PBF: AN OPPORTUNITY FOR THE PRIVATE - NOT - FOR - PROFIT SECTOR?

An interview with Bruno Meessen[1]

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Where does Performance - Based Financing (PBF) come from? Is it new? And if it is, what makes it new?

The history of PBF in low-income countries is so far an accumulative process of experiences that have inspired one another. To my knowledge, a project led by Management Sciences for Health in Haiti was the first time that health service providers were contracted and remunerated according to their coverage rate performance. The classical input based approach and the implicit standard behavioral assumption behind the approach – local actors are always committed to making the best use of aid resources for their population – were thus abandoned. Results were deemed sufficiently impressive to be broadly disseminated. Interestingly enough, the contracting was with national NGOs, a category of actors traditionally perceived as highly intrinsically motivated.

In Cambodia, the strategy was applied to the public sector. It started also from another angle. In Takeo hospital, the contract aimed to smoothen the departure of the supporting NGO, without destabilizing the achievements. The contract stipulated a rather straightforward way to compute the remuneration: instead of the traditional input based approach, from then on the hospital had to be remunerated proportional to the revenue gained from users. This was a simple but already very powerful way to define 'performance'. In Sotnikum and Thmar Pouk, the strategy was used in health centers and the district hospital, but the objective there was supporting the financing of health facilities in order to increase staff revenue in an effort to combat discouragement among the staff. In Pearang, the model was pretty similar to the Haiti experience. The issue there was the need to boost coverage of maternal and child health care services. Cambodia has been crucial to the understanding of what is possible in contracting matters with public health providers. The third big development took place in Rwanda. There, one has gradually, but with strong leadership displayed by the health authorities, clearly entered a reform logic, both with respect to the financing and the management of public or faith-based facilities. Without any question, Rwanda has been the first poor country to turn PBF into a strategic axis to develop its health system, and integrate the strategy unambiguously in the public budget. The scheme has also increasingly become more sophisticated in recent years in Rwanda, including in terms of quality measures.

Current knowledge on PBF learns us that there are a number of strengths and weaknesses. On the positive side, there are the improvements in performance, productivity, staff motivation, morale and interactivity, availability of (quality) documentation. On the negative side, there is the increased burden of administrative tasks, possibly at the expense of the delivery of care, the potential gaming, the possible distortion in care, etc. If the contractual arrangements in which the Faith-based facilities would engage take the character of PBF (or PBC i.e. Performance-Based contracting), how could positive elements be optimized and negative effects restricted?

In fact, I believe that we should avoid misunderstanding to begin with. Every type of contract has its strengths and weaknesses. The main drawback of the traditional input based contracts is the fact that they tend to reinforce the top-down bureaucratic logic and can deal a fatal blow to the sense of initiative of the managers of health facilities. Obviously low productivity is often the result.

With a contract relating payment to the achievements, one does not pretend anymore to decide in the place of managers on the 'how', rather one is very explicit on the results one is expected to produce. But obviously there are also downsides. The key question is whether the advantages outweigh the disadvantages. In my opinion, in a low coverage, low productivity and bureaucratic environment (e.g. the public sector), the PBF approach has obvious appeal.

Another frequent misunderstanding is to perceive health facilities today as functioning fully under an input-based approach. The

