



# The Puzzle of Isolation Bonuses for Health Workers

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*In results-based financing (RBF) schemes in Sud-Kivu and Bas Congo provinces in the Democratic Republic of Congo, health workers in far-flung health facilities can earn a bonus up to 20% larger than those who work in the most urban facilities. Variants of these “isolation bonuses” are also used in RBF schemes implemented in parts of Kasai Oriental, Kasai Occidental, Province Oriental, Nord Kivu and Bandundu provinces.*

This brief note examines what isolation bonuses are and why they are used.

## What are isolation bonuses?

The RBF schemes referred to above are of the “fee-for-service” type, meaning that the financial inducement to provide more services takes the form of an additional payment for each additional unit of service that is rendered. The payment varies by service type (usually according to the priority, difficulty and financial cost of delivering the service) and the total bonus payment is equal to the sum of the services delivered multiplied by the value of each individual service.

In addition, health facilities in isolated areas are sometimes paid “isolation bonuses.” These are an upward adjustment of the bonus according to the geographic location—or degree of isolation—of a health facility. In a fee-for-service RBF scheme, this usually means that remote facilities are paid more than urban facilities for each service delivered. Separate performance-related fee schedules then exist for different facilities. Sometimes, though, the isolation bonus involves an adjustment to only one or two indicators in the fee schedule, which changes the relative weights of the indicators and, thus, changes the incentives faced by remote and urban workers to deliver particular services.

For the purposes of the payment of bonuses, “isolation” can be defined in terms of an urban-rural dichotomy,

in terms of distance from the major town, in terms of distance from the reference hospital or other similar categorization.

## Why use an isolation bonus in an RBF scheme?

It is not immediately obvious why isolation bonuses are used in RBF schemes. Surely, horizontal equity would require that both urban and rural health workers have the opportunity to earn bonuses of equal size? Some might even argue that one could consider paying lower maximum bonuses in rural areas because the cost of living is lower.

**Table 1: Hypothetical fee-for-service schedule for a primary health center**

Service unit	Price (US\$)
No. of new curative care consultations	1
No. of children fully immunized	1.5
No. of institutional deliveries	2.5
No. of women using a modern method of family planning	1
No. of pregnant women with at least 4 prenatal care visits	1.5
No. of at-risk pregnancies successfully referred to the reference hospital	2.5

**Table 2: Hypothetical fee-for-service schedule for a primary health center—with isolation bonuses**

Service unit	Urban areas price (US\$)	Rural areas price (US\$)
No. of new curative care consultations	1.0	1.2
No. of children fully immunized	1.5	1.8
No. of institutional deliveries	2.5	3.0
No. of women using a modern method of family planning	1.0	1.2
No. of pregnant women with at least 4 prenatal care visits	1.5	1.8
No. of at-risk pregnancies successfully referred to the reference hospital	2.5	3.0

### VERTICAL EQUITY

The counter-argument, also equity-related, is that remote and urban health workers are not in similar starting positions and, thus, should be treated differently.

Isolation bonuses are often built into RBF schemes to compensate for the (perceived) greater challenges that remote health workers face in delivering services. Since a rural population is more dispersed, and typically faces greater physical and financial barriers to accessing care, it requires a greater effort from a remote health worker than from an urban health worker to deliver a similar amount of services. The remote health worker, therefore, is arguably deserving of larger rewards.

Health workers in remote areas are arguably deserving of larger rewards

This line of argumentation may give rise to an isolation bonus that takes the form of a proportional increase in the price of each indicator (similar to Table 2). Alternatively, the bonus may take the form of an adjustment to only specific indicators where the issue of the remoteness of

the health facility is most likely to affect performance. An example of the latter is an upward adjustment of the price paid for the successful referral of at-risk pregnancies in an RBF pilot in Katanga province in the Democratic Republic of Congo. Health centers that are located the furthest away from hospitals receive a larger payment per at-risk pregnancy that is successfully referred to the hospital because a successful referral over that distance involves more motivation, effort and financial cost.

### A PERFORMANCE-BASED FORM OF HARDSHIP ALLOWANCE

Those familiar with health worker compensation schemes may also see some similarities between isolation bonuses and the hardship allowances that are paid to health workers in many countries, such as Indonesia and Zambia, to compensate for the disadvantages of working in remote areas. The broader policy objective of isolation bonuses in this context, then, is to attract health workers to, or retain them in, rural or isolated areas. Structuring a hardship allowance as part of a results-based financing scheme has the added advantage (from the perspective of the purchaser) that the hardship allowance is not an automatic salary supplement, but a supplement that is conditional on performing well in that environment. In other words, it provides the opportunity to earn more money, but does not guarantee it unless performance improves. It is probably also a more politically palatable form of hardship allowance in environments where authorities fear that higher salaries in the health sector may induce wage inflation across other sectors.

### To pay an isolation or not to pay an isolation bonus?

The decision to incorporate an isolation bonus in the design of RBF programs is one that all project designers should consider. There is potential for both equity and efficiency gains. However, it does add an additional level of detail to the design and raises another set of issues around which consensus will need to be built, and the additional gains of introducing this refinement may be relatively small

compared to adjustments to other elements of an RBF program. Consequently, and depending on local capacity, it may be prudent to introduce isolation bonuses only once an RBF program is up and running. At the technical level, it would not require a massive overhaul of the existing RBF design, but simply a change to the computation formula. Introducing the isolation bonus at that stage would have the added advantage that the appropriate size of the bonus could be estimated based on actual data on differences in urban and remote health worker performance under the RBF scheme.