Results-Based Financing in healthcare

Developing an RBF approach for healthcare in different contexts: the cases of Mali and Ghana

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Is it:

'Before the curse of statistics fell upon mankind we lived

a happy, innocent life, full of merriment and go and informed

by fairly good judgment.' – Hilaire Belloc

Or:

'What gets measured gets done.'?

Contents

Abbreviations

CSO	Civil Socisty Organisation
DHS	Demographic Health Survey
IEC	Information, Education and Communication: Health education
ITN	Impregnated Treated (bed-)Nets
MOH	Ministry of Health
P4P	Pay for Performance
PBF	Performance Based Financing
RBF	Results Based Financing

Introduction

In a nutshell, Results-based Financing (RBF) is a concept which (often partly) replaces input-based funding with output-based funding. Health service providers – and eventually users - are paid for predefined and verified results. The basic principle is 'the money follows the patient' i.e. if healthcare facilities attract more patients and provide better quality services, then they will receive more incentive payments. RBF should not be seen as a 'topping-up' of salaries, but as a change in the funding mechanism.
This booklet shows you **how to get started** once you have decided to implement RBF. It is not about proving evidence that the system works, for this we refer to relevant articles. The body of knowledge on incentive-based programmes has grown rapidly over the past decade, but surprisingly little has been produced on how to implement such programmes in a sustainable manner. This booklet attempts to fill this gap by proposing eight process steps based on the generic principles of RBF, arriving at an approach that responds to your (national) context. Each of these steps comes with the necessary tools and instruments. We have also added our ideas on the architecture of RBF, the role of actors, and on potential challenges and solutions. First and foremost this is a tribute to working at the operational level, aiming to stimulate your process to develop a fitting model based on the principles of result-based financing. One important lesson has been not to focus too much on finance, but to increase the capacities of medical and non-medical actors to stimulate resourcefulness in terms of result-based thinking and working, instead of 'business as usual'.
You may have noticed the warning sign on the cover: *'does not contain magic bullet'*. While RBF has great potential, it is not a 'quick-fix' medicine for all problems within healthcare. Indeed, introducing a new concept like RBF may even lead to new problems; but these can be anticipated and can be dealt with. This booklet suggests ways to deal with them. It does this without creating the illusion that this is a 'cookie cutter' approach.

We hope that the examples in this booklet will stimulate your creative thinking and strengthen your capability to design and adapt RBF programmes in a way that improves the healthcare system in your setting. The examples are drawn from KIT and SNV's experience in Mali, where this 'process approach' was carefully thought through so that RBF would suit a particular country's context. Interestingly, this led to different models between employed in Mali and Ghana, so we assume that this one-size-fits-one approach may help you design your own model. This booklet addresses different interests: for policy-makers to develop implementation policies, for development partners seek traceability and effectiveness of their funding, and NGOs for implementing RBF. If you picked up this booklet because you were afraid to ask 'stupid' questions about RBF, or are encountering problems in its implementation, then continue reading. You will update your understanding on how to design and implement RBF.

1
It's a process approach

'That's a problem'

In development, we need to ask ourselves why certain results are not achieved, and of course why something is successful. We need to ask: 'but why?' to get a better understanding of the bottlenecks or enablers in any chain of events and to come up with relevant solutions and lessons to perform better. For example, a typical conversation with a monitoring officer might be something like: 'Why do so few women come for delivery to the facilities in your district?' 'Because we cannot sufficiently inform the women. *'Why not?'* 'Because we cannot go into the communities.' *'Why not?'* 'Because we don't have fuel for the car.' *'Why not?'* 'Because we don't have money to buy fuel.' But: ***why not?***

When suggesting potential solutions to identified problems, the answer is too often *'that's a problem,'* when what is really meant is: 'I don't have the necessary input to act and realize results'. In this way the owner of the problem effectively pushes the problem to the next level. The solution, according to the owner, is beyond his or her reach and control, giving the impression that nothing can possibly be done, so the only alternative is to sit back and continue complaining about the ineffectiveness of the system; taking action may involve being challenged by a superior. Therefore, it's more comfortable to not take action *if you have a good excuse*. Result: no action, so no results achieved!

RBF turns this around and makes health staff benefit from presenting a solution. The health staff will be paid for output and the more (s)he undertakes, the more results, the more funding for finding even more results. If (s)he does not fill the tank of the car, (s)he has a problem – whatever the excuse.

Throw away the cookie-cutter

There is no cookie-cutter approach to improving the performance of a health system. Any health system has its specific social, political, economical and institutional characteristics. Improving the performance is a process, which must take these characteristics into account. Our experience in Mali and Ghana has given more content to the words 'process approach', which is what we share with you in the following chapters of this booklet.

Focus on results, not on finance

The Paris Declaration and the Accra Agenda for Action provide a *strategic framework* with a strong emphasis on results, accountability, country ownership, harmonization and predictability of foreign assistance. RBF is a *tactical* mechanism that helps to redesign the health system in order to implement the longer-term (inter)national strategic aims. To make it *operational*, RBF needs to be accompanied by several practical tools and to empower all actors involved to use these tools effectively. In summary, we propose the following division of responsibilities when setting up a RBF approach (see table below).

Table 1 Division of responsibilities when setting up a RBF approach

Management level	Concepts & Mechanisms	Contracts	Planning cycle
Central: Strategic – to aim	MDG, AAA, SWAp, Budget Support, IHP+, Multi-annual country plans	Design contracting approach – framework, roles, and responsibilities	Long
District: Tactic – to design	RBF, PBF	Performance framework contract – agreement on general objectives and conditions between purchaser and providers	
Facility: Operational – to act	Results-Based Action Plans, Results-Based contracts, Verification tool	Results-based contracts – between facility and staff on exact targets and incentives	Short

Recognizing the fact that RBF is not an operational, but a strategic purchasing concept helps to understand that a lot of work is needed to make it operational. To this end, systems need to be built, capacities need to be strengthened and instruments need to be developed. A contract between the different actors is at the heart of RBF, results-based planning by the provider represents the blood circulation, and monitoring and verification of results the backbone of the system.

The RBF approach should focus on the R of 'results', rather than on the F of 'finance' i.e. RBF is not just about paying for results (the 'F') – it is also about how RBF is organized so that the results can be obtained. However, when introducing the concept of RBF, there is a risk that 'Finance' is what most people will think of. The expectation that money will fall from RBF heaven may lead to unrealistic expectations and a non-sustainable programme, particularly when scaling up. Interestingly enough, our experience in Mali and Ghana shows that results already increased by setting up the RBF arrangements, before paying for results.

We introduced the concept to a team of healthcare professionals. When we started discussing what we needed to get RBF up and running, one of the first questions was, 'can we have a car?' Pointing to the car park we replied, 'look there are dozens of cars there, why don't you use them?' 'No, this one is for the malaria project, that one is for TB and all the others are for each of the other programmes'. This may show that years and years of input planning provide a Pavlov response. This mind-set will not change overnight, but there will always be someone in the room who will start to ask the right questions, like 'what is the link between that car and increasing assisted deliveries?' In other words: 'how does RBF work?'

The one-size-fits-one approach

Most of the positive experiences with RBF are in countries in post-conflict situations,

such as Rwanda[1]. At the beginning of this century performance-based financing (PBF) was introduced into Africa, in Rwanda, to speed-up health results after the war. To this end, two Dutch NGOs (HealthNet International and Cordaid), replaced the 'ex ante' financing of inputs based on a budget by 'ex post' financing of outputs and appeared to be successful. It was therefore scaled up to national level, where again the results were judged to be highly positive – as was recently confirmed by an impact evaluation[2].

The Norwegian and British governments installed a trust fund at the World Bank to support piloting P/RBF in other countries. This trust fund aims to accelerate the attainment of MDG 4 and 5 through PBF. Since then, many low- and mid-income countries are looking to Rwanda as an example of how to improve their own health results through PBF. Rwanda has become a visitors' centre for government officials, where they can learn about PBF's great potential. But they all return from Kigali asking the same question: how can we implement this in our own country? They recognize how good the idea is but can't see how to fit the model into their own context.

To cite one example, Rwanda was faced with a post-war situation in which institutions and governance structures were practically non-existent. So setting up new (RBF) institutions where an NGO acted as the purchaser (the AAP – *Agence d'Achat de Performance*) didn't pose too much of a problem. In Mali and Ghana, the healthcare sectors do have governance institutions and 'rules of the game.' This provides different constraints, and different opportunities. Another approach is needed for countries with a well-established healthcare architecture. We elaborate on the specific context and institutions of Ghana and Mali in chapter 6.

In Rwanda facilities in the intervention group had a 23% increase in the number of institutional deliveries and a significant increase in the number of children visiting a facility for preventive care (56% for children aged 23 months or younger, 132% for children aged 24-59 months. The intervention had no effect on the number of prenatal care visits or children fully immunized.

There is an overall consensus in West Africa, certainly in Ghana and Mali, that the Rwanda model should not be copied and pasted to their context or to any other country. But then what? How can it be implemented in countries with varying socio-economic, political and institutional determinants?

The phrase, *'it's not a model, it is an approach,'* has become our mantra as we searched for the appropriate RBF design for Mali and Ghana. Using the words 'process' and 'approach' may seem like an excuse to remain vague, when people really want concrete and clear-cut answers. It is however a deliberate, phased approach that is needed to arrive at an appropriate model, to prepare the actors for future tasks and to allow them to adapt the RBF tools and apply them to their own context. Here, we suggest tools and instruments that will make it even more concrete.

[1] The experience with performance-based payment of healthcare providers in Rwanda and other countries has been well documented. We will refer to relevant literature throughout this booklet, including references in the bibliography
[2] Lancet 2011, impact evaluation p.1427

2 Defining RBF

An essay and glossary (Musgrove, 2010) describes how different terms are used, and points out significant distinctions among types of RBF programmes. RBF is defined as 'a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider or consumer of health services after predefined results have been attained and verified. Payment is conditional on measureable actions being undertaken'. Musgrove sees RBF as an umbrella term. Recently the Center for Global Development produced a paper 'proposing a way of classifying and distinguishing the range of incentive programs being debated today' (Savedov, 2011) In short, we use the definitions of the different types of Conditional Cash Payment systems as follows:

- In Pay for Performance (P4P), one institution is at the same time purchaser, verifier and payer of the services of the health service provider: it will determine the 'results', their 'price', and will 'verify' the results and then pay.
- In case of PBF and RBF (see chapter 3, The RBF principles), there is a clear split of function between purchaser, provider, regulator and verifier.
- The difference between PBF (Performance-Based Financing) and RBF (Results-Based Financing) is that PBF only has supply side incentives, while RBF has both supply- and demand side incentives.

Health services' performance

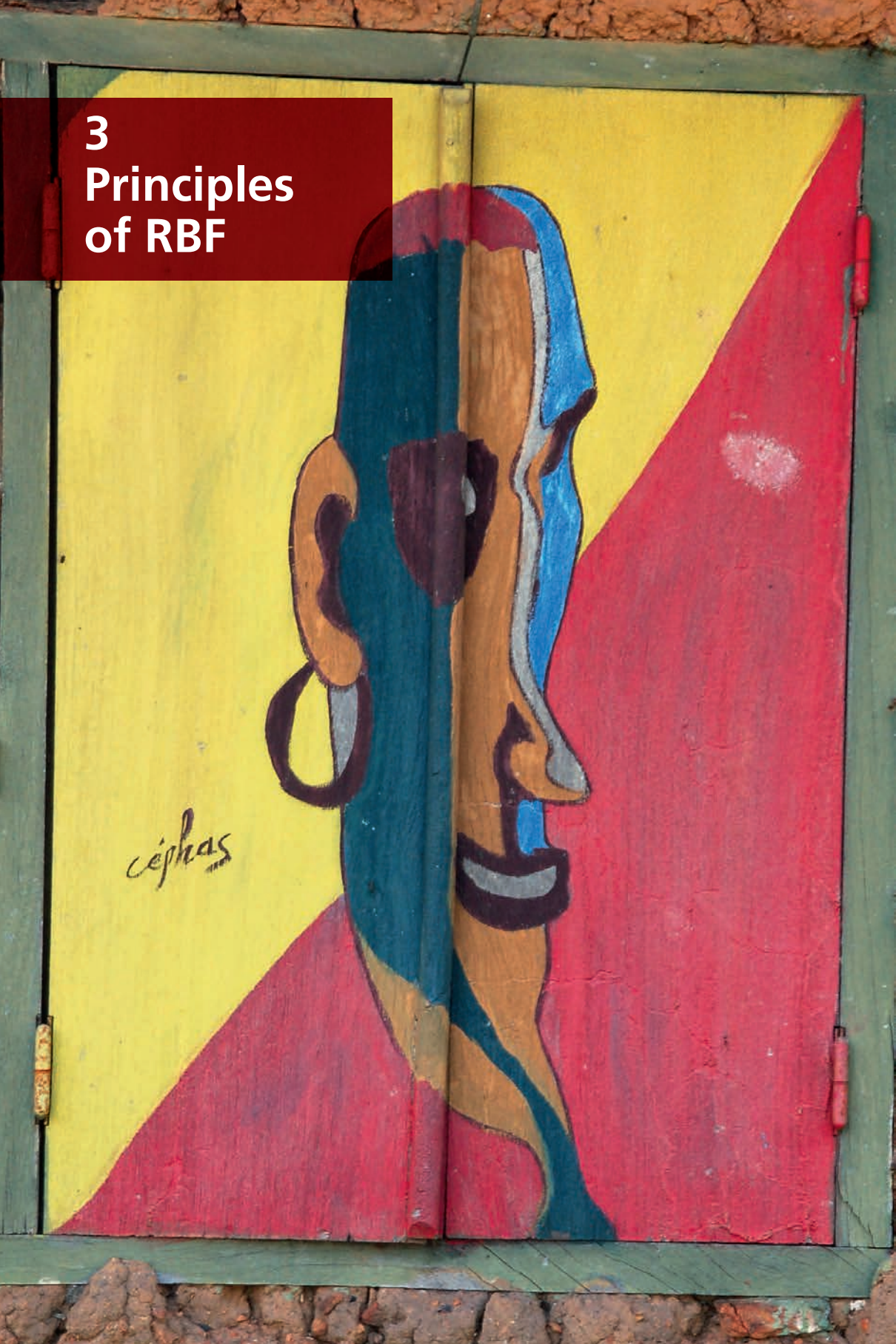
The performance of health workers can be defined in a number of ways. WHO suggests measuring performance by looking at their: (1) availability (measured through such indicators as waiting time); (2) competence (ability to adequately diagnose and provide services, but also how the health system performs); (3) responsiveness (respect, communication and attention given to the needs from the patient's perspective); (4) productivity (quantity of results) of health workers or facilities, and (5) information on payments and (absence of) corruption.

In this booklet, we use 'performance' in terms of productivity (number of outputs, rather than attaining targets or coverage of certain priority programmes) *and* of quality of care as perceived by the patient as well as by professionals. Also, in quality of care we use two ways of looking at its assessment: *'ex ante'*: *(**being in the condition** of providing quality care)*, and 'ex post' control, *(assessing if the quality of the services that **were delivered** was up to standard)*. Since RBF is about results, we focus on the ex post type of quality care. For further reading we refer to Chapter 7.

RBF, PBF, P4P or *'achat de performance'* all aim at motivating healthcare workers to perform better. To achieve this, one can stimulate both their *intrinsic* motivators (such as career perspectives, post-academic training, being responsible at decentralized facility level), as well as their *extrinsic* motivators such as financial incentives. This also applies to RBF.

