Performance-based financing as a way to build strategic purchasing in FCAS: potential and pitfalls

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What is PBF?

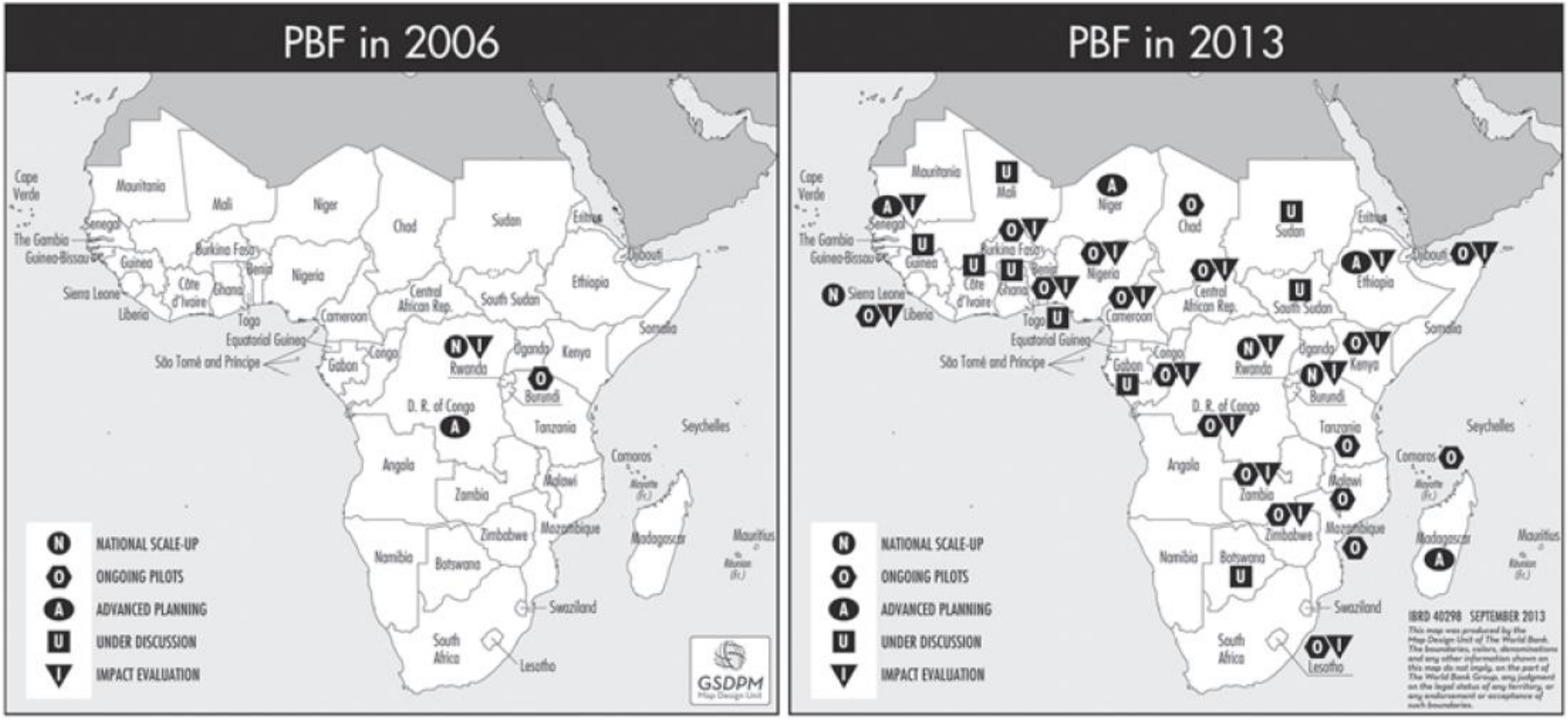
- Many different forms and terminology within the RBF school

- PBF aims to improve health services by providing payments 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 division of functions between regulation, purchasing, fund-holding, and service delivery

- It has expanded rapidly across low and middle countries, over the last decade, and especially in FCAS settings, but relatively little work on how context affects PBF

  - Conflicting arguments: some argue that PBF is unlikely to be effective in fragile settings while others point out that precisely in situations of weak institutions there is more potential for PBF to re-align relationships and improve accountability

PBF in sub-Saharan Africa



Source: Fritsche et al., 2014

Patterns of 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	

Bertone, M., Falisse, J-B., Russo, G., Witter, S. (2018) Context matters (but how and why?) A hypothesis-led literature review of performance based financing in fragile and conflict-affected health systems. *PLOS ONE,* 13(4): e0195301.

PBF adoption over time

- All PBF programmes in SSA implemented before 2006 are in FCAS settings (Rwanda, Burundi, DRC, Cameroon, Cote d'Ivoire)
- The first countries to have scaled-up PBF nationwide are also FCAS: Rwanda (2008), Burundi (2010) and Sierra Leone (2011)
- Appears to have been a successor to PBC model supported earlier by donors in FCAS (Cambodia, Haiti, Afghanistan and Liberia)
- Often multiple schemes – e.g. DRC (7) and Burundi (6) over past ten years

Some of the PBF controversies

1. Drivers

Adaptation to local needs or donor-driven?

2. Fit to context

Flexible or copy/paste?

3. Implementation

Plan versus reality

4. Health system impact

HSS or vertical distraction/adding to fragmentation?

5. Equity

Enhancing or undermining?

6. Efficiency

Increasing efficiency or costly distraction?

7. Quality of care

Promoted or neglected?

8. Effectiveness

Especially in relation to health outcomes

9. Mechanisms of change

Money, incentives, clearer roles, local autonomy, skills building, feedback on performance – all or which of the above?

10. Spillover effects

System reformer versus gaming, demotivation etc.

11. Tensions in the model

Autonomy versus control

12. Sustainability

Institutionalising capacity and funds

Overall questions for panel and audience

In FCAS settings:

1. Has/can PBF improve the accountability and functioning of purchasers?
2. Has/can PBF improve the engagement with and responsiveness to populations of the purchasing system?
3. Has/can PBF improve the effectiveness of provider payments?

How? In which contexts? With which designs and at what cost?

Our panel

1. **Maria Bertone, ReBUILD –** reflections on adoption of PBF in FCAS and its impact on relationships in the health system

2. **Eelco Jacobs, KIT –** lessons from adaptation of PBF in humanitarian settings

3. **Manjiri Bhawalkar, Global Fund –** funder's perspective on PBF and evidence needs

4. **Jos Dusseljee, Cordaid –** view from an implementer – designing and implementing PBF in FCAS settings

5. **Gwati Gwati, Ministry of Health, Zimbabwe –** reflections from the MoH on RBF/PBF, its past contribution and future potential

6. **Isidore Sieleunou, PBF Community of Practice member and researcher -** reflections on PBF research and its contribution to practice

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