

# 2022 6<sup>TH</sup> ANNUAL HEALTH FINANCING FORUM

## From Performance-based Financing (PBF) to Strategic Purchasing of PHC services

Financing Primary Health Care:  
Opportunities at the Boundaries

June 14-16, 2022

Co-hosted by:



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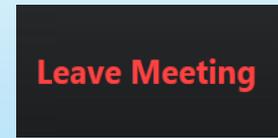
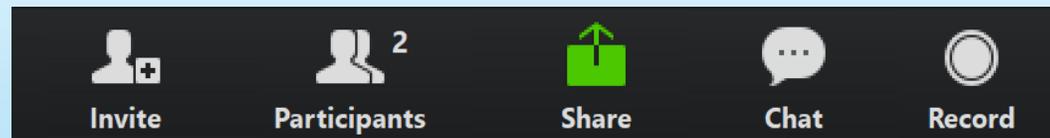
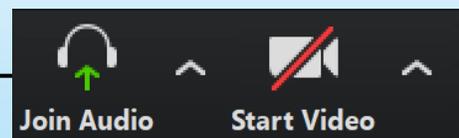
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# Interactions & Questions : **Virtual Participants**

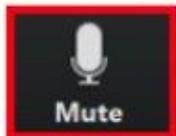
**\*Join Audio:** Select how you want to join the call; either by phone or through your computer.



**Participants:** Click here to see the list of participants in the meeting.

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# Interpreters Available

The screenshot shows a Zoom meeting interface. The main video area is dark. At the bottom, there is a toolbar with various icons. A red circle highlights the 'Interpretation' icon. A red arrow points from the text 'Select your language' to the language menu that appears when the 'Interpretation' icon is clicked. The menu includes options for 'Off', 'English', 'French', 'Russian', and 'Spanish'. Another red arrow points from the text 'Mute the original language audio.' to the 'Mute Original Audio' option in the menu. To the right, a 'Participants (8)' list is visible, showing several participants with their names and roles, including interpreters.

**Select your language**

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Zoom Meeting

Speaker View

Participants (8)

Find a participant

- KH Kara Howard (Host, me)
- A aidakereksizova (Interpreter)
- Taya Levine
- IG Iciar Gomez (Interpreter)
- E Elena (Interpreter)
- EP Esperanza Pombo
- K Karine Matusiak (Interpreter)
- KC Kristin Cairns (Interpreter)

Elena

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yes no go slower go faster more clear all

Invite Mute All Unmute All

June 14<sup>th</sup> / 13:00-14:30 EST

## Side Event 2

# From Performance-based Financing (PBF) to Strategic Purchasing of PHC Services



**Thiane Gueye**

Coordinator of the Health Economics Unit and President of the Women's Association, Ministry of Health and Social Action, Senegal.



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**Dr. Stephen Banda**

Director of Policy, Planning and Health Economics, Ministry of Health and Child Care, Zimbabwe.



