Let’s Get Together: Community of Practice for Results-Based Financing (RBF) is Launched

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A Community of Practice (CoP) for results-based financing (RBF) was launched in February 2010 during a weeklong workshop on RBF in the central African nation of Burundi, as part of the Health Systems for Outcomes (HSO) initiative of the World Bank. One of five virtual CoPs hosted on the HSO website¹, the RBF community of practice aims to:

- Cultivate expertise in countries, by identifying local RBF experts, expand their numbers and upgrade their skills;
- Consolidate best practices and identify areas where there are knowledge gaps;
- Organize interactions between researchers and policymakers and inject evidence into RBF policymaking; and
- Connect practitioners and experts in developing countries instead of having donor agencies act as go-betweens.

The CoP was launched alongside a showcase of Burundi’s RBF scheme, which provides incentives to health facilities based on quantity and quality indicators and was launched nationwide in April. Burundi is the second country in Africa, after Rwanda, to design and implement a nationwide RBF program. Many other countries such as the Democratic Republic of Congo, Cameroon, Central African Republic, Ghana, Sierra Leone, Tanzania, and Zambia, are implementing promising RBF programs as well.

RBF for health has come a long way over the last decade. What began with scattered successes, little rigorous evidence, and lots of skepticism, is now many diverse successes, a growing body of evidence, and a growing tide of support for the concept. This, coupled with a massive injection of cash (in September 2009, the U.K. and Norway announced they will contribute US$420 million to support results-based financing programs to improve maternal and child health) has resulted in an explosion of RBF programs—from Kyrgyzstan to Zambia.

The attention and resources are welcome, but they underscore the importance of learning and communication among practitioners. Says World Bank senior health specialist Gyuri Fritsche: “The fundamental purpose of the RBF workshop was to enable practitioners who work in far and destitute locations to engage with like-minded folks. [It] was a tremendous success and South-South collaboration got a great jolt.”

The CoP’s Committed Cadre

At the helm are a small group of RBF experts and health economists—based primarily at AEDES (the European Agency for Development and Health), a public health consultancy headquartered in Belgium, the Institute of Tropical Medicine in Antwerp, Belgium, and the World Bank—which will manage and administer the CoP while it is still in its infancy.

They are old friends mostly, who like to talk about their early days in the “trenches” when RBF was just beginning, just an experiment, in places like Cambodia, Afghanistan, and Rwanda. There is a lot of camaraderie among them, a lot of shared excitement about their work. None of them would say RBF is fool-proof, a silver bullet, but they are confident that these programs can and will work.

¹The others focus on human resources for health; finance (including RBF); pharmaceuticals; governance and service delivery; and infrastructure and information and communications technologies.
The strength of their commitment is borne out of careers spent looking for solutions to seemingly intractable health woes and inequities in poor countries, and many disappointments with traditional approaches along the way.

Piet Vroeg of the Dutch NGO CORDAID, which is closely involved with Burundi’s PBF scheme, remembers working in the Democratic Republic of Congo (DRC): “I was coordinator of an emergency medical assistance project in Uvira DRC. With the start of the liberation war of Zaire in 1996 the security deteriorated to such extent that we had to be evacuated...my last view from the plane was several burning refugee camps, at that moment the fragility of an emergency approach became very clear to me. You work hard, save lives but your results can evaporate in thin air within days.”

Vroeg and many others believe that RBF, because of the way it reorients the entire health system towards results and accountability, can bring change that lasts.

Claude Sekebaraga, formerly of the Rwandan Ministry of Health and now a World Bank official based in Nairobi, is another CoP leader and RBF believer. A charismatic Rwandan doctor, he remembers working in post-genocide Rwanda, and how much things changed after RBF was introduced in rural health facilities—when health workers suddenly felt they had a stake in making health facilities better. “I chaired the first national PBF workshop in Rwanda as Director of Health Services. Two heads of health centers explained how PBF changed the spirit of their management. It brought to be a big change of mind on how to manage the human resources.”

