Innovations in Results-Based Financing (RBF) in the LAC Region

May 22, 2014
How many countries in LAC have (supply-side) RBF?
- 5, 9, 13 or 20?

Is there correlation between having RBF and success in World Cup?

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize</td>
<td>Bolivia</td>
<td>Haiti</td>
</tr>
<tr>
<td>Brazil</td>
<td>Chile</td>
<td>Nicaragua</td>
</tr>
<tr>
<td>Costa Rica</td>
<td></td>
<td>Panama</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peru</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uruguay</td>
</tr>
</tbody>
</table>
Is there correlation between having RBF and success in World Cup?

62% of LAC countries with RBF have qualified for World Cup finals

33% of LAC countries without RBF have qualified for World Cup finals
Which actors in the service delivery chain are incentivized in LAC RBF?

<table>
<thead>
<tr>
<th>Actor</th>
<th>RBF applied?</th>
<th>Cond. Cash Transfers</th>
<th>Capitation-Based Schemes</th>
<th>Disb-Linked Indicators</th>
<th>Output-Based Disb’ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>National/Federal Gov’t</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provincial/State Gov’t</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Municipal Government</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Health Insurance Entities</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals / Clinics</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agents/Organizations</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Health Providers</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Workers</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Mobile Health Teams</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Households</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Goal:*

- ↑ demand for key services
- ↑ access for vulnerable
- broad goals
- ↑ public health activities
RBF As Part of Capitation-Based (Insurance) Schemes

- Ultimate goal: access to health care (esp. preventative) for vulnerable (otherwise uninsured) groups, via public health insurance + RBF.
- States/regions (or municipalities) receive a fixed capitation payment for each eligible (otherwise uninsured) person that they enroll.
- Size of capitation payment depends partly on performance indicators at state/region level (e.g. immunization coverage, % of healthy newborns).
- States/regions use funds from the capitation payments to pay health providers (at various points in the service delivery chain) for services provided to the enrollees, e.g. via fee-for-service.
- Health providers have high degree of autonomy in use of funds.
- In-depth external verification is done at all levels (substantial cost).
- Examples in LAC: Argentina, Belize, Bolivia, Brazil, Chile, Costa Rica, Dom. Rep., Nicaragua, Panama, Peru, Uruguay.
Disbursement-Linked Indicators (DLIs)

- Similar to P4R instrument which was based on projects with DLIs.
- One or more actor receive(s) DLI payments (e.g. State) – usually not health providers.
- Payments are based on achievement for a set of indicators measured at state level (on service coverage, regulatory actions, others).
- Payments are not linked to unit cost or premiums. On paper, payments are made for a set of eligible expenditures (e.g. salaries).
- Payments often go to Finance Ministry or equivalent.
- Common in Brazil (several examples). Also done in Argentina, Barbados, Nicaragua.
- Independent verification is important, but costs much less than with capitation-based schemes or Output-Based Disbursements.
Output-Based Disbursements (OBDs)

- Used to incentivize public health activities or PHAs (e.g. smoke-free municipalities, blood donations)
- Usually, several states, municipalities or other public entities receive the payments
- Financing provided is based on unit operating cost of each PHA and so this has to be estimated, unlike with the DLI approach.
- External verification is essential, as with other RBF schemes.
- Can be done for sectors other than health, with health impacts (e.g. paying for number of new water points in Bahia state, Brazil)
- Sometimes done concurrently with capitation-based schemes or DLI schemes.
- In LAC, done in Argentina, Brazil, Peru.
Dominican Republic Experience: Capitation-Based Scheme

Christine Lao Peña
Senior Human Development Economist
Overview: RBF implemented through DR Health Sector Reform Project