**Eeshami Kandpal**

Senior Economist, World Bank



**Hamish Colquhoun**

Health Financing Consultant, World Bank



**Ellen Van de Poel**

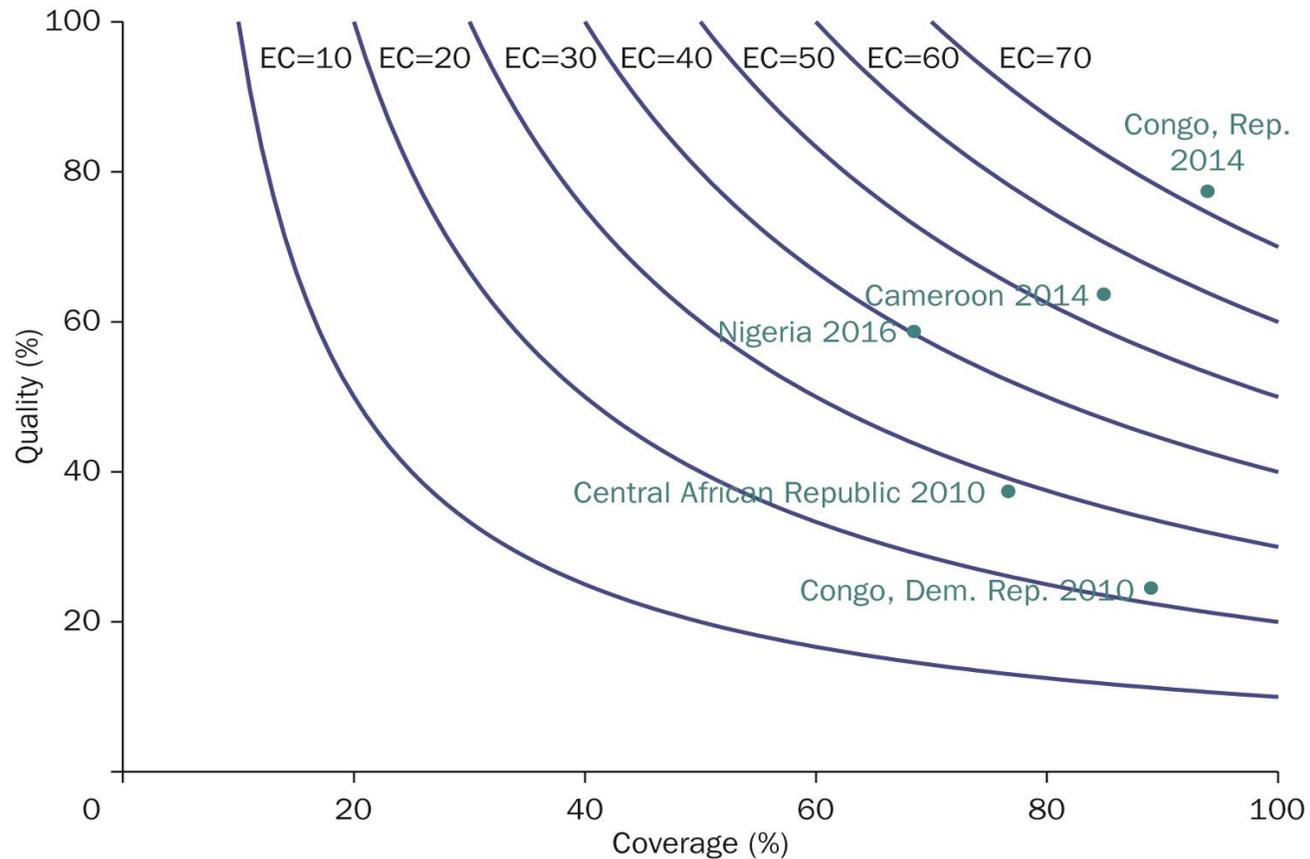
Health Financing Lead, WB/GFF

# Improving Effective Coverage in Health

## What this report does

- 1. What does the evidence say about performance pay in low-income country health systems?**
  - Assess impacts on coverage and effective coverage (health coverage with minimum content and quality) of [maternal and child health services](#)
- 2. What are the key constraints to quality?**
  - Which [constraints](#) to quality can be addressed by [performance pay](#).
  - Can we realistically expect it to improve quality? By how much?
- 3. Can demand-side approaches improve coverage and effective coverage of maternal and child health services?**
- 4. How do PBF projects compare to direct facility financing (DFF)?**
- 5. What are the key lessons for the design of health financing reform?**

# Quality of care is a serious problem: an example from coverage versus quality of antenatal care



Coverage: Percent of women giving birth who had 1+ ANC visits  
Quality: Of these, percent who had: 4+ visits, 1+ visits with skilled provider, blood pressure taken, and blood and urine samples taken (i.e. correct treatment).  
Data source: MICS

# Key findings on antenatal care quality

- **2/3<sup>rd</sup> of poor quality not attributed to poor worker effort**
  - Many competing constraints
  - Performance pay is unlikely to be a silver bullet
- **Wealthier women 3x as likely to receive high quality care than poorer women**
  - Lots of within-country variation in facility quality
  - But also some within-facility inequality: user fees; patient information
- **Health system financing remains a challenge but must address structural capacity, medical training, and worker effort**
  - Coverage versus effective coverage from available household surveys
  - Assess constraints to quality before designing interventions aimed at improving quality

# The bottom line: PBF projects vs business-as-usual

- **Coverage**

- In most contexts, **some improvements (Diaconu et al. 2021)**

- **Quality**

1. **Performance pay is not a silver bullet for worker effort in primary health care in low-income settings**

- Limited impacts of performance pay on clinical quality even with fewer competing constraints– US, UK (Glickman et al. 2007; Petersen et al. 2006)

2. **Largest impacts on quality of care are observed for structural quality**

- Not entirely surprising given large gaps in facility infrastructure and that only 1/3rd of underperformance is due to underused capacity

→ Are there more cost-effective ways of financing structural improvements?

