Reflecting on innovative health financing: Findings from research on PBF in fragile and humanitarian settings

Maria Bertone

Institute for Global Health and Development

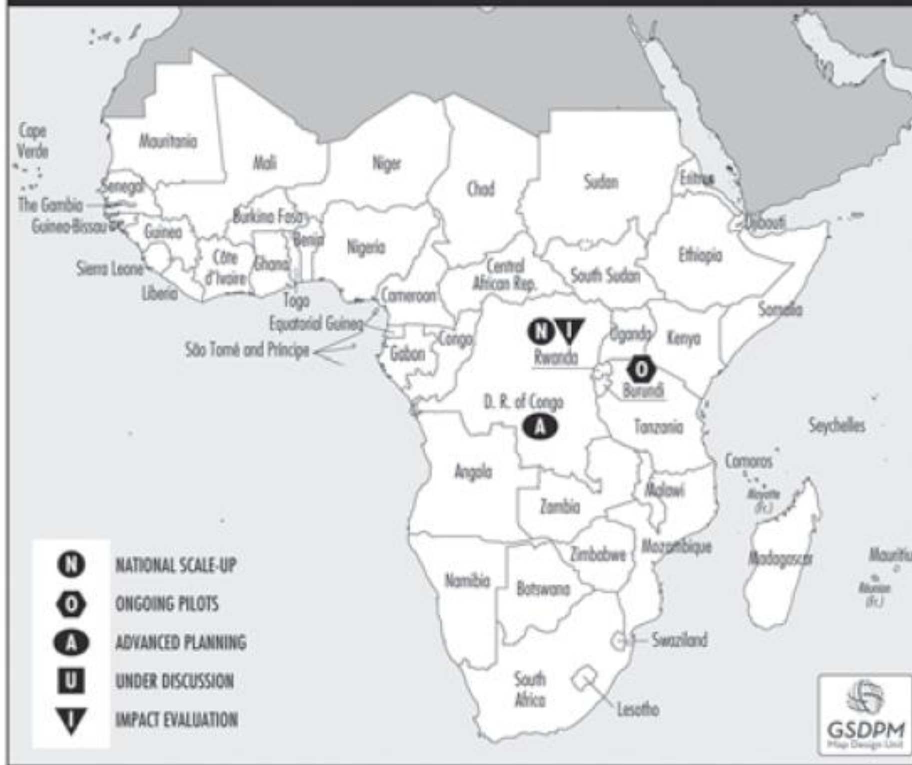
Performance based financing

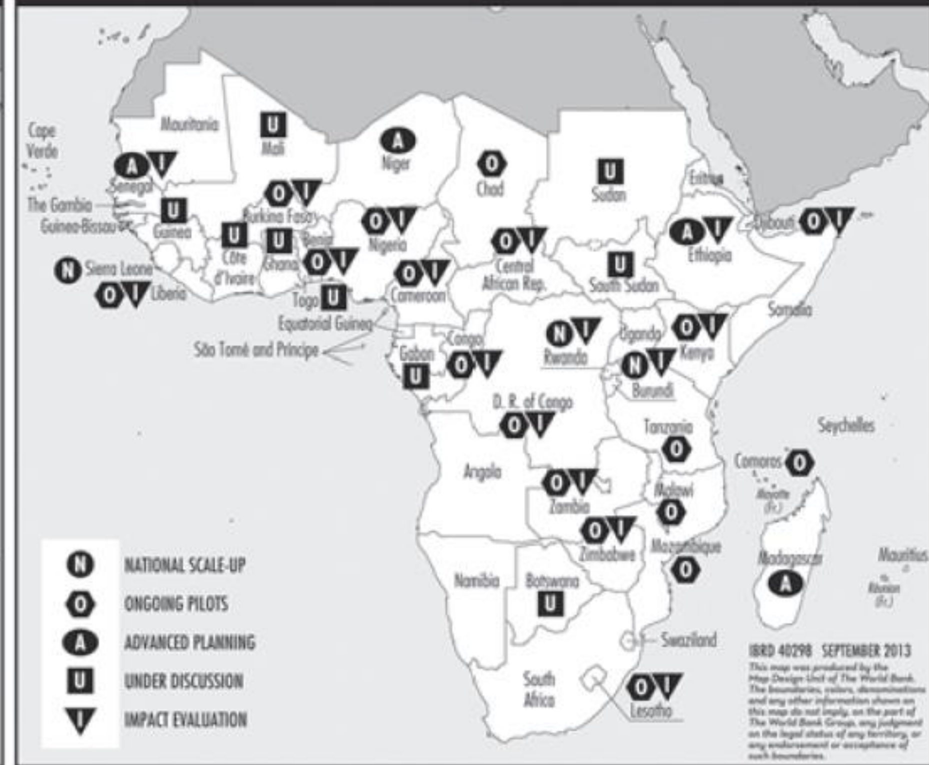
An 'innovative' health financing mechanism