Performance of the sector is not determined by providers alone – much will depend on the clients, the patients. Therefore, the RBF approach also creates opportunities for demand side incentives such as vouchers for pregnant women to pay for transport to attend ANC or assisted deliveries.

3 Principles of RBF



In Ghana and Mali there was a strong feeling that the Rwanda model should not be copy-pasted to their context. The various experiences and research (Toonen, 2009) did allow us to identify the principles underlying the RBF concept. These principles guide the development of a contextually fitting RBF model. Each of the eight process steps (as identified in chapter 5) is assessed against the following principles.

Principle 1: governance through contracting

It is tempting to start with the F of RBF, but RBF is first of all a contracting approach, it is not about introducing a bonus culture. In this way RBF can offer a solution to the existing complex governance structures by clarifying accountability relations in healthcare in West Africa. As it will become clear further on, when we describe the context in Mali and Ghana, many institutions are *made* responsible for health – but in the end, none of them *takes* responsibility and is held to account for it.

RBF uses contracting as an instrument for capturing agreements between local actors about their roles and responsibilities on the one hand, and on agreed upon expected results on the other hand. Actors negotiate these results, taking into account their respective stakes and mandates. Expected results or performances are defined in terms of productivity and quality of services. If the results are achieved these will be compensated through financial as well as non-financial incentives as defined in the contract. The development of the contract *through negotiations* is an essential phase; different actors need to come to an agreed upon contract that suits all stakes and mandates of each of the stakeholders.

There will, preferably, be different levels of performance contracts: (i) between the purchaser and the provider; (ii) between the facility and its healthcare staff; and (iii) between the purchaser and the regulator. To assure accountability on results, individual healthcare facilities should be contracted. The purchaser, with whom the contract is negotiated, should be present at local (district- or local government) level, to ensure an optimal fit to local circumstances and local health priorities, and to guarantee effective monitoring by the purchaser.

Principle 2: planning for results

As countries seek to improve their health results through RBF by shifting gradually from input- to output funding, the way they plan needs to change accordingly. In the case of input planning, providers plan inputs they think they need in order to implement what they are asked to do. In case of output planning, first the priority results are defined – not by providers, but by the purchaser, who represents the interests of the patients. The provider will then be invited to be creative and innovative in proposing a plan for attainment based on the proposed priorities. In our experience this is a difficult first step for many providers. They tend to answer first in terms of the usual inputs they need,

without questioning if those inputs have the potential to lead to the intended results. As in the car example. Will a car for the DHMT indeed lead to increasing the number of deliveries assisted by skilled personnel? Or are there other cost-efficient ways to uplift the bottlenecks?

It may also be a challenge for purchasers to define priorities, as they mostly rely on the providers to tell them what is needed. But the purchaser should have an active say in what is needed for the population it represents. Of course, this bottom-up plan needs to match the wider strategic framework that has been designed at national level. The deconcentrated agencies of the National Ministries should play this regulatory role, as checks and balances must be in place.

Principle 3: checks and balances *– through independent verification*

Contracting stimulates transparency and accountability because expectations and responsibilities are clearly defined. The development of the contract is essential, as different actors need to be able to hold each other to account. In RBF checks and balances are even more important, as financial incentives are at stake; it is easy to imagine that results might be reported that have never actually occurred. So, results need to be verified by an independent entity.

Nowadays, healthcare is most often managed by one single institution, the MOH, which is at the same time policy-maker, regulator, purchaser, verifier and provider of care – based on 'input-financing' through a hierarchical deconcentrated system. As this is about a contracting approach, there should first of all be a split of responsibilities between both parties signing the contract (the purchaser and the provider), and another between the purchaser and the regulator. This requires a certain adaptation of the rules of the game[3] between existing institutions in countries where the Ministry of Health holds all responsibilities. Such a change should ensure:

- The purchaser function is clearly split from the regulatory function and from the provider's functions.[4]
- The purchaser has enough autonomy to negotiate desired expected results.
- The purchaser has good means of verification to be able to assess if the provider did produce the outputs that were claimed.
- The regulator has the means to verify if the outputs produced are within the country's policies and norms and standards regulating the provider's autonomy.

[3] In chapter 5 the roles and responsibilities as described above are depicted in figure 1.

[4] For example, in many PBF programmes, the purchaser role is assigned to the MOH at central or at operational level. In the Ghana and Mali examples it was judged that there would be a conflict of interest if the MOH would decide whether MOH providers would receive financial incentives or not.

- The verifier has access to registers of the facilities to check whether reported outputs were justified. Preferably verification is also needed at household level to see if the patient in the register has indeed received the claimed service.

And, of course, the contracting partners should have enough autonomy in using the RBF funds to improve results further:

Principle 4: autonomy at the operational level

Results in healthcare will never be achieved by policy makers, but by the contracting partners at operational level. These partners need a high level of autonomy to:

- Allow easier involvement of the 'patient's voice' (particularly for the contracting partner representing the population) in selecting priority results that will respond to their needs.
- Support the decentralization process which is on-going in almost all – African - countries.
- Find innovative and creative solutions appropriate to their context.

A recent impact evaluation of the Rwanda experience (Basdinga, 2011) shows that incentives have an increased effect on services in cases where the providers have more control over the delivery of services, such as the quality of prenatal care.

In the classical, deconcentrated way of organizing the healthcare sector, the control that providers have over the planning and management in their facility is limited. Not only does this not encourage taking action to improve services, it is often used as an excuse for not being able to perform. In RBF, service providers are invited to put forward solutions that will create an optimal ratio between outputs and inputs, within their own specific context. They never have total autonomy since national policies will always impose certain restrictions. However, providers should be autonomous when negotiating contracts with the purchaser, as well as in managing, planning and, ideally, in managing all RBF resources, including the hiring and firing of staff.

This key principle should motivate contracting partners to select and deliver priority efficiently. It should make them more entrepreneurial, more creative and encourage them to become more responsive to their clients' wants and needs.

Principle 5: introducing 'managed market' principles

Healthcare systems differ in several aspects from commercial markets. In healthcare, providers can create certain demand since they have knowledge that the 'clients' don't. Also, curing a patient not only affects the patient, but may also prevent the patient's

environment from being subject to that disease (so called 'externalities'). And since good health is a priority, 'clients' will often be prepared to pay prices they can't afford. The clients (patients) need protection, which is why stewardship of the MOH at central level is necessary to manage the RBF market principles, as well as to regulate at operational level through (quality) norms and standards in alignment with national priorities.

But there is a demand/supply relationship in healthcare too. RBF strives to introduce 'managed market' principles to healthcare. Most RBF projects look to the following market mechanisms: (i) increase competition between different types of providers (public as well as private) to avoid monopolies and unequal power relations; (ii) introduce incentives, both financial and non-financial, that are based on services delivered rather than on inputs; (iii) increase freedom of choice for clients between service providers; (iv) involvement of clients in decision-making on managing healthcare; and (v) introduce incentives for clients (or patients). This brings us to the next principle.

Illustration: the power of transparency
We step outside to take a short break from work with a doctor in the district of Rwanda and discuss improvements made in his clinic, which have led to better results after introducing PBF. When asked why he had not made these improvements earlier, he replies that he does not want to perform less than the other clinics in the region. Recently, all performances were transparently placed on a website. Secondly, he said, it's clear and certain now on what I will be held to account.

Principle 6: providers responding to demand

Improved results in the sector are not determined by providers alone, they depend on patients using services. If providers want to improve results, they will first have to look at their clients' interests when developing their strategies. Results will only improve if patients are successfully encouraged to use the provider's services. Providers will therefore need to improve the quality of their services, that is, the quality *as perceived by clients*. They will have to identify what prevents clients from using their services, where the bottlenecks are, and then develop strategies to overcome them. Bottlenecks may include risks (as the patient sees them), transport to the facility, financial and socio-cultural barriers, or the organization of their own services that may not be client-friendly. The provider may even decide to use the funds they received through RBF to decrease user fees, or they may decide to organize better transport from the village to the facility or improve outreach services – to seduce their clients. The strategies how to seduce will depend on the specific context of the healthcare facility and the user community.

Another way of ensuring that providers will better respond to the wants, needs and demands of the clients is to ensure that representatives of the community play an important role in managing the facility, including the this development of result plans and contracts. These representatives would

In Ghana, 35% of married women do not receive the modern family planning methods they say they want (DHS 2008).

then translate demand to the providers, hold them to account when it comes to the results that have been promised, and perhaps act as purchaser of quality care.

Another question is why health funding would only be used to finance the supply side? The PBF impact evaluation in Rwanda (Basinga, 2011) suggests that: 'for services that depend more on patients' care-seeking behaviour, the programme could provide financial incentives directly to the patient rather than to the provider'. There is also a place for demand side incentives, such as vouchers for pregnant women to attend four ANC visits and then a delivery assisted by qualified personnel.

We suggest applying these six RBF principles to any given context since they are crucial for the development of an appropriate design. We have learned that the improvement of results through RBF may be just as attributable to what we would call the 'RBF-arrangements (particularly principle 1 to 5) as to the financial incentives. Understanding these principles may provide you with resourcefulness and that of other actors involved, when designing a PBF programme. Applying these principles in your specific context can help to avoid or minimize some of the challenges we identify in the next chapter.

4 RBF architecture

The 'generic' architecture of RBF

To adapt RBF to existing institutions in the national context, an appropriate institutional framework needs to be developed, its appropriateness being assessed against the principles as defined earlier. The framework should ensure a clear split of functions, in which the tasks and responsibilities of contracting partners are made transparent and do not overlap. This is key to the future success of the contracting approach.

The 'generic' diagram (figure 1) illustrates the roles and responsibilities of the regulator (MOH), the fund holder at central level (Ministry of Finance, donor, INGO or other), the local fund holder at operational level and the (public and private) health providers. In our approach, this generic diagram needs to be adapted to specific country and health system contexts – see the Mali and Ghana examples.

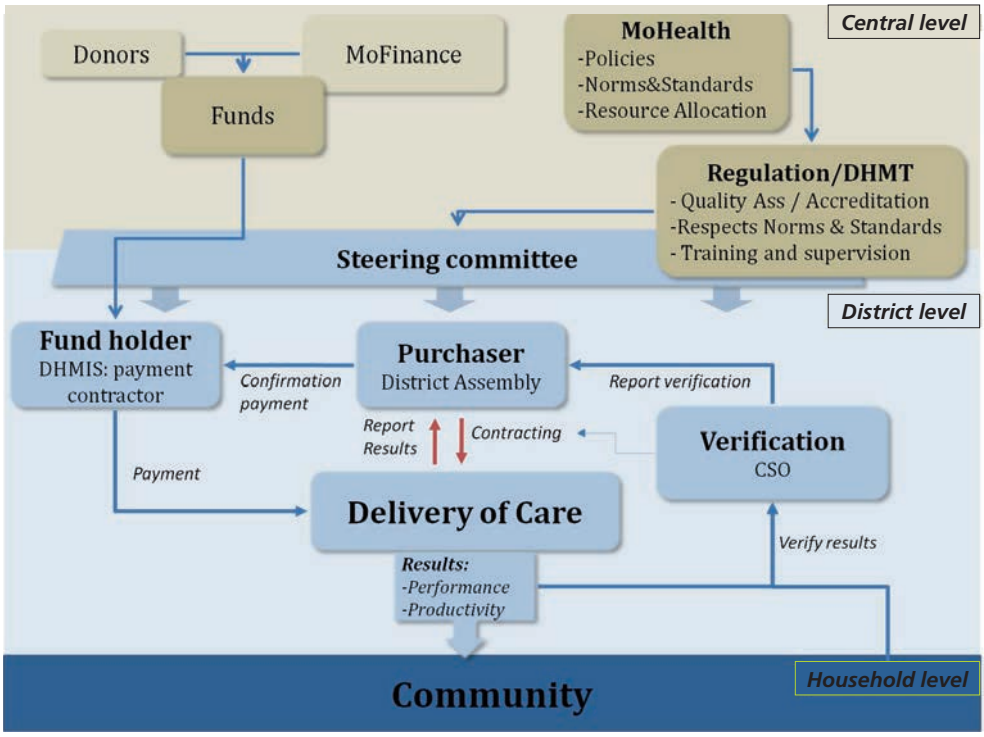
The diagram shows that the **provider** offers (curative, preventive and promotional) services to the patients; the productivity and quality of these services is subject to RBF. To increase their performance, the **purchaser** first defines the priority results with local stakeholders. The purchaser then suggests that the provider makes a results-based business plan outlining a strategy to attain the required health outputs. The purchaser then goes on to spell out what is needed in terms of (human, financial, material) resources to implement that strategy. This is the starting point for negotiations between the purchaser and provider that will lead to a contract that clearly spells out the expected results, setting them against the necessary resources, incentives and sanctions in the case of these results being obtained (or not). Results are defined in *outputs*, not in 'targets' or 'coverage', and in terms of quantity and of quality of care. The purchaser ensures that verification activities are carried out (they may be contracted out to an independent agency), in order to assess if outputs were indeed delivered as reported by the provider. The **local fund holder** will pay the reported outputs after *verification*, conform the contract. The local fund holder receives the funds from the central level (from a donor, the MOF or MOH) to pay for the results that were ordered by the purchaser. The purchaser is not necessarily the local fund holder, but this could be an option.

Regulation will probably be carried out by the MOH since it concerns respect for national policies, norms and standards, certainly regarding the (professional) quality of care. Where necessary, its district team will also coach providers to be creative in seeking ways to improve results.

The **Steering Committee**, representing all the different stakeholders, oversees the contracting partners. The stakeholders are usually representatives from community organisations, the purchaser, providers and regulator. The Steering Committee provides 'ex ante' the frame and limitations of the contracting, approves the framework contracts and represents a level of 'ex post' arbitrage in cases of escalating disagreements between purchaser and provider. The Steering Committee receives verification reports.

Below are a few examples that give an idea of how these key functions are interpreted in different countries. Most come from post-conflict countries, where new structures could be built, such as the introduction of an NGO to fulfil the purchaser role. The challenge we identify and address in this booklet is to identify existing structures that could take up the role of the different institutions mentioned above, in countries that have an existing and functioning framework.

Figure 1: Generic institutional framework RBF



A few examples from other countries

Various modalities for funding arrangements evolved from the 2009 KIT/WHO multi-country study[5], summarized below.

In the **Democratic Republic of Congo**, the purchaser was also the **local fund holder** and was implemented by an NGO in all the below cases. The fund holder had direct contact with the regulator (the provincial health bureau), with variations on the level of autonomy as follows:

[5] PBF develops fast. Some examples provided here have since changed

a. In South Kivu, Cordaid channelled funds through the health departments of the local diocesan offices, which are now moving towards the establishment of an independent local fund holder agency office.
b. In the Kasaï region a project unit was set up, assuming responsibility for the functions of purchaser and local fund holder. The unit still relies on NGO funding and is supported by TA. It will gradually be transformed into an autonomous organization.
c. A third type of approach consisted of contracting a local NGO to serve as fund holder, without exit strategy.

In **Burundi** new structures were developed to accompany the change from input to output financing. The Local Fund Holder Agency *(l'Agence d'Achat de Performance - AAP)* is a new autonomous administrative structure with a workforce of 10 to 12 (some 50% are qualified). It was not a part of government structures; various stakeholders (CSO, NGO, civil administration) take part. The AAP is responsible for incentive payments, verification and the general administration of funds awarded to the provider.

