Questions and Answers with Dr. Benjamin Loevinsohn:  
Contracting, intrinsic motivation, and the future of results-based financing (RBF)

BY LINDSAY MORGAN¹

Dr. Benjamin Loevinsohn is a Canadian physician and a lead public health specialist at the World Bank which he joined in 1999. He is currently the health, nutrition, and population cluster leader for central Africa, and worked for many years as team leader for health sector activities in Afghanistan and Pakistan. He is the author of Performance-Based Contracting for Health Services in Developing Countries – A Toolkit. In this interview he talks about contracting, intrinsic motivation, and the future of results-based financing.

You studied to be a doctor in Canada. So why aren’t you a doctor in Canada?

My mother would like to know that too. After I finished my residency I went to work as a country doctor in Nicaragua. It was a nice combination of doing curative care but also looking at bigger picture issues—motivating health workers, worrying about preventive care, dealing with supply chains that didn’t work. And it confirmed the bug that I had felt before.

Where did the initial bug come from? I know your brothers are also in development. Is this a genetic thing?

I have two brothers, and both of them work in global health. Growing up, ideas were big things in my family. We would have debates about things on Friday nights. By far the biggest thing that we saw around us was global poverty and there was this idea that it was something worthy of taking on. There is also our parents, who were born and grew up in Nazi Germany and were lucky enough to escape. I think that had an indelible effect on all three of us. We’re lucky to be here.

After working in the Philippines and with the Asian Development Bank, you came to the World Bank in 1999, where you have become known as something of a guru on contracting health services. Why are you so into contracting?

When I was studying at Harvard there was a presentation done by a health economist showing that faith-based organizations in Uganda provide substantially better quality of care than the public sector. I remember sitting in this brown bag seminar and being appalled. I thought the idea of anybody but the public sector providing health services was a really awful thing.

Why awful?

I thought of it as a threat to public financing of health services, a way of privatizing both the financing and delivery of health services and of weakening government, as if health wasn’t that important.

So what made you change your mind?

A couple of things happened. One was I actually had to work with some of these health systems. The more I saw publicly

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delivered health services the more problems I saw, and some of them were fairly fundamental. Not every government
does a poor job, but for every Sri Lanka that does a reasonably good job there are lots of others that don’t and I tended to
work in them.

The World Bank report Bureaucrats in Business was also influential for me. It had twenty or so case studies of
government-owned services or companies and what happened to them when they contracted in management and it
really got me thinking about—ok the ownership can still stay with the public sector, but there’s really no reason why the
management has to be public sector.

**Can’t similar results be achieved with incentives in the public system? You’ve been involved in those kinds of schemes
too, in Burundi and Rwanda.**

Sure, it’s possible to create incentive structures within the public sector to do a better job. Has it happened? Not very
often.

**Why not?**

First is the willingness to pay bonuses to managers based on their performance, while giving them flexibility and
autonomy. There are lots of rules and regulations in civil services in the public sector that are impediments to innovation.
Part of what would happen in contracting in Cambodia and elsewhere was that NGOs would introduce innovations and
would figure out better ways of doing things. Creating the space for people to innovate is really central. If we can do that
in the public sector, great, I’m totally there. My experience has generally been that it’s anathema.

It’s an empirical question though: on average, will publicly managed services do better than privately managed? So far, I
lean towards the non-profit private sector but I’m happy to be wrong on this.

I had dinner in Monrovia a few months ago, and was talking about performance-based contracting in Afghanistan with
some people who had worked there. Here’s what they said:

-Sure, service delivery expanded rapidly and the performance-based contracting model
-outperformed the others. But the differences were relatively small and driven primarily by huge
-increases in funding—which helped to rapidly expand health service delivery in other countries, like
-post-conflict Mozambique where there was no contracting.

**How do you respond to that?**

I don’t know enough about Mozambique to be sure. But I’ve done a reasonable amount of work in South Sudan, which has
had a huge influx of cash—more than $26 per capita per year and a flood of technical assistance. Everybody and his cousin
is there. And they just came out with the preliminary results of the 2010 multiple indicator cluster survey and we can
compare them to 2006 results and health services have deteriorated. Coverage of measles, antenatal care, institutional
delivery have actually declined in four years, despite this huge influx of money. So I’m not sure that money is enough.

Yes there was a lot of money that went into Afghanistan, but the quality and quantity of services improved. And people
forget that what progress was made has been happening during a time of increased, not decreased, insecurity. That didn’t
happen in South Sudan. South Sudan has been pretty much calm since the comprehensive peace agreement was signed in
2005, but you still didn’t get results.

I don’t know about you, but when I travel, I often get strong reactions to RBF—strong negative reactions. One question
that comes up over and over again is about sustainability, and there seem to be two strands to it. The first is: these
programs are really costly and they rely heavily on technical assistance, and they’re really complicated. Is RBF really
sustainable past the donors? We’re introducing fundamental reforms, but donors aren’t around forever. What happens
five years from now when RBF isn’t the trendy thing anymore and the money is going to other things?

