What is Results Based Financing?

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Outline

1. Why consider Results Based Financing (RBF)?
2. What is RBF and how might it address performance problems?
3. Potential pitfalls
4. A taste of the evidence
5. A snapshot of design and implementation
Can you guess what country this comes from?

“The current system does not reimburse for coordination of care for beneficiaries who receive treatment from several different providers and does not provide financial incentives to encourage providers to invest in improvements in the overall health of beneficiaries”

United States Institutes of Medicine: Rewarding Provider Performance: Aligning Incentives in Medicare. February 2007
“The new approach to paying for results motivated us to question how we were reaching out to underserved members of the community. We realized that we could work together more effectively, use information to manage betters, and work harder to achieve results. We like the new system because it rewards us for what we believe in such as immunizing children and assuring healthy deliveries.”

Stakeholder interview from an NGO in Haiti in 2006.
The challenge...

Progress in India is far from spectacular...India is moving slowly towards achieving targets of MDGs, but to achieve them with the stipulated time limit, it will need to accelerate pace of interventions to reduce both child and maternal mortality.

What is Results Based Financing?

**Results Based Financing (RBF)** is “Transfer of money or material goods conditional on taking a measurable health related action or achieving a predetermined performance target” *

**Financial risk** is the assumed driver of change

“No results, no payment”

*From the Center for Global Development Working Group on Performance-Based Incentives*
Why consider Results Based Financing?

- Too many children are dying from preventable and easy and cheap to treat conditions.
- Too many women are dying from complications related to pregnancy and birth.
- Seems clear that continuing to do what we have been doing in the past is not resulting in improved health status for all—especially the poor and marginalized.

*Business as usual is not working*

There is a growing body of evidence that RBF may be part of the solution.

– Much evidence comes from contexts with weak capacity and far from “ideal” enabling environments.
Note there are many labels, little clarity!

- Pay for Performance or “P4P”
- Results-Based Financing
- Output-Based Financing
- Performance-Based Contracting
- Performance-Based Financing
- Performance-Based Incentives
- Conditional Cash Transfers
- Conditional Cash Payments

Definitions, distinctions, and overlaps are briefly discussed in the *P4P Blueprint Guide.*
Concept

Payers
(Government, Health Programs, Insurers, Communities)

Money, Goods, Other Rewards

Results

Recipients
(Households, Service Providers (Facilities, Health Workers), Health Programs, Sub-National Levels of Government)
Levels to consider: from payer to recipient

- National Government
- State Government
- Sub-State Level (District, Municipality)
  - Demand Side (Household, Individual)
  - Service Provision Level (Public, Private)
Let’s begin in a typical rural health center
Are financial incentives the needed motivator?
Why it’s hard to improve health services

• Widely dispersed actors involved (managers, providers, patients), making minute-by-minute decisions about health-related behaviors that are impossible to observe centrally

• Decision makers on supply and household sides have different information, face powerful incentive environments

Modifying behaviors requires aligning incentives to increase likelihood that health actors will take actions to improve health results.

Central command-and-control unlikely to work.
Intrinsic vs. Extrinsic Motivation

- People are motivated by intrinsic and extrinsic forces
  - e.g., professional pride, altruism and
  - e.g., money, recognition, awards

- RBF focuses on extrinsic motivation. Payment comes from an external source

- Aim is to motivate with extrinsic rewards in a way that reinforces intrinsic motivation
Possible pitfalls

• Excessive attention to reaching targets, to detriment of other (harder to measure) types of performance

• Undermining intrinsic motivation, turning health care delivery into “piecework”

• “Gaming,” including erosion in quality of institutions’ service statistics
What challenges can RBF address?

• **Increasing utilization**
  – Overcoming financial and physical barriers to access that poor households face
  – Overcoming information and cultural barriers that inhibit utilization

• **Strengthening capacity to provide services**
  – Catalyzes changes that strengthen management.
  – Improves information systems and the use of information for decisions.
  – Motivates health workers.

• **Improving quality**
  – Preventive care services utilized by more people
  – Rewards correct diagnosis and treatment

• **Improving efficiency**
  – Better use of inputs to achieve health results
Examples- Supply Side

Payment to providers (individual health workers, service providing institutions) and sub national levels of government linked to attainment of predetermined results.

- Federal to province transfers linked to results (Argentina)
- District teams and facilities rewarded to increase utilization of priority services (Zambia, Tanzania)
- Governments or private payers pay service providers (public and/or private) when they deliver services in exchange for vouchers (Bangladesh, India, Kenya, Nepal, Pakistan, Uganda)
- Governments pay public, nonprofit and for profit service providers partly based on results (Burundi, Egypt, India, Rwanda)
- Hospitals paid based on improved performance on clinical vignettes (Philippines).
What to expect...