- Supports GODR overall goal: improve quality of health expenditures & health services
- Primary Health Care focus
- Phased geographical coverage:
  - 2 regions from 2011; 3rd region from Sept. 2013
- Performance-based contracts between MOH and Regions, in coordination with National Health Insurance (NHI)
  - 50% = capitation for essential health services package
  - 50% = regional performance for 10 indicators (MCH & comm. diseases; NCDs) of coverage & quality
Overview: DR RBF Scheme

- Incentives: usage parameters
  - 100% for Primary health care level
  - Ceilings for regional admin. cost and personnel

- Monitoring mechanisms: based mainly on existing systems
  - Clinical Management System
  - External Technical Audits - international consulting firm
SUCCESSES

- Fosters results-oriented & learning culture (local & between countries)
- NHI adopted RBF mechanism in the Project regions
- Improvements: data recording & info verification systems/mechanisms
- RBF regions account for ~ 81% of Clinical Mgt. System (CMS) entries nationwide
- Notable progress in indicators (2011 to 2013)
  - % children < than 15 mos. w/ complete vaccination scheme acc. to protocols: 0.01 to 46.7
  - % of pregnant women monitored for risk acc. to protocols: 0.43 to 18.8
  - % of children monitored for growth & devt. acc. to protocols: 0.27 to 25.8
  - % of individuals > 18 years w/ hypertension screening acc. to protocols: 0.89 to 45.2
Challenges

- **Start-up:** transaction & time intensive esp. establishing systems (e.g. CMS roll-out) & institutional coordination mechanisms but worth it

- **Ongoing:**
  - Behavioral: % of doctors resist systematic CMS use
  - HMIS: CMS bugs (e.g. freezing screens)
  - Other health system issues
    - Lack of properly functioning equipment (e.g. weighing scales, test kits)
    - Irregular internet access for certain facilities
Innovations in Results-Based Financing in the LAC Region: The Panama Experience: Capitation Based Scheme

Carmen Carpio
Senior Operations Officer, LCSHH
May 2014
Reflections and Lessons

- Improve coordination: 79 health rounds every 2 mos.
- Simplify reporting requirements: 79 reports every 2 mos. and 4 mos.
- Automate IT management systems to support RBF implementation
- Review links between results achieved and payments, e.g. binary system
Thank you!!!
The Panama Health Team

L to R: Rocio, Carmen, Natalia, Alfredo,
Not pictured: Evelyn and Sonia
Brazil Experience: Disbursement-Linked Indicators

Daniela Pena de Lima
Senior Operations Officer
Overview

The RBF schemes in Brazil were implemented through investment operations and within the following context:

- WB financing is NOT additional to regular budgets and is a small share of government’s investments;
- Difficulties in implementing traditional operations: (i) strict relationship between inputs and financing, and (ii) difficulties in adopting WB’s procurement rules;
- Need to support existing government’s flagship programs and multi-sector programs (eligible expenditure programs - EEPs);
- Need to strengthen a results-based culture in the public sector - providing incentives by linking WB’s disbursements to achievement of results (disbursement-linked indicators - DLIs).
The Results Framework

Indicators are used to monitor the project and disburse - outputs, inputs and processes:

- Percentage of aggregate budget allocation for eligible programs spent (budget allocation);
- Four-year strategic plan based on project-generated evidence (evidence-based policy making);
- Proportion of municipal secretariats with epidemiological information on HIV and AIDS on institutional websites (timeliness and reliability of the national surveillance system);
- Proportion of HIV-positive patients with first CD4 count below 200cells/mm3 (testing and diagnosis/delivery of services);
- Municipal secretariats executing at least 70% of resources received from federal level/or achieving agreed targets (increasing decentralized management capacity);
- Percentage of contracts procured using the electronic system (fiduciary).
Successes

RBF operations using DLIs:

- Strengthen culture of results and evidence-based management;
- Allow for a more rational and flexible allocation of resources by supporting existing government’s programs and disbursing to treasury;
- Can establish a chain of incentives involving different actors:
  - From Bank to federal level;
  - From federal level to sub-national level and civil society organizations or final beneficiaries – ex: AIDS-SUS project, *Bolsa Família*.
- Allow inclusion of rewards and penalties;
- Strengthen use of local systems;
- Allow flexibility (by including non-procurement items).
Challenges