It is a fair question. But sustainability only matters if results-based financing actually works. If it doesn’t work then the
sustainability question is academic and who cares.

**What do you think?**

So far I would say yes, the evidence is ok. It’s not overwhelming. That’s why we need to develop the evidence base
further. I understand why people are skeptical, and that’s why we should continue doing rigorous impact evaluations. It also depends on how much bang we’re getting for the extra bucks. How much does it take to effectively introduce performance-based financing? Is it $3 additional per capita per year in low-income countries? Could it be done for $1.50? Do we need to incentivize all the health workers in a health system, which is quite expensive, or can we get roughly similar results by incentivizing managers, which might be a lot cheaper? We really should break it down to: is it cost-effective, and are there alternative ways to get similar results? We haven’t pushed the envelope far enough on that score.

The other sustainability question I hear a lot is subtler, and has to do with people’s worries that RBF messes with intrinsic motivation. I heard someone say recently: if you give mothers something tangible to come in and have their kids immunized, when you take it away, they won’t do it anymore.

First of all is, for the mothers who come, they probably have a reduced risk of dying and their children have a reduced risk of dying. That’s a good thing right? Dismissing that, saying, well we had an impact but it doesn’t matter because in the long run… I find that objectionable and actually immoral. It’s basically saying that if we do something good for people, it doesn’t matter if it doesn’t affect the huge universe forever and ever. If it’s successful, if it works, that’s a good thing, especially if it’s at reasonable cost.

The second issue is about, so when you take away the incentive, does the rate of institutional deliveries go back to what it was previously? Does it go lower than it was before?

Do we have evidence on this?

This is an evidence-free zone. This idea that if you take the incentive away things will go back to how they were or even worse: prove that to me. I’m happy to be convinced if that’s where the evidence leads, but I don’t see it.

The concern seems to be that we are transforming good people and making them into bad people, people who only care about money, but I don’t think that that’s what’s happening at all.

I’m with you. It comes out even more so when incentivizing health workers. There’s this real fear that we’re going to destroy their intrinsic motivation.

Ritva Reinikka, the World Bank’s Sector Director, Human Development, Africa Region, wrote a revision of her policy working paper from ten years ago, Working for God. They used some interesting analysis to show that faith-based organizations responded to increased financing in a very altruistic way: they decreased user fees, increased their services, and no additional money accrued to the health workers or managers. So faith-based organizations may in fact be intrinsically motivated. I fail to see how providing a faith-based facility with a payment per service interferes with that intrinsic motivation.

I don’t think most people are upset for getting paid more for what they’re already doing. No one’s come up to me and said: you’ve ruined my intrinsic motivation. I used to do this because I believed in serving humanity and you have reduced me to a groveling piecemeal health worker. They don’t say this to me because I don’t think that’s what’s going on.

We have a healthy set of first generation experiences with different kinds of RBF: supply and demand side, contracting, fees for services, target approaches. Where do you see RBF going over the next 5-10 years? What will be the new, cool things?

What is it that Yogi Berra said? I make predications but never about the future.

You’re very noncommittal.

My sense is that, as a smaller percentage of health services are financed directly out of pocket, and there’s more of an insurance mechanism, contracting arrangements will become more common. The world is urbanizing rapidly so the next 20 to 30 years will see more people with more options in terms of where they get their services because they’ll be physically closer to a larger variety. Countries are also getting richer, and as people get richer they will move away from out of pocket expenditure towards some prepayment or insurance. As insurance increases, purchasing will increase, so I think there’s an opportunity to engage in purchasing services, whether through RBF or PBC.
One area we have not explored that much but should be explored is community health workers. We’ve done primary healthcare facilities, we’ve done hospitals, but we really haven’t done much with community health workers and I think that’s one area where we’re going to expand.

We also need to make sure there’s space for people within PBF not to be too focused on one model. Within the model, there are ways of getting better at it, and we need to make sure there’s space. There’s not one way of doing things.

When we look back also 5-10 years from now, is there anything we will wish we had done differently?
That’s a hard one. I think, on average, we’ll think it works pretty well and you can probably get better results than publicly delivered services. But that doesn’t mean it’s not possible to screw it up. It’s possible to do PBC badly.

How?
Not specifying what the results are; focusing on processes rather than results; not paying attention to monitoring and evaluation; not making contract management somebody’s job.

One big advantage we have is having a lot of technical assistance and a community of practice and the benefits of the Internet, which means that we can learn lessons in close to real time. When things are going off the rails, we can figure out what they are.

A lot of your work has been in post-conflict and fragile countries. Do you get bored in stable countries?
Ha. It wasn’t by design. But the interest in working in conflict or post-conflict fragile states is that there are fewer vested interests, there’s more opportunity to innovate, and it’s harder for people to argue that the status quo is fine and all we need is more money. There’s an interest in innovation that provides the space to look at different ways of providing services. Maybe that’s why I’ve ended up there.