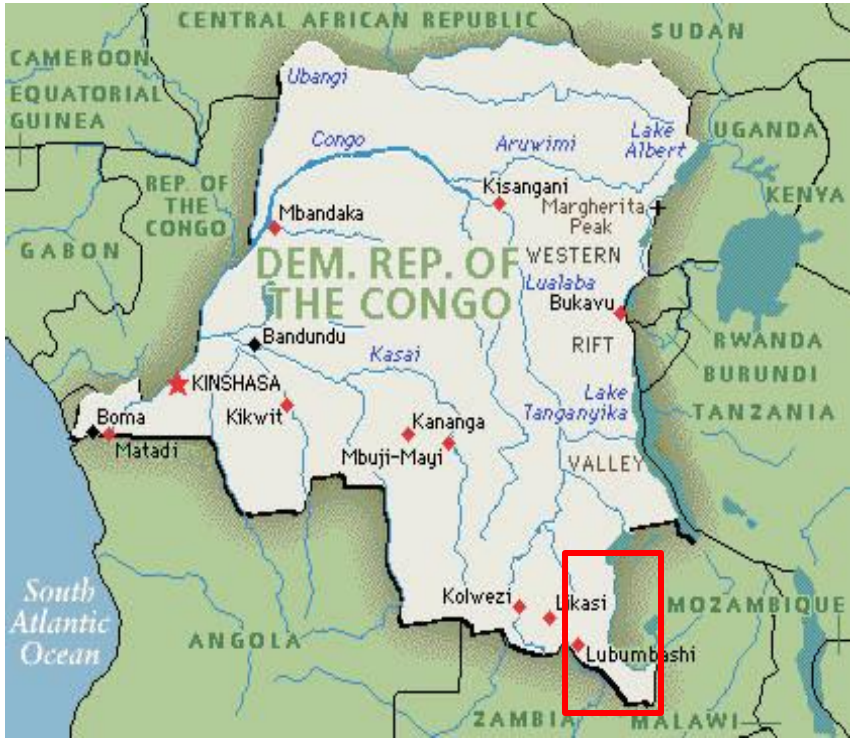
DRC Haut-Katanga PBF Pilot

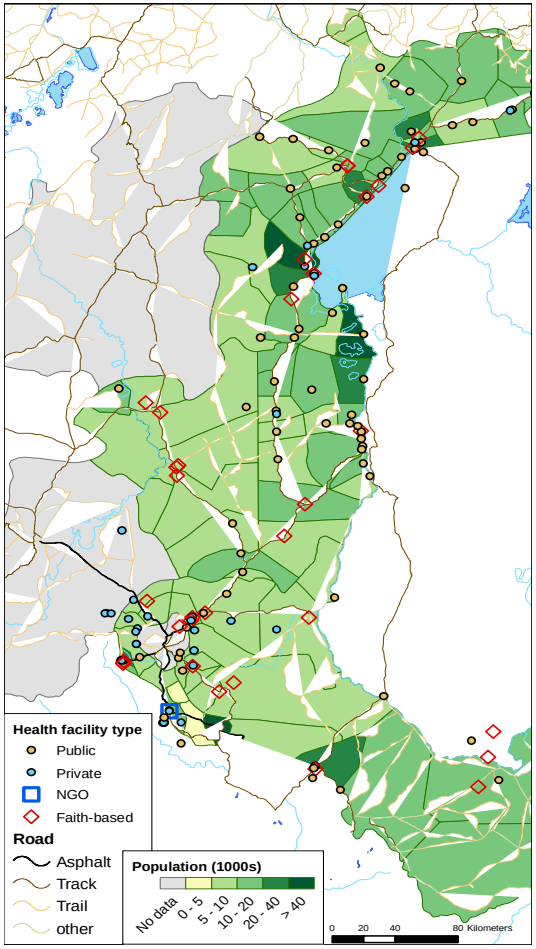
Experiential knowledge, lessons learned and recommendations for future operations