RBF operations using DLIs:

- Are not easier to prepare or supervise – the opposite may be very true.
  - Require increased focus on results and time to ensure proper M&E arrangements;
  - Require attention to certain details: quantity, pricing and timing of DLIs; independent verification agency, and waivers (?);
  - Require implementing agencies with effective M&E systems;

- May not have enough support from the involved sectors as resources go to treasury.

- May require restructuring as disbursement arrangements are based on expected accomplishments that may not become reality – different from traditional disbursements based on procurement of inputs.
The Experience with Output-Based Disbursements in Argentina

Vanina Camporeale
Senior Operations Officer
AR Essential Public Health Functions and Program Projects I and II (USD 681M –started 2007)

Project Objectives:

- Strengthen national and provincial capacity to carry out 11 Essential Public Health Functions (such as monitoring, surveillance, health promotion….)

- Increase coverage and clinical governance of 7 Public Health Programs (NCDs, Vector-bone diseases, Safe Blood….)

Reduce population’s exposure to principal risk factors
Overview

Component 1: Strengthen National & Provincial health capacity

Traditional Investment

Financings goods, works and consultancies for activities such as: developing information systems, surveys, rehab. of regional blood banks..)

Component 2: Support the purchase of medicines and supplies

DLI & External Verification

Disbursements from the Bank to the MOH conditioned on the number of Provinces with functioning monitoring systems for procured supplies

Component 3: Reimburse provinces for public health activities (PHA)

OBD & External Verification

- MOH refunds to Provinces a share of the operating cost of each PHA, according to their performance after mid-term evaluation (from 50% to 80%)
- PHA performance needs to be measured, registered and verified by the external party
- Bank recognizes expenditures as eligible when MOH submits the verified reports.

Experience with OBD in Argentina
Public Health Activities as Outputs

Design

- Identify activities related to program coverage and strengthening of functions (e.g. applied doses of BCG, certified smoke free areas):
  - Can be standardized
  - Can be measured; unit of measurement, baselines and targets for each activity
  - Can be implemented and recorded periodically
  - Can be verified by an external party

- Identify operational unit costs of delivering PHAs
  - Only non procurable items; financing given for a share of the total unit cost.

Implementation

- Identify and agree with the Provincial MOH on annual targets to be achieved
- Define protocols for each PHA (to be agreed with the Provincial MOH) and for the External Audit
Public Health Activities a Practical Example

- **Safe Blood Program**
  
  **Project Objective:** Increase in voluntary blood donations  
  **Result:** increased from 6% to 30%

How the Project tracks the indicator:

- **Traditional Financing:**  
  - Construction of a regional blood bank

- **Eligible Medical Supplies:**  
  - Procurement of reagents to screen blood

- **PHA:**  
  - Blood donation campaign by regional blood banks (minimum 25 donors)  
  - Unit of measurement: # of campaigns  
  - Refund frequency: 4 times each year  
  - Unit cost components: professionals’ and technicians’ extra time, travel and meals, promotion materials, data collection  
  - Unit cost: AR$ 7000 (USD 870)
OBD – Successes & Challenges

Successes

– Improved quality of the data and records
– Promoted standardization of processes
– Promoted accountability of each provincial program and integration between national and provincial units
– Recognized as a strategic management tool, bringing these areas to management’s attention
– Promoted autonomy in the use of the funds at the Provincial level

Challenges

– Identify PHAs that are aligned with project’s objectives
– Financing provided for unit operating costs (not total unit cost) can result in small incentives.
– Need to develop guidelines and protocols for each PHA as well as information systems for record-keeping
– High cost of the external verification; exceed 20% of the component.
Comparison among approaches: Questions for policymakers

Luis Orlando Perez
Senior Public Health Specialist

Strictly Confidential © 2014
Country experience

Nicaragua-SWAP
Main context characteristics: post conflict country; LIC, weak institutions, limited health network without basic capabilities, multiple donors. Need to rebuild capabilities, central incentives.