• Time limited measurable interventions respond quickly.
  – Immunizations, vitamin A, generic curative care visits, deliveries.

• Extended duration, time limited interventions take longer to show results- but results do come.
  – Prenatal care, tuberculosis treatment completion

• Chronic conditions requiring considerable lifestyle change pose the toughest challenge- but evidence suggests promise.
  – ART, diabetes, hypertension

Time-limited measurable interventions are good candidates

**Immunization coverage:**

- **Supply side in Haiti:** NGOs paid partly for results achieved a more than 13% increase in immunization coverage per year over those paid for inputs.


- **Nicaragua CCT (both D and S):** Increase of over 30% compared to control areas- even larger increases for the extreme poor.

Time-limited measurable interventions are good candidates

Institutional Deliveries:

- **Supply side in Rwanda**: Impact evaluation of nationally implemented RBF attributed a 7.3% increase in institutional deliveries between 2006 and 2008 in regions with PBF as compared with control regions that had similar investments and budgets but no PBF. Source: Basinga, Paulin and Christel Vermeersch. “Pay-for-Performance (P4P) for Health Services in Rwanda”, PPT presentation at CEDES conference, December 2009.

- **Supply side in Haiti**: Significant increase in attended deliveries under RBF. NGOs paid partly based on results achieved a more than 19 percentage point increase in skilled deliveries over NGOs paid for inputs. Source: Eichler, Auxila, Antoine, and Desmangles, “Haiti: Going to Scale with a Performance Incentive Model”, in Performance Incentives for Global Health-Potentials and Pitfalls. (2009).
Extended duration, time-limited interventions take longer to show results

Tuberculosis treatment

- **Demand and supply in tuberculosis control**: Many TB programs use food to encourage adherence, some use other material goods, others use financial rewards.
  - In 3 Russian oblasts, food, travel subsidies, clothes and hygienic kits caused **default rates to drop from 15-20% to 2-6%**.
  - In the US, $5 payment increased proportion of homeless people **following up after a positive TB test from 53% to 84%** and regular monetary incentives increased treatment completion.

Chronic conditions requiring considerable lifestyle change pose the toughest challenge

**Diabetes**

- **US supply side:** Managed care plan provided bonuses linked to performance on a composite score of effective output (completion of screening tests) and outcome (hemoglobin and blood pressure levels). Average composite score for participating physicians increased 48%, compared to only 8% among non-participators.

**Addiction and Lifestyle change**

Demand and supply side incentives have also been tried for conditions that are addictive and require considerable lifestyle change:

- Smoking cessation (UK, US)
- Alcohol and cocaine use (US)
- Obesity (US)

Many show short term results while incentives are paid - but behavior often reverts if/when the program stops.

The process in a nutshell...

1. Design
2. Start-up Investments
3. Ongoing operations
4. Learning agenda

Caution:

• RBF is not static. The design will change as you learn what works and the system evolves.
• Pay adequate attention to management and initial implementation needs.
• Be humble!
Design

1. Assess and prioritize performance problems
2. Select recipients
3. Indicators, targets and how to measure them
4. Payment rules, sources of funds, and how funds will flow
5. Determine management and operational roles and systems
   - How recipients will be selected
   - Establish terms of performance agreements, MOUs, contracts
   - Routine monitoring and validation
   - Payment
   - Assess and revise
Start-up investments

• Assure availability of critical inputs.
• Strengthen information systems.
• Revise fiduciary and financial management systems.
• Train recipients
• Develop the capacity to manage RBF at each level.
Functions needed to administer RBF

1. Recipient Selection
2. MOUs, Performance Agreements and Contracts
3. Results Reporting and Monitoring
4. Payment Generation
5. Assessment and Revision
Learning agenda

• Process monitoring to understand what is working and what is not.

• Routine evaluation:
  – Pre-post is part of all RBF programs.

• Impact Evaluation: can generate policy support and “staying power”.
  – May want to randomly select control and intervention areas using phased roll out.
  – If RCT is not feasible, consider data from control areas.
7 Worst Mistakes to Avoid

1. Failure to consult with stakeholders
2. Failure to explain rules to recipients
3. Too much or too little financial risk
4. Fuzzy definition of indicators and targets, too many indicators, targets that are unreachable.
5. Tying hands of managers
6. Insufficient attention to systems and capacities needed to administer programs.
7. Failure to monitor unintended consequences, evaluate, learn and revise.
Thank You!