Relationship MMI and Performance Based Financing

Session prepared by:

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Objectives presentation for MMI

- **To present a (short) history of the contractual approach within MMI;**
- **To advocate why MMI members should be interested in such “liberal” and “World Bank like” approaches as “Performance” Based Financing;**
- **To present some underlying concepts on PBF;**
- **To present the encouraging Cordaid PBF results in terms of effectiveness and efficiency in Rwanda, RDC Burundi and RCA.**

History MMI and the contractual approach 1

- Paper 1997 Viewpoint: Public versus private health care delivery: beyond the slogans by Daniel Giusti and Bart Criel in Health Policy and Planning.
- Description of what is public and what is private health service. Authors argue that we must move away from the administrative definition.
- There are govt hospitals that operate as private for-profit institutions and do no pursue services with "public" value such as in Zimbabwe and Uganda. Vice-versa there are private initiatives that have great public value.

History MMI and the contractual approach 2

We may mention a number of criteria to define which health facility provides "private" or "public" services such as:

- social perspective
- non-discrimination
- population-orientation,
- government policy guided

=> Health facilities that fulfil the above are eligible for public funding (govt, church or private owned).

History MMI and the contractual approach 3

- Basically during the 1990s MMI supported the contractual approach so that their members could obtain public finding.
- Tom Puls, Prof van Balen, Widmer (and others ..) worked hard to promote the contractual approach at international fora such as the World Health Assembly
- Contractual approach manual developed by MMI

History MMI and the contractual approach 4

- In the meantime lessons learned between 1998 – 2004 with field experiences made that the *more general* "contractual approach" gradually moved towards the *more specific* "performance based financing".
- Millennium conferences with Bishops in English and French speaking Africa reconfirmed the contractual approach (and in Cotonou also with performance elements) in 2004 and 2005.

Why should MMI promote their members to incorporate performance based financing?

1. Evaluations show disappointing results with input financing and traditional centralised district health models: Cyangugu Rwanda – several programmes in RDC, others.

2. Growing ambition to achieve an impact and results more effectively and efficiently in the context of the Millennium Goals and Health Packages to reduce poverty, morbidity and mortality.

3. MMI members will find it increasingly difficult to gain contracts and financing from multi and bilateral aid agencies if they persevere in traditional approaches.

CORDAID moved since 2002 from traditional systems towards performance based financing, and became their strategy in 2006 => RESULTS

- **Rwanda 2001**: Cordaid largely contributed to making PBF national policy in 2006 with very encouraging and published results (Meessen Bukavu – Schneidman World Bank HIV/AIDS – Soeters, Habineza, Peerenboom Cordaid Cyangugu – Fritsche MSH USAID – CTB/BTC Kigali rural)
- **RDC 2003:** Several projects in Sud Kivu & Kasai Occidental provinces with very encouraging results and since March 2007 full support for PBF by the MOH (Workshop Kinshasa).
- **Tanzania 2004:** Details Arjanne Rietsema.
- **Burundi 2005:** Cordaid initiated PBF in two provinces (HNI-TPO in another) and helped the MOH to create a national PBF steering committee.
- **RCA 2007:** Initiating PBF in collaboration with IX ème FED project European Union in 5 préfectures sanitaires

CONCEPTS: Why is there growing interest in contracting (health) services?

- Seen as a way to make use of superior effectiveness of **market mechanisms** while at the same time avoiding **market failures**

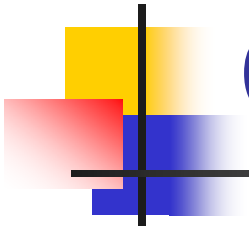
- Improving **efficiency** among private AND public actors by applying competition for contracts (renewals)

What is the problem with traditional (input) financing? 1

- **Central planners make mistakes and inputs do not correspond with the real needs.**
- **Inputs are poorly distributed so that some health facilities receive too many while others receive none.**
- **Final responsibility is mostly with central planners – and not with the service providers at health facility and community level.**
- **As a result, providers are unable to take initiatives or to show their creativity in finding local solutions for non anticipated problems or issues specific for a certain region.**

What is the problem with traditional (input) financing? 2

- **Poor performance has no consequence for both planners and providers because the inputs are already disbursed, cannot be withdrawn and the two stakeholders can blame each other for failure.**
- **Those providers who work *less* profit *more* because they can carry out other activities for their personal interest. As such this centralized input mechanism establishes *perverse financial incentives.***
  It demoralizes good performers and encourages failure.