PARSS project design

- **PDO: to ensure that the target population in project health zones has access to and use a well defined package of quality essential health services**
- **Target population: 10 million people in 5 provinces**
- **Timeline: 2007-2014**
- **Comprehensive intervention package:**
  - Construction and rehabilitation of facilities
  - Provision of equipment and medicine
  - Health worker and district training
  - Enhanced supervision
  - Reinforcement of HMIS system
  - User fee reduction policy
- **Intervention became operational in April 2007**
  - Performance-related bonuses introduced in **June 2010**
- **TOTAL PARSS BUDGET: $335 million**
  - **Haut-Katanga PBF Pilot: $1.2 million**

Haut-Katanga district





Pilot design vs. implementation

	Planned Design		Actual Design	
	Financial Incentive Group	**Comparison Group**	**Financial Incentive Group**	**Comparison Group**
Volume of Payment	Same		No difference in volume of payment overall – although higher payments in comparison group during first six months, budget neutrality respected for remainder of pilot	
Payment Mechanism	Payment based on the quantity of health services provided by the facility = Fee-for-service mechanism	Payment based on the size of the facility (the number of health workers on governmental payroll)	Payment based on the quantity of health services provided by the facility with a fixed total budget = Point system	As planned
Technical Verification	One visit every month by IRC/PARSS supervisors and the health zone administration - for verification of consistency between facility registers and declared data		As planned (no visit when there was no payment)	

Pilot design vs. implementation (2)

	Planned Design		Actual Design	
	Financial Incentive Group	**Comparison Group**	**Financial Incentive Group**	**Comparison Group**
Community Verification	One verification every month of 30 patients per health area in a subsample of health areas – for checks of accuracy of the registers to detect phantom patients. Sanctions on a case by case basis.	No verification planned	Although 28 verifications were expected, only 6 were conducted. No sanction except payment adjustment proportional to discrepancies.	2 community verifications for comparison purpose (no consequence on payments)
Autonomy	Facility manager could decide on payment allocation within the facility	Facility manager followed the governmental payroll which indicates who should receive what	As planned	

Pilot design vs. implementation (3)

	Planned Design		Actual Design	
	Financial Incentive Group	**Comparison Group**	**Financial Incentive Group**	**Comparison Group**
Equipment investment support	Some equipment provided by PARSS		As planned	
Drugs	Drugs for pharmacy stocking provided by PARSS		As planned	
Training	Health worker clinical training (by IRC)		As planned	
User fees	All health facilities in the pilot committed to reduce user fees		Overall reduction in user fee schedule despite substantial variation in level of reduction across facilities	
Baseline survey	Yes		Due to delay in project start-up and changes in health facility included in the pilot, The baseline sample did not match perfectly the pilot sample. Baseline survey used for balance checks but not for impact estimates	
Endline survey	Yes		As planned	

Potential effects of design characteristics

Advised design and implementation	Haut-Katanga Pilot, DRC	Potential effects of weak design and implementation
Well-balanced benefit package at all levels	Only one level covered and in addition incompletely covered (only 7 services). Three additional services at the referral health center.	Potential for providers to focus on certain services to the detriment of others; lesser linkage and referrals between health center and hospital levels
Rigorous results verification	Very limited ex-ante verification; instead of 28* (once per month); only 6*. Sanctions for discrepancies were light. No counter verification.	Opportunities for increases in phantom patients; incomplete or weak verification mechanisms can lead to lack of trust in results
Use of community verification and client satisfaction surveys	Very limited community-client satisfaction surveys; results unclear and unknown	Lack of trust in results; increase in phantom patients; no feedback on perception of clients on services rendered
Use of a quantified quality checklist with the result tied to payments	No use of the quantified quality checklist; no quality measures tied to payment	Could potentially lead to an increase of quantity combined with a lesser increase of quality, no increase in quality, or even a decrease in quality

Potential effects of design characteristics (2)