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truth is that user fees are an output-based mechanism; yet only curative services are charged; then, this creates an incentive to overlook preventive services. In Rwanda, the first move was to introduce PBF for preventive activities. Interestingly enough, the unit fees paid by the third-party for preventive services rapidly led health centers (especially faith-based ones which tended to over-develop their curative services) to pay much more attention to interventions with high impact for children and mothers.
Having said this, I want to stress two caveats of the approach: (1) there are numerous dimensions of the performance of health facilities that are extremely difficult to measure; in that case, PBF is probably not the right track; personally, I am very concerned about the efforts made by some to turn PBF into a general approach for the whole health administration. That looks dangerous. (2) The second caveat concerns the fact that sooner or later each way of financing has to be revised in order to correspond to new challenges. The difficulty in this respect is what is commonly referred to as 'path dependency': stakeholders refuse to drop a model that suits them just fine. For example, everybody agrees that the American health care system is today very problematic due to the incentives towards overproduction built in the system, yet it will obviously require an enormous amount of political capital and struggle by the Obama administration to reform this flawed system.
I see one major advantage of the PBF approach for Faith-Based Organizations: it acknowledges that their services should be remunerated as much as services provided by public facilities. In fact, the distinction between public and private loses much of its relevance. One must be vigilant that the government is fair in its treatment of the different types of providers, but there are institutional arrangements and principles such as the separation of functions that (can) mitigate such a risk. For the public providers, the main advantage is that the logical next step of the strategy is to award them more autonomy. In fact, their status moves closer to the status of FBOs. A problematic aspect in some countries is the family planning issue. Under PBF with a public aim, the purchaser may prefer to remunerate modern contraceptive methods. With PBF, the loss of income for FBOs refusing to offer these methods is obvious. But maybe this is not a bad thing.

Are the negative effects that we have documented in our research in Uganda (PEPFAR contracts with faith-based hospitals) intrinsically related to PBF or rather to other factors, e.g. deficiencies in the current PNFP/Public sector relationship?
The truth is that one ought to have a holistic vision of the institutional arrangements that structure the health system. In context A, the optimal contract will be this or that, while in context B, the ideal contract will be different. If the contract is set up the wrong way, perverse effects will result.

Relational contracts (still) are the rule in Public-/ Faith-Based health sector relationships. What about the application of PBF contracts in this specific context: is it indicated? And what is your opinion about the future of relational contracts?
So far the main contract has been the convention. This type of contract is traditionally rather general and not specific to the health facility. The contract is thus what economists call 'incomplete', as is the case with public facilities. Furthermore, if I am correct, these conventions are quite vague in terms of duration. This means, among other things, that poor execution cannot really be sanctioned by the non-renewal of the contract. History has shown that governments were often the actors not respecting their financial commitment. This indicates a third shortcoming: FBO have no real means to sanction the government, as the main victims will be the population – a well-known problem for all those with a humanitarian commitment, i.e. intrinsic motivation.
The PBF contract is much more 'complete'; the health centre knows exactly how much it will earn if it produces the required amount of different kinds of activities. Furthermore, if the manager's individual income has a performance-based component, he gets immediately a reward for his initiatives and efforts. He does not need to worry anymore whether his good performance will be noticed by his superior and rewarded one day by a promotion. Such a rapid reward for effort is valuable in settings where the future is uncertain and needs quite urgent.
I believe that in the future more explicit performance related contracts could become the norm in low-income settings. Having said that, there will always be elements that are less suitable to contracting, like the response to a sudden epidemic.

The Faith-Based health sector is characterized by a high level of staff commitment, important intrinsic motivation and strong professionalism. The major problem in the Faith-based sector however is the increasing scarcity of financial and human resources, whereas the use of PBF with public sector facilities is precisely seen as a means to boost of staff demotivation and professionalism. Under these circumstances, would PBF be an appropriate strategy in contracting policies with the Faith-based sector? Or would you propose other contracting models than PBF to be considered in the case of the Faith-based sector?
One danger is obviously that extrinsic motivation could jeopardize or even crowd out intrinsic motivation. Nevertheless, I think that with a well conceived model one can avoid or at least decrease this risk. PBF is above all a way to remunerate health facilities and their management team. I do not like too much the emphasis on the performance related bonuses. That creates confusion in the minds of people: performance will always be broader than one can measure. But PBF is also a somewhat hidden strategy to increase the income of health staff without getting into an open conflict with the IMF. Hence, this might overcome part of the current brain drain problem. I believe that the faith-based sector has potentially a lot to gain from PBF. Anyhow, this will boost and confirm their innovative and strong performance capacity. Make no mistake though: as we have seen in Rwanda with PBF, public providers could very well wake up too. One way or another, the population will benefit.

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