CONTRACTING THEORY

DIFFERENT FORMS OF CONTRACT

Characteristics of a CONVENTIONAL CONTRACT :

- **The purpose of the contract is clear,**
- **The contract is of limited duration,**
- **After contract establishment the parties know exactly what to expect; the future is foreseeable.**
- **These contracts are enforceable**

Examples: building a health centre; laundry services for a hospital.

BOUNDED RATIONALITY

- **HOWEVER, the reality for health services is another matter and it may not be possible to be sure about the future.**
- **Unexpected events may occur: disease burden shifts; available resources change; war – coup d'état; crops fail due to bad weather influencing purchasing power of patients, donors do not fulfill commitments, etc**
- **This, economists call "BOUNDED RATIONALITY", according to which contract agents are incapable of correctly perceiving all the choices open to them or the consequences of their choices.**

➔ RATIONAL CONTRACT

- Nevertheless, entering in a contractual relationship is still desired:
- We may then talk of a RATIONAL CONTRACT:

=> This is based on the parties' confidence that each will act in their mutual interest.

Contracting: the next phase...

In Europe: Performance Based Financing

In USA - WB: Pay for Performance P4P

Basic idea: *More work* and *better quality* => *higher reward*

Examples

- **Australia and New Zealand health reforms**
- **Contracts with NGOs have become common**
- **Whole services contracted out**
  - **Bangladesh, Cambodia, Afghanistan, Pakistan**
  - **Rwanda, DRC**
- **HIV**
  - **Home based care**
  - **Counseling**
  - **Treatment support**
  - **South Africa, Pakistan, India**

PBF contracting varieties:

- **Between public sector organizations (e. g MOH, provincial - district health authorities; peripheral steering committees – govt health facilities)**
- **Between fund holders (public or private) and health providers (public or private)**
- **Between fund holders and community based organizations.**
- **Contracting is not limited to health sector**

  (e.g. contracting schools – rural development)

Getting Value for Money – Performance based financing

- Ensure maximum worth against each € spent
- Costing involves population based targets.
- Achieving outputs is expected to achieve impact.
- Results of expenditure should be measurable
- Subsidized indicators should be objectively verifiable
- There should be adequate means of verification of output in terms of quantity, professional quality, patient satisfaction and cost

Subsidy for Output

- System provides high subsidy for desirable interventions (birth spacing, immunization), and low or no subsidy for activities for which patients already pay reasonable fees. This to prevent over consumption and cost escalation.
- Subsidy should be adapted to desired results:

  poor results **->** higher subsidy,

  too high results **->** lower subsidy.
- Poor should benefit more

What are the costs of PBF?

- Heavy subsidies through *input financing* an option such as paying salaries, buying drugs, while enforcing free care?

  Would probably cost in Afghanistan €20 public subsidy per capita per year – in Burundi costs € 7,00 MSF Belgium (study July 2006)

- Alternative could be *performance based purchasing* of good quality output from providers operating in competition.

  Would probably cost €2-5 per capita to achieve the same as above and will drive down prices through competition and wish to obtain subsidies by HF

CRUCIAL ARGUMENT FOR PBF

- $ 1 PBF subsidy has the same vale as $ 3-5 input financing through salaries, drugs, equipment top down construction schemes, etc

  => more value for the same money

- This convinced the Rwandan authorities in 2004 and they immediately introduced PBF nation wide in 2005 even before results had been published in several scientific papers.

What do we target?

Globally:

- Millennium Goals: These mostly concern the poor and specific health problems

Nationally:

- Basic Package of Health Services at health centre catchment area level
- Hospital Package

Example of verifiable indicators to subsidize at MPA level I

- OPD consultancies
  (target one consultancy per person per year) ($ 0.25)
- Children fully immunized ($ 3.00)
- Proportion births attended by skilled attendants ($ 5.00)
- Contraceptive prevalence rate increased from baseline to 40% consisting of the sum of the following sub-indicators:
  - Oral and injectable contraceptives, ($ 1.50)
  - IUD and implants ($ 5.00)
- TB detection rate (number of sputum positive cases detected as % of target based on estimated prevalence) ($ 10.00)
- Cure rate among TB cases detected to 80% ($ 20.00)