Uruguay – NCD prevention project
Main context characteristics. MIC; better than average LAC health results; openness to sector reforms, focus on NCD prevention. Bureaucratic managerial style.

Argentine-Road Safety
Main context characteristics. weak capacity to deliver works and services; large disparities in quality, need to assure quick gains by focusing on specific works and services, complex federal arrangement.
## Comparison of approaches. Policy maker perspective

<table>
<thead>
<tr>
<th>Factors that could lead to success</th>
<th>OBD</th>
<th>DLIs</th>
<th>Capitation Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clear Project Objectives</strong></td>
<td>Limited focus &amp; specific uses</td>
<td>Broad support</td>
<td>Specific use</td>
</tr>
<tr>
<td><strong>Assess country/sector technical capacity</strong> (on project’s health aspects: HR, supplies, equipment, infrastructure; on support structures to deliver health services: HR management, Budgeting &amp; Accounting, Procurement; Information systems, Audit, M&amp;E, etc)</td>
<td>Minimal basic capabilities</td>
<td>Basic capabilities need support</td>
<td>Good basic capabilities</td>
</tr>
<tr>
<td><strong>Incentives to whom</strong></td>
<td>Programs managers Providers/producers</td>
<td>At higher Gov’t level(s) (within/outside sector)</td>
<td>At all levels within the sector</td>
</tr>
<tr>
<td><strong>Support for sustainability</strong></td>
<td>TA for providers/information system</td>
<td>TA</td>
<td>TA along entire results chain. Assure changes at Institutional and managerial levels. Silent reform</td>
</tr>
</tbody>
</table>
Some suggestions…hopefully useful

- **For all three approaches:**

  **Think about the results chain and incentives.**

1. **Describe** and write it.
2. **Validate** it with counterparts and actors along all the entire chain.
3. **Ask** about what you think are the incentives throughout the results chain.
   a. Which they are?
   b. How do they work?
   c. Who or whom would receive them?
   d. Are they sustainable without the project?
SWAP-DLI:

**Environment:**
Difficulties in meeting investment loan requirements:
- Strict relationship between inputs and financing
- WB’s procurement rules

Useful to supports MOH improvements in operations/ processes for health service delivery:
- Budgeting, procurement, information systems, quality procedures,
- Managerial processes, supply chains, building beneficiaries’ database, etc.

**Consider:**
- EPE with items amenable to due diligence.
- Without big procurement or safeguard issues
Easy information tracking for the Eligible Program Expenditure
Realistic goals for DLIs
**OBD:**

**Environment:**
Useful to define and enhance (in terms of quantity and quality) standardized “outputs/outcomes”.
- Must closely track the desired specific services/works
- Need to be measurable
- Must be useful to improve related information systems

**Consider:**
Possible challenges in costing outputs.
- Possible need for initial advances (seed funding)
- Avoid high audit cost relative to payment size
- Need to assure funds reach the true implementers/managers
- Enough time needed to institutionalize processes.
Capitation Payments

Environment:
Useful to extend coverage & to improve quality of services.
  • Easy to disburse & transfer money….sometimes!!
  • Silent reform process

Consider:
Capacity to build + maintain beneficiaries database.
  • At least minimal public or private capability to deliver services
  • Strong information system to track results.
  • Need to enhance routine administrative and or epidemiological data system
  • Sustainability without project or external financial support.
  • It takes long time to institutionalize processes & change managerial and legal frameworks
THANK YOU

FOR MORE INFORMATION
WWW.RBFHEALTH.ORG

Join the Conversation
facebook.com/RBFhealth
slideshare.net/RBFhealth
@RBFhealth