Advised design and implementation	Haut-Katanga Pilot, DRC	Potential effects of weak design and implementation
Use of a fee-for-service provider payment mechanism	Not real FFS; more of a weighting for relative value, and then apportioning available budget based on value obtained.	Reward for effort unclear, increasing productivity may lead to a devaluation of the value of each service delivered. May be interpreted by providers as being penalized for high achievement
Individual fees and total earnings that are significant and paid regularly	Irregular payments; total earnings remained the same during the intervention at $550 per month per health facility on average	Small bonus payments may be insufficient to remedy staff coping mechanisms; purchase drugs, equipment, and minor repairs. Lower rewards provides fewer opportunities to invest in improving the quantity and quality of services

Experiential knowledge on successful PBF design characteristics

No.	Characteristic
1	Existence of a **well-balanced benefit package** (15-25 services) at health center and referral hospital
2	Rigorous **ex ante and ex post results verification** occurs
3	**Separation of functions** among regulator, provider, and purchaser serves to improve accountability and credibility of results
4	Use of **community client satisfaction surveys** to gather information from clients on use and to gather their opinions
5	Use of a quantified **quality checklist** (balanced score card) with the result tied to payments
6	Use of a **fee-for-service provider payment mechanism** makes measuring outputs easier and links efforts directly to rewards
7	**Strategic purchasing** with a focus on underprovided and underutilized preventive services
8	Individual fees and total **earnings that are significant and paid regularly**
9	**Most money to the most cost-effective services**: two-thirds of performance payments go to the community or health center level and one-third to the first-level referral hospital
10	**Inclusion of equity measures** that orient payments to destitute geographical areas, facilities and the poor

From PBF Toolkit (Fritsche et al., 2014 (forthcoming))

Experiential knowledge on successful PBF design characteristics (2)

No.	Characteristic
11	Enhanced financial and managerial **autonomy** for health facility resource mobilization and use
12	Strengthened role of **health facility management committee** in decision-making processes
13	Quarterly or monthly payment cycles with facilities using **indice tools for improved financial management**
14	**Performance frameworks for the regulator** (health administration at the district and provincial levels)
15	Use of **quality improvement and investment units** to provide means for health facilities to upgrade quality
16	**Health facility management instruments** such as the business plan, indice tool, and individual monthly performance evaluation.
17	**Coaching and technical assistance** by the purchasing agent
18	Existence of a **district PBF steering committee** for improved governance at the decentralized level
19	**Use of a web-enabled application with public front end** for improved data management, strategic purchasing and public accountability
20	**Continuous coordination** between technical assistance and the government
21	**Capacity building** at health facility, district, and national levels

From PBF Toolkit (Fritsche et al., 2014 (forthcoming))

Recommendations for improved PBF design

- Lessons from operational experience from ongoing PBF schemes in several countries (Rwanda, Burundi, DRC, etc.) underline the importance of several key PBF design characteristics to take into consideration for successful interventions.
- In considering future PBF programs in the DRC and similar contexts, designs could be strengthened by:
  1. **Increase output budgets** for operations in similar contexts to around $3 per capita per year;
  2. Use a **fee-for-service** provider payment mechanism
  3. **Introduce the quality checklist** at the health center and hospital level and **make performance payments contingent on quality**;
  4. **Introduce health facility management tools** (business plans, indice tools, individual performance evaluations);

Recommendations for improved PBF design (2)

- In considering future PBF programs in the DRC and similar contexts, designs could be strengthened by:
  5. Introduce **performance contracting for the health administration** at all levels;
  6. Strengthen **community verification** and **counter-verification**;
  7. Strengthen the **ex-ante verification** and **coaching**;
  8. Introduce a comprehensive **web-enabled data management system** (data analysis, reporting, payment);

Recommendations for improved PBF design (3)

- In considering future PBF programs in the DRC and similar contexts, designs could be strengthened by:
  9. Introduce **geographic equity bonuses** (hardship allowances);
  10. Introduce **investment units** to allow facilities to upgrade their quality quicker
  11. Strengthen governance through the introduction of decentralized **PBF Steering Committees at the district level**

- Finally, strong and continuous implementation support and supervision is essential

Thank you