- PBF aims to improve health services by providing bonuses to service providers (usually facilities, but often with a portion paid to individual staff) based on the verified quantity of outputs produced, modified by quality indicators.
  - In many cases, there is a separation of functions between regulation, purchasing, fund-holding, and service delivery
  - Envisages autonomy of providers to define service provision strategies and how to spend funds (PBF 'principles')
- Seen as a (potentially) systemic reform (Meessen et al, 2011)
- Not totally new idea, already adopted in HICs. Has expanded rapidly across low and middle countries, over the last decade

Performance based financing

Diffusion in sub-Saharan Africa





Source: Fritsche et al., 2014

PBF in fragile and conflict-affected settings

How does 'context' affect PBF?

- Relatively little work on how context affects PBF
  - Conflicting arguments: some argue that PBF is unlikely to be effective in fragile settings. Others point out that precisely in situations of weak institutions there is more potential for PBF to re-align relationships and improve accountability

→ Literature review to explore the extent to which *context* influenced the adoption, design and implementation of PBF schemes in fragile and conflict-affected settings (Bertone MP, Falisse J-B, et al, 2018)

→ Where? When? Why? How?

Where?

PBF adoption in FCAS

- 23 (43%) out of 53 FCAS countries have/had at least one PBF programme
- 19 (56%) out of 34 PBF programmes in SSA are implemented in FCAS

Afghanistan	Comoros	Guinea	Nigeria
Burundi	Congo (Republic)	Guinea Bissau	Rwanda
Cambodia	Cote d'Ivoire	Haiti	Sierra Leone
Cameroon	Djibouti	Lao PDR	Tajikistan
Central African Republic	DR Congo	Liberia	Zimbabwe
Chad	The Gambia	Mali	

When?

PBF adoption in FCAS over time

- All PBF programmes in sub-Saharan Africa implemented before 2006 are in FCAS settings (Rwanda, Burundi, DRC, Cameroon, Cote d'Ivoire)
- The first (and, for now, only) countries to have scaled-up PBF nationwide are Rwanda (2008), Burundi (2010) and Sierra Leone (2011)

Why?

Patterns and drivers of PBF adoption in FCAS

- Low levels of interpersonal trust, need to strengthen accountability and good governance to which PBF is seen as contributing
- Lack of trust between donors and government and fiduciary concerns
  - PBF is seen to address by setting up an independent cash flow system directly to facilities
- Flexibility (or absence) of strong institutions
- Less entrenched interests and power relations
- Decentralization and facility autonomy?
  - Often present in practice because inherited from the conflict period, but rather *de facto* realities than openly acknowledged policies