The provincial level played an important role in implementing PBF. The Provincial Health Committee acted as the steering committee for provincial health affairs, having full jurisdiction for the entire provincial health system. The Provincial Health Bureau provides the **regulatory function** for PBF, mainly through its responsibility for quality control. A *newly installed* Provincial Piloting Committee for Contracting oversees the implementation of PBF. This PPCC is a MOH-linked body that consolidates the different PBF invoices and performance payments, while also acting as mediator in the event of conflicts of interests.

The PPCC contracted out the **verification** to different bodies – village health committees, NGOs and university students. Verification is undertaken at district level in collaboration with the Provincial Health Bureau. Indicators selected to assess performance include both curative and preventative care. The number of indicators monitored for PBF is higher in Burundi than in other country experiences, and also differs between districts. Household surveys are carried out each year to verify findings and assess client perceptions from a general quality perspective.

In all these cases a *new* institution is introduced to the system to be the purchaser and local fund holder. This can be justified in a post-war situation with national governance institutions that have virtually collapsed. The same applies to the new provincial health bureau in both Burundi and the Democratic Republic of Congo. The new bureau is again a new multi-stakeholder institution with participants from the provincial government, civil society and development partners.

Tanzania and **Zambia** witnessed Cordaid's introduction of output-based financing, replacing previous input-based financing to selected diocese-supported hospitals. In both countries there was virtually no involvement by MOH, neither at central nor peripheral

levels. Neither was there community involvement, hence the lack of the regulatory function. The role of the local funding agency had been assigned to the diocesan health offices. In both countries, the contract was drawn up between the funding agency (Cordaid) and the local fund holder (the diocese), *not* with the providers, who are the ones who will achieve results. As a consequence, the health facilities were excluded from direct contract negotiation on results and the incentives linked to these. For that reason, no effect on performance could be expected from PBF, here; the providers need to be contracted and held to account on attaining the results.

The examples from Zambia and Tanzania show how important the designing of RBF arrangements is for holding providers to account when it comes to results. DRC, Burundi and Rwanda have all installed new institutions to purchase quality care. The big question now of course is how to develop a more appropriate institutional framework in more stable countries, something that will be dealt with in the next chapter.

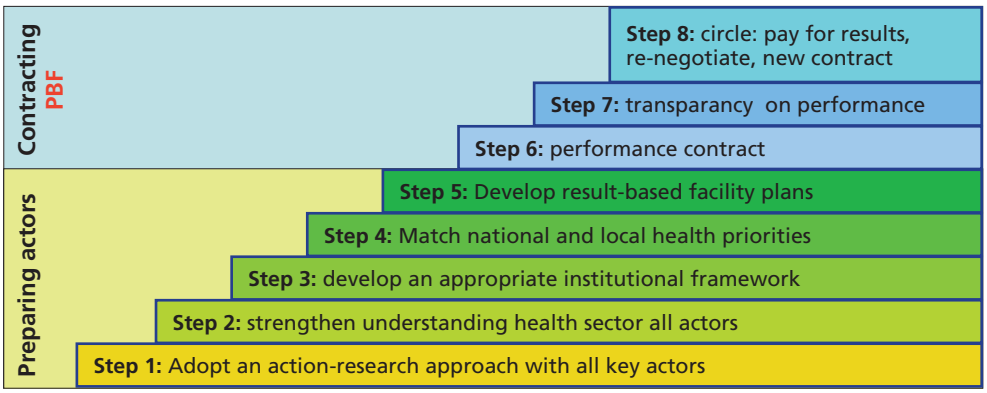
5
Eight steps approach for the implementation of RBF

The approach

The problem in implementing the principles of RBF is where to start. What to do first? And second? Am I on the right track? What did I forget? Where's the recipe book? Unfortunately there is no recipe, book, just lots ingredients to add flavour to the RBF mixture. Also, we need a good kitchen – in other words, a good institutional framework. So how do we get there? In Mali we developed a generic approach with eight steps. It aims to build and implement context-specific RBF models. We used this approach in Mali and Ghana and finally arrived at two different models, each adapted to the country context. In other contexts the same approach can be used to arrive at yet another model.

The Mali experience of developing a contracting approach is extensively described (Hilhorst, 2005; Toonen 2007, Lodenstein 2009). A step-wedge design was developed. From this experience we have deducted nine steps for the implementation of the RBF principles in a sustainable way (see overview of steps in figure below). These steps do not always follow each other in chronological order, but missing one would undermine the effectiveness of the final RBF model. One of our most important recommendations is to make sure the preparatory phase has been finalized before starting the RBF contracting approach. Preparing the key actors for a contracting approach and RBF is an important process that is too often overlooked.

Figure 2 A process approach to prepare actors and systems for PBF



Step 1: Adopt an action-research approach

The first step is really more of a principle, as it should apply to all these steps. The basis for successful implementation is to adopt a learning, or 'action/research' approach as we call it – *(re-)searching for the appropriate model*.

This is also why we encourage a pilot in which all actors go through all eight steps before starting a full-fledged RBF programme. A pilot is a safe environment in which all actors can experiment and experience what the change means at their level. This simulation will stimulate actors to step out of their normal behaviour patterns and go through the full learning cycle.[6] Also, it is important to identify a potential **entry point** to start discussing the need for change and to get the actors to focus on a joint agenda. The entry point will be a particular challenge or an issue that several actors are confronted with and where there is a level of consensus about the need to intervene. In Mali, this entry point was the lack of clarity in roles and responsibilities due to changes in decentralization policies. In Ghana the entry point was a disappointing level of performance at operational level against a relatively high national health budget (see next chapter for more details).

A participatory action/research approach creates the necessary space to ensure:

- A common understanding of the need for change and the potential of RBF in particular.
- Sufficient understanding of the *actual* responsibilities that are attributed to each of the future contracting partners to gain mutual trust.
- Sufficient understanding and trust of their *future* roles and responsibilities.
- Time to prepare local actors to own and manage the system without dependence on external support.

This way the terms of agreement are created between different stakeholders who can jointly design the contracting approach that can lead to the RBF arrangements during the next steps. This could also lead to a formal agreement (see step 3) in which they agree to partnership working, to respect related laws and regulations, to respect defined responsibilities attributed to each of them, and that the aim of their joint efforts is to improve health results. The Mali and Ghana case studies show how such an action/research can be set up.

Step 2: Strengthen (non-)medical actors in their understanding of health sector management

It is important to include non-medical actors in the contracting approach; they will be asked to represent the patient's voice in the RBF set-up, to render health services more responsive to the needs and demand of patients and citizens in general. Who those non-medical actors are, depends on the context and their future role. In general, we noticed that non-medical actors usually don't dare to touch the medical space: 'the doctor will know'. They will usually look at issues they feel familiar with, like financial affairs, or the building of a health centre. They are most often hesitant in discussions concerning what is happening inside a health centre and what the results will be in terms of quantity and

[6] This refers to 'simulations' as a means to stimulate persons to go through the full learning cycle (Kolb) and breach the short learning circuit in which persons are active without being reflective, which leads to 'static activeness' (van Deemter, 2002).

quality. Reports that may inform them may be inaccessible or written in too technical terms. In other words power relationships between medical and non-medical contracting partners may be unequal, and this could hinder contract negotiations and effective partnerships.

If non-medical parties (such as community-based (health) associations, local governments, health insurance agencies and NGOs are to become credible contracting partners, they need to be well-prepared. Firstly they will need to be able to analyze results as reported by the health centre staff, so that they can prioritize, and to hold providers to account on these results. They will need to understand what the options are in planning resources for the health facility and/or outreach activities. They will need to learn how to act with the medical partners during meetings. This must all be in place before the non-medical actors can play the purchasing or oversight role that is expected from them in a PBF future. In Mali an **information tool** was developed for non-medical doctors to simplify health information and evaluate health performance (SIEC – see chapter 6 about Mali).

But medical actors need preparation too. They need information about the official roles of the non-medical structures, which are usually seen as a potential source of problems: *('What do they know about medical affairs? I am a medical professional')*. At best they are seen as a potential source of local funding. There is a need for a change in attitude and to see the potentially positive side of collaboration with non-medical actors. But also, and perhaps this is the most difficult task, they will have to learn to plan differently. Results-based planning forces them to prioritize results and set about achieving them; it is about developing related strategies, and then prioritizing the available funding to fund activities in line with those strategies. Following this results chain may lead to the conclusion that the usual training and health education sessions designed to educate women on the advantages of ANC may not be the most effective strategies. All of the women in a particular district will probably have heard that news already. Instead, the providers will be forced to think of relevant interventions to help those informed women overcome the existing bottlenecks in accessing ANC services. It is often useful to carry out bottleneck studies at household facilities and at local governance levels, to identify the exact bottlenecks that need to be overcome.

Step 3: Develop an appropriate institutional framework

Particularly in those countries with a well-established health architecture, such as most West African countries, a contracting approach like RBF needs to be embedded in the prevailing national governance structures. Existing tasks and responsibilities will probably need to be strengthened or adapted in a number of aspects. Actors will have tasks and responsibilities that are new to them and that they have never previously been prepared for, even if they have those responsibilities already within the existing structures. They are used to 'managing by inputs', but have no experience in managing by results.

The split of functions in RBF almost requires a health reform in countries where the ministry of health is a purchaser, regulator and provider of healthcare all at the same time. As a pragmatic solution, actors are invited to sign a **performance framework contract** in which they agree on an institutional framework that enables:

- The roles and responsibilities to be clearly defined, stating which institution will be the future purchaser, which the fund holder and which the regulator.
- The purchasing, regulatory and provider functions to be clearly split from each other to ensure checks and balances.
- The provider to have sufficient autonomy to use RBF resources in an optimal way in obtaining negotiated desired results, e.g. to hire and fire staff.
- The purchaser to have good means of verification to be able to assess if the provider in really did produce the outputs that were claimed.
- The regulator to have the means to verify if the outputs produced are within the country's policies and norms and standards.
- The steering committee to be able to provide the boundaries for contracts and to referee in case of a conflict between the purchaser and provider.

This *performance framework* contract should allow for flexibility and not put restrictions on the actors. It is a basic understanding about the direction and contributions of each actor, as well as about their readiness to explore an alternative performance model. The quarterly contracts linked to this performance frame (see step 6) will define the details.

See www.kit.nl
Instrument 1:
Standard performance framework contract, which is the general part of a 'model contract'.

Depending on the situation it could also be an option to identify different types of performance contracts e.g. between the purchaser and the regulator, between the purchaser and the provider, between the facility and its health staff (on distributing payments according to individual results).

Step 4: Match national and local health priorities

National policies determine national priorities in the health sector, so these will provide the boundaries for the results plans and for contracts at the operational level. However, policies do not produce results: these are achieved at operational level. Therefore it is important to stimulate analysis at the decentralized level to determine local priorities.

This analysis needs to be evidence-based. The way inputs are used to reach outputs will be determined by the **context**, so inputs will need to be used in a different way in different contexts. This is why a blanket approach needs to be avoided. For example in district A almost 100% of the children up to 1 year old are already vaccinated, while nutrition is a big problem, or the number of children who die after birth. In district B

vaccination of children under 1 year is however still a problem. Only with a **situational analysis** can these different priorities can be identified.

We built the capacities of local organizations in order to develop baselines at district level to inform where the performance gaps are. In focus group discussions, medical and non-medical actors discuss priorities from their different perspectives, parting from the baseline data to come to joint selection of local priorities, ensuring that these respond to the demands of the population. The identified priorities are then put in results chains, in order to identify the activities that could lead to those results, as illustrated in the referred document.

See on-line www.kit.nl **Instrument 2**: results chain '

This process step requires facilitators who can support the different types of actors in identifying and selecting integrated local solutions to achieve the priority results, instead of responding to the priorities of a vertical programme. In selecting local needs, specific attention was paid to:

- Improving quality of care, which is more of an issue in West African countries then productivity, and key to the problem of low utilization of services.
- Focussing not only on supply side, but also on demand side incentives.
- Focussing not only on financial, but also on non-financial incentives.
- Avoiding 'perverse effects', not focusing only on a few specific indicators.

When starting the real pilot it is of course important to conduct a solid baseline study to establish whether the characteristics between facilities in the intervention group and facilities in the control group are not statistically different, thereby being able to tell if introducing RBF made a difference.

Step 5: Develop results-based facility plans

As stated before, classical 'input planning' often leads to a lengthy process of discussions and arbitration, and providers have limited control over the planning and management in their facilities; there are superior hierarchical levels that may overrule. This does not encourage health workers to improve their services, it may even demotivate them. RBF intends to bypass these discussions by using a contract negotiated with the provider. Ideally, facilities should be autonomous when it comes to developing results-based plans that outline how to achieve the identified priority results without interference but with support from superior MOH levels.

See www.kit.nl **Instrument 3**: standard results-based plan.

Instead of *directing*, higher levels need to facilitate; superior levels should support health facilities in analyzing what could make them successful i.e. achieve the results. To this end they are asked to help analyze bottlenecks in the contextual factors at both facility

and household levels, identifying what may enable or block attaining the identified priority result. Secondly, they support the facility on how to organize the services in such a way that it can overcome the hiccups and achieve better results.

In RBF, service providers are responsible for the best management of their resources, thus being invited to make choices that will create an optimal output/input ratio within their specific context. Interestingly, in our experience, most actors start developing results-based plans with a classical shopping list of inputs. It takes time spent with the partners, reflecting on whether such a proposed input will result in an increase of the results aimed for, or not. Introducing RBF requires a change in mindsets and behaviour, moving towards more entrepreneurship among the different contracting partners.

This is the last step of the preparatory phase, after which contracting actors have the basic required capacities and tools to ***start RBF****. Once the contracting partners seem to understand contracting and verification (and, if funding is available), the results-based payment as a unit price for each output can be added to the contract. What happens in the case of fraud should also be described.*

Step 6: Negotiate performance contracts

As explained in the RBF principles, service providers are never 100% autonomous. They are autonomous when it comes to negotiating RBF contracts with the local fund holder, in managing and planning, and in managing all resources deriving from RBF funding. Interference by superior hierarchical levels should be limited as much as possible to ensure that national policies, norms and standards are respected. They should also not interfere with how RBF resources are used. This is dealt with in the framework contract in step 4. Local partners should have enough autonomy to be entrepreneurial and creative in responding to local priorities.

See www.kit.nl
Instrument 4:
standard contract.

A quarterly contract is negotiated between contracting partners based on the results-based plan developed by the provider. A standard contract will comprise the following subjects:

- The priority results in terms of quantity of outputs (not coverage).
- The priority results in terms of quality of care.
- An analysis of the priority results in the last quarter.
- The strategies proposed by the provider to achieve the results.
- The activities needed to implement those strategies.
- The way input and output funding will be used to carry out these activities, and the source of funding.
- The proposed results-based plan of the facility will be placed in annexe.

As RBF is a contracting approach, commitments should not be one-sided; the community should also 'deliver' as we explain in the final chapter. That is why it is not only the actions and funding of the provider that should figure in the quarterly contract, but also those actions of the other contracting partners that are needed to achieve results. For example, a local government could take action on controlling the illegal sale of medicine.

In addition to the provider's contract, the **district health team** could also receive a results-based contract to carry out its regulatory and coaching tasks at operational level, alongside its contract with the steering committee and based on a performance framework.