Example of verifiable indicators to subsidize in MPA level - II

- Proportion of children that have received vitamin A supplement increased to 90% ($ 0.05)
- In-patient days ($ 0.50)
- Proportion of pregnant women having at least three antenatal care service contacts ($ 5.00)
- Bed nets distributed ($ 1-2.00)
- Individual counseling mental patients ($ 1.00)
- Group counseling mental patients ($ 5.00)

Arguments for PBF to institutions instead of individuals

- Strengthens incentives for institutions to meet targets and supports their autonomy
- Avoids government bureaucracy ...
- Institutions take financial risk, strengthens incentives for using resources wisely
- Payment by results gives strong incentives to motivate staff and improve management

Pre-conditions for performance based financing

- The **purchaser – provider split**

  Purchaser should not be involved in internal management of health facilities and be independent to chose most efficient public or private provider.

  (World Development Report 2004)

  Importance of **contestability for contracts** !

  For efficiency reasons there should be competition for contracts at start as well as ongoing

  (Palmer & Mills, 2000).

Rationale for the regulatory – purchasing split 1:

- In most mid and high income countries contracting, fund disbursements and output monitoring is not the role for district health teams but for **health insurance organisations** operating independently from the regulatory authorities and service providers.
- In low income countries such health insurance mechanisms are either non-existing or still in their infancy stage. However, the rationale seems equally strong for **separating the regulatory and fund disbursement functions** as alternative for more conventional strengthening of district health teams

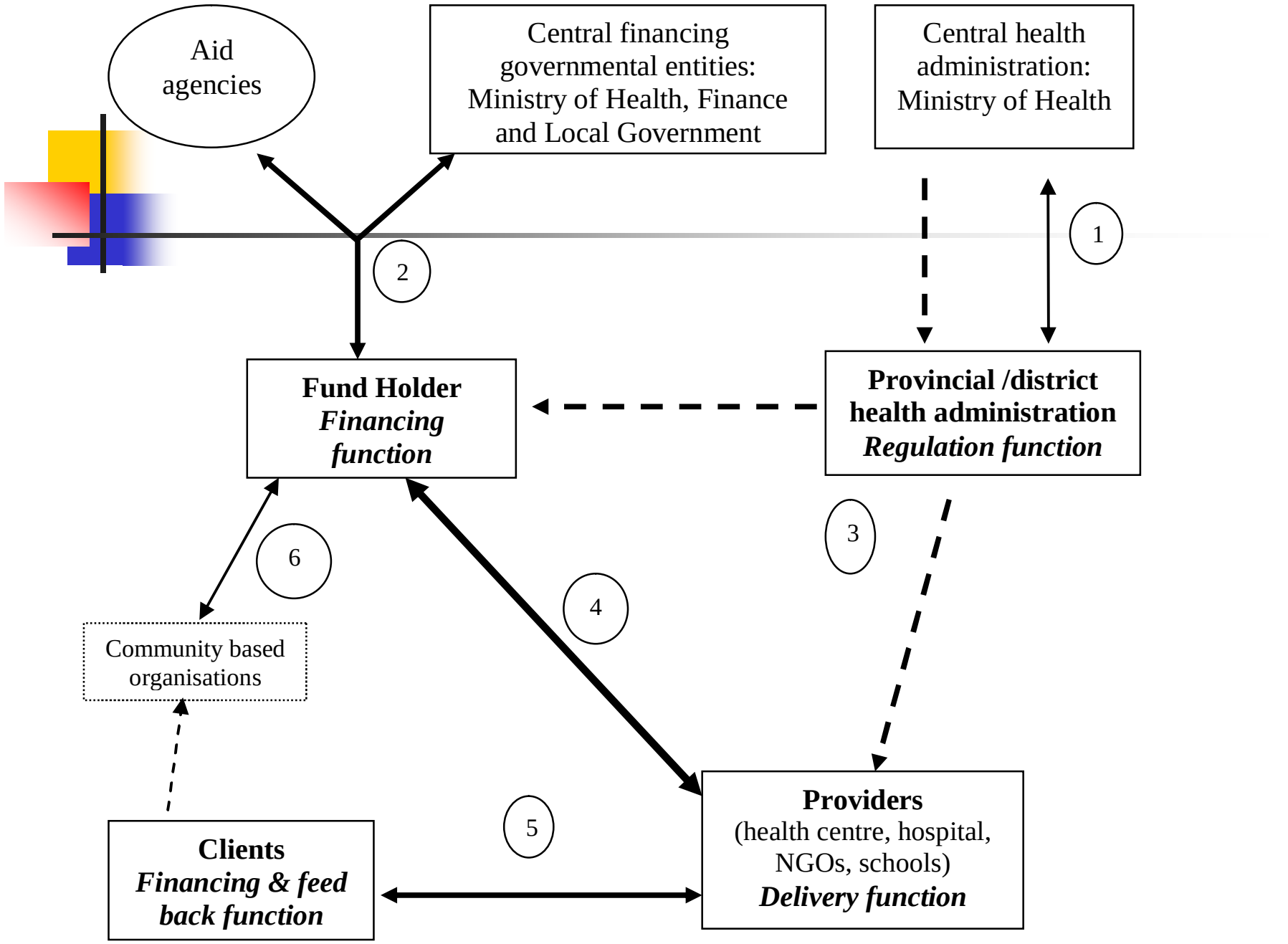
Rationale for the regulatory – purchasing split 2:

