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Performance-based contracting in health

The experience of three projects in Africa

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Performance-based contracting in health is an example of a results-based financing approach to improving health service delivery. In 2003 and 2004 the Global Partnership on Output-Based Aid (GPOBA) supported the design of three schemes using performance-based contracting in Uganda, the Democratic Republic of Congo, and Rwanda. GPOBA's technical assistance has led to three innovative projects funded by the World Bank and the Canadian International Development Agency (CIDA). This note reviews early lessons from these schemes.

Health care and performance-based contracting

In developing countries, health services are often of low quality, with issues like drugs being unavailable and high absenteeism of personnel. This leads to under-use of services and thus to poor health and preventable deaths, especially among the poor. Low-cost interventions with a high health impact could lead to significant improvements in public health. In many cases, lack of funding is not the only reason why poor people lack access to quality health care; inefficient allocation of resources is also a contributing factor.

Results-based approaches such as performance-based contracting are one way to address poor allocation of resources within a health care system. Performance-based contracting gives service providers the freedom to take decentralized decisions on how to provide services. It also provides an incentive to use resources in an efficient way, as it shifts performance risks to service providers by, for example, reimbursing them for interventions performed or making part of their earnings contingent on meeting pre-agreed targets. This helps to align interest between the sponsor of a project, the intended beneficiaries, and the service providers, so that health system inputs are used to achieve maximum results. Performance-based contracting also increases transparency in public funds, reducing waste and corruption. In some extremely poor and post-conflict countries, contracting out services can be a way to quickly increase access to health care.

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Approaches to performance-based contracting

Performance-based contracting pays a third party provider on the delivery of pre-defined outputs (typically the quality and quantity of services delivered) and/or outcomes (typically related to use of services).

Performance-based projects differ in who chooses service providers. For some projects service providers are *selected by the government*, usually using competitive bidding, to exclusively provide services in an area. In other projects, for example in voucher schemes, multiple service providers compete for *patients* who *choose* service providers themselves, based on perceived quality.

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Two types of performance payments are *fees for services* performed and *performance bonuses*. Fee-for-service means that service providers are reimbursed a pre-agreed fee for each service provided. Bonus payments are tied to reaching performance indicators and are usually combined with block grants that service providers can decide how to use.

To ensure *value for money* when using fee-for-service arrangements, either competitive bidding, unit costing or benchmarking can be used to determine an appropriate unit cost. Where service providers are chosen competitively, selection criteria may be, for example, the highest number of beneficiaries reached with a given amount of subsidy or the lowest subsidy per intervention required.

Some performance-based schemes pay a fixed *capitation* per enrolled individual or family, similar to private health insurance. Under such an arrangement the contractor bears the risk that he may have to perform more than the anticipated number of interventions, but stands to gain if fewer people fall sick.

Most performance-based contracting schemes contain an element of *geographical targeting*. Service areas are usually among the poorest in the country to better reach the intended target populations. Also, given that wealthier individuals usually make use of more up-market facilities and contracting schemes typically provide basic services, such health schemes tend to have an element of *implicit targeting*. Other forms of targeting such as enrollment of beneficiaries who are categorized as poor by a national welfare system are possible.

Vouchers can be used to target programs to specific groups and to market specific health interventions such as safe delivery. They also make it possible to limit the number of interventions performed to the available budget, as the voucher management agency can control the number of vouchers sold.

Performance-based schemes usually require *verification of outputs* delivered to prevent fraud. Typically verification can be delegated to an independent verifier unrelated to the project.

Rwanda

Rwanda is one of the pioneers of performance-based financing (PBF) in the health sector. A GPOBA grant funded a review of two pilot schemes supported by international NGOs, in order to inform the design of a national PBF model. The schemes[1] were launched in 2002 with the goal of increasing use of basic health services by motivating providers. Both schemes paid participating providers fees for each service rendered. Both public and NGO-administered non-profit health facilities participated in the schemes. In the case of the Cyangugu scheme, the NGO was responsible for negotiating contracts, setting fees, and making payments. In the Butare scheme, a steering committee comprised of government and NGO representatives negotiated purchase contracts with health centers, which in turn drew up motivation contracts with employees. The Cyangugu scheme had an independent verification system with supervisors, M&E officers, and patient satisfaction surveys. In Butare, the steering committee monitored results and relied on the health information system, with periodic random cross-checks.

The GPOBA-funded review found larger increases in use of core primary health care services, such as curative care visits and deliveries, between 2001 and 2004 in the provinces where PBF was piloted than in similar provinces without PBF. A third scheme was introduced in 2005 by the Belgian Technical Cooperation.

Based on the encouraging results of the three initial schemes, the Ministry of Health led the scaling-up of a national PBF model, adopted a national roll-out plan, and launched an impact evaluation of the scheme. Under the national model all providers participate in the scheme. Contracting is done by district steering committees and includes: (i) contracts between the Ministry of Health and districts; (ii) contracts between districts and health center management committees; and (iii) individual performance contracts. Health centers are reimbursed for services provided according to a standardized fee structure for 14 services, adjusted by a composite quality score. Hospital budgets are based on an average annual value per bed. Data validation is undertaken by trained data agents from the district health department. District PBF steering committees validate bills, the Ministry of Health approves payments, and the Ministry of Finance channels funds into health center bank accounts. Teams from district hospitals supervise health centers. Hospitals use a peer review system to assess quality of care.

[1] L'Initiative pour la Performance was supported by Health Net TPO and operated in the Butare province and another scheme was launched in the Cyangugu province by Memisa/CORDAID.