Step 7: Introduce transparency on performance

Once results-based payments have been introduced, it may be tempting for some of the providers to report more results then were actually achieved. Although in reality this may not be a big problem,[7] independent verification of performance (both in terms of quantity and quality of results) is required. In fact, this is not new; monitoring results is also part of input planning. Monitoring and supervision alone do not necessarily lead to increased provider effort. The difference in RBF is that (positive and negative) consequences are linked to the results, and it is clearly stipulated in the contract what exactly is expected from the provider.

To verify results, there are different types of methods:

- Monthly verification of the number of **quantitative** results at facility level. The results that were reported by the provider will be verified by comparing these with the patient registers in the same facility.
- Quarterly verification at household level of **quantitative** results. A number of patients will be randomly selected from the registers and visited at home to verify if the service was indeed provided. When the patient has visited the health facility, a short **patient satisfaction** questionnaire will be completed to evaluate the quality from the patient's perspective. Also, the selected household will be the starting point of a 'cluster' of seven households (as in the EPI coverage survey methodology) surrounding the first one, to see if there were persons here who visited the facility, and to fill in the patient satisfaction questionnaire.
- Verification of quality of care at facility level. Beside the **patient satisfaction** at household level, at facility level a list of quality criteria will be recorded according to a scorecard. This represents both the professional and the patient's perceptions of care quality.

[7] Between October 2008 and November 2008 the Ministry of Health of Rwanda did a one-off tracking survey and interviewed around 1000 patients to verify the accuracy of the records: it noted that false reporting was less than 5%. Health, Development and Performance (HDP, 2008)

This part will strengthen the health system beyond the use of data for verification. The need to accurately produce data on output will enhance existing capacity to collect and analyze data. The provider will be certain beforehand about what (s)he will be held accountable for. Availability of data will enable the possibility of (social) accountability and provide better information for researchers, which could again be used to create evidence for policymakers. Standard methodology and standard verification instruments are needed to allow verification to be done also by non-medical staff such as local NGOs.

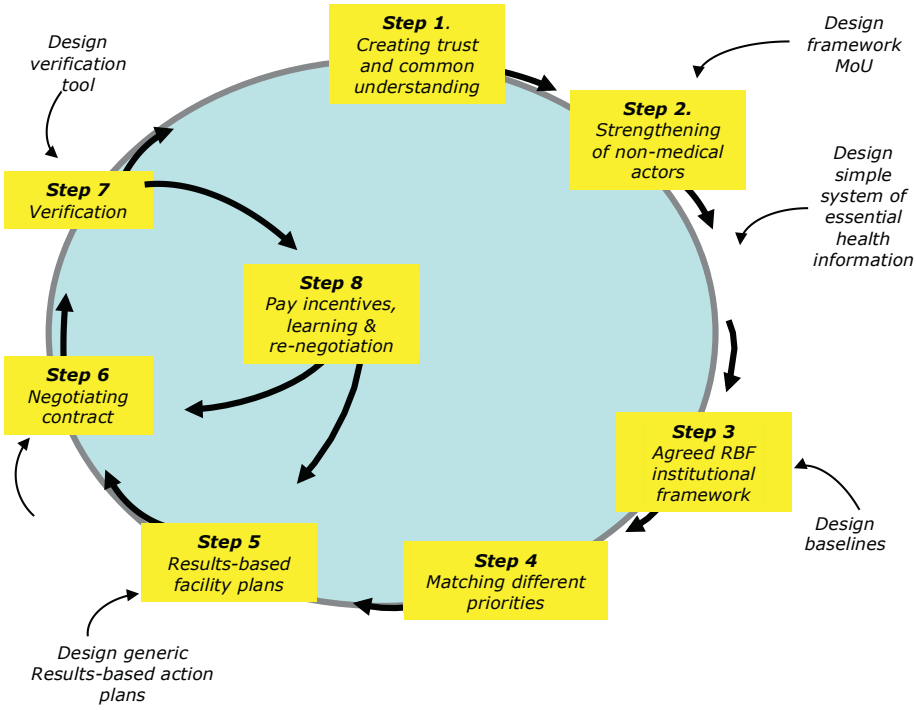
See www.kit.nl **Instrument 5**: verification tools.

Step 8: Pay incentives, learning and re-negotiating

Conditions for providing quality care change continuously; risk factors such as cholera may crop up or disappear, but there must also be space for learning to adapt to unforeseen challenges or unintended effects, to identify successes and to re-evaluate priorities (if necessary). For those reasons, a three-month cycle has been introduced in the contracting approach to allow for the flexibility to react to new circumstances. For that reason, when results are presented, the strategies implemented by the provider will be evaluated and, if successful, replicated. If they were not successful, there will be discussions as to what can be done to overcome these problems. Then a new phase of the RBF cycle will start, repeating steps 4 to 7.

This process approach allows for learning and adaptation to fit the specific context of any country. It helps identify ways to open the boundaries of the health system in order to create opportunities for contracting partners, including non-medical actors, to identify and negotiate their own interests. In other words, we should go through this process only to improve the services and make them respond to the needs and desires of the population.

Figure 3 Generic development cycle for the approach for contracting and RBF



6
One approach, different models

Understanding the context

This chapter highlights some of the important elements of the context of Ghana and Mali where we implemented the process steps described in the previous chapter.

Ultimately, the process steps in both countries were very similar: a contracting approach, and then results-based financing. However, the outcomes of that process, the architecture and the implementation arrangements for RBF, were very different.

"I don't need opinions, give me facts"

Context matters. Before we start describing the two cases, it should be understood how different the health situation is in each country. The table below shows the development of the MDG-related indicators. For example, maternal and child mortality are lower in Ghana than in Mali, but there is little difference in delivery by skilled personnel. Infant and child mortalities in Ghana are lower than in Mali, while the immunisation coverage is higher. Furthermore, one can see that for some indicators, improvement is faster in Mali, while for others they are faster in Ghana. Conditions to improve health indicators – such as female education, water and sanitation, per capita income – are different; in Mali the **conditions** are more challenging.

Introducing RBF is a major change process. Different **actors** in the health system have different stakes, which will be affected differently with the introduction of RBF. They will therefore respond in various ways to RBF. It is important to understand the specific role, responsibility and stake of each key actor and to anticipate what they will stand to lose or gain. Some may easily agree to the changes, but some will dispute their necessity. Creating an indisputable sense of urgency is essential for each change process, certainly for RBF. Good knowledge of the facts that determine the health situation and system of your context is needed to be a credible **change agent**. At the start, information and evidence may create common ground to discuss the need for alternative performance concepts.

For these reasons, and as described in step 4, before signing contracts we incited the services to do a situational analysis. To analyze the actual state of play of all health data and the trends of the last few years. But the context analysis was not confined to the health data – it was also an analysis of the existing institutional arrangements to identify the appropriate structures that could fulfil the future RBF roles.

Table 2 Level of attainment of the Millennium Development Goals in Mali and Ghana

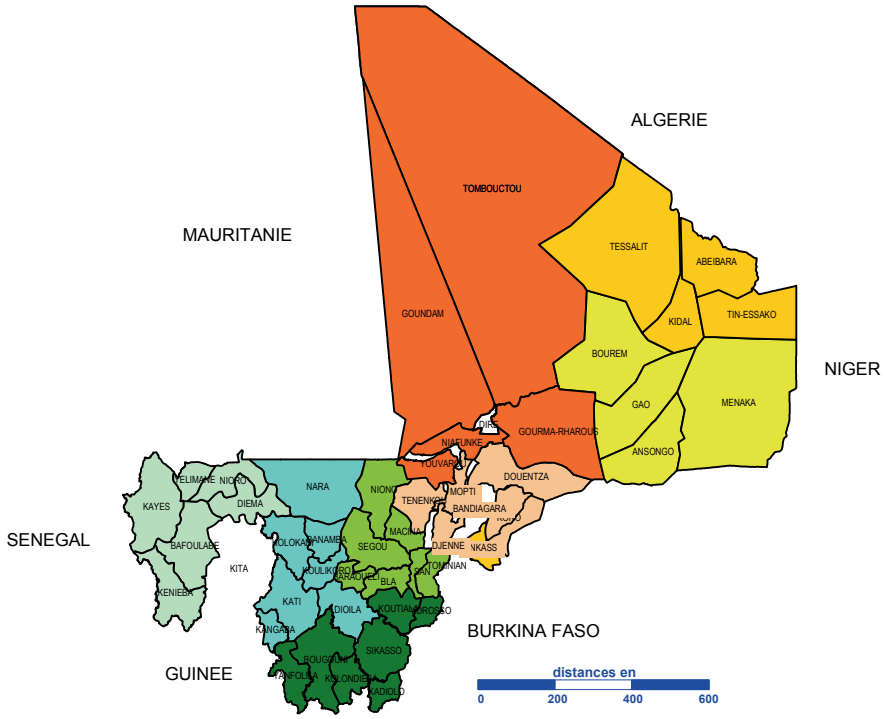
Millennium Development Goals	Mali		Ghana	
	2000	2009	2000	2009
Goal 1: Eradicate extreme poverty and hunger				
Prevalence of undernourishment (% of population)	18	12	9	5
Goal 2: Achieve universal primary education				
Total enrolment, primary (% net)	45	75	64	77
Goal 3: Promote gender equality and empower women				
Ratio of female to male secondary enrolment (%)	55	64	82	89
Goal 4: Reduce child mortality				
Immunization, measles (% of children ages 12-23 months)	49	68	84	86
Mortality rate, infant (per 1,000 live births)	120	103	68	49
Mortality rate, under-5 (per 1,000)	217	194	106	72
Goal 5: Improve maternal health				
Adolescent fertility rate (births per 1,000 women ages 15-19)	167	161	84	63
Births attended by skilled health staff (% of total)	41	49	44	59
Contraceptive prevalence (% of women ages 15-49)	8	8	22	24
Maternal mortality ratio (modelled estimate, per 100,000 live births)	980	830	500	350
Pregnant women receiving prenatal care (%)	57	..	88	95
Unmet need for contraception (% of married women ages 15-49)	29	31	34	..
Goal 6: Combat HIV/AIDS, malaria, and other diseases				
Incidence of tuberculosis (per 100,000 people)	300	320	210	200
Prevalence of HIV, total (% of population ages 15-49)	1,4	1,5	2,4	1,9
Tuberculosis case detection rate (all forms)	13	15	27	30
Goal 7: Ensure environmental sustainability				
Improved sanitation facilities (% of population with access)	32	36	9	13
Improved water source (% of population with access)	44	56	71	82
Goal 8: Develop a global partnership for development				
Mobile cellular subscriptions (per 100 people)	0	27	1	50
Net ODA received per capita (current US$)	27	76	31	55
Other				
Life expectancy at birth, total (years)	46	48	58	57
Literacy rate, adult total (% of people ages 15 and above)	19	..	58	66
Population, total (millions)	10.5	13	19.5	23.8

Source: World Development Indicators database: http://data.worldbank.org/news/wdi-database-updated

RBF 'a la Malienne'

Context

To date, more than 1,000 CSCOMs (community-owned health centres) have increased access to Primary Health Care in rural Mali. Despite the regular increase in access and a threefold increase in health financing over the past years, Mali remains **off track** in terms of meeting the MDGs. From the 2006 DHS, Infant Mortality stands at 103 per 1,000 live births, and maternal mortality at 830 per 100,000 live births. The adolescent birth rate is 190 for every 1,000 women; 49% of deliveries are attended by skilled personnel; 35.4% of pregnant women have received four or more ANC services; 8.2% of 15-49 year old women use contraceptives, while 31.2% of women declare to have unmet family planning needs. Resources (human, financial and physical) allocated to CSCOM are insufficient, while the available resources are usually not used in an appropriate and efficient way, as they are not linked to results but based on input planning. As a consequence, CSCOM have difficulties responding to local needs and medical staff often don't feel responsible for obtaining results.



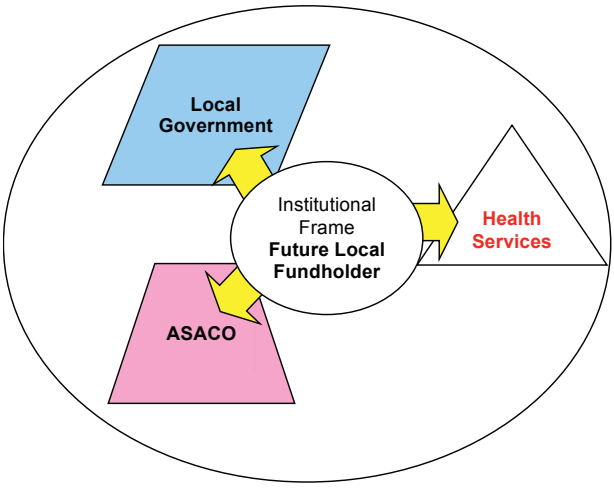
The health sector in Mali has experienced different decentralization reforms that have affected the performance of health services at the operational level. The first was deconcentration within the Ministry of Health (MoH), and involved delegating tasks to the District Health Medical Teams (**DHMT**). A second appeared under the health reform (*Politique Sectorielle*, 1990) and gave the ownership of community health facilities (*Centres de Sante Communautaires* or ***CSCOM***) to a community health association

(*Association de Sante communautaires* or ***ASACO***). The third type was the devolution of certain mandates to elected local governments (***Communes***), which are, since 2002, responsible for basic service delivery including health at local level.

The health system needed to adapt itself to this new, complex context, which offered challenges as well as opportunities to strengthen the delivery of health services. A move towards more decision-making power at the local level offered opportunities for increased mutual accountability, as well as making health services more responsive to the needs and demands of the local population.

However, the reforms also led to the emergence of new actors, more complex governance relations and a confusion of roles and responsibilities. One of the key challenges was tackling distrust between the three types of actors in decentralized health management (DHMT, ASACO and Communes) who all felt responsible for health services at decentralized level. And in fact by law, they were. There was no clear division of mandates and roles, and this limited effectiveness. In this context, SNV and KIT conducted a situational analysis in 2005 to identify the issues in the health system according to key informants at central and at operational level.

Figure 4 Contracting actors in Mali



The health services thought they were responsible because they represented the MOH – although responsibilities were deconcentrated, not transferred to them. The ASACO (representing the community) thought itself to be mainly responsible, because it became the legally recognized 'owner' of the health facilities during the health reforms in the early '90s. The Communes (local governments) thought they were responsible because they were democratically elected and, according to law, they had become responsible for all basic services – including health.

This shift of powers demanded a rebalance, which formed the starting point for the discussion of a pragmatic distribution of roles and responsibilities and accountability. It was decided that this would be best approached by introducing contracts. When these were being drawn up, the discussion arose as to whether there would be consequences if contractual obligations would have to be met. That was the start of RBF.

So in Mali, the change was instigated by decentralization reforms. Although the immediate reason for change may be different in Ghana and Mali, the underlying challenges are similar: low-performing health systems at decentralized level.

Meanwhile, the World Bank had invited high-ranking health authorities from Mali to Rwanda to learn about the successes of RBF. They came back inspired and were keen to introduce the system in Mali, but when started the policy-making process, they realized it was not so easy to develop *'RBF à la Malienne,'* i.e. within the specific context of Mali.

Preparatory phase (steps 1 to 3)

In 2004, KIT designed an operational research method to develop an approach to supporting local partnerships in association with the MOH and the National Directorate of Local Authorities. SNV/Mali, being present at the operational level, was associated by KIT to build capacity in the region of Koulikoro. Our approach was developed in Mali – the eight steps described above were established during the process itself and after its completion. We nonetheless describe them below, even though we reason backwards here.