- Creates better **checks and balances**

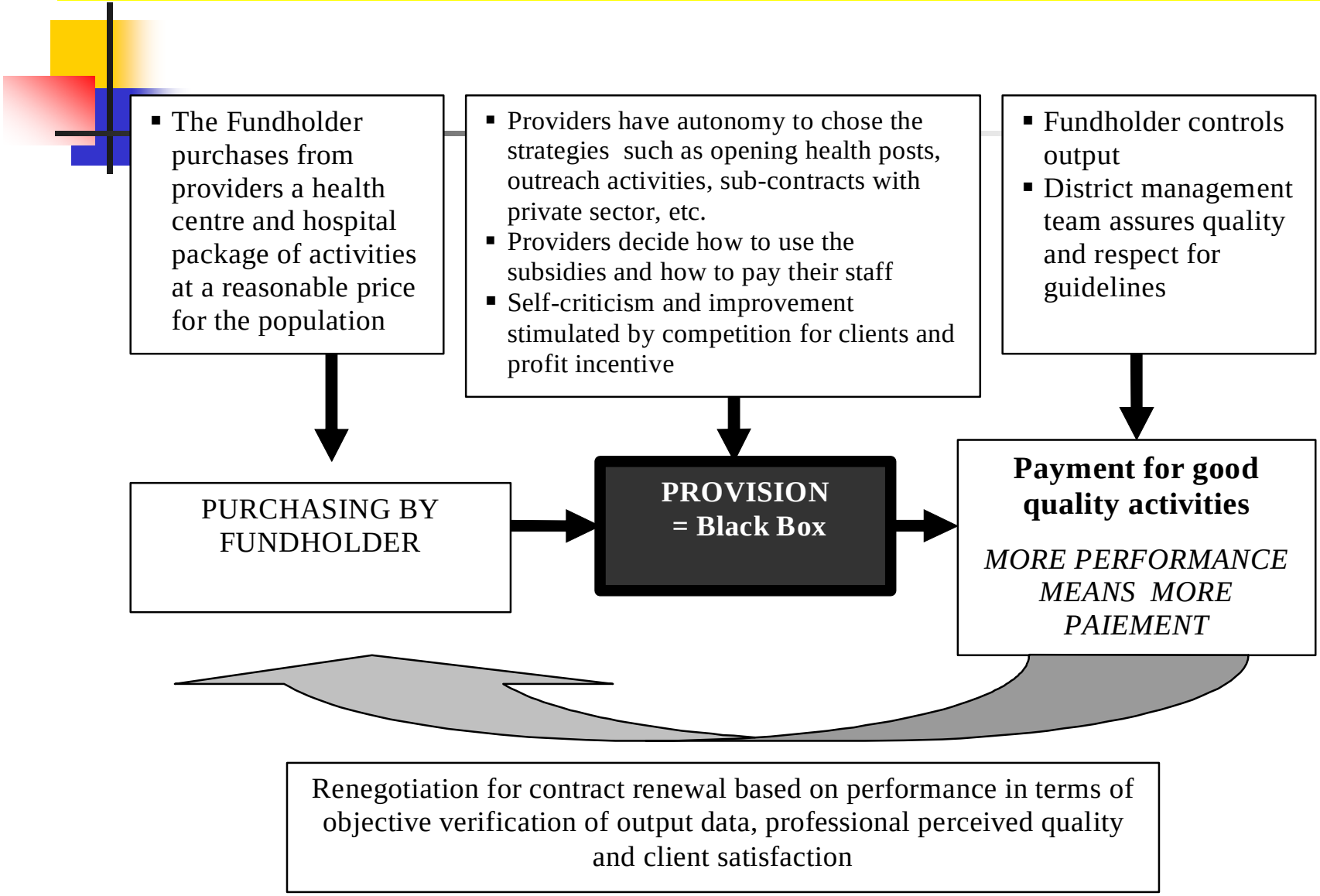
  The health authority should "regulate" and not be involved in "money" matters, which may lead to **conflict of interest and corruption**