# PBF and Direct Facility Financing (DFF) projects

## PBF projects

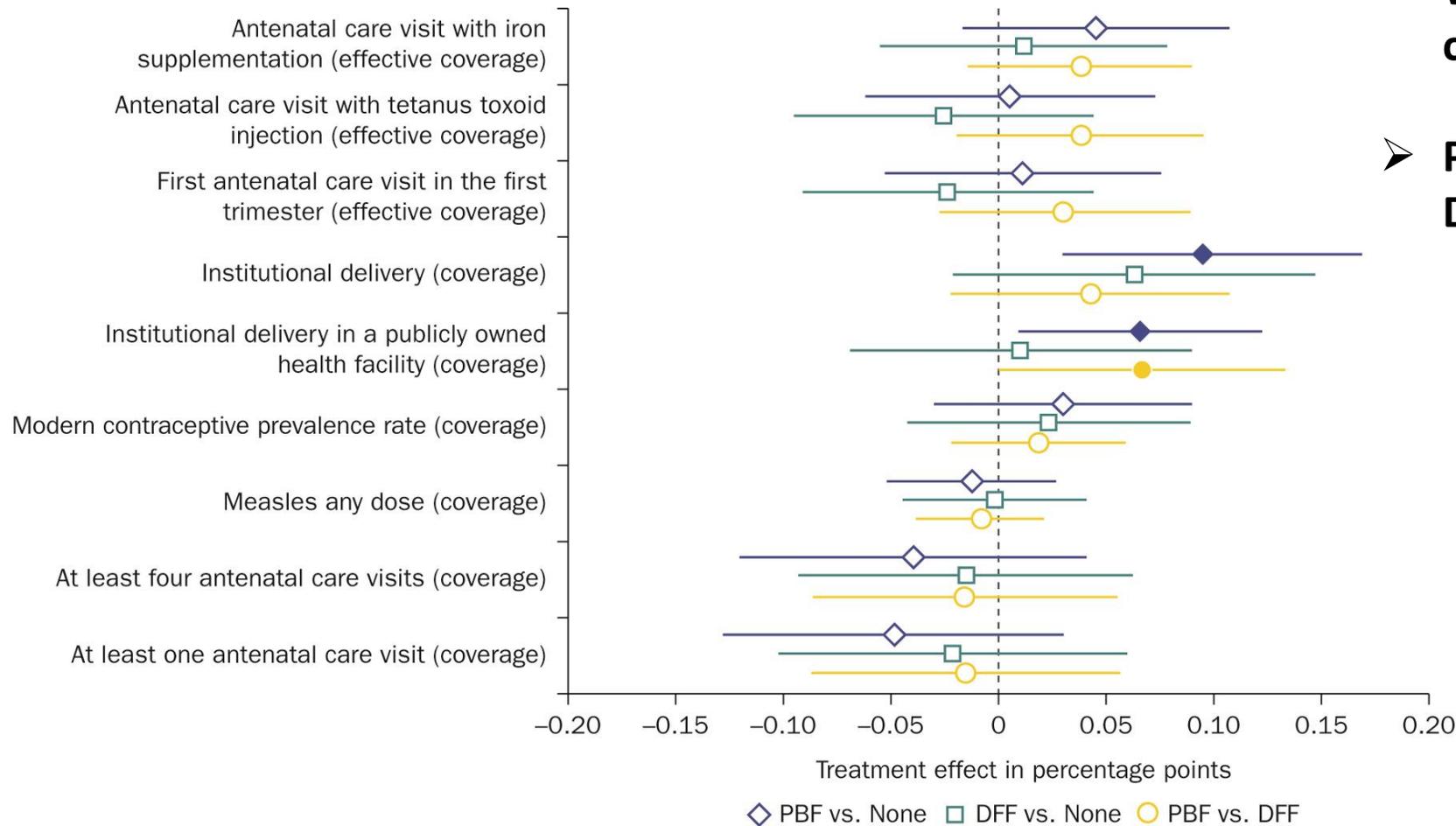
1. **Performance pay**
2. **Operating budgets/autonomy**
3. **Transparency/accountability:**
  - a) Facilities report performance on the purchased services– typically every month.
  - b) Payments based on these reports.
  - c) Third party audit of the reports, often every quarter.
4. **Community engagement**

## DFF projects

1. **Performance pay**
2. **Operating budgets/autonomy**
3. **Transparency/accountability:**
  - a) business plans, dashboards
4. **Community engagement**

- In WB (HRITF) PBF portfolio, 5 projects directly compare PBF and DFF approaches. We look at all of them.
  - Cameroon, Nigeria, Rwanda, Zambia, and Zimbabwe
  - Three also included a business-as-usual arm: Cameroon, Nigeria, Zambia
  - In two, PBF disbursed twice as much as DFF: Nigeria and Zambia

# The bottom line from all HRITF PBF projects and DFF projects: results from pooled analysis



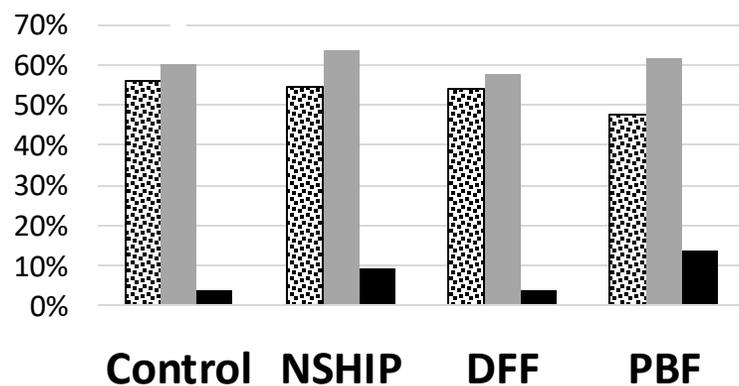
- We consider many indicators of coverage and effective coverage
- PBF projects only outperform DFF for institutional delivery.

