



The World Bank and Results-Based Financing for Health

Most developing countries, especially those in Africa, will not achieve the Millennium Development Goals (MDGs) for maternal and child health by 2015 unless progress is greatly accelerated. To address this challenge, governments and development partners are seeking innovative strategies—such as results-based financing (RBF)—to increase the impact of investments in health. RBF mechanisms have been introduced or explored in more than 40 low- and middle-income countries. Interventions include immunization, contraception, antenatal care, skilled attendance at birth, postnatal care, and growth monitoring.

The Promise of RBF

A key objective the World Bank's 2007 Health, Nutrition and Population Strategy is to tighten the links between lending and results through increased use of RBF. Early evidence from RBF pilot programs shows great promise for increasing health service utilization and improving service quality, increasing efficiency, and enhancing equity. It focuses on health results (such as the number of women receiving early antenatal care and delivering their babies in health facilities), rather than inputs (such as the construction of health centers and staff training), tightly linking budgets and financing to results.

RBF programs can work at different levels of the health system. Some RBF programs work on the “supply side,” paying incentives to health facilities for performance tied to services—not only paying for quantity of the services provided but also taking into consideration the quality. Other RBF mechanisms work on the “demand side,” providing financial or “in-kind” incentives to certain target groups to overcome barriers to health service utilization. In some countries a combination of demand- and supply-side incentives is used.

RBF is not a panacea; it is a systemic intervention to improve service delivery. RBF programs need to address the causal pathway of the problems within the health system and target the appropriate levels (clients, health facility, district level) to ensure that intended results are attainable. It is imperative that health facilities have a significant level of autonomy and decision-making power over resources to ensure they can achieve the intended results.

RBF can enhance accountability and improve health information systems since reported results are verified when linked to incentives. Local authorities verify results, which are publicized for each organization or health facility. The decision to pay health facilities for results often occurs at a decentralized level and in the public sector with the involvement of civil society. Community involvement at the health facility level helps ensure accountability for performance incentives. Quality assurance mechanisms are closely tied to implementation and quality assurance mechanisms are incentivized through balanced score cards. In addition, RBF can increase transparency and accountability from the community level to the national level.

Health Results Innovations Trust Fund

The Bank's multi-donor Health Results Innovations Trust Fund (HRITF) supports RBF approaches in the health sector for achievement of the health MDGs, particularly MDGs 1c, 4, and 5. The governments of Norway and the United Kingdom have committed US\$558 million equivalent to the HRITF through 2022. The HRITF supports the design, implementation, and monitoring and evaluation of RBF approaches; develops and disseminates evidence for implementing successful RBF approaches; builds country institutional capacity to scale up and sustain the RBF approaches, within the national health strategy and system; and attracts additional financing to the health sector.

Results

In *Afghanistan*, the government reduced the death rate of infants and children under five by 22 percent and 26 percent, respectively, in just three years. In the absence of effective government delivery of health services after the war, the government contracted out health services to non-governmental organizations (NGOs) in 2002. Performance-based contracting ensured that NGOs had significant freedom to decide how to use resources innovatively to reach intended



results. Performance on quality of care of all contracted health facilities, as measured through a comprehensive balanced scorecard, increased by 32 percent from 2004 to 2007.

In **Argentina**, Plan Nacer, a social insurance program, aims to increase the utilization of health services by pregnant women and children less than 6 years of age. It subsidizes providers to provide an estimated 80 services free of charge to pregnant women and mothers (up to 45 days after delivery), as well as children under age 6. The intergovernmental RBF scheme transfers funds from national to provincial level. Sixty percent of the funding is determined by the number of eligible beneficiaries enrolled in the province and the remaining 40 percent is determined by the achievement of stated targets for ten output and outcome health indicators. The Provincial Health Insurance subsequently reimburses the providers on a fee-for-service basis for the agreed upon 80 services. An early evaluation indicates that the program increased the probability of a first prenatal care visit before week 13 of pregnancy by 8.5 percent and before week 20 of pregnancy by 18 percent over the control. Beneficiaries increased the number of prenatal check-ups by 0.5 visits, or 17 percent over the control. Pregnant women also benefitted from improved quality of care, measured by increases in the likelihood of vaccination and ultrasounds. Improvements in the quantity and quality of services resulted in better child birth outcomes, including an increase in average birth weight of 69.5 grams (a 2 percent increase over the control), a reduction of 27 percent in the likelihood of children born with very low birth weight (under 1500 grams), and a reduction in neonatal mortality.

In **Burundi**, funds for “selective free health care” and RBF funds from the Bank, the European Union, and six other sources pay for a fee-for-service conditional on quality of care system. This payment mechanism comprises an estimated 20 percent of total health expenditure for RBF. Semi-autonomous provincial purchasing agencies strategically purchase a cost-effective package of basic health services. Grassroots organizations and other non-state actors are closely involved in the institutional set-up of this system, including capacity building, monitoring, evaluation, and approval mechanisms. Another innovative Burundi mechanism is the “equity bonus”, where the fee-for-service is graduated depending on the poverty rate of the area in which the facility is located.

In **Mexico**, demand-side mechanisms, such as conditional cash transfers or vouchers, are explicitly targeting the poor with eligibility based on poverty status. Oportunidades (called Progresá until 2002), has been recognized as a landmark Mexican social policy for its use of demand-side RBF mechanisms to incentivize investments in human capital by poor families. Oportunidades provides transfers to targeted poor households, based on the verification of the household’s compliance with pre-specified co-responsibilities in education, health, and nutrition. Health and nutrition conditions require periodic checkups by all household members; growth monitoring for children under 5 years of age; perinatal and postnatal care for pregnant women; nutritional supplements for infants and pregnant women; and “self-care” health education workshops for an adult in the household, preferably the mother. Oportunidades represents a significant break from the traditional relationship between the State and marginalized areas, as poor households are empowered to be entitled to certain rights and responsibilities, in turn creating a greater and more-informed demand for social services. After a decade of implementation, program evaluations have shown positive results in both reducing current poverty as well as improving the future of children through increased investment in their health and education. Specific results in health include increased preventive and curative health visits (by 35 percent in rural areas and 26 percent in urban areas); decreased maternal deaths and infant mortality decreased (by 11 percent and 2 percent, respectively); increased growth by children under two years of age (1.42 cm greater height compared to non-beneficiaries); reduced number of anemia cases for children under age 2 (by 12.8 percentage points); higher levels of adequate nutritional intake of iron, zinc, and vitamins A and C (over 90 percent of beneficiary children); and a reduction in sick days among children under age 5 in rural areas (by 20 percent).

In **Rwanda**, a recent impact evaluation of a performance-based financing scheme found large and significant positive impacts on birth attendance at health facilities, preventive care visits by young children, and the quality of prenatal care in facilities that received financial incentives. Provision of incentives to providers for increasing the quantity and quality of services led, as compared to baseline, to a 21 percent increase in institutional deliveries, a 64 percent increase in preventive visits for children under two years of age, and a 133 percent increase in visits for children ages 2-5. The evaluation suggests that paying health facilities for results is a feasible and effective way to improve health outcomes and health system performance. This evaluation demonstrated the power of incentives and showed that the same results could not have been achieved by simply increasing the amount of resources provided to health facilities.