeful that evaluations will provide solid evidence that the concept can work in Africa. Dan Kress, Deputy Director for Global Health Delivery at the Bill & Melinda Gates Foundation’s Global Health Program, says “We are cautiously optimistic that these innovations can improve utilization, and improve working conditions of health care providers, all of which can improve health care outcomes for the poor.”

The Potential of RBF

So what’s all the fuss about? The fuss comes mainly from the fact that a number of developing country experiences strongly suggests that RBF can work. As governments design and implement RBF mechanisms many are discovering that it helps to improve health; strengthens health systems; spurs innovation, creativity and country ownership; and encourages reforms that confer authority and flexibility to local service-delivery levels, fostering problem-solving where it’s most needed.

IMPROVING HEALTH OUTCOMES⁴

The new volume, *Performance Incentives for Health*, which reviews a variety of country experiences with RBF, shows that when poor patients or households have been offered financial or material rewards for adopting health-promoting practices, they respond and health indicators improve. Similarly, when health workers and facilities are given bonuses upon achieving targets, those targets tend to be met.

In Haiti, a government scheme supported by USAID paid NGO health providers that agreed to reach certain targets such as proportion of children fully immunized and pregnant women receiving prenatal care. In the seven years that the program has been operating, huge improvements in key health indicators have been achieved (including a remarkable

13 percentage point increase in full immunization coverage). NGOs now reach about one-third of the population, providing essential services in the complicated context of violence, poverty and limited government leadership.

In Rwanda, the national government selected features from three donor-supported RBF pilots to construct a national, unified approach for paying public and NGO service providers based on services provided. Between 2001 and 2004, RBF provinces saw an increase in curative care visits per person from 22 to 55 percent and institutional deliveries nearly doubled (from 12 to 23

percent). “I think that Rwanda, with the help of partners, is showing the way,” says Moussa Mbaya, Secretary-General, Ministry of Health and Prevention, Senegal.

Results-based financing has also been shown to help to increase patient demand for health services. Evaluations of large-scale conditional cash transfer programs in Latin America and the Caribbean show increases in the use of clinic services for children (Honduras, Nicaragua, Colombia) and prenatal care (Mexico, Honduras) and decreases in childhood stunting (Mexico, Nicaragua, and Colombia).

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STRENGTHENING HEALTH SYSTEMS, REFORMING INSTITUTIONS

In addition to improving health, results-based financing can contribute to strengthening a country's health system. Because accurate monitoring and evaluation of RBF schemes require the development of robust health information and management systems, incorporating the RBF concept, even into donor funds aimed at specific diseases, reinforces efforts to improve the timeliness, credibility and accuracy of national reporting and monitoring, thus contributing to improving the overall capacity of a country's health system.

RBF can also help countries introduce key reforms that would be difficult to tackle head on, but are more easily addressed indirectly as part of an RBF program. So for example, RBF aims to empower health workers at district and local levels, giving them more decision-making power and control over their budgets. This requires a decentralization of power that can make top officials queasy. But when it is linked to results, the reform—which places responsibility for monitoring closer to the sources—is easier to swallow. “RBF and its focus on results gets at huge reforms through the back door,” says Amie Batson, senior health specialist at the World Bank.

EMPOWERING INDIVIDUALS, SPURRING INNOVATION

In global health, an idea like RBF—which allows people on the ground to think of solutions that makes sense in their own communities and context—is truly innovative. RBF is “more of an agreement between countries and donors than a prescription on what countries should do,” says Margaret Cornelius, Associate Program Officer, Global Health Delivery at the Gates Foundation, an agreement that unleashes workers' intrinsic motivation by trusting them to do good work, while simultaneously acknowledging their need for external rewards, whether money or the respect of their peers.

Interesting things happen when individuals are encouraged to think through creative solutions to better health for the people they serve. In Afghanistan, NGOs addressed the problem of a shortage of female health workers in rural areas by offering couples incentives such as better pay, housing and entertainment subsidies (i.e., DVD players and generators) to move and work in those areas. In another innovative scheme, NGOs, in partnership with the Ministry of Health, provided an 18-month, accredited training course for community midwives, who, after they passed a qualifying exam, were recruited by the NGOs. In 2002/2003 only 25 percent of health facilities had a trained midwife; by 2008, over 85 percent did, even though the number of facilities doubled in that period.