During this preparatory phase, the programme identified, tested and elaborated modalities and practical tools to prepare the local actors for the process of becoming informed, contracting partners, a pre-condition for sustainability. Key elements of this approach focus on building trust between Communes, ASACO and service providers. KIT developed a consultative framework for SNV, inviting each of the three partners in the district to individually discuss the issues identified during the situation analysis of the preparatory phase. Meetings were then organized between all three stakeholders to discuss those issues once more, but now jointly.

Gaining trust by introducing action-research

[Step 1] It became clear to all partners that they were not fully aware of each other's responsibilities, and where their own ended. It was decided to inform each of the three actors about the legal status and mandates of the other two. This established mutual understanding for each other's position and the need for more collaboration.

Since the community representatives in Mali (both ASACO and Communes) were not well enough prepared to become informed partners in the partnership, they received extra support. In Mali the three actors started collaborating on a low-risk joint activity to obtain a joined vision; health planning was already officially carried out on a joint basis, but was limited to health services developing the plan, then consulting with the others to reach agreement. The change now was to start the process jointly, from the setting of objectives up to the annual planning itself.

[Step 2] As the contracting partners were not able to analyse the health reports to assess the performance of the health services, the SIEC/S *(Système d'Information Essentielle pour la Commune/Santé)* was developed, based on a minimal package of information related to their expressed health priorities. A specific scoreboard was developed, using traffic

lights to record whether results were developing well, average, or badly. Contracting partners needed to fill in this scoreboard themselves, to ensure that they would actively analyze health services' performance in preparation for the contracting approach. **[Step 3]** Only the introduction of the SIEC/S had immediate effect in setting priorities. Where the involvement of non-medical actors was previously limited to discussing buildings, after being able to analyze (part of) the health data, they began activities aimed at improving the performance of the health centre (see box).

This (the micro-planning tool and the SIEC/S) all resulted in non-health actors becoming acquainted with holding providers to account for results. This first phase of the approach has become a national policy and the tools have been published in the form of a guideline.

The mayor of the Commune of Wakoro in Mali, went around on his motorbike to speak with members of his constituency. He discussed with women and their husbands how better care could be guaranteed for women delivering in the nearest health facility. Why did he do this? The mayor took part in a workshop where he learned to understand health service data through the SIEC. Then again – what was his stake? It appeared that he also understood that improving performance of services in the villages could mean a potential success for his own re-election.

See www.kit.nl
SIEC **(Instrument 6)**

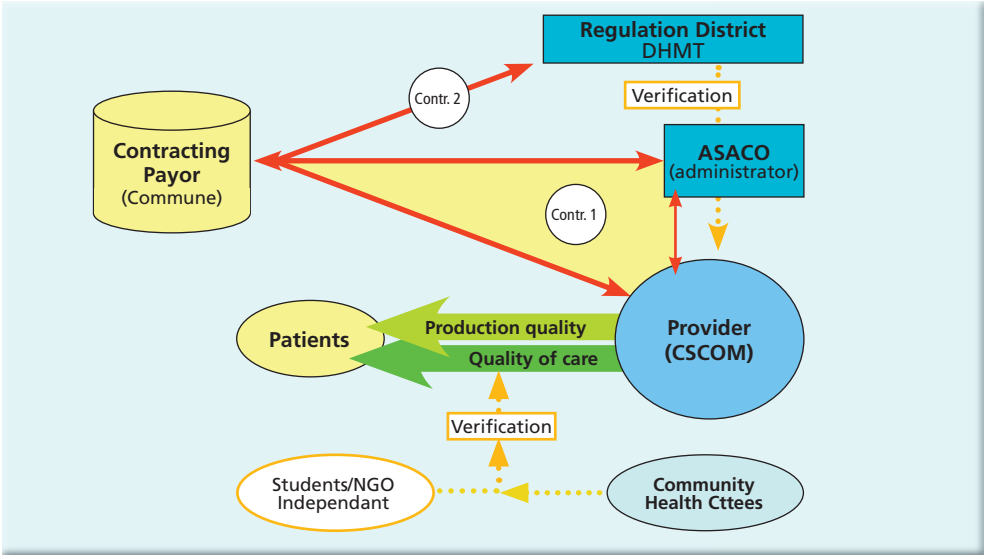
Contracting approach in Mali (steps 4 to 5)

In this preparatory phase KIT/ SNV had not yet introduced the term RBF, using instead 'contracting approach'. We emphasized the need for collaboration through an alternative framework, using performance contracts.

[Step 4] There was already a law in place that permitted the implementation of the contracting approach, and a first attempt to establish a **standard contract**, the CAM *('Convention d'Assistance Mutuelle')* had been launched. The CAM, however, was very generic. The general agreements between partners (ASACO and Commune) were already defined nationally, but negotiating expected results or commitments from each of the partners was not needed in the CAM. Hence the CAM could not be named a 'contract', but served as an entry point to start discussions on the contracting approach/RBF.
During several meetings with each of the three decentralized actors, and with them all together, the institutional framework for contracting took shape:

It was decided not to limit the contract to the provider (CSCOM) and the purchaser (Commune) only, but to make it a tripartite performance contract, involving the ASACO too. Also, it was decided that a second results-based contract would be developed between the Commune and the regulator (DHMT), to ensure the supervision and verification of registers. For verification of the number of outputs and the quality of care, independent agents such as NGOs, Community Health Committees and students would be contracted. In this tripartite contract, the provider would be held to account not only by the deconcentrated health system (DHMT), but above all by *non-medical actors*: the ASACO and the Commune.

Figure 5 Institutional framework for RBF in Mali



Each year all partners sign a **framework contract**, based on the CAM, in which the broad lines for how the partnership operates are defined in terms of the distribution of tasks and responsibilities between the partners, the priority results that are to be obtained, the improvements in quality of care that are to be made and the use of existing resources – funding and staff. This annual framework contract is followed by quarterly contracts, which are highly specific in defining for the following quarter the exact results, the strategies to achieve those results, the related activities and the funding that is needed. **[Step 5]** Drawing up the quarterly contract is completed as follows: first of all the Commune and ASACO analyze the SIEC/S to assess what they think should be the priority results for the following quarter. The CSCOM then develops a **Results-based Plan** that defines the strategies and activities they think would lead to those priority results. This results plan is then subject to **negotiation**. This is carried out by the *'Comité Paritaire'* on behalf of the Commune and the ASACO. **[Step 6]** This Comité, consisting of representatives from the ASACO and the Commune, already existed as part of the CAM, but had no clear role. Now it does. If negotiation is carried out between partners on a level playing field, it is probably one of the most important parts of contracting. Hence the importance of a preparatory phase for the non-medical actors.

There are several CSCOMs and Communes in one district. Before starting the contracting approach all these stakeholders were already represented in the *'Conseil de Gestion'* at district level, where the regional level is also present. This was then given the name of Steering Committee, which has the task of defining the boundaries for all contracts in the district, and of acting as arbiter in cases of conflicts that cannot be solved by the contracting parties themselves.

In Mali, these actors came to concerted and joint action, resulting in responsive health services. No baseline study was carried out on increased health coverage; unfortunately we only have only retrospective HMIS data that shows some improvement, so this improvement cannot necessarily be attributed to the contracting approach. Even so, if this proves to be true, there could be two main reasons for the improvements: firstly, the service delivery contract makes clear exactly what is expected from both the provider, the Commune and the ASACO. It also clarifies what the priority results are, what needs to be done on quality of care, **and** *that these results will be verified*. These results respond to local needs. Secondly, service providers are held to account on results by local stakeholders, including civil society.

Results-based Financing (steps 7 to 8)

In Mali participants realized that rewards and sanctions needed to be introduced when it came to contracts; if agreements were not complied with, then sanctions would have to be introduced. It was at this point of the process that the Results-based Financing concept was introduced.

Several meetings were held to explain and discuss the 'F' in the RBF approach and to discuss the issues that might be part of a RBF contract. Meetings were organized first between each of the stakeholders separately, to promote understanding between different backgrounds and perspectives. Then the three met together and negotiating started. One of the decisions made was that available **local inputs** such as local taxes, user fee incomes and subsidies for basic services channelled through the Communes, would be used to finance results instead of inputs.

The shift from the contracting approach to RBF was made easier by the fact that the RBF contracting arrangements had already been developed. It was decided to make the Commune the party to sign the contract and to pay for the results after verification. The last point was the funding that was needed to pay for the results. The MOH itself had decided to use a part of its MDG5 trust fund (financed by the Dutch Embassy) for piloting RBF in three districts of the Koulikoro region.

During these discussions one of the mayors stood up and said: 'If I understand it rightly I could say, "I will pay you 10,.000 FCFA once you have vaccinated 100% of the children in my Commune?"' When the answer was 'yes' he said: "O.K I pay". This was money the Communes received and paid for ANC, but without verification of results

Since the first trials with the contracting approach and the RBF in Koulikoro, there has always been close contact with the central level of both the MOH and the Ministry of Local Governments. Representatives of both ministries regularly visited the district. Also, KIT/SNV organized meetings every two or three months, outside office hours so that decision-makers from the ministries could attend. After the meetings, held at 5.30pm, participants attended what was jokingly called a 'results-based dinner'. At the dinner, the progress that had been made in Koulikoro was presented; design issues were brought up and discussed and there was always a lively brainstorming session. This all helped to reduce the breach between policy-making and implementation.

RBF à la Ghanéenne

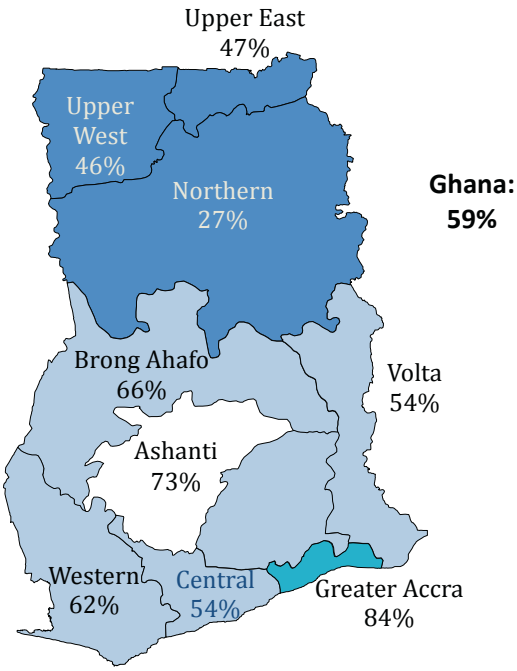
The '**entry point**' in Mali for taking action was the lack of trust between these actors and confusion about the distribution of their roles and responsibilities. In Ghana the entry point was the limited progress made in health outcomes.

Context

Ghana has made significant progress in health outcomes. However, a lot of effort is still needed to make sure that health outcomes, particularly maternal health outcomes improve. Ghana has enjoyed strong real GDP growth rates (over 6%) for the past three years and reached middle-income status in 2010. Ghana's health sector has benefited from this growth: the per capita expenditure on health has grown from $US 6.7 in 1996 to $US 13.5 in 2005 and $US 27 in 2008. This level of expenditure makes up nearly 15% of Ghana's budget.

However, health indicators in Ghana remain off track when it comes to meeting the MDG for 2015, in particular for poor and rural households where great effort is needed if these goals are to be met. Maternal mortality rates remain high despite declining slowly over the past two decades, from 740 per 100,000 live births in 1993 to 451 in 2008. If this trend continues, maternal mortality rates will be reduced to only 340 per 100,000 by 2015; the MDG target is 185. Ghana still needs to reduce the mortality rate in the under-fives by 35% and infant mortality by 48% to attain MDG 4. These are aggregated figures. There is a vast difference in indicators between rural and urban areas. For example, the mortality rate for the under-fives is 90 per 1,000 live births in rural areas and 75 in urban areas.

Figure 6 Deliveries attended by Skilled Provider (DHS '08)



On top of this, around 93% of the government's contribution is used to pay for salaries, leaving very limited funding available for services and infrastructure. This raises the question of how to get more and better results from the human and financial resources available.

On the specific context issues for RBF, the following: in Ghana there is a different provider payment mechanism. The NHIA (National Health Insurance Authority) pays for curative services and has introduced an accreditation system. Devolution to local governments exists in Ghana, but with limited devolved powers. Ghana Health Services (GHS) is the MOH's implementation agency. It both provides and regulates care. Another difference between Ghana and Mali is that Mali has a higher number of private and faith-based providers.

Preparatory phase (steps 1 to 5)

In January 2009 the government of Ghana was awarded a World Bank grant to implement RBF and a Technical Working Group put forward a RBF design. However, this had little in common with the basic principles we outlined in chapter 3 and so far, implementation has not begun since there has been no agreement on the institutional architecture of RBF in Ghana. Based on our positive experiences in Mali, SNV/KIT decided to start a similar process approach in Ghana at the end of 2009, knowing that a solid preparation and the involvement of (local) partners, could lead to an appropriate framework. We are currently finalizing the preparatory phase (step 5), and preparing for the contracting steps (6 to 8).

[Step 1] In Ghana there were several windows of opportunity to discuss performance or the lack of it, linked to a reflection on alternative payment mechanisms:

- The government of Ghana itself applied for a World Bank grant to start RBF.
- There was a common understanding at both central and operational level that results in the sector had not followed the increase of funding at the same pace.
- Various health reforms (such as the Health Insurance) had not led to the expected improvements.

In 2010, we organized regional workshops in the Northern and Western regions of Ghana. Participants varied from representatives from community health organizations, women's groups, GHS at different levels (facility, district, and regional), faith-based organizations, local NGOs and Health Insurance staff.

To introduce such a relatively new concept, we started by presenting the current health situation in their region, based on data from official sources. When asking them if *they* saw a need to improve the performance of their health sector they recognized the urgency. The tone was set by the regional health director who stressed the need to discuss alternatives to improve the performance of the region's health services. Presentations of the contracting approach we developed in Mali and RPF were both received enthusiastically, but there were lots of questions: who would fund it? Would such a reform not be overruled by decision-makers at the national level? We explained that the MOH and World Bank were already working on RBF at central level.

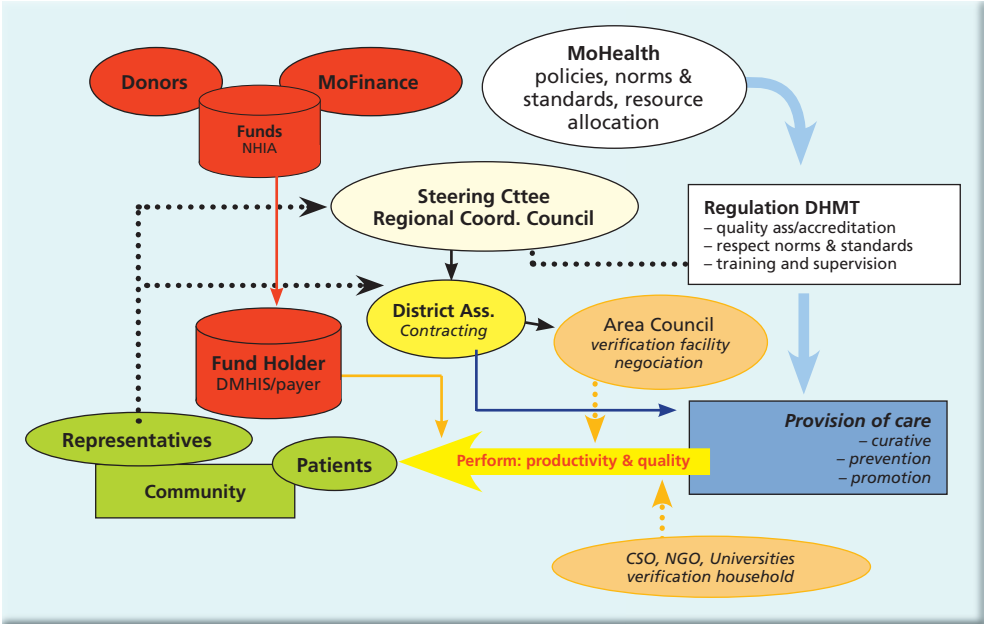
Capitalizing on the sense of urgency that was created, the participants were invited to identify innovative 'results-based' solutions to the main challenges. Most of these however were 'business as usual': more training, and money to buy fuel. Most of the interventions had been in place for a long time: IEC, informing the women on ANC, training and supervision, etc. When asked to identify the main bottlenecks that prevented them from achieving results, the answers had nothing to do with the solutions proposed earlier: limited motivation of health staff, services not being user-friendly, patients encountering obstacles when accessing services, etc. Participants were familiar with the constraints but health staff couldn't tackle these issues because of the activities they had been given to do by higher levels, within the funding attached to them: there was very little room to move.