- Peripheral Sector Wide Approach should be done by a team with adequate technical capacity in management, negotiation, public health, administration (insurance company, NGOs).

- Fund holder should also be under regulatory scrutiny and bid for contracts


Aid agencies
Central financing governmental entities: Ministry of Health, Finance and Local Government
Central health administration: Ministry of Health
1
2
Fund Holder
Financing function
Provincial /district health administration
Regulation function
3
4
5
6
Community based organisations
Clients
Financing & feed back function
Providers
(health centre, hospital, NGOs, schools)
Delivery function

How does performance based financing work?



How to achieve quality?

- **Targeting mechanism with public money should not only be based on output (or quantity), but also on quality.**
- ***Quality reviews* of health facilities VERY IMPORTANT: Role for health authorities.**
- **Aim to stop unjustified diagnostic and therapeutic procedures at high cost?**
- **Patients and communities should play an important role in improving patient perceived quality e.g waiting time, cost, respect: Strengthen the *consumer voice*.**

Verification of “performance” very important

- Strengthening HMIS and verification of output and falsification.
- Quality reviews by regulator
- Involvement of consumer / patient in influencing provider behavior. Money follows patient. Patient satisfaction surveys influence contract renewal and subsidy.

How to target the poor?

- Negotiate overall lower fees against subsidies while applying blanket subsidies for health facilities
- Apply isolation bonus for remote and poor areas
- Develop equity fund to prevent catastrophic costs for the very poor individuals
- Formalize informal private sector
- Reduce unjustified diagnostic and therapeutic procedures in informal private sector
- Prohibit quacks from practicing, and thereby protect the poor

RESULTS

- Cambodia
- Rwanda
- RDC

In Cambodia the results in a district with 200.000 people were the following (HPP – 2003)

	Baseline 1998	Evaluation July 2001	% Change
Delivery in Health Facility	3%	20%	550%
Two or more ANC visits	3%	25%	740%
Knowledge 4 or more modern FP methods	21%	68%	224%
Modern FP method used by women	14%	30%	117%
Percentage children fully immunized	24%	52%	116%
% children with diarrhoea given ORS packets	11%	28%	151%

OOPHE reduced by 40% between 1998 & 2001 from $18 to $11 per capita.

	1998	%	2001	%
Direct public expenditure at health facility level	$ 0,63	3%	$1,55	11%
Payment contract management	$ -	0%	$1,63	12%
Out-of-pocket expenditure	$17,90	97%	$10,70	77%
Total public and private health expenditure	$ 18,67	100%	$13,88	100%

Results Rwanda and RDC

- Comparable with Cambodia results
- Encouraging results in Rwanda are published in several papers (World Health Forum)
- Encouraging results RDC as presented in March 2007 to the MOH and donor agencies in Kinshasa – will be published during 2008.

QUESTIONS FOR MMI?

- Is there evidence that traditional financing systems achieve the same results after 30 years of trying and disappointments?
- While PBF systems are correctly under strict scrutiny to show results the same questions are rarely asked for input oriented and centralised traditional financing systems.
- This issue has nothing to do with ideology or the “bad intentions” of the World Bank or the EC ... but simply how to assist the poor in a more effective and efficient manner
- MMI members should move on ... and start new PBF schemes so that we can present the concepts and results during next year’s World Health Assembly.

Geneva 18th of May 2007

Merci !