Robert Soeters, director of SINA health, a consultancy, used not to believe that a market-oriented approach to health care could be both efficient and equitable. He got his start in Samora Machel’s socialist Mozambique. “At the time,” he says, “we strongly believed in African Socialism being the solution for development.” But after witnessing many abuses of power and lack of freedom, doubts about the abandonment of the market mechanisms of supply and demand crept in. In the 1990s, he and others began to develop a system called sub-contracting, which later grew into RBF.

“The most remarkable story I can remember concerning the force of PBF was in Cambodia where according to established anthropological knowledge Khmer women would not deliver in health facilities, as their ancestral spirits would not allow it. According to the anthropological wisdom, women had to deliver where their parents had lived. Two years (1999 – 2000) into the Asian Development Bank-financed contracting program, the institutional delivery rate remained at a dismal 2-3 percent irrespective of the subsidies we provided. Then in 2001, I visited a Khmer health center where a doctor had suddenly achieved a 50 percent institutional delivery rate in his community. This was a spectacular result. I asked him: how did you do this?

He told me that during the Pol Pot regime near the health center there had been a killing field and that the spirits of the deceased had been gathered in the trees around the health center. This made women reluctant to stay overnight in the health center. Given the money the doctor was losing from the foregone PBF subsidies and after consultation with the local authorities, he decided to cut all the trees around the health center and from that moment on women began to attend. Once he had done this, all the other health chiefs in the surrounding health centers made similar decisive gestures to the spirits and institutional delivery rates began to increase and the problem was solved. This proved to me the force of PBF—the strategy to achieve results should be left to the providers and not to some central bureaucrat in a Ministries of Health office.”

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2Results-based financing is commonly referred to as performance-based financing (PBF) in the French-speaking countries of the African Great Lakes region.
But not everyone is convinced of the powers of RBF. Just before the Bujumbura workshop, one of the attendees, a long-time public health expert, decided not to come, citing, in an email sent to all his colleagues, philosophical objections to RBF. Financial incentives, he said, commercialize health care, induce cheating, and create distrust of and among health workers. And dissent is not welcome—the club of proponents are single-minded, arrogant, and rarely willing to admit the limits of their own theories.

One morning in Bujumbura, I asked one of the leaders of the CoP: do you think criticism or doubt ever get drowned out at events like this? He was thoughtful: yes, he said, we should talk more about the limits of PBF, but "look, for years there was no progress, and now something is actually working...and I don't think we should let doubt get in the way of at least trying this. If someone has a better idea of what we should do, fine, but until then, we need to do this, we can't wait."

**What's Next?**
The RBF Community of Practice will have a presence on the HSO Web site, which will include a calendar where members can post events, meetings, and other activities; a collection of tools, documentation and other knowledge; profiles of community members; and a blog. Contributions will be voluntary, but CoP leaders anticipate that contributions will come easily, since contributors will likely enhance their professional visibility.

While content for the Web site is being prepared, CoP members are already communicating through a Google group, which sends out weekly, sometimes daily, emails alerting members to the latest research, conferences, and job opportunities. Another workshop is being planned and the CoP is even working on a logo. The possibilities are many, but at least for the time being, communication among and between CoP members will continue to be as organic as it always was.

**No Time for Gradualism**
RBF is a complex health system reform and potential pitfalls remain. Indeed, part of the impetus behind the formation of the CoP is to minimize the dangers—through increased communication among practitioners in the field, to improve the design and implementation of programs and build consensus for the concept.

And the ultimate goal, of course, is simply to ensure better health for poor people in developing countries. "The success of our work first in Asia," says Soeters, "and for me personally Cambodia 1998 onwards, Afghanistan 2000 onwards...later Rwanda, the DRC, Burundi, and the Central African Republic is so overwhelming that I am grateful to have chosen the difficult path of changing the many paradigms of the old socialized primary health care model into a much more realistic and market-driven model, BUT without changing the social objectives."

Given these successes, it is perhaps understandable that the RBF Community of Practice members are an impatient bunch; there is an urgency to replicate past successes. Says one CoP member: “One thing is certain: time is short.”

**Interested in joining the community?**
Go to: [http://groups.google.com/group/performance-based-financing](http://groups.google.com/group/performance-based-financing)

You must have a Google account and request to be a member of the group.