At the end of the workshops, the key decision-makers committed to adopting an operational research approach to (re)search the appropriate RBF model to fit their context. Activity agreements were signed with four districts in the three regions. Key partners agreed on the approach and direction: a performance contract that would define the distribution of roles and responsibilities. The way to get there was not defined at the beginning and needed to be developed through *recherche d'actions* as was done in Mali. This left the direction and speed of the process to the key stakeholders.
Workshops were organized in the interested districts to discuss how roles and responsibilities could be distributed between actors. A very different dynamic developed in each district. The districts in the Northern Region took action almost immediately; it was difficult to get them 'back' in the process to agree on an appropriate institutional framework. The Western Region took a more deliberate path, first setting up a multi-stakeholder platform in which the basic principles of RBF were (re)discussed and potential frameworks developed.

[Step 2] Ghana has a well-established and complex health governance architecture, with a health insurance scheme that already has purchasing power. Civil society is perceived as vibrant. SNV carried out a CSO capacity scan, providing a basis for further discussion and engagement (see box). A KIT study into the political economy of Human Resources policy-making in Ghana (Toonen, 2010) confirmed that patients' voices are scarcely listened to when holding health services to account for their performance. Social accountability on the performance of the sector is hardly put into practice in Ghana. This is also due to the fact that CSO and local actors lack the skills, tools, instruments and resources to hold health services to account. After explaining the PBF principles and the content of those functions, similar institutional frameworks were developed for both regions:

Capacity scan of NGOs in Health
In 2010 SNV finalized detailed profiles of 385 health NGOs, with information on the scale and scope of their programmes and other organizational characteristics. One interesting finding is that 74% focus on HIV/AIDS, TB and Malaria programmes and not on more generic health systems strengthening. Planning of these NGOs is mostly short-term and their approach is predominantly (traditional) sensitization awareness raising and behavioural change.

Figure 7 Institutional framework for RBF in Ghana



Interestingly, when the MOH and World Bank team went on to carry out a similar exercise in the Eastern Region, the institutional framework that resulted was similar to the previous two. The difference with Mali is that a) the local government in Ghana (the DA, District Assembly) was less advanced in the devolution process, and b) there was a district mutual health insurance scheme (DMHIS) that was already experienced in purchasing services from providers through a system of ex-post payments for services. Also, in Ghana, there was a system of community-based healthcare (CHPS) below the District Assembly at Area Council level.

When discussing the mandates of the different actors, the picture as shown in table 3 arose.

It must however be noted that this was not a one-off exercise. There were also some conflicting opinions. The DHMT thought it was its 'natural right' to be the purchaser *vis a vis* the provider. Surprisingly, it was the regional level that pointed out that they could not be both the interested party (provider) and judge (purchaser). DHMT and (most) providers are part of the same Ghana Health Services – a deconcentrated system.

Table 3 Roles and responsibilities contracting actors in Ghana

Functions	Institutions
Provider	The health team of the Health Facility (HF), providing quality care – this may from the public sector and from the private sector (be it 'for profit' or not).
Oversight at local level (decision making to pay)	The Health Committee of the District Assembly, which involves representatives of the District Assembly, the DHMT, DMHIS, CHAG and CSO. Oversees and arbiters in the case of conflicts between the contracting partners.
Regulator	The District Health Management Team (DHMT), supported by the Regional Health Directorate (RHD), is the 'regulator' and coach.
Purchaser (contracting)	District assembly as the 'purchaser' of quality care: district coordinating director (DCD) to sign contracts with health facilities (HC & HP and district hospital), and to allow the fund-holder to pay the provider for the results up to and after verification.
Local Fund Holder	The District Mutual Health Insurance Scheme (DMHIS), will be the Fund Holder, which will pay for results after the purchaser has given the order.
Verification of the quantity of services in health facilities	The DMHIS will verify quantitative results, comparing the report with facility registers.
Verification of the quality of care in health facilities	District Health Insurance Scheme and Civil Society Organization (CSO).
Verification at the household level: Patient tracking Consumer satisfaction	The (CSO), will be contracted for (i) support the DA in priority setting between health results and holding providers to account on results (ii) verify of results concerning quality of care in the Health Facility (iii) (counter-)verification: patient tracking at household level.
Counter-verification (random control of verification)	Technical committee (central and regional) and/or external consultancy.

Instead, it was proposed that the DA become the purchaser, representing the clients; it was argued that they would not have the capabilities to purchase services from the provider. The regional level pointed that it was their role already by law and that this could be learned and solved by standardized procedures and instruments. Even stronger comments came up when it was proposed that the DMHIS take up the role of purchaser; they would already do a bad job in contracting providers for the NHIA through long delays in paying the provider's claims – this was really a no-go area for the providers. In the end it was decided that the DMHIS would take the responsibility of verifying the claimed RBF results, as this was already their role, but that DMHIS would not be responsible for deciding on the payments (that would be the job of the DA) and that verification would be done using a standard list through standard procedures.

[Step 4] The local actors first invited a CSO to carry out a **baseline studies and situational analysis** based on existing H/MIS data, in order to define their priority results based on evidence. The data of the table below indicate that the situation between regions differs strongly:

Table 4 Comparing coverage data Eastern Region, Northern Region and national

Indicators	National	Eastern Region	Northern Region
Modern family planning	23.5%	24.2%	5.9%
ANC 1st visit coverage	95.4%	96.0%	95.6%
Institutional birth delivery by skilled personnel	58.7%	60.8%	27.2%
% of deliveries ending in a Caesarean section	6.9%	7.6%	2.5%
Post-natal care first day after delivery	57.4%	64.5%	38.4%
Fully vaccinated children	79%	76%	59%
Malnutrition: under-five children wasted	8.5%	6.4%	12.9%
Malaria: Pregnant women sleep under treated bednet	17.4%	21.6%	10.4%

Source: DHS 2008

So the approach will probably differ too, even more so as the data between districts in a region differs. In all districts, the same mother/child health issues came up as priorities; low coverage of assisted deliveries while ANC being quite high, low coverage of post-natal care after a woman leaves hospital, and low coverage of family planning methods, certainly in adolescents. So, the urgency of attaining MDG 4 and 5 is also present at operational level in Ghana. In the districts of the Northern Region, the issue of malnutrition was judged to be the main priority. This created the opportunity to engage partners with a specific focus on malnutrition, such as UNICEF and UNFPA. This way, vertical programmes became part of the strengthening of horizontal systems. It also allowed for bottom-up priority setting, based on the reality in each district.

[Step 5] Discussing priority results at district level again resulted in the usual activities: 'educate the women', 'supervise the providers', 'we need training', etc. So again it was discussed what the bottlenecks were, based on examples from the Demographic Health Survey (DHS-2008). It is interesting to note that partners at local level immediately understood the point; they came up with quite a number of bottlenecks they could remove, 24/7 opening hours for their facility, burying placenta after delivery in the cultural way, etc. It was not difficult to explain to providers how they could attract more clients, but this wasn't part of the vertical health programmes brought to them through the deconcentrated health system.

SNV/KIT organized workshops to strengthen the capacities of health NGOs in health systems. Partners were asked to develop **results chains**, in order to improve their ability to discuss priorities and bottlenecks with other (medical) actors. However, we acknowledge that not enough has been done in Ghana to prepare the non-medical actors, a key step in our approach. Local actors that were keen to get to the RBF phase, tried to speed up defining the key results and the institutional framework to arrive at the discussions on

results/payments as soon as possible. This probably has everything to do with the fact that we presented payment for results as the horizon of our approach right at the start. Even CSO and health advisors in RBF who had been trained were pushing.

This was realized by our team, who will revisit some of the steps that have been skipped to allow proper preparation of local partners. Is this a problem? No, it is a logical part of a process approach, enabling actors to deviate from their planning. Most important is that all steps are carried out and that all principles find their way into the model, though not necessarily in the order we propose in our approach. But the signing of the first contracts in Ghana now awaits funding, in order to pay for the results.

7 Paying for results

This chapter is devoted to the question of how to engage in the final step of the process approach – paying for results (step 8): selecting and measuring results, and setting incentives. It is essential that before introducing payments, appropriate measures are taken to meet the necessary conditions for:

- The selection of relevant quantitative results.
- The selection of relevant qualitative indicators.
- The calculation of incentives for each service at adequate level, matching demand and supply efficiently and sustainably.
- Results continuing to respond to the actual priorities. This requires room for learning, reflection and adaptation of priorities based on (changing) needs.
- Assessing the existing verification systems that are in need of strengthening, such as the M&E system, the financial/administrative systems, the existing provider payment systems and what is needed to make them 'RBF ready'?

'Appropriate' here means here that choices respond to the key issues mentioned previously, such as 'checks and balances', 'split of functions', 'autonomy at decentralized level'. These measures are interrelated and affect each other. For example in Mali we had initially proposed to finance all activities under the nationally defined Minimal Package of Activities (MPA), and that the decentralized level would decide which ones within the MPA should have priority, and how much. We calculated the cost of funding the MPA and it became clear that this would never be sustainable for the country, so indicators needed to be selected from the MPA. This again would however lead to perverse effects, in the same way that the financial incentives would lead to health staff prioritizing the selected indicators: something we wanted to avoid.

Selecting relevant quantitative results...

We already stated that results in RBF can be defined in terms of quantity and quality. The first is referred to as productivity – the number of services that result. Although we were aware of the risk of perverse effects in selecting the indicators, we had to be pragmatic. The most important funding agency for RBF is the Word Bank, which prioritizes results linked to accelerating MDG 4 and 5. However, this did not pose any problems, since the national policy in Mali and in Ghana was also most interested to battle maternal and child mortality, and also at the operational level, representatives usually selected mother and childcare indicators. So, in defining the **quantitative results** to be financed, the following indicators were most often selected:

1. *Number of normal birth deliveries at facilities attended by skilled staff.*
2. *Number of women with at least one post-natal care consultation.*
3. *Number of family planning clients provided with modern methods.*
4. *Number of children (0-12 months) fully immunized.*
5. *Two locally defined indicators.*

It was proposed that each contracted facility be able to add one or two locally defined indicators. It was also recommended to avoid selecting *'low hanging fruits'* as indicators. For example: in Ghana, the coverage of complete vaccination of children under 12 months old is already over 90%. Selecting 'number of vaccinated children' would be expensive and at the same time it would probably not make much of a difference. Since 90% of children are already vaccinated without RBF, payment for this 90% is already guaranteed, making each additional child vaccinated through the introduction of RBF very expensive. It would be more interesting to use RBF funds for more difficult indicators, like convincing women to use modern family planning methods. This would mean e.g. doubling the result from 15% to 30% if compared to increasing 'fully immunised children under 12 months' from 90% to 95%.

...and shortlisting qualitative indicators

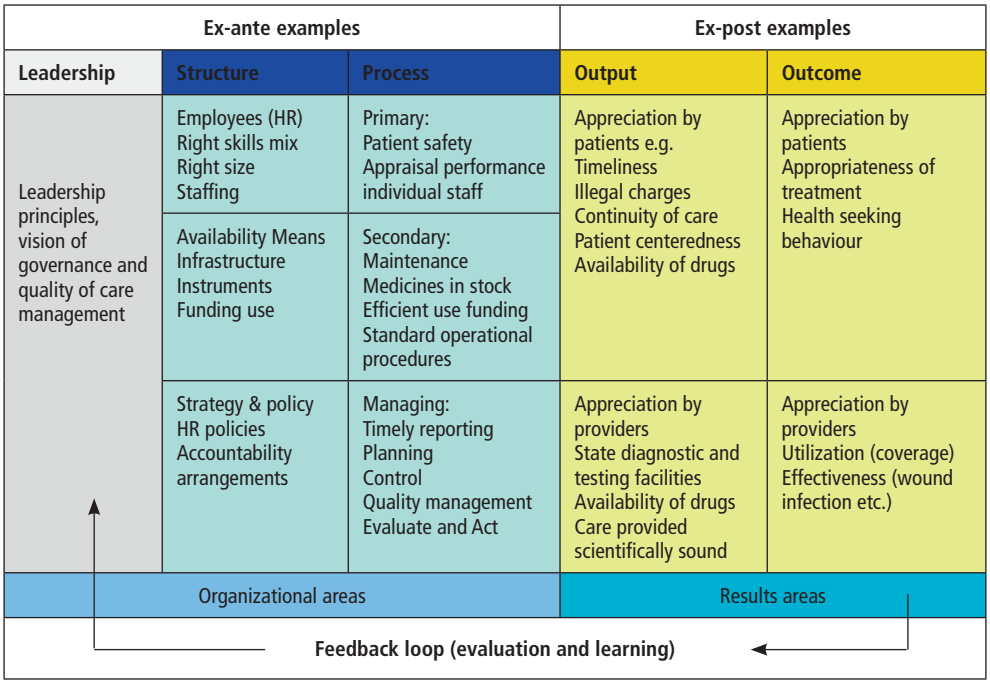
Quality of care is usually measured in terms of the equipment available, hygiene and sanitation levels, the human resources that are available etc. These all fall under the category 'accreditation criteria', or what we would call here 'ex ante control'. This is important and is of course necessary; it is about appreciating if health staff have the right conditions to provide quality care. But RBF is about paying for results, about 'ex-post' control, so in the RBF context, appreciating quality of care would mean: *was the care that was provided of good quality*? To ensure that 'ex-ante' Q/C conditions can lead to 'ex-post' Q/C results, different processes need to be in place, such as the organization of quality assurance (i.e. is there a quality of care committee?), or Standard Operational Procedures.

Finally there is of course the question of who judges this quality of care. From whose perspective? Is it the perspective of the client or the professional? The client's perspective is important as this will determine the willingness of the patient to use the services; the number of services delivered will correspond to the results received. The professional's perspective of course is important too, as it will determine whether using the service will lead to success. In the framework below, Quality of Care topics are given, as well as related issues (figure 8).

This framework is used to select criteria for a Q/C scoring list appropriate to the local context. Priorities for improving Q/C will be different between facilities. To this end, the programme has developed a long list of Q/C indicators and focuses group discussions with medical and non-medical actors in Mali and Ghana that have selected their priority indicators, resulting in a short list. For each contract in the different individual health facilities, contracting partners can define their priority results in quality of care from this short list.