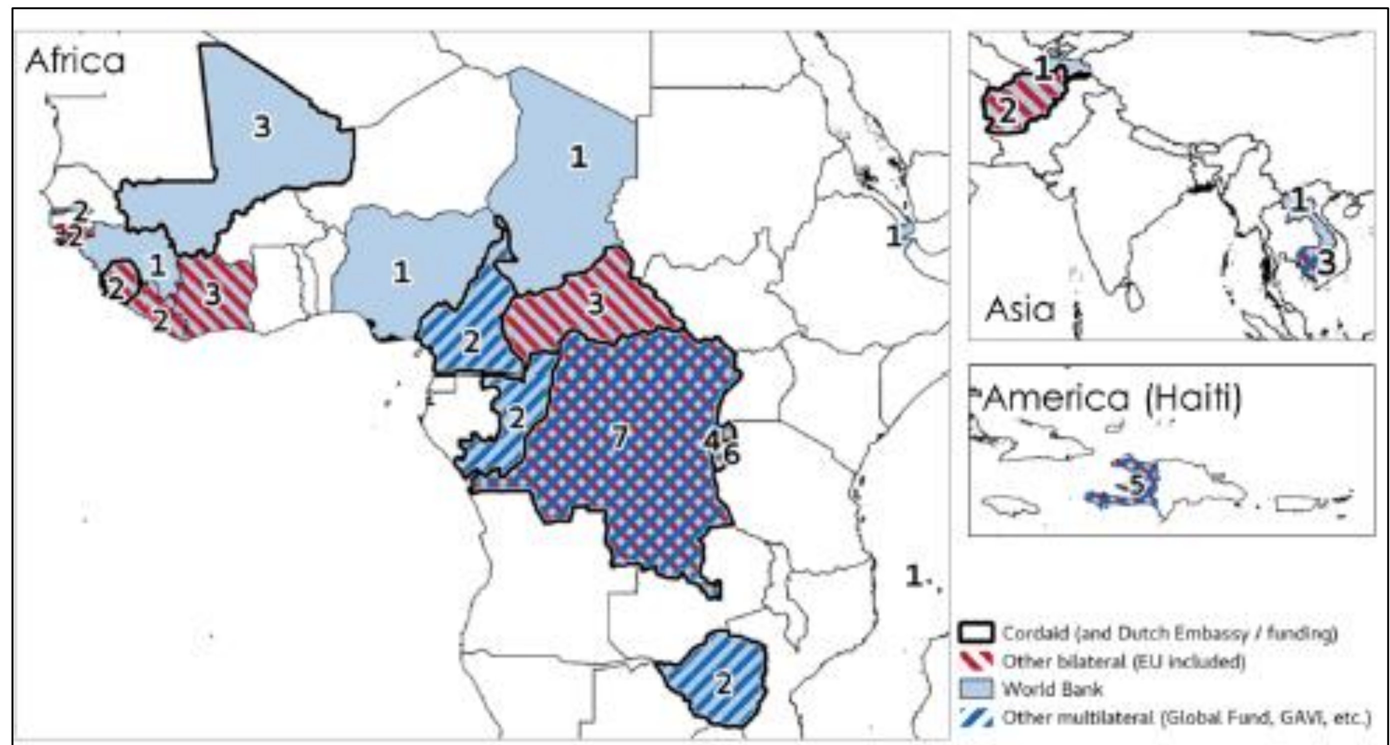
Why?

Patterns and drivers of PBF adoption in FCAS

- Larger-than-usual place of external actors
  - PBF diffusion via influential agencies, platforms and individuals
  - Advocacy and funding opportunities played a more important role as driving forces than the availability of evidence

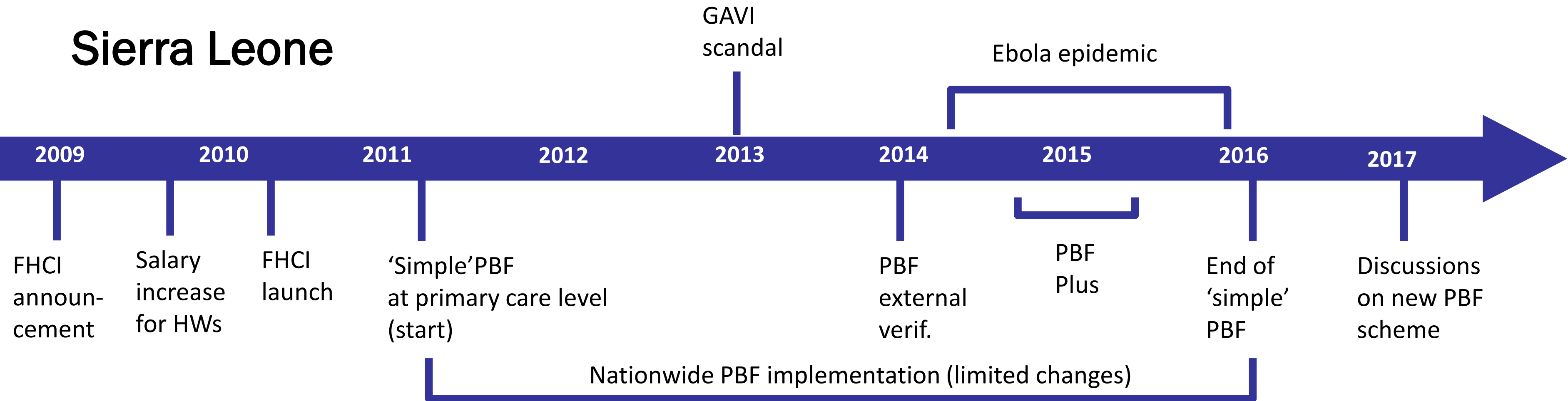
Case studies:

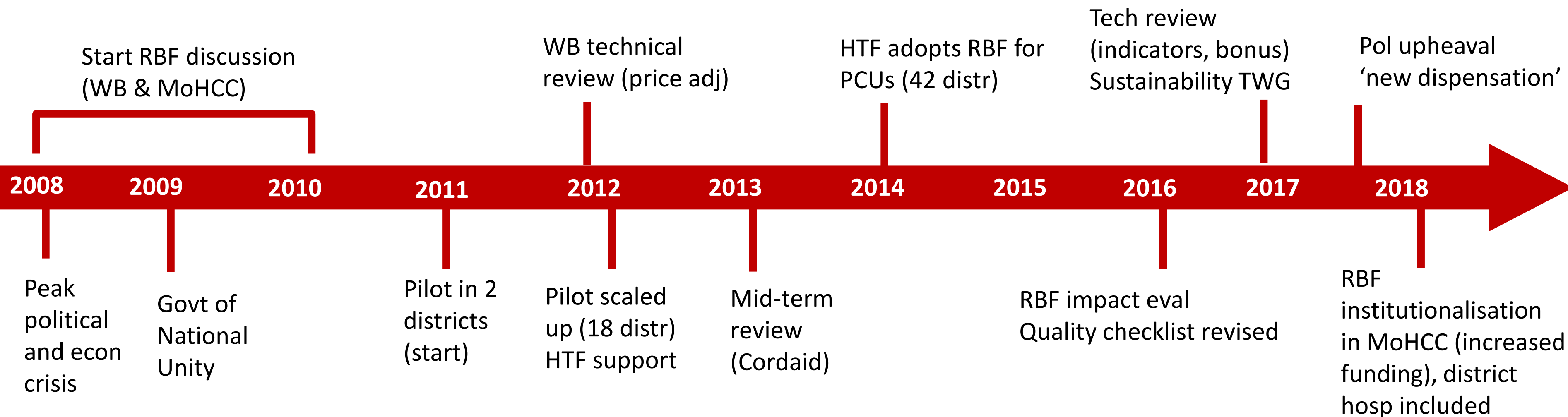
- Sierra Leone
- Zimbabwe



The political economies of PBF adoption

Examples from Sierra Leone and Zimbabwe





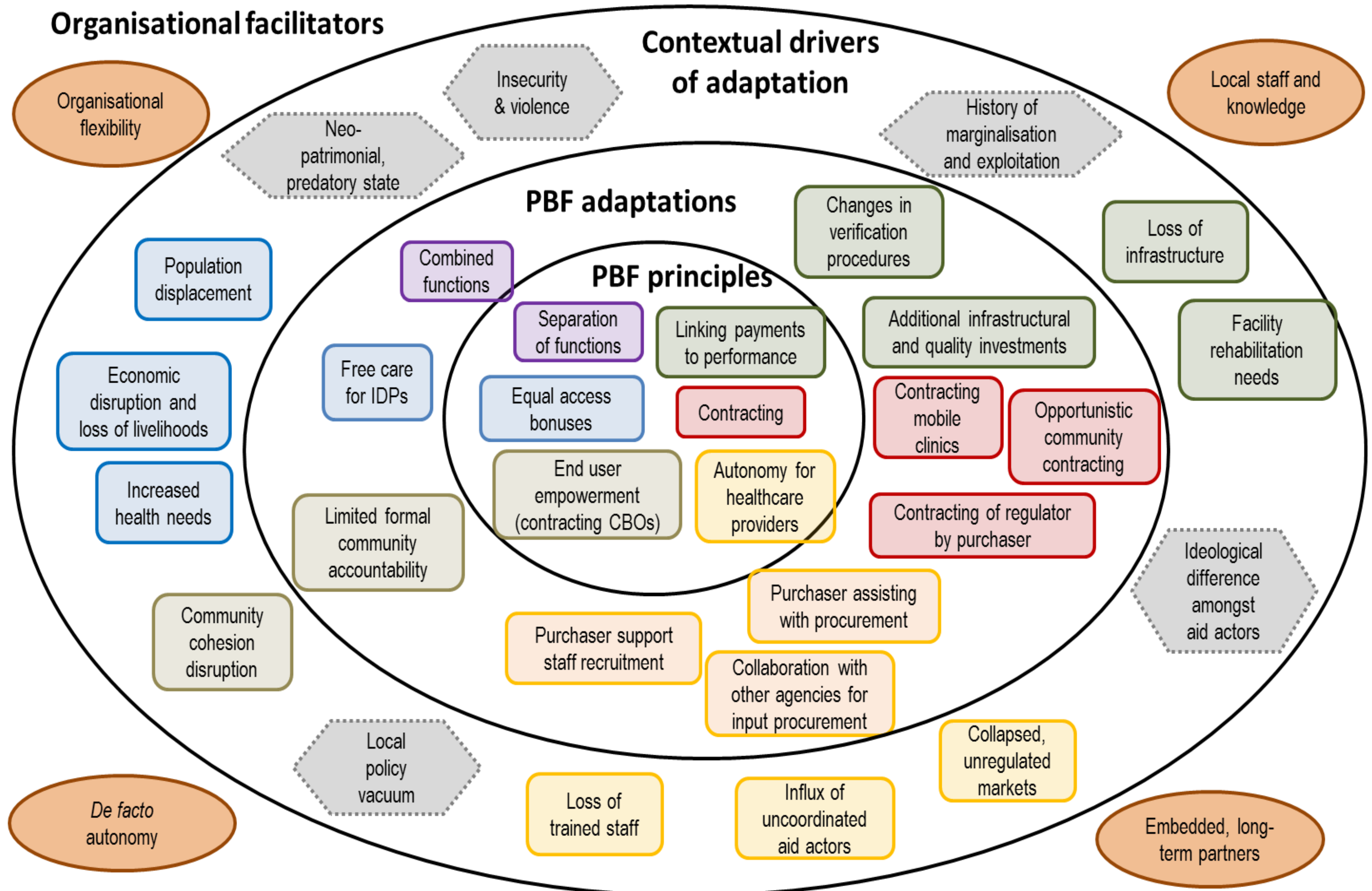
How?

PBF implementation in FCAS

- Very little evidence on how PBF effects on the health system are mediated by features of fragility.
- PBF sustainability (whether PBF continued over time)
  - Examples of start-stop(-start again?) approaches (Sierra Leone, Chad)
  - Sustainable schemes (Rwanda, Burundi) where PBF was linked to broader health financing/system reforms.
- Adaptation in design and implementation of PBF
  - Many schemes appeared to be a copy-and-paste from the first Rwandan project
  - Evidence of adaptation in acute, humanitarian crisis → case study on Central African Republic, northern Nigeria, eastern DRC (Bertone MP, Jacobs E, et al, 2018)

PBF implementation in humanitarian settings

Findings from a comparative case study



PBF and fragility

Some concluding thoughts

- More space for innovation in FCAS, or external pressures? Or both?
- Does PBF rebuild accountability and trust where they are most lacking, or simply circumvent the problem?
- Flexibility and adaptability are essential, as well as local knowledge and long-term engagement
- Important to move away from ‘silos’ (e.g., humanitarian vs development interventions)

References

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