The Rwanda experience suggests that performance-based incentive schemes can rapidly expand use and coverage, particularly for services which are easy to deliver and measure. It is not possible to fully attribute increased results to performance-based incentives, however, because other initiatives were introduced at the same time such as the nationwide roll-out of community-based health insurance. The national impact evaluation that is underway will provide more definitive information about the relative contribution of the PBF to better health results in Rwanda.

Uganda

The Uganda Ministry of Health and the World Bank, with funding from CIDA, undertook a study to determine whether private not-for-profit (PNFP) providers would respond positively to a performance-based contract for health service provision. The study included a sample of 118 facilities randomly selected from five districts.

Two groups of PNFP providers were given a block grant and freedom on how to spend the grant, within the constraints imposed by a memorandum of understanding with the government. In addition to the block grant, one group was awarded bonus payments if they achieved self-selected output targets. These two groups were compared to a control group of PNFP providers, private for-profit and public facilities. Providers receiving bonus payments could choose three out of six pre-established performance targets. By meeting all the performance targets, facilities could obtain a maximum bonus of 11 percent of the block grant. Data collection for the study was also used to verify whether the targets were achieved.

After 2½ years and three survey rounds, the study found that 22 out of 23 facilities receiving performance-based bonuses did reach at least one performance target, up from 17 after the first year, and that 12 reached all three performance targets, up from only 3. Performance bonuses went up from 2.2 percent to 5.2 percent of block grants. As service levels in institutions receiving block grants also improved significantly, no systematic or discernable impact of bonuses on the provision of health services by the PNFP providers was found. However, it appeared that granting autonomy in financial decision making had a positive impact on health service provision. In addition, service providers were aware that the project included monitoring of provider performance, so poor performance would be identified and might affect their ability to obtain future funding.

Possible explanations for the low impact findings are that bonus payments were paid to facilities and not to individual workers and that they may have been too small to significantly affect the behavior of providers, particularly if the incremental costs of achieving indicators were higher than the bonus. Also, the performance of the providers receiving bonuses lagged behind the control group in the first 18 months of the project, but was better thereafter, which may indicate that bonus systems require time to start working. In addition, some of the smaller-scale PNFP providers mentioned problems with the extensive documentation requirements of the projects.

The Democratic Republic of Congo

In 2002, the Democratic Republic of Congo was emerging from civil war and decades of misgovernment and corruption. Aside from low and intermittent salary payments, the health system had not received significant public funding or international aid for over 10 years. Many public facilities were relying largely on user payments. Building on existing experience of partnership with church-based organizations and NGOs under the Health Zone system of public service providers, an IDA-financed multi-sectoral emergency project competitively selected 10 national (church-based) and international NGOs to develop and support services in 85 Health Zones, covering approximately 10 million people. The organizations do not directly provide services, but channel resources and technical support to the Health Zone system. The contracts between the project and the NGOs are performance-based in that they set out expected tasks and results and they can be cancelled by the government if performance is not satisfactory—which happened in the case of one NGO.

Targets	Goal
Increase total outpatient visits (OPD)	10%
Increase treatment of malaria among children	10%
Increase number of children immunized	10%
Increase number of antenatal visits	10%
Increase number of attended births	5%
Increase uptake of modern family planning methods	5%

At the same time, the NGOs enter into performance-based contracts with individual Health Zone administrations and facilities. Such contracts usually set out performance indicators, such as immunization coverage or outpatient consultation targets. Health worker incentives are tied to performance on a list of indicators, often summarized by a single score. Reports on achievement of indicators are verified by the health administration and NGOs. About 15 percent of the NGOs' budget is allocated to incentive payments for health workers.

Although it is difficult to attribute improvements directly to the performance-based design, overall results are encouraging. Reported annual per capita outpatient consultations in the covered Health Zones rose from 0.06 at baseline to 0.17 in 2003 and 0.30 in 2007. Measles immunization coverage is reported to have increased from 25 percent to 92 percent, and coverage of assisted deliveries from 25 percent to 74 percent. The reported average consultation fee in project areas has declined from US$4 to US$2. Although it is not clear whether improvements are attributable to the performance design or simply to the much higher level of public resources made available to the system, a simple comparison in the city of Kinshasa of project Health Zones with Health Zones receiving support under other modalities suggests better results in the former.

Drawing on this experience, a US$150 million IDA-financed health sector project is currently starting to provide support to an additional 89 Health Zones covering around 10 million people. The project has competitively selected five NGOs to implement seven contracts. As an innovation, the contracts include incentive payments tied to the overall performance of the NGO, measured by an independent evaluation agency. In turn each NGO enters into performance-based remuneration arrangements with the Health Zones and facilities they support.

Lessons learned

The three schemes outlined in this paper achieved some encouraging results, such as increases in assisted deliveries and measles immunization and improvements in health workers' performance. In all three schemes, service providers who are free to make decentralized decisions and are subject to the accountability that results verification brings, showed improved performance compared to providers funded on an input-basis. In two of the three countries (Rwanda and the Democratic Republic of Congo), performance-based contracting in the health system is now being scaled up to the national level.

What still remains to be determined, however, is the relative importance of performance-based project design compared to other factors, such as increased public resources (Democratic Republic of Congo) or the introduction of community-based health insurance (Rwanda). In Uganda, it was unclear whether block grants with performance bonuses were more effective than block grants alone. The results of comprehensive impact evaluations in Rwanda and the Democratic Republic of Congo may help to answer some of the remaining questions.

About OBApproaches

OBApproaches is a forum for discussing and disseminating recent experiences and innovations for supporting the delivery of basic services to the poor. The series will focus on the provision of water, energy, telecommunications, transport, health and education in developing countries, in particular through output, or performance,-based approaches.

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