See www.kit.nl for both the long list as well short list of Q/C indicators. **(Instrument 8)**

Figure 8 Conceptual framework for monitoring quality of care



As RBF introduces financial implications after measuring, the indicators need to be even ***SMART-er*** (Specific, Measurable, Attainable, Relevant and Time-bound) than in the case of input financing. Taking this into account it should be decided ***if*** quality aspects will be part of the definition of the selected quantity indicators, and if so, which of the indicators as identified in the short list. For example:

Table 5 Examples of adding qualitative criteria to quantitative indicators

Quantitative indicator	Add	Qualitative aspect(s)
Number of deliveries	+	Attended by skilled personnel
Number of post-natal services provided	+	Immediately after delivery / in the first 24 hours / first week following the delivery
Number of services to provide modern family planning methods	+	All family planning services or only new cases or women under regular family planning control

However, it was decided not to take too many quality aspects (such as deliveries assisted using a partograph) into account in the quantity indicators as these would be too difficult to measure and would therefore become less SMART. E.g. in this example, staff may fill in the partograph after the delivery has ended, making it difficult to verify.

Selecting quantitative results holds the potential risk of perverse effects. This could be partly avoided by combining the payments for 'quantitative' and 'qualitative' results. In both Mali and Ghana, a small number of quantitative results indicators were selected from the MPA, and for the scoring list on quality of care results the entire MPA was addressed. Both quantitative and qualitative scores are linked through a 'carrot and stick' approach. Payment for the quantitative results could total, say, € 1000. If the quality scorecard then comes to, say, 70%, the facility would receive € 700. This is in contrast to the 'carrot and carrot' approach in which both quantitative and qualitative results will be rewarded separately. So, say, € 400 and € 300. in both cases the amount of funding available is the same, so will always come to a maximum (in this example) of € 1000. This approach was also adopted in Ghana, but in a different way, as 'quality of care' is defined in different ways in different contexts.

Calculating incentives

In input planning it is relatively easy to calculate how much should be paid. You take the number of items (salaries, vehicles, etc.) and multiply them by the unit price. In P/RBF this is different. It is not a case of how much money should be made available to meet the needs, but about how much money would make a difference in motivating providers to perform better. And even more – how much is needed to finance the activities believed to improve the results? So, for RBF we did not do a classic costing exercise, but a simulation. The **steps** of the methodology are as follows:

See www.kit.nl for examples of PBF costs simulations **(Instrument 9)**

1. Determine the total amount available for RBF
We took $US1 per capita of the total population in the district. (The amount derives from our experiences in other countries where PBF has been established.) Of course this is an arbitrary figure. In some places more is needed, in others less. But the amount can be adapted with each next step. It can be seen as a starting point.

2. Determine the amount needed to motivate the provider
This is of course the tricky part. During workshops we tried to identify the threshold above which providers indicated they would be motivated, and below which they wouldn't. In Mali this was 50% of take-home pay, in Ghana it was 15%. Salaries in Ghana are higher than in Mali. Then we verified if the amount calculated this way (all salaries in the district multiplied by the additional motivation) could be financed out of the amount calculated under step 1.

3. Determine the amount needed to pay for necessary investments in the health system
RBF funding is not (only) meant to motivate health staff by improving their income, it is not the intention to 'top-up' salaries. A major demotivating factor for health workers

is that they don't have the funding to invest in their health services that they think is needed to improve results. In our experience, this was an even more important issue for health workers then the salary issue: the latter seems to be more of an issue for policy-makers. Providers need funding to implement their creative solutions in order to respond to the needs of the population, to overcome the bottlenecks patients face to use their services and to finance the 'indirect costs'. These interventions were listed in workshops with all contracting partners, and their costs were calculated, and then verified to see if the amount calculated under 1 would be sufficient to pay for them.

An important decision to be made here was the relative allocation of the sum calculated under 1. (above), between 'investments' and 'motivation staff'. We used 70% to 30% in Mali and 60% to 40% in Ghana. Again we estimated in the simulation if the sum calculated under 1. was enough to pay for this.

Some providers mentioned e.g. to sub-contract local transporters for timely transport of women in labour at an affordable price, others proposed to sub–contract TBAs for timely referral. An alternative approach was to decrease the fee for a delivery, this decrease could then be funded from the provider's incentive.

4. Determine the amount that should deliver the necessary funding

The funding needed to pay for motivations (2) and for investments (3) should be created by the ex-post payments for results, i.e. by the number of services produced. For the simulation, we took the results that had been agreed on, and multiplied this with the unit price for each result that had been agreed upon in the workshop. This again is not a scientific exercise, but is about discussing and finding a minimum threshold for each result that the provider indicated would motivate them to increase their performance. A calculation was made regarding the cost of these results-based payments to verify on the one hand if this could create the amount needed (calculated under 2. and 3.), and if this could be paid out of the amount that was calculated under 1.

In this, it was assumed that the amount needed to pay for the results would become increasingly higher after introducing RBF, since RBF expected to increase the number of services. We estimated that outputs would increase by 20% to 40% per year.

5. Determine preset rules for payment (carrot and/or stick)

As the carrot and stick approach was chosen, an estimate needed to be made of the quality of the score – the actual score and an estimate of what the expected score would be in the future. Of course this will never be 100%; there will always be something that can be improved in quality of care. For the simulation we took a quality score of 70%.

6. Determine the amount needed to pay for verification and supervision

This, again is based on experiences elsewhere; we took 10% of the amount calculated under 1. for the verification efforts, and for support by the regulator. This is a crude amount, as after this calculation the verifier (CSO) needs to negotiate such a contract as well as the number of supervision visits.

It should be clear that this is a simulation, necessary to estimate costs before starting RBF payments. The different assumptions should be clearly monitored afterwards as to whether they were realistic, and if the figures need to be changed to match the reality.

Strengthening existing verification systems

If the contract between the purchaser and the providers, which determines the results to be achieved (and how these will be rewarded) is at the heart of RBF, then verification is its backbone.

Above all, RBF an approach that seeks to strengthen health systems. Each attempt to monitor results should therefore seek to use the existing M&E system and, where necessary, strengthen it. To arrive at an appropriate system to monitor results, the following questions should be asked:

1. What information needs to be collected for RBF and who will use it?
2. What is the best process for monitoring and evaluation to obtain the right information at the right time and at the right place? This is necessary for a smooth flow of checks and balances on the one hand, and timely results-based payments on the other.
3. How ready are the existing M&E systems to provide RBF-ready information (e.g. the selection of the appropriate application)?
4. What are the gaps in the existing systems that need to be filled? How can existing systems be improved?

Monitoring and timely payment

As mentioned above, monitoring is the backbone of RBF. There are different phases in monitoring for RBF, or to verify results reported by the provider:

1. The provider reports on results after having achieved them.
2. These reported results will be verified in the registers at facility level.
3. At the patients' level, the receiving of the service will be verified.
4. Eventually, counter–verification will be carried out at random by an external agency to verify if the over-all RBF process (reporting, verification and payment of results) has been carried out correctly, according to the rules of the game and to the contracts.

A tight **time-line** is needed for these activities. In Mali and Ghana this was organized as follows: on the first week of each month, under RBF, the health facility (HF) will report on all results that were agreed upon in the contract to the purchaser, in terms of quantity of services, through the existing H/MIS. During the first week of the next month, the contracted organization for verification (DMHIS in Ghana, CSO in Mali) will verify at facility level the consistency between the report and the facility's records on the number

of services reported. The facility will make corrections to the report accompanied by a 'pre-invoice' to the purchaser; this is the results multiplied by the agreed upon unit price of the contracted service.

The results in terms of quality of care will be verified each quarter according to the scorings list that was agreed on. A selection of patients is made from the registers in the facility, and each patient is visited (patient tracking) at household level to verify if the services indeed were provided. The selected household will form the start of a 'cluster' survey: seven households around the first one will be selected for this survey. This is also intended to get the opinion of patients that may not have visited the facility. Each of the households will also be asked about their perception of the quality of care provided in the facility. In the facility itself, standard quality of care indicators will be measured.

Once the quantity and quality of services have been verified, the HF can make adjustments to the reports it presented, and present a 'final invoice'. The provider will then compare reported results and the reports on verification of number of services and the results of the quality score – and will then pay (as in Mali), or give the green light to the local fund holder (as in Ghana) or the bank to pay.

RBF is, for a large part, about (financial or other) incentives. These should be significant enough 'make a difference'. However, they should also be paid in time and in a transparent way to avoid frustrations. So a bank account for RBF at local level is to be recommended, and payments should be transferred from central level to the local fund holder in a timely fashion.

It is important that the person, or committee that approves for payment (after verification) is 'always' available. Payment should not depend on a person that is in a function that makes him often unavailable and therefore becomes a delaying factor.

An appropriate and equitable distribution of the incentives between the facility's staff is a sensitive issue – RBF may even become a de-motivating factor if this is not appropriately organized. To this end, a contract may be established between the facility and its individual health workers to determine individual incentives based on their results. An agreement should be drawn up each year to define what the results will be i.e. which are necessary to attain the facility outputs – the staff member will be held accountable for this.

Leave room for learning, reflection and changing priorities

These are some additional measures to further prepare partners for smooth transition into the eight steps of the contracting approach towards payments of incentives for results. It is clear that all this needs more preparation of the actors involved, since most tasks and responsibilities are relatively new. Frequent technical assistance, development of instruments and coaching are all needed to support these actors.

8 Improving our reflex

To many of us working in the health sector, the limitations of input-based funding systems are obvious. Financing in the health sector is not linked to results and it does not encourage the actors involved to achieve the desired results. However, introducing RBF is not a magic bullet to these limitations and may even introduce new challenges. In this chapter we present our approach to mitigate some of the major challenges. Again, this is not a 'cookie cutter' approach. Everyone needs to find their own solutions, appropriate to the context they are working in. First we argue how we see that RBF motivates health workers to improve performance and how an appropriate design commits communities to contribute to health services.

Spanning boundaries

In his article Thinking Systemically, Bob Williams stresses the relevance of boundaries to the systems concept (Williams, 2009). 'A boundary differentiates between who or what is "in" and who or what is "out.' It is therefore relevant to always assess who controls the boundaries, whose interests are being served and whose interests should be served.

A. Spanning boundaries – RBF motivates health services involvement

A **first significant boundary change** is that RBF shifts autonomy to health care workers, increasing their motivation to perform better. Motivating healthcare workers is particularly challenging in developing countries, with often deconcentrated health sectors. Typically where a lack of appreciation and limited discretionary space may squeeze out their creativity and pro-activity.

The art of autonomy
In his book *Drive*, Daniel Pink (2009) challenges our thinking about performance and motivation (p. 59). Too much focus on carrots and sticks can extinguish intrinsic motivation and diminish performance. He provides many business examples and references to research, which presume that people want to be accountable – and that making sure they have control over their tasks, their time, their technique and their team is a way to get there.

In all West African countries the health sector is deconcentrated. This may **undermine motivation** of health workers in various ways. While the staff may undertake creative, context-specific actions, a representative from a superior level may always frustrate these. This representative may think, and decide, differently, often because the decisions are made by 'vertical priority' programmes, which decide where the funding will go. The procedures that must be complied with are furthermore never-ending. Last but not least, career perspectives are determined by a staff member's superiors and are not based on one's own results. So the conclusion drawn by health workers is that it is better not to be pro-active at all. This attitude plants the seeds for the cultivation of unmotivated employees.

RBF takes us back to the basics. In the last decade, ODA support to the health sector focussed on policy and strategy development through Sector-Wide Approaches (SWAp) and Budget Support. Consequently, resources (financial, human and time) were

concentrated on the central, policy-making level. Many of the few public health experts in low-income countries were pulled from operational to policy level in order to write and rewrite lengthy policy-making documents instead of supporting health workers at service delivery points in improving results. Central and operational levels became increasingly disconnected and this impeded progressively achieving health results. Policies don't improve the health status in a country, service delivery points do. As such, **RBF addresses the basic question**: 'whose interest is being served?' As RBF changes the way health is organized and how it is funded, a new way of working will result.

B. Spanning boundaries – need to keep central level included

With shifting boundaries there is of course also the risk that other actors may **perceive a loss of control and power**. Central level may fear that the introduction of RBF will undermine its power. As this level is crucial to the success of RBF, this risk needs to be mitigated. Initially, support for piloting the RBF approach needs to be assured at central level, to give inputs on what is politically feasible (and what is not). But also to receive inputs from the pilot in developing a national RBF policy based on experiences on the ground to be able to scale-up the implementation arrangements. While the approach is being developed, good collaboration is needed between the MOH and other ministries involved, such as the Ministry of Finance and, in Mali, the Ministry of Local Governments. This level should focus on **stewardship** (policy development, setting norms and standards for RBF), not on interfering with management and the decision makers on practicalities at operational level. The actors should be given the **autonomy** they need to be creative in responding to local needs in the implementation of national policies.

Even so, this autonomy does not mean that the operational level should be left free in all its actions. The change will ideally be one within the enterprise culture: coherent with the RBF philosophy, away from ex-ante planning and control on activities towards ex-post control of the results agreed on. Central level would support the operational level by e.g. developing 'standard' instruments, without being explicit and leaving enough room for negotiations at operational level. It would provide technical assistance and coaching to decentralized entities of RBF on e.g. management issues, developing business plans, or contracts. These kinds of tasks would probably be delegated to the intermediate (regional, provincial) level – which is in most African countries already an official policy, but not much implemented. Most attention of intermediate level is biased from the district level towards central level.

Furthermore, central level is crucial in moving RBF from a pilot stage an **integrated health systems approach**. The RBF approach of course needs to be appropriately funded. Provision of RBF budgets should be available, preferably as a line item in the national health budget. When supporting the piloting of RBF, development partners should align and harmonize with the national approach, supporting the national RBF strategy and avoiding the development of different RBF 'islands' within one country. In short, while supporting the pilots, they should focus on strengthening health systems, which is a more sustainable, overall goal.

C. Spanning boundaries – including civil society

Currently local communities are under-represented in health system management. In the arena of public health most actors would easily agree that the interests of the local population would be better served by improving the health status of the population. In Ghana however, it is estimated that around 93% of the government contribution to health (without the contribution of health insurance) is used to pay for salaries. The system seems to serve the interests of medical practitioners more than the population living in underserved areas. There is no doubt that Human Resources for Health is key in achieving health results; but to improve them, a way has to be found to get patients to use their services. Therefore, the success of a provider will depend on the participation of its patient(s); in RBF funding follows the patient.

Why community involvement is beneficial

The term 'participatory approach' has lost some of its meaning over the years. Local communities may have been asked for their 'suggestions', which may or may not be picked up by those truly acting within the arena. We would never say that 'the community' should determine everything when it comes to health services, that it decides how many pills of how many milligrams of which drug a two-year-old child should receive to cure its malaria. But the Mali and Ghana RBF-models may demonstrate the importance of community involvement in managing health services.

There are different reasons why this appeared on the agenda:

Firstly, in these countries the MOH is purchaser, regulator and sole provider of services. It was considered inappropriate for its representatives to produce results, verify if these results were produced effectively, as well as deciding if they would be paid for, and if so, how much. An institution representing the interests of the client is needed to counter-balance the medical practitioners.

Secondly, there is a boundary between the provider of healthcare and its customers; a misbalance occurs between the two because of different 'market failures'. While health is a rare commodity for the customers, they can hardly influence its provision, because of a centralization of knowledge and providers-induced demand. They have little control over the providers when it comes to holding them to account on results. Salaries are paid at central level; improving salaries is about opportunities to climb upstream in the deconcentrated system of the MOH. Working at operational level, where results can be produce, is less rewarded and perceived to be of less importance.