Arjanne Rietsema of the Dutch NGO Cordaid, one of three NGOs implementing the Democratic Republic of Congo pilot, says that RBF is helping bring health centers to life: “health centers which did not have much power before...become active and seek to improve services as to have more clients and more income.” Similarly, in Senegal, also a Bank pilot country, task team leader Menno Mulder-Sibanda says, “we are supporting an innovative results-based management approach from the household level upward...communities and local government feel rewarded by the fact that they are capable of making a difference.”

MORE BANG FOR YOUR BUCK

According to David Roodman, a research fellow at the Center for Global Development, after each previous financial crisis in a donor country since 1970, the country's aid declined. Foreign assistance tends to be procyclical—that is, shortfalls in aid and domestic revenue tend to coincide, and, as InterAmerican Development Bank health expert Amanda Glassman says, “aid for health is no exception.” It is thus more crucial than ever that donor funds translate into improved health—and results that can be measured. Donors understand the importance of investing in health—good health improves labor productivity, facilitates learning, and contributes to economic growth and poverty reduction—but policymakers need evidence, which RBF programs, if monitored and evaluated, can provide.

And Avoiding Potential Pitfalls

There are many reasons to be excited about RBF. It has the potential to strengthen dilapidated health systems, motivate and empower health workers, and, best of all, improve health. "Our countries should pay you guys from the World Bank for opening our eyes on a very real success story of a country [Rwanda] which turned around its entire health sector to achieving the MDGs," says Mouhamadou Lamine Diallo, the Director General of Administrative Function of Senegal. But this is just one side of the seesaw. On the other side are the skeptics, and they have important questions and concerns about the results-based financing concept.

Some are uncomfortable with the idea of paying people for something it is assumed they should do anyway, concerned that financial incentives will diminish workers' intrinsic motivation. Others worry that paying for certain targets will lead to a neglect of other important targets, or that the system will encourage people to falsify data in order to receive the incentive or bonus. There is also the potential for unintended consequences, like in Honduras, where conditional cash transfer payments per child may have contributed to an increase in fertility. It also remains unclear

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whether paying for performance will work in contexts where achieving results is beyond the control of even the most motivated health worker. RBF schemes also require a significant investment for planning up front and monitoring and evaluation can be expensive.

In short, ideas are easy. Making them work is hard. As Sameh El-Saharty, senior health policy specialist at the World Bank, said: "it's not the what, it's the how." Avoiding the many potential pitfalls requires that programs be carefully designed for each country's unique context, implemented with the flexibility to adjust when lessons are learned along the way, and diligently monitored and rigorously evaluated.

RBF Holds Promise, But Careful Design, Implementation and Evaluation Are Key

As with any new idea in global health, there is a tension between the two poles of the seesaw. On one side sit the skeptics, who know better than to be taken in by the latest fad or trend. One day it's cellphones, the next day it's circumcision—but the skeptic knows there are no silver bullets. On the other side sit the optimists, who understand that making a new idea work is challenging but are convinced it just might work. Where the skeptics see a labyrinth of hurdles and uncertainties, the optimists see blue skies of ingenuity.

Of course there is no clear dichotomy between the skeptic and optimist. Each seasoned global health professional is a bit of both. No one believes RBF is a panacea. No one believes it is doomed to fail either. Where there is a high degree of convergence among observers it centers on one thing: that RBF is worth a try. The evidence, it is true, is still limited. But the evidence we have clearly demonstrates that RBF can improve health, and in challenging contexts. The many positive spillover effects of RBF, like strengthened health systems, hold even more promise—that these improvements will be sustained over the long term.

Programs must be carefully designed and assessed to ensure RBF does not increase inequity; that it is reasonably cost-effective; and that it can be done in different places. The World Bank's Health Results Innovation Trust Fund is aiming to answer some of these questions. But for now, what we know is that RBF can make people healthier. And that's something to be excited about.

Footnotes

- ¹ Lindsay Morgan is a Washington D.C.-based writer and analyst specializing in global development and health.
- ² Great strides have been made, for example, in extending access to antiretroviral treatment. In 2002, only 50,000 HIV-positive people in Africa had access to ARV medicines. At the end of 2007, over 2 million Africans were receiving treatment. And the percentage of children protected from malaria by insecticide-treated nets increased almost eightfold, from 3 percent in 2001 to 23 percent in 2006, in 18 African countries, according to the WHO.
- ³ http://siteresources.worldbank.org/DATASTATISTICS/Resources/WDI08_section2_intro.pdf
- ⁴ Information from this section is derived from Rena Eichler and Ruth Levine, *Performance Incentives for Health: Potentials and Pitfalls* (Washington, DC: Center for Global Development, 2009).