# Nigeria: Experience with PBF/DFF highlighted impact of more facility level funding for PHC

3 Groups Compared	PBF	DFF	Control
Autonomy	✓	✓	Purposively chosen business as usual
Strengthened Supervision	✓	✓	
Payment	Payments for Quantity & Quality	Infrastructure Grants not linked to service delivery. Half the amount received by PBF	

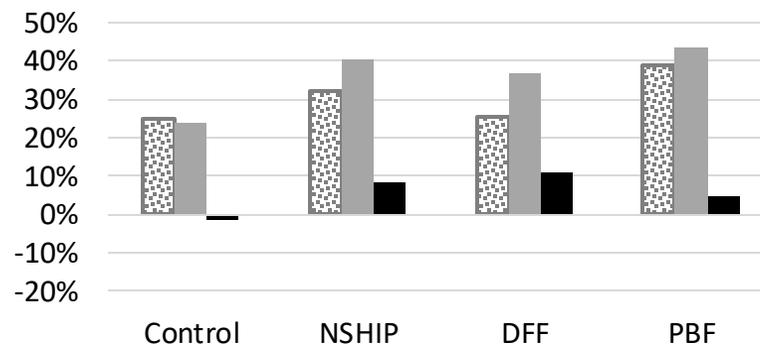
- Almost all NSHIP facilities improved quality whereas only half of control facilities did. No difference between PBF and DFF.
- No impact on health worker knowledge as measured by clinical vignettes.
- Significant improvements in clinical practice of on ANC and under 5 curative care.

**Percentage of births in any facility**



Baseline(2014) [Left y-axis]  
 (Midline-Baseline) [Left y-axis]

**Percentage of children aged 12-23 fully vaccinated**



Midline(2017) [Left y-axis]  
 Difference-in-Difference(DD) [Right y-axis]

# Our key takeaways

1. Little evidence for impacts for across-the-board performance pay in under-resourced, unfinanced health systems
2. **Direct facility financing with autonomy and accountability can deliver many gains** at lower cost and with relatively easier implementation.
3. **Before designing health financing reform:**
  1. Assess coverage versus effective coverage to identify “**low-hanging fruit**” for performance pay
  2. Assess constraints to quality of care to ensure they are in locus of control of the frontline worker
  3. Baseline utilization should have **room for improvement** but not be so low as indicate **demand-side** barriers.
4. **Combine demand-and-supply side approaches**
5. **Sequence interventions and use performance pay strategically**



# **Mainstreaming Results-based Financing in the Zimbabwe Health Sector's PFM System**

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# Assessment framework

- Assessment of PFMS alignment with RBF principles to guide reform options;
- Situation analysis organised by four pillars:
  - Performance orientation; Autonomy; Financial management capacity; Unified financing.
- Descriptive analysis – no ‘right answers’ about where system should be;
- Roadmap collaborative development with MoHCC and MoFED;
- Progress status:
  - Situation analysis complete and validated;
  - Roadmap options developed through workshop, now being formally drafted in report.

# Some key findings

- c.10% of GoZ health budget intended as RBF payments to facilities;
- Most other funding is input-based:
  - Significant opportunities to strengthen mechanisms for how these inputs link to results;
- At PHC level, FM capacity is low:
  - ‘Guided autonomy’ approach used for spending RBF, with strong involvement of districts;
  - Facility level autonomy for spending non-RBF funding is very limited;
- Timing of funding flows from central government can be unpredictable.

# Some planned reform actions

- Further strengthen roll-out of Program Based Budgeting:
  - Strengthen reporting structures, indicators and targets;
  - Ensure specific contributions of different provinces, districts and facilities to sub-program and program results targets are clear;
  - Facilities to become cost centres in the budget (from 2023);
  - Integration of RBF and PBB verification processes.
- Greater integration of overall health spending into IFMIS to ensure holistic data on spending which contributes to results:
  - Ex-post quarterly reporting of RBF spending;
  - Greater incorporation of donor spending and facility user fees;
  - Longer term aspiration for local government spending to be integrated into national budget.
- Improve communication to facilities on exact timing of funding flow release.

# POLL



Or

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# Discussion

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