Thirdly, the first policy brief of ODI's Africa Power and Politics Program states: 'citizen pressure is at best a weak factor and at worst a distraction from dealing with the main drivers of bad governance.' We do not agree with this statement per se. It is however

true that civil society is often sidelined, making it difficult to contribute to results. With a contracting approach contribution to results can be made clear.

Fourthly, results can only be achieved when balance is restored between provider and consumer. And this can only be achieved when the representatives of the community actually represent that community, and when their capabilities are strengthened.
Hence our efforts to introduce a preparatory phase: we want above all to prepare non-medical stakeholders before they start with contracting and RBF.

Marrying communities' rights and responsibilities within RBF

The RBF approach spans the boundaries of the system to involve the community (through their representatives) and provide them with a formal role. But why would the other actors be interested in changing the status quo? Importantly, by accepting their roles, the community representatives do not only gain rights, but also responsibilities. As RBF is a contracting approach, commitments should not be one-sided; the community should also 'deliver' as the following examples from Mali and Ghana show in table 6.

In summary, as may be read from the figure below: medical and non-medical perspectives need to be balanced. Only by meeting the interests of both sides will better results be achieved. The contracting approach is based on negotiating between the contracting partners. Negotiating means that both types of interests will be defended, so both perspectives will be represented in the objectives (priorities). Contracting will mean that agreements are clearly defined and measurable: so they can and should be verified. If there are incentives linked to (achieving) the results, the provider will have more 'room to move;' more freedom to be entrepreneurial and achieve even more results. To obtain more results, providers will need to become more responsive to the needs of the community. The civil society has an interest in obtaining as many results as possible, but also in not paying more than necessary – only for the verified results. Results thus need to be verified by their representatives.

We don't want to over-emphasize the importance of the demand side, but in a lot of RBF literature most of the attention is given to the supply side. We simply think that there should be more of a balance between demand and supply in RBF.

Table 6 Description of communities' rights and responsibilities

Community Rights	Support provided	Responsibilities
Setting objectives in health results according to their perspective, to voice their priorities in health. To that end, play a decisive role in strategic planning, in contract negotiations, in setting the baseline, and in deciding on the choice of indicators and the reward per indicator.	In Ghana, various civil society organizations were trained by SNV/KIT to develop baselines on the actual performance in their district. Discussing baseline data between medical actors and non-medical, the latter gained a better understanding to be able to define their priorities in health and voice their opinions.	Representatives of the community are involved in boards overseeing the implementation of RBF – but also in co-financing the PBF approach at their level. Engage and act. For example, by mobilizing the constituency to discuss health priorities or for vaccination campaigns. Or health staff demanding in the contract from the Commune that illicit drug selling be monitored.
Verification: community organizations are contracted to verify if patients actually visited facilities and to evaluate patient satisfaction.	KIT/ SNV prepared tools to verify the use and satisfaction of patients.	CSO should inform the community they are assumed to represent, and involve them in downstream accountability. This will mean a more active attitude.
Monitoring and evaluation: actively involved in deciding on what will be monitored and evaluated, in carrying out M&E activities, and in analyzing the M&E results.	The SIEC/S tool in Mali was developed to be able to hold providers to account: it is also a right to be able to M&E.	The community should also undertake actions at their level, resulting from their analysis of M&E results – like encouraging activities to improve water and sanitation conditions, etc.
Rights-based approach: right of freedom of choice of preventive, promotional and curative services. Patient centred services: compatible with social-cultural customs and treated respectfully, regardless of sex or social-economical status; inclusion of the poor in health services.	Training on results chains, explaining the meaning of health data; facilitating priority setting sessions; setting up multi-stakeholder environment.	Co-financing the system –community organizations should be ready to bring in resources (financial, material, time) to co-finance the attainment of the results agreed upon in the contract. This may be through labour, improving living conditions of health staff, etc. Estimating the level of poverty to allow for exemption measures.

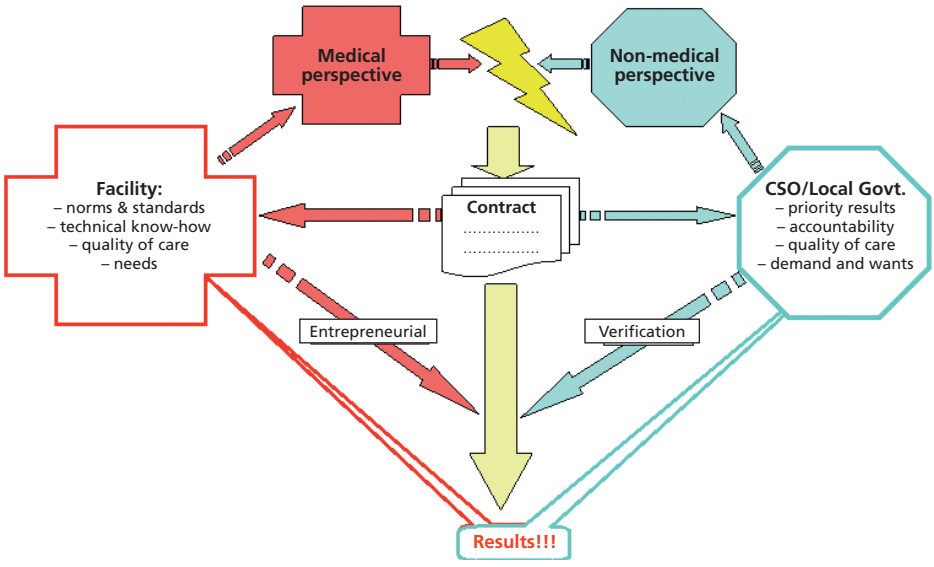
From resources to resourcefulness

The basic assumption of this booklet is that there are no institutional templates that are valid for all countries and for all stages of their development. We refer to an interesting theory posted on a blog: 'the purpose of development interventions must move from deluded attempts at 'creation' of development from *blueprints*, to acceleration of the *evolutionary* process that drives development in the real world'[8]. Our RBF approach aims to give hands and feet to the acceleration of this evolutionary process. It is about combining direct 'expert' support with support by facilitating local problem solving.

Secondly we assume that there is (too) much focus on resource mobilization and not enough on mobilizing resourcefulness. There are great examples where individuals have made a difference just by being more resourceful. Making services more socially and

[8] http://www.oxfamblogs.org/fp2p/?p=5384

Figure 9 Collaboration between community representatives for responsive services



culturally acceptable will attract more women, it need not involve big investments to marry traditional 'guidelines' with the professional principles of good healthcare. For example, in particular districts of Ghana women traditionally give birth into a hole in the ground. The Saboba district of Ghana came up with its own solutions to problems identified, and introduced for example facilities that were also open on market days, since the existing opening hours were not favourable to patients who had to walk long distances. Or, for example, sub-contracting traditional birth assistants (TBA) for timely referral and to help pregnant women get to clinics. It is interesting to note that these interventions were introduced when financial incentives for outputs were not yet available.

Stimulating demand-side

If providers are paid according to the number of results, they need to be creative in seducing patients to use their services; this will stimulate the demand side. But will this be enough? Improving results in health is not only a matter of stimulating providers. It's also about stimulating the demand for services. Why only use health funding for providers while it is also about the dynamic between provider and client in increasing health results? Perhaps we should not suggest that clients be paid for using the services, but be supporting the clients to overcome the financial barriers they face in using the services. And of course – as this is about RBF – in that case payment should be also results-based.

To give an example: a woman could be given a voucher at her first ANC visit and each succeeding visit would be noted by the provider on her voucher. Once she has made four

ANC visits and her delivery has been attended by skilled personnel, and these results verified, she can then exchange the voucher at the bank for a certain amount of money. Alternatively, instead of money, the voucher could be exchanged for baby articles, such as clothing, soap, etc.
We have no experience yet with such a system, since we are still developing a system that allows for checks and balances, for methods to verify results and for an institutional framework with actors that are impartial when it comes to deciding 'yes' or 'no' on whether to pay the woman.

Sustainability issues

The issue of sustainability in RBF will always be raised when starting up RBF. And not only concerning the funding of RBF programmes; it will also be argued that benefits of incentives may dissipate over time (Werner, 2011). The impact evaluation of the Rwanda P4P experience shows that the analysis presented does not include evidence of the effect of RBF schemes on health outcomes (Basinga, 2011). Longer follow-up will be needed to assess whether the effects are sustained. Here we address the different aspects of sustainability: financial, institutional, technical and socio-cultural.

Financial sustainability, or how to finance scaling up RBF to national level

As most countries are in a piloting phase, one important question that is often raised is about macro-economic sustainability; how to fund RBF after piloting, after donor funding for the pilot ends. Ultimately, piloting is intended to provide evidence that RBF will improve results in a country. If the policy-makers are indeed convinced that this is the case, there are different options. If macro-economic conditions allow (e.g. increasing GDP), they may decide to allocate additional funds to the sector, and make these results-based. This is not the case in most countries. So, if the policy makers are convinced, they will have to allocate existing funding in a results-based way. This may be a part of the existing funding e.g. for recurrent costs of existing donor funding, or they may decide to pay part of the salaries results-based. This may all lead to important reforms and necessitate wide stakeholder consultation – including the MOF and health workers' trade unions.

Paying for results is often seen as topping up salaries. The level of financial incentives for health staff demands a good understanding of the national context. Using incentives to top up already high salaries in Ghana would not be sustainable. In our approach this is not about topping up, though this may sometimes be partly the case. It is mostly about investing in health interventions to improve quality of care and make funding available for 'indirect costs'. RBF is about stimulating entrepreneurship, being creative and innovative in finding solutions to constraints at local level. These kind of indirect costs (several examples have been given) are not possible to plan for through national input financing plans. So RBF is about investing in health interventions, rather than about topping up salaries.

Financial incentives are not the only, or perhaps even the most important motivating factor for health staff to perform (better); please see the KIT study mentioned in the first chapter. We have been studying what non-financial incentives could motivate staff, besides the financial ones. First of all this was being responsible for organizing the services in an appropriate way to achieve result – this will be taken care of automatically in RBF, it is its foundation. Just like the fourth: the esteem of the community to be served. Secondly we mentioned being held to account on results as the most important criteria for one's career, not (as actually is the case) being promoted, which is based on seniority. The next one was to receive more training, preferably training resulting in a diploma, probably with the idea of having more chance at promotion, too.

Creating an atmosphere in which people feel they are contributing to the achievement of a bigger objective will lead to satisfaction, which is one of the biggest motivators.

A man entered a city and noted the activity of numerous carriers. He stopped one and asked: what are you doing? 'Carrying bricks' was the reply. He stopped another and was told: 'I'm earning a living'. Then he asked a third carrier what he was doing. His reply was: 'I'm helping to build a cathedral'.

A more difficult question in this context is about the cost effectiveness of RBF. The contracting arrangements seem to lead to increase costs – like verification and counter-verification. Little research has been carried out into the assessment of cost-benefit regarding the increased transaction costs; the information on transaction varies greatly.
Designing such a study is complex, because there are different issues at stake that should be taken into account. E.g. we proposed not to introduce a new institution as purchasing agency but instead to work within existing institutions for reasons of institutional sustainability – but also in order to reduce transaction costs. Another issue is that, because of the RBF arrangements, results will increase alongside the transaction costs, so the cost per service may not increase. Introducing RBF arrangements will result in strengthening the existing health system, which also would justify increased costs. Verification is another word for monitoring, which also needs to be done in input financing, so it should not be regarded as an additional cost.

What will be more difficult to study is the following. If RBF is fully implemented, it would lead to cost-containment at central level; it would decrease time and resources in negotiating budgets with higher hierarchical levels, and mean less need for staff at the top of the health pyramid, in the case of *countries that are courageous enough to adapt resources to real RBF needs*, including decentralizing (human, financial, logistical) resources. It is not certain that such a health reform can be expected.

Technical sustainability

Perhaps we should say that there is no problem in terms of technical sustainability; health workers will deliver the same type of services as in the context of input planning. But, there is a difference here; from experience elsewhere (Great Lakes) we know that districts under PBF may perform better – but some clinics do better then others. Most often we could attribute this to a lack of leadership, or to a lack of creativity in the facility. There is a need to coach providers and give them technical assistance in developing their results-based plans, certainly at the start of a PBF programme.

Another issue arises if health workers have the absorption capacity for an increase in demand, but this problem may be solved by the facility itself by attracting more personnel funded by RBF payments.

But there are more important constraints to overcome. Firstly, one risk with PBF is that health workers may choose to work in facilities where it is easier to achieve results: this may drive them out of under-served areas. Even more, it is often more difficult to retain staff in under-served areas, but also more difficult to achieve results given the poor conditions. We negotiated with funding agencies to introduce relatively higher payments for results in under-served areas, at the expense of better-off areas.

Another risk in PBF is the probability of perverse effects; providers have a financial incentive to deliver an excess of those services that are targeted for results payments under RBF, at the expense of services that also are needed but will not receive such payments. The way we solved this was to select a limited number of services for output payments (thus risking perverse effects), but for the quality scoring the total nationally defined 'minimum of package of activities' was taken into account. By using the 'carrot and stick' approach, the quality score defined the level of output payments. Also, contracting cycles were kept short, so excesses could be identified quickly.

Social sustainability

In this chapter the importance of community involvement in local priority setting to make providers responsive to local needs and demand received a lot of attention. Through RBF, community involvement will take on another meaning; it will become more decisive as it comprises their involvement through the whole planning cycle, including agreeing on payments of the results. It will empower them. The Local Governments of Mali and Ghana are, by law, supposed to manage all deconcentrated health and education services. However, this role was never given any substance, RBF was. But because these actors have little experience in purchasing health services, for sustainability reasons there is a strong need to prepare the non-medical actors.

It is often stated that RBF would not be equitable. In itself it is not more or less equitable then input-based systems; both depend on how the system is designed. When implementing RBF systems, developing a specific focus on financial accessibility for the most vulnerable people in society needs to be addressed. There are PBF cases in which

output subsidies could be used by health providers to enable inclusion of the poor. In RBF there is an incentive, other than in input-financing, to seek ways for inclusion of the poor and vulnerable. This will increase their outputs, so too their results-based payments. Where household surveys are carried out, they will give insight into the services that are clearly underused by the poor and vulnerable and therefore may be subsidized through the results-payments.

Equity needs promotion as it does not always arise spontaneously from the health staff. However, there will always be vulnerable people in society who will not be able to afford the services – with or without PBF. There are several ways to tackle this in designing RBF:

- Establishing equity funds: healthcare providers are asked to make a plan for a scheme to exempt the poor – this will need subsidizing.
- Payment schemes or loans, which enable patients to pay spread payments in time, could be funded through these equity funds.
- To target the poor, a differentiation in pricing of output payments may be introduced, favouring healthcare providers operating in poverty pockets.
- The financial accessibility of certain essential services may be increased by decreasing the user fee of services that are targeted for results-based payments, such as assisted deliveries. The RBF payments will then compensate for lost income from user fees.
- In the mentioned voucher schemes for demand-side incentives, the poor may be favoured.

However, as with input financing, the question will always arise of how to define and then how to identify the poor. Who decides who's 'poor' and what criteria are used? Health staff will need support in identifying how to include the poor.

Elements discussed in this chapter are subject to further reflection and discussion. We hope that the body of knowledge will increase through practice, improving our reflexes.

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Http://www.rbfhealth.org is a rich website, with lots of reference material.

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Colophon

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